STANDING COMMITTEE ON HUMAN SERVICES

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STANDING COMMITTEE ON HUMAN SERVICES

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Dakota-Arm River

[The committee met at 15:32.]

Chair Keisig: — Welcome, everyone, to the Standing Committee on Human Services. I am MLA [Member of the Legislative Assembly] Keisig and I am chairing the meeting this evening. We are joined today by MLA Chan, MLA Bromm, MLA Kropf, MLA Burki. MLA Roy is subbing in for MLA Blakley, and MLA Conway and MLA Teed are joining us today as well.

We'll be starting our meetings here today with the consideration of two bills, which will take us till the 4:30 recess, and we'll be back at 5:30 to move into consideration of Health estimates.

Bill No. 36 — *The Change of Name Amendment Act, 2025*
Loi modificative de 2025 sur le changement de nom

Clause 1

Chair Keisig: — Our first order of business is the consideration of Bill No. 36, *The Change of Name Amendment Act, 2025*, a bilingual bill. We'll begin with consideration of clause 1, short title.

Minister Cockrill is here with officials from his ministry. I would ask that officials please state their names before speaking for the first time, and please don't touch the microphones. The *Hansard* operator will turn your microphone on when you are speaking to the committee. Ministers, please introduce your officials and make your opening remarks. And Minister Carr is joining us as well.

Hon. Jeremy Cockrill: — Thank you, Mr. Chair and committee members, for joining us for consideration of these two bills. Obviously Minister Carr has joined me as well here, and from the Ministry of Health we have Tracey Smith, Norm O'Neill, and Tami Denomie. Also from eHealth Saskatchewan we have Jennifer Lindenbach.

In lieu of opening comments, I'll let my comments from the second reading speech on both pieces of legislation stand, as well as the news release which has been publicly available since the introduction of these bills. And happy to answer any questions from committee members.

Chair Keisig: — Thank you very much, Minister. I will now open the floor for questions. MLA Teed.

Nathaniel Teed: — Thank you very much. So one of my responses to the bill in adjourned debates went around the privacy element of name changes. And I'm wondering if this bill makes any attempt to ensure the privacy of individuals as they go through the name change process.

Hon. Jeremy Cockrill: — So in terms of the privacy of individuals who are changing a name, the really only maybe significant difference would be around changes to spousal notification in *The Change of Name Act*, which I think actually would be an improvement in privacy for individuals. But most of the amendments speak to naming conventions and so on.

The other pieces — I mean obviously some of the amendments — talk about interaction with law enforcement agencies. And obviously, I mean, if law enforcement agencies are requesting information, that would be for legitimate reasons, potentially a missing persons case or so on. So no significant change to privacy. In fact, if anything, an enhancement with the spousal notification change.

Meara Conway: — On the spousal notification piece, you've gotten rid of the requirement to provide proof that a spouse is aware of a name change. Is that in relation to . . . Like, a domestic partner, is that in relation also to a child that you share potentially with that partner? Can you speak to that?

Hon. Jeremy Cockrill: — So in a case of a couple, you would still maintain the requirement to have both parents be aware of the name change of a child. Obviously if there is a custody agreement, then eHealth would be looking at the custody agreement to understand who has decision-making power. Shared custody agreements still require, you know, the notification and consent really of that. If it's a situation where one parent has full custody and full decision-making power, obviously eHealth would take that into consideration as well.

Meara Conway: — Can you speak to this strengthening of privacy, particularly in the intimate partner violence context? Like our understanding is that these changes have to be published in *The Saskatchewan Gazette*. So is that correct? And are you waiving that requirement in this situation? Like how are there added protections to privacy now in that context? Can you just lay it out in more granularity please?

Hon. Jeremy Cockrill: — So obviously the changes in the legislation speak to the spousal notification. There are existing regulations around that are not changing as part of this because they are in regulation. In terms of criteria set out for non-publication, those regs are not changing.

Obviously if the situation meets the criteria set out in regulation — witness protection, an instance of domestic violence, you know, safety obviously being the main consideration here in terms of the individual's safety being compromised — then that would not be published in the *Gazette*, as long as it meets those criteria as laid out in the regulations that are not changing.

Nathaniel Teed: — You mentioned a couple of the criteria as to why names would not be published in *The Saskatchewan Gazette*. Do you have a full list of criteria that would mean a name not published in *The Saskatchewan Gazette*?

Meara Conway: — And what is the process for kind of making the case that you are covered by one of those exceptions? If you could just clarify it for us. Do you understand the question? Yeah, okay. Thanks.

Hon. Jeremy Cockrill: — So maybe I'll just speak to the process part of the question first, and then talk about the exemptions. So the process part, I mean if you're seeking an exemption of publication, you would select that as part of your change-of-name application.

[15:45]

It's my understanding that eHealth reviews that request prior to processing the change of name. My understanding is there's some instances where somebody may request a change of name, but if they don't meet the exemption requirements, they may choose to not go ahead with that change of name. So that kind of speaks to the order of operations, if you will, of how eHealth handles those.

The exemptions laid out in section 5 of the regs, I can read them here or refer you to look at section 5. I mean it talks about, you know:

> a person who:
>
> has been or will be a witness in a criminal proceeding; or
>
> has provided information to the police in relation to a criminal investigation;
>
> a person, other than a person mentioned in clause (a), who has participated in or will participate in a criminal proceeding; or
>
> a person who is related to or closely associated with a person mentioned in clause (a) or (b).
>
> A person who is under the age of 15 years when the person's name change is registered pursuant to section 10 of the Act is exempt from the requirements of subsection 14(1) of the Act.
>
> For the purposes of subsection 14(1) of the Act, the director is not required to publish a notice of a change of name in the *Gazette* if, in the opinion of the director:
>
> (a) publication of the notice would be contrary to the public interest; or
>
> (b) publication of the notice would cause undue hardship for the applicant or any other person who is a subject of the application.

And that one right there — that's 3(b) — that would be the one that was referred to most when there is an exemption granted. And it goes on in terms of others, but I would just refer members to section 5 of the regs.

Meara Conway: — I appreciate that. And I'm sorry. I neglected to put the regulations in my binder, but I did save many trees in the process. Where I'm going with that is just, I guess, specifically because there's no intention to change the regulations is my understanding, is the mechanism to ensure that a change of name is protected in a domestic violence context, is that usually then under . . . sorry, you said 3(b) is the most commonly utilized? Would that capture those situations where someone's made the case that they don't want to publish the change of name for reasons of like fear, having to do with domestic violence?

Hon. Jeremy Cockrill: — Yeah, and again, if you could take an opportunity to read that at a later time, I mean it does . . . The wording there I think speaks directly to that. You know, "publication of the notice would cause undue hardship for the applicant or any other person who is a subject of the application." So I think that speaks to instances where somebody feels as if their personal safety might be affected.

Meara Conway: — I'm just wondering. Along that vein — one of the things that particularly my colleague, who has a relevant critic area, has been hearing about — we see increasing instances where, particularly in the trans community, there are applications for name changes and that comes with concerns around privacy. We know statistically that trans folks are more likely to experience threats.

Was there any attempt to consult with the trans community? And are you aware of whether applications for exemptions for name changes in the situation of a trans youth or adult, whether they are typically granted exemptions under that broad definition of undue hardship?

Hon. Jeremy Cockrill: — So maybe I'll just . . . I think there's some important context here. So you know, roughly it's about 1,000 change-of-name requests across the board. The number of exemption requests, I understand over the last several years — it's been about 20 or 30 years — so 2 or 3 per cent of all applications.

You know, there have been some changes in internal processes at eHealth so that one person reviews all the exemptions so it's treated consistently, right, rather than having different officials look at different applications. There's consistency in terms of how it's applied.

I will say that whether it's somebody who's experienced and been a victim of domestic violence and is seeking to change a name, or whether it's a member of the trans community, there does have to be rationale of the undue hardship that's mentioned in the legislation. And that's consistent across all applications for exemption. It is not just kind of repeating what's in the legislation, but actually explaining what that undue hardship is and understanding, you know, from a legal perspective that there has to be some burden of proof put on the applicant in terms of explaining that.

Meara Conway: — Of the 2 per cent or so of these name changes where an exemption has been requested, are there examples where an exemption was granted to a member of the trans community?

Hon. Jeremy Cockrill: — So recently most of those 20 or 30 applications a year have been from members of the trans community in Saskatchewan. I think it's important to note that the approval rate across the board for exemptions is . . . I don't have that number, but it's rare that an exemption is not granted. And again sometimes it's a case of eHealth seeking more information.

Again to explain what I talked about, like the rationale of undue hardship, but my understanding is it's rare for an exemption not to be approved. And again speaking to the changes made in the last year and a half, two years, that's again developing those consistent internal processes so that, you know, again if there is undue hardship that an individual may feel, we obviously don't want to force them to publish their name.

Meara Conway: — Thank you for that. I understand you don't have necessarily this data today, but I'm just curious. Does eHealth internally track the stated reason for the request around the exemption and then the acceptance rate, so to speak? And you know, we update legislation so rarely and so I'm just wondering if there's any appetite to, in the regulations, identify some of those underlying reasons for exemptions that come up again and again.

I can think, for example, in a domestic violence context you don't always have proof, so to speak. And I say this as someone who worked as a defence lawyer with Legal Aid for years. I can't tell you how many domestic violence trials I actually ran, because often complainants just don't show up. So to have a smoking gun, you know, is very tough from a legal perspective. So you know, it strikes me that the burden is put on the individual to prove the exemption.

And I'm just wondering if we know . . . You know, we have high rates of domestic violence. We know we have a particular, maybe, safety risk in the trans community. Is there any thought being put to enumerating any of these contexts in the regulation to kind of streamline that or give folks that are coming at that from this perspective, you know, one less barrier, so to speak?

Hon. Jeremy Cockrill: — When you say "enumerating," do you mean like a reporting of previous statistics within the regulations? Or what do you just specifically mean by that? Sorry.

Meara Conway: — Yeah, sorry, I should be more clear. So there's like a definition of undue hardship, but commonly you'll see in legislation, "including but not limited to" a situation of domestic violence, being a member of the trans community. You know, there's ways of kind of identifying these frequent reasons for exemptions that just kind of tip off your officials to the fact that, you know, there's a reason these exemptions exist. They keep coming up again and again in these particular communities.

And then sort of an opportunity, I guess, to take away some of that burden on the individual, especially in these situations where — especially I think of interpersonal violence — where it's very difficult to prove that you're a victim of interpersonal violence from a legal perspective often.

[16:00]

Hon. Jeremy Cockrill: — So we don't internally track right now the reason for that. I mean there will be regulatory changes, you know, if this Act were to be passed coming down the road. Something we can look at, I guess. I would just say though, you know, any time you're dealing with a relatively small number of situations, then there's privacy considerations around that.

You know, you raise an interesting question around burden of proof, and a fair question I would say. You know, the burden of proof on the individual, it's not tied to a charge. So it's probably lesser of a burden of proof to change your name than it is in a court of law. So again, I think this is where having the consistency of one person reviewing all the applications, I think, is important in terms of making sure that approach is consistent across those 20 to 30 people a year.

Meara Conway: — Yeah, and just to be clear, like I'm talking about the burden of proving undue hardship specifically for the exemption. And it's a funny thing, burdens of proof. Like I can think of a peace bond situation where courts are pretty flexible in terms of accepting the word of someone that they don't feel safe, for example, in ordering a peace bond. But these burdens do exist, and I think there's ways through legislation or regulation where we can just kind of ease some of those barriers, where we know this comes up again and again.

So I would just urge the government to take a look at that, but I think I'm happy to move on. I know my colleague has a couple more questions.

Nathaniel Teed: — I was just wondering if the government considered any streamlining process for a once-only name change. I know that some of the barriers around name changes is the multiple jurisdictions that they have to, you know, go into to change their name. And I'm wondering if that was considered as part of this legislation.

Hon. Jeremy Cockrill: — Can you just clarify "streamline"? What exactly are you . . .

Nathaniel Teed: — So like having to go get your licence changed, your health card changed, a passport changed. I wonder if there was any consideration into the barriers that that might pose and the cost that those might be considered of an individual.

Hon. Jeremy Cockrill: — Okay, thanks.

Yeah, the streamlining of other services, I guess, you know, when somebody is changing their name, I mean the onus is on them then to go and get a new . . . Passport is done federally, right? And you know, I guess it's 30 days or you get a refund now or something like that. But that would be a federal operation, so I can't speak to how the federal government's trying to streamline that operation. It does seem like they are making some efforts in that regard.

I mean in terms of the streamline, I mean if the change of name is approved, you get a new health card in the mail and off you go in terms of accessing other services in terms of getting a new driver's licence and so on. That's done by SGI [Saskatchewan Government Insurance], not by eHealth, right.

Meara Conway: — Sorry, I spoke too soon. I actually have one more question. But then I think it's our last question. Just going back to this exemption piece, I just took a quick look at the regulations. Like it wasn't clear to me what happens if an exemption request is denied. Like what are the person's options?

And if you apply to change your name, you're kind of going about your life, and then you realized, oh wait, the fact that this is public is causing me undue hardship. I wasn't aware at the time maybe, but now I'm experiencing it a hardship. Are there mechanisms to then apply like kind of retroactively for an exemption? Could you speak to those two things.

Hon. Jeremy Cockrill: — So I'll answer the retroactive piece first. When something is in *The Saskatchewan Gazette*, it's kind of hard to take it out. So we have had requests, I understand, to do that. And I mean, it's in the Legislative Library. It's online. I

mean, it's in there. There has been suggestions perhaps where somebody could change their name again and then request non-publication, right. So there's an avenue there. But yeah, once something's in the *Gazette*, it's . . . There's a reason it's the *Gazette*.

So in terms of what happens if an exemption application is denied, again the vast majority that have come in in recent years are approved. And for ones that are maybe, I understand, not approved at the outset, there's a conversation with that individual. And I mean they can come back, and you know, continue to make that case for undue hardship. So in the situations that that has happened in recent years, that's been the course of operating, is, okay, the individual provides more information or paints the story a little bit more to indicate that.

Meara Conway: — I'm hearing it's a fairly co-operative, accommodating process.

Hon. Jeremy Cockrill: — Absolutely.

Meara Conway: — Okay. Thank you. Those are all my questions.

Nathaniel Teed: — That's all I have, and I think we'll consider those questions for both bills.

Meara Conway: — Yeah, I think.

Chair Keisig: — Well seeing no further questions or comments from committee members, I want to thank Minister Cockrill and Minister Carr and your officials for answering the committee's questions. We will proceed to vote on the clauses. Clause 1, short title, is that agreed? Do not hesitate to voice. Thank you. I am a little hard of hearing.

[Clause 1 agreed to.]

[Clauses 2 to 16 inclusive agreed to.]

Chair Keisig: — His Majesty, by and with the advice and consent of the Legislative Assembly of Saskatchewan, enacts as follows: *The Change of Name Amendment Act, 2025*, a bilingual bill.

I would ask a member to move that we report Bill No. 36, *The Change of Name Amendment Act, 2025*, a bilingual bill, without amendment. MLA Kropf moves. Is that agreed?

Some Hon. Members: — Agreed.

Chair Keisig: — Agreed. Okay, well thank you, Minister Cockrill. Do you need a few minutes to bring in any different officials for Bill 37?

Hon. Jeremy Cockrill: — No.

Bill No. 37 — *The Vital Statistics Amendment Act, 2025*
Loi modificative de 2025 sur les services de l'état civil

Clause 1

Chair Keisig: — Okay, next item on our agenda is consideration of Bill No. 37, *The Vital Statistics Amendment Act, 2025*, a bilingual bill. We'll begin with the consideration of clause 1. Any questions from committee members?

Nathaniel Teed: — We can consider the questions for Bill 36 for Bill 37.

Chair Keisig: — Okay. Seeing no questions from committee members, I will move on. We will proceed to vote on the clauses. Okay, clause 1, short title, is that agreed?

Some Hon. Members: — Agreed.

[16:15]

[Clause 1 agreed to.]

[Clauses 2 to 25 inclusive agreed to.]

Chair Keisig: — Carried. His Majesty, by and with the advice and consent of the Legislative Assembly of Saskatchewan, enacts as follows: *The Vital Statistics Amendment Act, 2025*, a bilingual bill.

I would ask a member to move that we report Bill No. 37, *The Vital Statistics Amendment Act, 2025*, a bilingual bill, without amendment.

Terri Bromm: — I so move.

Chair Keisig: — MLA Bromm moves. Is that agreed?

Some Hon. Members: — Agreed.

Chair Keisig: — Minister, thank you for your due diligence on this. Do you have any closing comments?

Hon. Jeremy Cockrill: — I do not.

Chair Keisig: — Thank you for your brief statement. MLA Conway, do you have any closing comments?

Meara Conway: — I do not.

Chair Keisig: — Well thank you, everyone. We will recess now and this committee will reconvene at 5:30. We will come back for Health estimates. Thank you, everyone.

[The committee recessed from 16:18 until 17:30.]

Chair Keisig: — Well welcome, everyone. And welcome to members of the committee that are joining us here tonight: MLA Bromm, MLA Kropf, MLA Burki, MLA Roy which is chitting in for MLA Blakley, and MLA Conway who is chitting in for MLA ChiefCalf.

General Revenue Fund
Health
Vote 32

Subvote (HE01)

Chair Keisig: — The committee will now be considering

estimates and supplementary estimates no. 2 for the Ministry of Health. We will begin with consideration of vote 32, Health, central management and services, subvote (HE01).

Minister Cockrill is here with his officials and Minister Carr. I would ask that officials please state their names speaking for the first time. Please don't touch the microphones. The *Hansard* operator will turn your microphone on when you are speaking to the committee. Minister, please maybe do not introduce your officials but please do make your opening remarks. And to all the officials here today, please do not adjust my chair seat. It was moved, and it really bothers me.

Thank you, Minister Cockrill, and thank you for your opening comments.

Hon. Jeremy Cockrill: — Well that's noted, Mr. Chair. I was going to introduce all my officials, but respecting your position I will not do that. I will just point out, though, we have officials joining us tonight from not just the Saskatchewan Health Authority but also the Ministry of Health, the Saskatchewan Cancer Agency, Saskatchewan Healthcare Recruitment Agency, eHealth Saskatchewan, and 3sHealth. And that's really an attempt to make sure that we can provide as fulsome answers as possible to members of the committee.

I would like to make some opening comments just to speak about the health budget for 2026-2027. This year's provincial budget is all about protecting Saskatchewan and working together to protect key priorities for Saskatchewan people. Health care is obviously at the top of the priority list, as we know people care deeply about the health care system.

In early March, Premier Scott Moe, Minister Carr, and myself announced the patients-first health care plan, a province-wide, action-oriented strategy that addresses what we've heard first-hand from Saskatchewan patients and Saskatchewan providers. The patients-first health care plan outlines over 50 action items, including expanding the scope of practice for health care professionals; expanding access to virtual care; strengthening our health care workforce with more physicians, nurses, nurse practitioners; as well as many other key actions.

The 2026-2027 budget protects and puts Saskatchewan patients first with a record $8.5 billion health investment to improve access to care across the province. This year's budget will connect more residents to a primary care provider, enhanced emergency and critical care, support seniors, invest in mental health and addictions initiatives, and modernize facilities and technology within those facilities. Now our renewed focus is to deliver better access and improved care to Saskatchewan patients and their families.

I want to thank the Ministry of Health and all of our health sector agencies for their commitment in delivering patient-first care to the people of Saskatchewan. Our health care professionals are dedicated to building a responsive and an integrated health system that delivers the right care at the right time and as close to home as possible.

I want to extend my sincere appreciation to our valued health care professionals, including physicians, nurse practitioners, registered nurses, paramedics, lab techs, imaging techs . . . It's a long list, Mr. Chair, of the folks that work in our system in facilities in communities large and small. It's meaningful work, Mr. Chair, that provides care for patients. Now not only do they save lives, but they work tirelessly to improve the quality of life for all Saskatchewan people.

Now our government also strives to better support health care teams so they can address challenges in the health care system and improve access and outcomes for patients. Investments in this year's budget demonstrate our government's commitment to improving quality of life for residents by protecting the progress that has been made, expanding access, and putting patients first.

As mentioned, this year's record investment in health care is nearly $8.5 billion, an increase of 393 million or 5 per cent over last year's budget. And that investment will deliver on several key commitments, including connecting patients to a primary care provider; strengthening emergency acute and critical care services; investing in better quality of life for seniors and individuals needing complex care; providing a record investment in mental health and addictions programming; continuing investment in the health human resources action plan, the most ambitious plan across the country; and delivering ongoing investments in major infrastructure projects, including new hospitals, new long-term care homes, and additional urgent care centres in the province. I'm pleased to provide further detail on how we are delivering on these commitments.

Now we're also making significant investments in our health partner agencies to support them in delivering care that will put Saskatchewan patients first. The Saskatchewan Health Authority's operating budget will receive a record total budget of $5.15 billion in 2026-2027 to advance patients-first plans and improve access for patients.

The Saskatchewan Cancer Agency's budget will receive a 10.5 per cent increase for a record investment of $308.6 million. This increase will ensure Saskatchewan patients have access to high-quality, world-class cancer care close to home, including the most current and effective drugs available, therapies, and cancer treatment options.

eHealth Saskatchewan will receive a total budget of $170.8 million, a 6 per cent increase, to support health sector growth and deliver secure and reliable technology. The Saskatchewan Healthcare Recruitment Agency will receive a total $5.6 million operating budget to maximize efficiencies and support recruitment activities to attract health care workers. Hopefully we'll have an opportunity to talk more about the Saskatchewan Healthcare Recruitment Agency later this evening and how we have adjusted that mandate to deliver better results for our health human resources action plan.

We are focusing on spending on investments that have a lasting impact for patients and their families. And by protecting and improving our health system, patients can access the care they need when and where they need it. Now this budget puts patients first by connecting thousands more Saskatchewan residents to a primary care provider. And having better access to a family physician or nurse practitioner creates more consistent, relationship-based care between patients and providers.

It's well known that nearly 20 per cent of Canadians don't have

a regular care provider, but in Saskatchewan we are determined to change this trend. Over the last 12 months, we've launched the largest publicly funded nurse practitioner-led expansion in our history to bolster primary care. Twenty-three new nurse practitioner contracts were signed in the last six months, and these contracts will increase capacity to deliver care to more than 18,000 patients attached to those nurse practitioner panels. More individuals and families will now have a provider to turn to when health concerns inevitably arise. This will reduce pressure on emergency rooms and deliver care that's consistent and close to home.

This budget provides ongoing support to this ambitious nurse practitioner expansion by now opening contracts to an unlimited number of nurse practitioners. We've just had our last intake of nurse practitioner contract applications close this week. The ministry is reviewing these applications this week. We'll be very excited to announce several new contracts across the province in the coming weeks. Mr. Chair, this is really an exciting time for nurse practitioners in Saskatchewan.

Now this initiative provides similar opportunities for nurse practitioners that are available to family physicians in the province. An $11.9 million investment in primary and preventative care will fund additional nurse practitioner contracts and significantly increase capacity. Saskatchewan will continue to advance our commitment to ensure that every resident has access to a primary care provider by the end of 2028.

Now a pilot project will support certain contracted nurse practitioner clinics to hire additional primary care team members, such as registered nurses or licensed practical nurses, to further increase access for patients. Now, Mr. Chair, this is an important part of this year's budget. We've previously talked about the success of the innovation fund — our partnership with the Saskatchewan Medical Association — that has allowed physicians around the province and supported them through resources to hire additional health care professionals as part of their team, building out better access for patients but really building out that relationship-based team care.

Investment increase will fully fund resources added last year to address sexually transmitted blood-borne infections in the province. Funding will focus on prevention, testing, diagnosis, treatment, and ongoing care. This funding will increase program staffing capacity and support expansion for the prenatal outreach and resource team, or PORT [prenatal outreach resource team], in northwest Saskatchewan, in my home community of North Battleford. This is a team that's run by an organization called Sanctum. Members will be aware of the PORT team and the good work that's been done in other communities, and it's been exciting to see this team expand to new communities in the province and then resourced as part of this 2026-2027 budget.

Now Saskatchewan is putting patients first by investing nearly $98 million in emergency, critical, and acute care improvements to address hospital bed capacity, develop more urgent care centres, advance surgical and medical imaging services, strengthen pediatric care, stabilize emergency medical services, and support several other key investment areas.

Sixty new permanent in-patient beds will be added to Royal University Hospital and St. Paul's Hospital with the addition of 36 and 24 beds respectively. The additional beds will help stabilize patient flow and improve safety for both patients and for staff. This increase is also allocated to the ongoing project that we've had at Saskatoon City Hospital with the expansion of 109 acute care beds, featuring 60 medicine beds, 22 acute rehab beds, 12 acquired brain injury beds, and 15 high acuity beds. Forty of these 109 beds at Saskatoon City Hospital are opened and staffed and operational today, and this budget will help us to deliver the last 69 beds as part of that project.

This budget will provide further supports for intensive care for critically ill and surgical patients. An investment increase will permanently staff four additional intensive care unit beds at St. Paul's Hospital in Saskatoon. Construction will begin on a seven-bed expansion of the ICU [intensive care unit] at Royal University Hospital to ensure access to timely life-saving care.

And I'll just say that all these projects — the one I talk about at Saskatoon City Hospital, St. Paul's, and as well as the bed expansion at Royal University Hospital — is really demonstrating taking existing assets that we have in Saskatoon and using them as efficiently as possible to maximize capacity and improve patient flow.

The 2026-2027 budget provides a substantial increase to support pediatric enhancements across Saskatchewan. This funding increase will ensure safe, sustainable care for critically ill and premature infants and children requiring specialized services. Saskatchewan continues to grow its impressive pediatric programs under the leadership of Dr. Terry Klassen, with further supports to permanently staff six pediatric in-patient beds at Jim Pattison Children's Hospital. We will also expand neonatal intensive care unit capacity at Regina General Hospital from 25 to 28 bassinets. We're also providing permanent funding to support NICU [neonatal intensive care unit] nursing positions that were previously added at Regina General Hospital.

This year's budget continues investing in urgent care centres. A significant increase will support enhanced staffing levels in Regina and build out a full care team to staff the first Saskatoon urgent care centre. The province has partnered with Ahtahkakoop Cree Developments to build a state-of-the-art urgent care centre in Saskatoon, expected to open in early 2027. The budget also supports continued work to develop five more urgent care centres in the province — in Moose Jaw, North Battleford, Prince Albert, and additional urgent care centres in both Regina and Saskatoon.

We have seen strong patient demand for Regina's urgent care centre, and since opening in July 2024, Regina's urgent care centre has cared for over 65,000 patients. That's more than 100 patients per day on average. By introducing this new same-day urgent care model into our system, the urgent care centre has eased pressure on Regina's emergency rooms, and I'm very excited that Saskatoon patients will soon benefit from this additional door of access to care.

Now providing safe and reliable ambulance services is a priority for Saskatchewan. Saskatchewan is proud to have 107 ambulance services operating in 109 different communities to provide province-wide EMS [emergency medical services] coverage. This year's budget is a significant one for the EMS sector. We are enhancing emergency medical services by increasing capacity and resources and delivering better patient response

times.

We'll continue building a sustainable, resilient EMS workforce through additional mental health supports. And the investment in additional health supports is something that we heard about directly from front-line paramedics, who often see patients in their most vulnerable state and are seeing them in often what's an uncontrolled environment if they're attending a car accident or other situation. They see some pretty traumatic things, and it's important that we support those health care professionals.

Now since 2022-2023's budget, Saskatchewan has made significant investments to support 215 additional full-time paramedic positions in 76 different rural and remote communities. This year's budget will support an additional 24 annualized full-time paramedic positions in 12 communities as a part of stabilization efforts for our EMS sector.

[17:45]

Previous investments made in modernized technology reduce emergency room demands. And new computer-aided dispatch systems and enhancements to 911 allow nurses to better triage calls and refer lower acuity patients to more appropriate community-based care settings.

Now over the past three years, the province has also supported approximately 270 bursaries for primary care and advanced care paramedics, along with additional funding to support emergency medical responder training. These programs help to ensure communities have access to skilled EMS providers. And this budget will continue to support bursaries for EMS students in the province because we know that a strong paramedic workforce ensures timely care across the province.

Now in the past five years, Saskatchewan has increased annual diagnostic capacity at really an astonishing rate: by over 55,000 more CT [computerized tomography] scans, 15,000 more MRI [magnetic resonance imaging] scans, and additional PET/CT [positron emission tomography/computerized tomography] capacity by 1,300 patients annually. These are significant additions to support a growing province and support patients receiving the right care at the right time.

The 2026-2027 budget will continue accelerating diagnostic capacity to provide specialized imaging services for thousands more patients each year, increased access to diagnostic supports and earlier diagnosis, better treatment planning, and improved health outcomes for patients.

Increased funding will also be dedicated to surgical services. Focused improvements will be on spine surgery and joint replacement surgery pathways to reduce wait-lists and deliver more timely access to surgery for patients. Centralized surgical scheduling, expanded pool referral programs, and improved patient preparation programs will help reduce wait times and ensure operating rooms are used as efficiently as possible.

There's really been much progress to celebrate when it comes to surgical care in Saskatchewan. We've established a robot-assisted-surgery program, with four systems operating in both Saskatoon and Regina, performing nearly 500 robot-assisted surgeries in the past year. We've also been leveraging our private surgical partners — privately delivered, publicly funded: about 17,000 publicly funded surgeries privately delivered, which is about 18 per cent of provincial procedures annually. Saskatchewan performed over 100,000 surgeries last year, which is a 30 per cent increase over 2020.

Now increased funding will enhance the provincial genetics and metabolics program, one of the fastest growing areas of medicine. This program provides critical diagnostic and treatment pathways for individuals and families affected by complex or rare health conditions. And although this is separate from the investments made in the pediatric space, the increased investment here from both a capital and operating perspective in genetics and metabolics has significant impact on pediatric patients, ensuring that they are receiving a diagnosis as quickly as possible and returning some of that work that was previously being done out of province to being done right here by qualified Saskatchewan health professionals.

The 2026-2027 budget will strengthen kidney health programming as well by funding positions that support safe, consistent patient access to dialysis services.

Saskatchewan will also be investing over $9 million to better protect and improve quality of life for seniors and individuals needing complex care. I won't go into the details on this as Minister Carr highlighted these details last year.

Mental health and addictions responsibilities also reside with Minister Carr, and she did provide full details yesterday on the record funding for initiatives in this area in this year's budget.

Now as I stated earlier in my comments, Canada — really nationwide — every province is experiencing pressures in delivering timely and reliable primary health care to residents. According to CIHI [Canadian Institute for Health Information], as I mentioned earlier, roughly 20 per cent of Canadians lack a regular health care provider such as a family doctor or nurse practitioner. There are fewer family physicians providing full-time primary care and fewer new graduates choosing family medicine. Finite training capacity and a competitive environment for health care workers across jurisdictions have also contributed to those challenges.

I've talked about our health human resources action plan, the most ambitious plan across the country. And Saskatchewan has invested more than $460 million to boost the health care workforce as a part of this plan since 2022. Over 7,500 nurses and other health care professionals have already joined the system as a result of this HHR [health human resources] action plan. Steps have been taken to deliver measurable progress across the health care system, and according to CIHI, Saskatchewan's recent investments are starting to make a difference. We have one of the strongest health care workforces in Canada, and our staffing levels surpass the national average.

We're committed to building on this progress to make a difference for Saskatchewan patients. This year's health budget will invest $117.2 million, an increase of 28.6 million, to evolve the health human resources action plan into a new phase with ambitious career opportunities for Saskatchewan residents, added initiatives for Saskatchewan's valued health care teams, and further empowerment and expanded role for the

Saskatchewan Healthcare Recruitment Agency.

And I'll pause to make sure that this is clear for committee members. What has been done in this year's budget — as part of the patients-first plan but then committed to again in the budget — is the responsibility for all external recruitment being transferred to the Saskatchewan Healthcare Recruitment Agency. This provides a single door of entry for folks interested in a health care career in Saskatchewan, whether they already reside in Saskatchewan, whether they reside in another province or country. And we look forward to the results being shown out of that change when it comes to recruitment.

A $12.4 million increase will be dedicated to the College of Medicine to continue building the future workforce for Saskatchewan. The college will add 20 more undergraduate seats for a total of 128 available seats for medical students and increase our residency seats by 10 for a total of 160.

We're going to continue supporting new training programs in Regina and Saskatoon for anesthesia, dermatology, and plastic surgery, among other specialties. Those three that I mentioned specifically have been a challenge in recent years. And again the more that we can add those residency seats and training programs right here in the province, that will pay dividends for many years when it comes to recruitment and retention. In addition to the new training seats, we will continue supporting previous seat increases as well as academic positions that have been added over recent years.

A $6.7 million increase will be dedicated to physician recruitment and retention by supporting the rural physician incentive program. We'll be expanding the program to regional communities such as Yorkton, Moose Jaw, and North Battleford, among others, supporting assessments for internationally trained physicians able to relocate to the province and funding to incentivize trainees in high-demand residency programs to practise in Saskatchewan.

Strengthening the physician workforce will improve access to care and support continuity for patients. More graduates are staying. More providers are choosing Saskatchewan. And new roles such as physician assistants are strengthening the care teams that we have across the province.

Saskatchewan is building the next generation of talent with hundreds of new training seats and new health science programs. Last week I had the opportunity to participate in the launch of a health care careers level 20 online course through the Saskatchewan Distance Learning Centre. And this course will give high school students or interested adult learners early exposure to potential career opportunities in our health sector. I understand from the folks at the Saskatchewan Distance Learning Centre that registration opened a couple of weeks ago and already seeing good interest in terms in registrants for that particular course.

Meara Conway: — Minister.

Hon. Jeremy Cockrill: — I've just got a few pages left in my comments.

Meara Conway: — We're going on 25 minutes, respectfully. We schedule estimates; we ask for a certain amount of time to scrutinize the budget on behalf of the people of Saskatchewan. I think it's getting a bit excessive, respectfully.

Chair Keisig: — Minister Cockrill, please carry on with your comments. You've answered many of my questions in your opening statement, and I truly appreciate that.

Hon. Jeremy Cockrill: — Okay, we'll continue here.

The 2026-27 budget will provide new funding for career-laddering opportunities for health care professionals already working in Saskatchewan's health care system. New funding will support competency-based assessments to retain continuing care assistants, and it will also assist in career laddering from a CCA [continuing care aide] to a licensed practical nurse to a registered nurse.

Nearly $1 million in new funding will support a registered nurse to nurse practitioner career-laddering opportunity offered in select communities to support students. This initiative will support up to 25 Saskatchewan registered nurses who wish to train as a nurse practitioner for a return-of-service agreement to their community.

New funding will also support a unique Indigenous continuing care assistant pilot program to meet the future health human resource needs in northern Saskatchewan, in particular the new long-term care facility in the community of La Ronge.

In addition the 2026-2027 budget includes ongoing funding to support successful recruitment activities, including $8.7 million for new and existing recipients of the Saskatchewan rural and remote recruitment incentive program. And since that incentive was introduced in 2022, the incentive has attracted more than 500 new employees in rural and remote communities experiencing service disruptions due to staffing challenges. $870,000 to support licensure for internationally educated health care professionals through faster pathways to ensure a stable and growing workforce is in place to support current and future patient needs.

Now Saskatchewan will continue to make progress on its ambitious health infrastructure projects, with state-of-the-art new builds and facility upgrades across the province. The total capital budget in 2026-2027 is $636 million.

The major infrastructure investments include ongoing construction of the Prince Albert Victoria Hospital, the Regina long-term care specialized facility, the Grenfell long-term care project, the La Ronge long-term care project, the Royal University Hospital ICU expansion project, the Saskatchewan Health Authority and Saskatchewan Cancer Agency pharmacy clean room renovations, the Saskatchewan Cancer Agency Saskatoon patient lodge, the complex-needs facilities expansion to both Prince Albert and North Battleford, phase 2 of the Regina electrical infrastructure renewal program, equipment and IT [information technology] for Saskatoon's urgent care centre, as well as additional dollars to support planning for the new urgent care centres in the communities that I mentioned previously.

There's also dollars . . . and we talked a little bit about this yesterday, and I'm sure we'll be happy to talk about it again

today, in terms of continued planning dollars for major projects, including the Yorkton Regional Health Centre, Rosthern Hospital, Esterhazy integrated care facility, Battlefords and district care centre, a new six-bed youth detox unit at Calder Centre, the Regina-based multiple sclerosis clinic that will provide comprehensive out-patient care in southern Saskatchewan, as well as capital upgrades for the Regina long-term care standard bed project.

Saskatchewan will continue to embrace tools and technologies that modernize our health care system. These capital investments will stabilize and enhance laboratory medicine services across Saskatchewan, replace the end-of-life renal data system with a modern provincial electronic records system, and enhance the provincial endoscopy software.

In closing, I want to thank the committee for the opportunity to provide details on the significant investments made in the Ministry of Health budget for 2026-2027. Thank you.

Chair Keisig: — Thank you very much, Minister. And I also want to thank you for avoiding the use of acronyms; I truly appreciate that.

I will open up the floor for questions. MLA Burki, do you have any questions? MLA Conway.

Meara Conway: — Thank you, Chair. I just want to thank the hard-working civil servants that have joined us here tonight. We're now about a half-hour in.

Minister Cockrill, I'm just going to start with some general questions about the budget. The way I'm hoping to do this is just to sort of kind of provide a context and then maybe have a back-and-forth as opposed to one question at a time.

I'm looking here at page 16 of the '26-27 Estimates, and I see that the government of course outspent its anticipated '25-26 budget. And I see here that you're forecasting to spend just over 8.4 billion when . . . And I understand that forecast includes the estimate that would have been voted on last year plus a $338 million special warrant. So we see that health spending is running about 4.2 per cent above the original estimate.

I'm wondering if you can break down the areas where you overspent, break down where the funds under the special warrant would have gone to, how that money was allocated, and whether you track what you've sort of overspent on in a more detailed way. Well of course you do, but if you could outline that for the committee, that would be great.

[18:00]

Hon. Jeremy Cockrill: — So as the member is aware, I mean the figures on page 16 of the Estimates under the forecast for '25-26, again that is still a forecast with yesterday being the final day of the fiscal year in question. Obviously those year-end numbers, there'll be work to compile that over the coming weeks and months.

You know, questions specifically relating to the special warrant amount of $338 million. There's operating pressures within the Saskatchewan Health Authority including contract nursing costs, overtime costs, other compensation pressures, higher-than-budgeted medical and surgical supplies. And I think that can be understandable given, again, the trade uncertainty around the world and the fact that, you know, many medical supplies are manufactured in the United States.

Infrastructure operating costs and other operational pressures. The $17 million for the Saskatchewan Cancer Agency typically have to do with higher drug expenditures. That's what this $17 million is for. The $14 million, there's $14 million for physician services, and that again typically comes from higher utilization of fee-for-service physicians in the province. Obviously if they are busier and billing more, that's where that pressure is coming from, as well as pressures relating to different specialist contracts. There's $12 million for eHealth, primarily to deal with higher service desk volumes, maintenance expenses, and capital project delivery costs.

There is a $10.2 million expense in the special warrant for the Canadian Blood Services utilization pressures, you know. And again that's an example of a cost that is unlikely to repeat next year, just given the fact that we do now have a new agreement with Canadian Blood Services, and there was incremental funding provided in the budget for that. So with the new agreement as well as dollars in the budget, that would be, you know, looking ahead to the '26-27 fiscal year, one that we would not necessarily expect to see repeated next year.

Meara Conway: — This is of course not the first year that we've seen this happen, where we've overspent on health in particular in, I would suggest, a pretty significant way. Because what we see here is that we basically . . . When we look at actual spending in '25-26, it's essentially the same as what we expect to spend in '26-27. It's a 0.7 per cent bump. That's assuming the forecast isn't higher than what it is now with that added special warrant.

Are you trying to hold down the growth of budgets by setting unrealistic budgets for management teams in health? Can you speak to why this seems to be a consistent pattern? I know you pointed to one small expenditure that doesn't appear to be something that would be repeated, but a lot of these expenditures seem like they just represent the reality of the cost of delivering health services. So can you speak to that concern that this is a pattern?

Hon. Jeremy Cockrill: — So you know, I would say first of all, and I think we had this conversation last year around . . . I mean, at the end of the day, if there's pressures the system is facing in a given fiscal year, you don't just stop providing health care with a month to go in the fiscal year. You know, you have to continue ensuring that services are provided.

I think generally though there's a conversation happening with myself and my counterparts across the country in terms of, you know, when we get together at federal-provincial-territorial meetings, we all represent the most significant budgets as part of our respective provincial governments. And I think everybody's aware that those challenges exist and, I think, are trying in many different ways to bend that curve while not sacrificing services and access available to patients.

And I'll just say we've made, I think, some good strides this year in working with the Saskatchewan Health Authority to start to

address some of their overhead costs and their administrative costs, I'll say. But the reality is we have needs on the front line as well, and so we were able to redirect those savings with the Saskatchewan Health Authority to front-line positions. And again I'll point out that the 2025-2026 numbers on page 16 in the Estimates, they're still forecasts, right. So you used the example, well the forecast could go up. The forecast could go down as well, so there is that possibility as well.

Another area, you know, where significant work has been undertaken is really reducing the spend on contract nursing. You know, in 2023-2024 fiscal there were about $98 million spent on contract nursing. In the 2024-2025 fiscal year it was about $68.6 million. And obviously the number for '25-26 is still a forecast because we haven't gotten to year-end numbers, but I would say we are forecasting right now to be about $40 million spent on purchase salaries or contract nurses.

[18:15]

And you know, we've talked here before and we've talked publicly about trying to bring those numbers down by 30 per cent. There's, I'd say, some very good progress in that space. And again, you know, your words were "unrealistic budget." I think the reality is we're trying to ensure that services and access are preserved for patients, and then understanding where in the system there may be cost pressures that we can start to take a closer look at and address without affecting the care that patients receive.

Meara Conway: — Thanks, Minister. I'm just struggling with how the budget this year is essentially what we spent last year, given those pressures in health care are not going away, and if anything some of those pressures are only getting worse.

I'm wondering, we have tens of thousands of health care workers right now without a contract. We had SEIU-West [Service Employees International Union-West] here with us today talking about how it's been four years without a raise. The contract before that they took 0, 0, 1, and 2s, I think, or maybe it's 1s and 2. But they're not going to be willing to take something like that again. I think we all know that. I'm just wondering, does the '26-27 budget include funding for all of those pending collective agreements?

And SAHO [Saskatchewan Association of Health Organizations], what is SAHO's annual budget? And what portion of SAHO's annual budget is spent on bargaining, including expenses?

Hon. Jeremy Cockrill: — So maybe I'll just start with your questions that are specific to SAHO. SAHO's budget is increasing this year from 4.05 million to 4.53 million, so that's just shy of a 12 per cent increase. You know, the reason for that is positions have been added really for general operations as well as the market-based supplement program that we have in many of our agreements, so important that we are providing timely updates to that.

And I will say too, I mean the general operations . . . And your question was how much of that money is spent on marketing. I mean at the end of the day I would say all of it, because SAHO's mandate is all compensation related, right, whether you're in active bargaining or whether you're making adjustments to the market-based supplement. So you know, SAHO's whole mandate is bargaining or compensation related.

You know, I think you could say also the reason for the increase to general operations . . . And you know, I made comments to this end — I believe it would be in the fall — around really focusing efforts on bargaining to try and move tables forward. There are several tables open at the moment. Obviously as you add bargaining days and weeks of bargaining, that takes more staff time. So again when you talk about adding staff for general operations, I think that really speaks to an increased focus by SAHO on those efforts.

In the budget writ large, there's $110 million in additional funds to settle contracts. Now again, $110 million . . . Typically when dollars are booked, we're at a point in negotiations where there is a financial offer on the table or likely to be a financial offer on the table. So I should be very clear. I don't think $110 million, if we're able to get to an agreement with, say, providers or SUN [Saskatchewan Union of Nurses], two of our larger tables, I don't expect that number to cover the incremental cost of those agreements.

Again, you know, that's figuring on the progress that may be made at the bargaining table. But again so there's several smaller tables, in terms of number of members being the metric there, that are open right now that I think are more advanced and getting very close to dollars being talked about at the table. So there is a recognition that we're moving forward on bargaining, more resources behind SAHO, and I'd say a renewed focus on getting to agreements that work for health care workers and for patients.

Meara Conway: — Thank you, Minister. So that 4 million and change, like what do you do to sort of keep track of the cost of bargaining, if I could put it that way? Do you think that captures the entire cost of bargaining from your end? I mean obviously unions incur a significant cost as well. But can you speak to whether that would cover that? Is that something you even sort of track in that sense?

And then if you think that 110 million, which I understand has been set aside in this budget for any financial offer, is not going to be sufficient, why did you not like book more, reserve more in this budget, knowing that those collective agreements are a huge part of how we're going to move forward in terms of recruitment and retention and building a sound and stable health care workforce in this province?

Hon. Jeremy Cockrill: — I'll quickly answer your second question, and I will get information for you on your SAHO question. As I stated, all the tables that are currently open are at various stages of bargaining. When we get close to a financial offer, there is a financial offer on the table, dollars will be booked for that. We're not at that point yet with some of our larger tables. We hope to get there soon, but again I think there's a few more discussions that have to take place at those tables before we get to talking dollars and cents. So that's why the number is 110 that was booked for now. I'll get you an answer on SAHO though.

Meara Conway: — Thank you.

Hon. Jeremy Cockrill: — Your question on cost of bargaining

and I guess maybe . . . I don't know if you want to be more specific. Obviously I mean, for example, with the providers, this week I understand we're in Saskatoon at that table. Next week we're with the providers here in Regina. So there's a back-and-forth there.

I mean I would say, you know, again all 4-some million dollars is really targeted at bargaining efforts, whether it's at the table or the work that SAHO does behind the scenes on job classification, interpretation, labour relations. Again I mentioned the market-based supplements as well.

[18:30]

And so I mean really again the organization's entire mandate is to bargain with all the tables that are active at any given time, so obviously in . . . And again that's just on the employer side of the table.

What union partners spend I mean ultimately decide how many people you bring to a meeting or what that cohort looks like. So I can't speak to what partner unions would be spending on their interactions at the table with us, but I think it's fair to say that really the entire spend through SAHO is really targeted at getting to agreements at our tables.

Meara Conway: — Well maybe I'll just clarify. And you know, this is in a new portfolio for me so partly it's my own ignorance. But you know, you mentioned adding additional days for bargaining, for example. Is that like net neutral for government expenditures, or does that mean an extra cost?

Hon. Jeremy Cockrill: — Well there would be an additional cost, as I specified too. I mean the more days of bargaining means you have more staff there when you have multiple tables open as well, right. I mean and certainly the commitment that I've made to certainly the three provider unions as well as to the Saskatchewan Union of Nurses is that we would put more resources behind bargaining in the fall. And so this budget and the increase there I think makes good on that commitment.

Obviously the end commitment is getting to an agreement. But as we have more days and more opportunities to get closer to an agreement, I think that reflects government's investment in that part of the process. Obviously that's not the end agreement but part of the process to get there.

Meara Conway: — It's a worthwhile investment. I'm just trying to get a sense of what exactly that investment is. So I'm wondering, do you track like costs per day? Are you just kind of flying blind when you add those additional days? I'm just trying to understand strictly from a numbers perspective. Is that something you track, measure, assess? A day of bargaining, an added day of bargaining, for example.

Hon. Jeremy Cockrill: — So obviously when there's more days . . . I'll back up to give some context. So for SAHO, when you're at the bargaining table there's obviously SAHO staff there. Those salaries are incurred by SAHO. There would also be other employee representatives there, whether it be from Saskatchewan Health Authority, Saskatchewan Cancer Agency. So when it comes to additional bargaining days, there would be costs borne by SAHO. SAHO would cover, even if they're not SAHO employees, they would cover per diem costs and travel costs to and from wherever the bargaining is occurring. So obviously if there's more days bargaining, there will be higher costs in that direction.

I mean obviously the employers, if they're covering . . . Let's take the Saskatchewan Health Authority for example. I mean that would be Saskatchewan Health Authority bearing that cost. It's not necessarily an incremental additional cost though, because it's part of that individual's job to participate in bargaining. And if they weren't bargaining, they'd be working on other labour relations matters in their office in Saskatoon or wherever. So there are additional costs. They're borne out by multiple organizations I guess is what I'm trying to say.

Meara Conway: — Can you just clarify? You said SAHO would cover per diems, and did you say salaries? Like would they . . . No.

Hon. Jeremy Cockrill: — No, SAHO is only covering salaries of SAHO employees. But for the non-SAHO employees, so other employee representatives that may be at the bargaining table, SAHO would cover, and I mean it's kind of in the weeds but would be covering travel expenses, so kilometres and per diem rates, which are at government rates that any other individual in government would receive.

Meara Conway: — Thank you. And there's no other kind of budgetary line item that would capture those costs? Those costs are all flowing out of SAHO?

Hon. Jeremy Cockrill: — I mean you could say . . .

Meara Conway: — Sorry, to clarify: like apart from the fact that, as you pointed out, you'll have like SHA [Saskatchewan Health Authority] representatives and their salaries paid by SHA. But there's no other line item where SAHO expenses appear on the budget, except through SAHO.

Hon. Jeremy Cockrill: — Yeah, I think that would be correct to say. And again it's not like . . . At the end of the day, the significant cost when it comes to bargaining is when we get to an agreement with all of our partners. That's the number that matters at the end of the day to health care workers and the provincial budget.

In terms of a bargaining cost roll-up, it's not like we have a, you know, day-by-day analysis of . . . You know, salaries aren't broken down day by day. So I guess if you're looking to drill down to more detail, I'm not sure we'll be able to provide that.

Meara Conway: — I appreciate you going as far down this rabbit hole as you have so far. So returning to the 110 million — so just again for my edification — when a financial offer is extended, you have to book that amount in the budget. But there's no other provision in this budget for situations where a financial offer has not been extended. Do I understand that correctly?

Hon. Jeremy Cockrill: — So when government does table a formal financial offer, that is booked. Because again we're telling that partner, hey, if it all ended today, that's the minimum of what the offer would be.

What's booked this year, is I would say a notional amount recognizing that there is going to be pressures in this space as we proceed through bargaining. So this is a notional amount to, you know, offset the future expense pressures that will come out of the bargaining space.

And again I was very clear earlier. I mean, if all the tables were settled today, $110 million would not cover all of them, nor should it. But it's a notional amount saying this is where we, you know, at the very least where we expect that would be at the minimum of where we would get to across all of our tables, hoping obviously that we do make progress, right.

Meara Conway: — Thank you. Just to clarify for me, so 110 is more than those booked financial offers that have been made, allowing some room for what you refer to as a notional amount? Am I understanding this correctly?

Hon. Jeremy Cockrill: — That would be fair to say, yeah.

Meara Conway: — Fair to say. Okay, thank you. Before I move on, I did raise the issue of the letter I tabled yesterday. Will you be in a position to table the responses to those questions? I would really prefer not to spend a lot of time on that tonight because of course those were questions I asked last year. But can you update me on where that's at?

Hon. Jeremy Cockrill: — Yeah. I'll just say, you know, I mean, following last year's estimates, you know, my office carefully reviewed *Hansard* and provided information back to the committee where there was a clear commitment by either myself or Minister Carr or an official. You know, if you feel maybe that . . . Maybe we would disagree on the clarity of the commitment perhaps, but certainly where the staff in my office felt like there was a clear commitment, that information was provided to the committee.

Meara Conway: — Okay. So your position is you didn't make a commitment to provide those items that are outlined in my letter. And you're refusing to provide them, or you will provide them?

Hon. Jeremy Cockrill: — We can review your letter, Ms. Conway. I mean, what was your point from yesterday? Again, you know, after reviewing *Hansard* myself, I think where there was a clear commitment made, the information has been provided.

Meara Conway: — So you say you're going to review my letter. It's the same letter I've now sent four times, respectfully, Minister, but we can spend some time on this if that's your preference.

So I guess I'll just ask you outright. You track disruptions data. You track it by community and facility impacted. You track it by the nature of the condition and length of disruption. And my understanding is you can easily provide it back to November 23rd. We canvassed this last year.

[18:45]

Can you table, at a later date, disruptions data from November 2023 to as recent as today's date as possible? So that's my first question.

My second question is vacancy data back to 2022. We had a discussion about how going further than 2022 would require manual work. So we had a back-and-forth, and on page 8 Minister Carr undertook to provide that information to me "[within a] few days." I still haven't received it. Can you commit today to providing hard-to-recruit, permanent, full-time as well as part-time chronic vacancies back to 2022?

The vacancy table that we discussed last time about full-time equivalents and casual, part-time, full-time positions broken down by region/facility going back five years, can you provide that to me with updated information on that?

And then the amount spent on contract nursing. The number you provided tonight is a little off from what you provided last year. Last year you said 91 and change. Tonight you said it was, I think, 97 or 98. Can you provide an update on that as well as a list of all — and this is added tonight — a list of all third-party agencies you are counting in that?

And then wondering if you can provide SIPPA [Saskatchewan international physician practice assessment] data. Number of doctors who broke their contract before it ended, and the number of doctors who stayed on to practise in the community where they had the agreement beyond the date of their contract end.

Hon. Jeremy Cockrill: — So there was some vacancy data provided to the committee in June of last year, June 16th. I'm sure you would have that letter. I understand that that's not . . . that maybe wasn't the level of detail that you may have been looking for. When it comes to disruptions data that was previously requested as well as the vacancy data, I'm going to just ask Tracey over the next couple weeks here just to validate the data that we do have and then we can table that, whatever we have for you, at that time.

So I do have some verbal information on SIPPA. So since the SIPPA program was initiated in 2011, there have been 87 candidates who left their original community during the return-of-service period — 53 of those 87 relocated within Saskatchewan, and 34 left the province — and 74 who left the province within 30 days after fulfilling their return-of-service contract. So again, putting that in perspective though, is also there have been 639 successful candidates assessed through the SIPPA program.

And I'll just say, you know, in regards to the SIPPA program specifically . . . I think I talked about it last year a little bit because we were I think at the front end of it at that time, was a more fulsome review of the SIPPA program. Some of the challenges that we've seen in recent years through the SIPPA program, and just in terms of how the program has evolved. And then obviously since that review was done this last year, some changes have been enacted and come into place to improve that rate, further improve that rate, and get it back to the numbers where they were closer to when the program began.

Meara Conway: — Can you define success? Like do you mean completed their return of service? Is that how you define success?

Hon. Jeremy Cockrill: — Well certainly that would be one level

of success. And then, you know, the goal is obviously to, with the SIPPA program, to, you know, assess the candidates and prepare them for what will hopefully be a lifelong career opportunity in Saskatchewan, and whether that's in a rural community or in a more metro location.

Meara Conway: — So, Minister, just going back to the vacancy information that was tabled, that was a separate issue. That was mental health vacancies, broken down by region. This was a separate request for vacancy information. Can you speak to the vacancy table that I requested and the contract nursing list and amounts?

Hon. Jeremy Cockrill: — Yeah, so on the vacancy table you requested, I think we have that. I just do want Tracey to have some time just to validate that with the team over the next couple weeks. And we'll commit to tabling that before the end of April.

Meara Conway: — So I have a commitment from you that you'll table a vacancy table that cites full-time equivalents and casual, part-time, full-time positions broken down by region/facility going back five years. Correct?

Hon. Jeremy Cockrill: — We won't have it broken down by facility. I think we'll have a nursing vacancy rate that is broken down by all areas and then rural and north, but not by facility.

Meara Conway: — So you have a breakdown by region, just north and then all other? Sorry, can you clarify?

Hon. Jeremy Cockrill: — Rural and north, it appears. But that's why I want Tracey and the team to have some time to validate that just to make sure we're being clear on that. But yes, you have my clear commitment on providing some vacancy rate information. Again it may not be to the level of detail that you're asking for, so I'm trying to be clear in my response to your ask for a clear commitment. But we will provide that once we can validate that.

And then as well making a clear commitment to you on some disruption data going back to 2023. It appears we likely have that facility by facility, and so we will just work to validate that before tabling it so we give you the most accurate information possible.

Meara Conway: — Thank you, Minister. I understand you also track the reason for the disruption. So can I just get your commitment that you'll provide whatever you have on the cause of the disruption as well?

Hon. Jeremy Cockrill: — Whatever we have on that will be provided in that.

Meara Conway: — Thank you. And then I think there was an exchange — and Mr. Northcott might be able to shed some more light on this — but I think there was an exchange around you tracking several key metrics, including hard-to-recruit permanent full-time as well as part-time chronic vacancies. And I believe that that was tracked going back to 2022 by region and position. Can you commit to that data as well?

Hon. Jeremy Cockrill: — I'm not sure we'll have that for you, but what we are able to provide we will provide you.

Meara Conway: — Okay, thank you. And then the contract nursing amount, as well as the agencies that you include in those tallies, a list of those agencies. Can you provide that, the updated number as well as the list? And maybe kind of explain that discrepancy between the number you provided tonight which was 90 . . .

[19:00]

Hon. Jeremy Cockrill: — Ninety-three, yes. So I can explain that discrepancy. So obviously the number that was shared, we hadn't received all the invoices from our partner agencies when we had estimates last . . . Again we weren't quite done the fiscal year, I think, at that point when we had estimates, or we were about the same timing as we are this year. So not all the invoices from the contract agencies had come in at that time.

Meara Conway: — But that was the '23-24 number, so wouldn't you have had that number?

Hon. Jeremy Cockrill: — My understanding is we hadn't . . . There was accounting to making sure it was allocated to the correct year. So the numbers I provided you tonight are the most updated numbers I have available.

Meara Conway: — Okay, thank you. And sorry, you'll provide all of the agencies that you include in that global number of 98 million and all the agencies that you include in that $68.6 million tally?

Hon. Jeremy Cockrill: — We will endeavour to get as much information to you on that as we can. We might need some extra time to go back through all those invoices. But whatever we can find on that, we will provide to you.

Meara Conway: — Sorry to be cagey. I just want to be clear. You've tallied a number, so obviously you've tallied a number based on invoices from specific third-party agencies. So can you be very clear in what you provide in terms of the agencies where you have gotten that tally?

Hon. Jeremy Cockrill: — Yeah, we will. It just might take some time to go back a couple fiscal years, so that's all I'm saying.

Meara Conway: — I have time. I have time. Thank you, Minister. Moving along, there have been a number of . . . Let me start that again. I'm just wondering how you track and keep track of severances that you're paying out. My understanding is that there have been a number of terminations without cause that would lead to severance obligations, which of course will be part of this health budget. Can you speak to how you keep track of the amount that you're spending on severance?

I think I know the answer, and I'll tell you why I think I know the answer. Take Scott Livingstone, for example. He left in December of 2021, but then I noticed that in the SHA annual report the following fiscal year, his salary was still listed. And I think it went up from three and change to four and change. So I think that's how you account or like sort of provide for the severance that you pay out to folks.

But could you clarify how that's tracked and whether you are keeping track of how much of your health care budget is going

to paying severances out?

Hon. Jeremy Cockrill: — And are you asking in a general sense? You just used one individual as an example. Are you asking on any specific examples, or just in a general sense?

Meara Conway: — Just generally. I mean obviously you can't go into specific people. It's just Scott Livingstone was a very public example so, you know, there's a government news release of when he left, and then we have the public annual report. So it's a safe example for me to just sort of put this theory to you without invading anyone's privacy in an inappropriate way.

But is that correct? Is that how you track severances? Is that true of every agency, be it Cancer Agency, SHA, or Ministry of Health? And then do you track the amount that you're spending on severances?

Hon. Jeremy Cockrill: — So severance would be tracked on an individual employee basis, right. So for the example that you used there would be, you know, that number in the annual report or Public Accounts, depending on which health sector partner you're talking about. You know, that number next to that individual's name would include obviously compensation for time worked and then any severance-related costs or vacation paid out, you know, at the end of their employment. We don't roll that up into a single budget line item that's tracked on an individual basis.

Meara Conway: — Would that appear though as salary paid out to the individual in future years? Or would there be another place where that expenditure would exist?

Hon. Jeremy Cockrill: — I think you're kind of talking about in what fiscal year the cost of severance is accrued to the employer, whether it's in the current year where the employment relationship ended or into a future year. Is that kind of what you're getting at?

Meara Conway: — I think so. Can you answer that, and then I'll think about whether that is my question?

Hon. Jeremy Cockrill: — Sure. Sorry, I interpreted your question as kind of trying to understand when that number is booked, what fiscal year that's booked. So it's not necessarily . . . If you were terminated in the fiscal year '24-25, that number might not only show up in '24-25. Because obviously if there's continued discussions about what a settlement may be or a back-and-forth between the employer and the terminated employee and then it's drawn out for some time, there may be dollars that appear into a future fiscal year's annual report.

Meara Conway: — And that number would just continue to appear as that person's salary, correct? Because you don't have a separate line item for paying out severances.

Hon. Jeremy Cockrill: — Yeah, it would show as, you know, their name and a number, whatever that number would be, and it would be the roll-up of again time worked — that number that shows up in our reports, time worked — and then any severance or other money paid out to that employee.

Meara Conway: — And so there's no tracking of whether, say for example, there's a year where severance pay — like severance obligations as a result of, for example, termination without cause — is higher than usual? Like you have no mechanism to kind of track how that ebbs and flows?

Hon. Jeremy Cockrill: — I'll try to get some information to maybe answer your question in a more detailed way. But just based on the last answer I gave to you, that could be a flowing . . . Like you may not know that number for several years, right. Because if there's an obligation that strings out over time, it's not necessarily clean cut, you know, when the year-end financials come in for a specific fiscal year. Does that make sense how . . .

Meara Conway: — Yeah. I guess I'm just asking because, like you know, the government makes a decision, for example, to terminate without cause knowing full well that it's, whatever, it's two weeks per year or whatever it is, depending on the person. Maybe I'm getting that wrong.

Hon. Jeremy Cockrill: — They . . . [inaudible] . . . common law.

Meara Conway: — Yeah. And is that booked as any kind of risk? Or I guess I'm just wondering how the overall financial picture accounts for that when you're making these human resources decisions, these human resources-based decisions.

[19:15]

Hon. Jeremy Cockrill: — So I know our conversation here is really around maybe accounting or budgeting policy for, you know, severance obligations. Do you think it's important . . . Just something that you mentioned or the way you worded your last question I think needs a bit of clarity. I mean you talked about, you know, government decisions to terminate without cause.

I mean we've got operational leaders here from all of our health sector partners who make those operational decisions in terms of hiring and firing every single day. As part of the budget process, it's not a government decision in terms of termination without cause. We've got lots of faith in many of the folks here in this room to make those decisions on an ongoing basis.

And just a point of clarification from previous answers. In the SHA, I believe it's the annual report, there is broken out just for executives in terms of a line item there for — or column, pardon me — for severance. But that's just for executives and just for the SHA. That's the only place that it's reported separately. Yeah, so I hope that . . . Did I answer your question?

Meara Conway: — Yeah, I'm not suggesting that like you're making decisions about terminations without cause at the Cancer Agency, for example. I'm just trying to understand how we track these liabilities. Because of course it appears like someone . . . Like take the annual report. It appears like someone's still working there in that role, being paid out that salary, but of course they're not. They're receiving a severance, and maybe someone else is filling that role or maybe that role has been removed. But I'm just trying to understand, from a public financial management point of view, how you're considering this financial liability and how it's informing your decision making.

Like if today I were to ask, how much did you pay out in

severance in this past year compared to the year before, compared to the year before that, just to see if we're trending up or down, would you even be able to answer that? Like theoretically I know you can't get that number tonight. But is that something that could be determined? And is that something you're tracking at all in the bigger picture?

Hon. Jeremy Cockrill: — Well my understanding is we'd have to go back through individual employee payroll files essentially and find that and add that up year over year. So you know, in a system of 37,000 employees that would be a bit of a . . . could be a bit of a process to roll that up. As I said, in the SHA annual report that separation or that delineation is available for executive employees of the Saskatchewan Health Authority.

And I think too it's important to point out any severance obligations. If we look at the total cost of compensation across the health budget, any severance obligations would be a, you know, while still potentially significant as they are taxpayer dollars, it's a relative drop in the bucket to the larger spend on compensation in any given year.

Meara Conway: — And to clarify, like you said, you know, it would take some time to go through individuals. And I think that'd be a pretty hefty FOI [freedom of information] bill because I think of this in those terms because I'm in opposition. But it's not something that you as the Health minister can say, you know, hey guys, can you let me know what we spent this past year on severance versus previous years? That's not something that you track, that any department tracks in that sense, correct?

Hon. Jeremy Cockrill: — No, the kind of questions and discussions that I have — with whether it be Tracey or whether it be other leaders in the health sector — is really, you know, empowering them to find the best possible . . . the right people for the right roles across the province and trusting that they're weighing those decisions as operational leaders in whatever organization they represent.

Meara Conway: — Thank you, Minister. I just want to move along to the budget for the Athabasca Health Authority. For the second year or perhaps more — I just only looked at this past year and the year before — there's been no increase to the Athabasca Health Authority in the budget. Of course they are a major health provider in Saskatchewan and they face, you know, actually added pressures in terms of transportation, inflation, the like.

I had an opportunity to review an exchange in estimates last year between Ms. Mowat and yourself, where you shed some light on this in the last year's context. And I don't have the exact quote, but you just kind of said the revenue for the Athabasca Health Authority was higher than expected. They had a higher cash balance. I think you said it was like 10 or 11 million. And I'm just trying to understand how that happens. Again I'm relatively new to this role in health. Is that because they're not able to like hire certain staffing? Because we know there are particular challenges in the North.

Can you speak to what's going on there? Because obviously when we see a budget that just kind of sits there it's, you know . . . I think to myself, well are they just absorbing inflation? Like what's going on? Obviously the health needs and challenges are significant. So can we dig into that a bit?

Hon. Jeremy Cockrill: — You bet. It's a unique arrangement. I do remember the exchange we had last year. Not verbatim, so we'll make sure that we get the right wording on that explanation for you.

So as would make sense, I mean Athabasca Health Authority, they receive the grant from us, which again has been, '24-25 budget year, 7.259; '25-26, 7.259; this year's budget, 7.259. Obviously they receive funding from other sources. Federal government would be the other main funding source.

And you know, in their reporting back to us, you know, they've continued to have annual surpluses over the last several years. So you know, they're starting this year with essentially . . . Or the forecast for the '25-26 year is they have accumulated surplus of $14.449 million. So you know, really in addition to the grant that they receive from us of 7.259, they have twice that amount also available in their accumulated surplus.

Meara Conway: — Have they indicated to you that they don't want that grant to increase consistent with cost pressures?

Hon. Jeremy Cockrill: — Well I would say, I mean this isn't necessarily experienced specifically with Athabasca Health Authority, but my experience in government with other third-party entities is, you know, typically government is not going to increase when government reviews and sees accumulated surpluses in an organization. Government tends to not increase the grant to that third-party organization, if there's an accumulated surplus, unless that organization can prove that there's a significant increase in level of service.

But as I said, this accumulated surplus has been growing, you know, doubling actually in the last five years. So you know, that would indicate . . . Certainly we're open to discussions with Athabasca Health Authority ensuring that service levels are appropriate. But my understanding of how we work with third-party partners is really, if there's accumulated surplus that keeps growing, the grant typically does not grow.

Meara Conway: — Yeah, I'm just curious because particularly in a case where, you know, you were responsible for all funding . . . But because they do receive multiple funding sources, I was curious if they're satisfied with that arrangement given that there are other funding sources, and so the province's funding is stagnant where perhaps other funding sources are stepping up more.

Hon. Jeremy Cockrill: — I couldn't speak to that. Certainly again in our reporting relationship with Athabasca Health Authority, the accumulated surpluses continue to grow. And you know, we'll continue to fund that grant amount.

Meara Conway: — Thank you. The plan to extend diagnostic capacity, is the plan to use third-party service delivery? And can you speak to who that will be and whether there will be RFPs [request for proposal], or how you're planning to specifically expand that capacity?

[19:30]

Hon. Jeremy Cockrill: — So I mean there's lots of places to talk about when it comes to diagnostic capacity. Maybe I'll answer your question first on the medical imaging side. Is that kind of where, what you were meaning first, or other?

Meara Conway: — Either one. And I guess I don't know why I kept it to diagnostic because there's like surgical — as well — plans. So if you could speak to all of it.

Hon. Jeremy Cockrill: — Yeah. Sure, okay. Well maybe we'll get to surgical in a minute, like, because I'll need to collect some further information for that part of the answer. Maybe I'll just speak to, though, on the medical imaging side, you know, a $21.74 million increase in this year's budget. So $2.6 million of that is to add capacity for another 3,000 MRIs, 1.46 million to add capacity for 5,000 additional CT scans. Both of those would be a mixture of SHA and private operators — again, all publicly funded, so no patient pay in those scans.

There's $960,000 for the annual lease costs for a mobile CT scanner, 520,000 for additional PET/CT capacity, $200,000 for one FTE [full-time equivalent] for a medical imaging physicist, $5 million for the replacement of the PET/CT scanner at Royal University Hospital in Saskatoon, $3.3 million for the replacement of the biplane angiography unit at the RUH [Royal University Hospital] interventional radiology suite, $2.5 million for a new CT scanner at Regina General, $2.2 million for the replacement of various medical imaging equipment in rural health care facilities, $2 million for a replacement CT scanner at F.W. Wigmore Hospital in Moose Jaw, and then a million dollars as well for the upgrade to the interventional radiology suite at St. Paul's Hospital in Saskatoon.

So your question was really around, on the diagnostic side, if increases are . . . I mean, they're all publicly paid for. You're asking, I understand, if they're being delivered by the SHA or being delivered by private, third-party partners. And this is just where, you know, it's interesting to note that there's been significant progress on just the number of CT and MRI scans over the last number of years, helped by the fact that . . . you know, adding capacity in SHA facilities, but also adding capacity through third-party partnerships.

So I mean, last year — and these dates are up to March 22nd of 2026, so there's still 9 or 10 days still to go in the final fiscal year numbers — but total private MRI visits in Saskatchewan, 12,700 in the '25-26 fiscal year up until March 22nd. If you go to the CT side, that's 14,660. So you know, representing a fairly significant portion, more so on the MRI side, but a fairly significant portion of the capacity that's available to Saskatchewan patients, again publicly funded but delivered through third-party partners in Regina and Saskatoon.

Meara Conway: — Yeah, and I'm not hoping to get into, like, a debate about the utility. I'm just trying to really understand, like, who's doing those services. Sorry, you said . . .

Hon. Jeremy Cockrill: — I can list it by vendors, but . . .

Meara Conway: — That would be great. Like for the CTs, sorry, you said 14,000 and change for CTs and 12,000 and change for MRI through third-party . . .

Hon. Jeremy Cockrill: — Correct.

Meara Conway: — Publicly funded but privately delivered?

Hon. Jeremy Cockrill: — Correct. I can list those off. So on the CT side . . . And again, these are '25-26 year-to-date numbers up to March 22nd, 2026. So on the CT side, 7,042 delivered by NMI [National Medical Imaging] and 7,618 delivered by RAR [Radiology Associates of Regina]. And so that's right about . . . Sorry. Acronyms, Mr. Chair. My mistake. NMI is National Medical Imaging centre. RAR, Radiology Associates of Regina. My apologies, Mr. Chair, for that.

On the MRI side, year to date again in the same time frame: 3,516 delivered at Mayfair Regina; 2,967 delivered by Mayfair in Saskatoon; by National Medical Imaging centre, 4,142; and by Open Skies, 2,075. I am happy to also list off those from previous fiscals if interested, but there has been an increase year over year.

Meara Conway: — Sorry, and these are the numbers for the '25-26 year?

Hon. Jeremy Cockrill: — '25-26 year up to March 22nd, 2026.

Meara Conway: — Okay. Okay, if you could, if you have those numbers for the '23-24 and '24-25 years, I would be interested just to do a comparison.

Hon. Jeremy Cockrill: — Sure. So going back to CT in 2023-2024: National Medical Imaging, 2,976; and then Radiology Associates of Regina, 8,383. Staying on CT in the '24-25 fiscal: with NMI, or National Medical Imaging, 6,594; and Radiology Associates of Regina, 8,152.

Now if we flip down to MRI for 2023-24 fiscal year: Regina Mayfair, 4,402; Saskatoon Mayfair, 3,405; National Medical Imaging, 1,427; none for Open Skies. Open Skies did not start delivering until the '25-26 fiscal. Now if we go to the '24-25 fiscal: Regina Mayfair, 3,590; Saskatoon Mayfair, 3,302; and National Medical Imaging, 3,955.

Meara Conway: — Thank you. You mention that Open Skies didn't start until the '25-26 fiscal. Is that correct?

Hon. Jeremy Cockrill: — Delivering MRI. I mean they might have been offering other services in their facility. But in terms of publicly funded MRI visits, I don't have any publicly funded MRIs delivered through Open Skies until the '25-26 fiscal year.

Meara Conway: — So what was Open Skies providing through the SHA in '23-24 and '24-25? I see that they have entries in the annual report, so I'm just wondering what that was for.

Hon. Jeremy Cockrill: — Yeah. Thanks for the question because it was important. I almost missed a footnote here. Open Skies did perform some MRI scans — or MRI exams, pardon me — for the SHA in very limited volumes prior to the '25-26 fiscal year. My understanding is they had a specific machine that was suited better for bariatric patients, so that's who the SHA was working with to service bariatric patients. Then Open Skies had an equipment issue. Then when they got their new machine in, that's when the SHA entered into an agreement with them.

I should share — and again this isn't . . . unless you want to debate the utility of this program — but just it does answer your questions in terms of additional capacity coming online. A procurement was done to add more capacity. So National Medical Imaging will be adding a second MRI machine, and university Medical Imaging in Saskatoon will start doing MRI and CT, it looks like, in late summer of this year.

Meara Conway: — Thank you. So Open Skies, prior to '25-26 those numbers are for that bariatric imaging. Do you know what you've spent this past fiscal year with Open Skies?

[19:45]

Sorry, I'm actually going to ask you that same question for Open Skies, Associated Radiologists, NMI, Mayfair — all of those companies you just asked for. So instead of you running back and forth . . .

Hon. Jeremy Cockrill: — We'll attempt to get you . . . see what we have for year-to-date numbers for all providers.

Meara Conway: — Even a ballpark.

Hon. Jeremy Cockrill: — So we don't have any year-to-date fiscal numbers for '25-26 for any of those providers. In previous years, that's — as I think you pointed out and is what you're quoting from — in the SHA annual report in terms of the payee disclosure report. So in future, like for when the annual report is completed for '25-26, those numbers will be in there.

Meara Conway: — Okay thank you. I could not find entries for Mayfair either in the SHA annual reports. Like I never know — again, I'm just learning the lay of the land — I never know are these contracts through SHA? Which ones are through Ministry of Health? I couldn't find an entry for Mayfair in either Public Accounts or SHA annual reports.

Can you clarify how that expenditure appears and where it appears? Like for past years and going forward?

Hon. Jeremy Cockrill: — So these agreements, just to clarify, they're held within the SHA, not the Ministry of Health. And your question in regards to Mayfair, they would report under a different name and that's a corporate . . . like different companies — say, you know, numbered company, dba [doing business as], whatever. So they would be under Radiology Consultants Associated.

Meara Conway: — Thank you. I understand we don't have the numbers; we have some of the volume, but we don't have some of the dollars. But just in terms of being able to assess this going forward, for Prairie Skies and Associated Radiologists LLP — and I'll come back to Radiology Consultants Association — can you break down . . . So take Prairie Skies for example. In '23-24, 15 million and change was spent, and then in '24-25, 14 million and change was spent. Can you break down those amounts? How much was spent on what type of diagnostic service for Prairie Skies, Open Skies, Associated Radiologists LLP?

I have those numbers, but those are all in the SHA annual report. So I'm just wondering if we can collapse those numbers a bit so we can understand a bit more about how much is going to various diagnostic services.

Hon. Jeremy Cockrill: — So we don't have that information. Obviously, I mean the SHA reports in the annual report how much is paid to each vendor. And as I said, I stated earlier which vendors do which services. But in terms of broken out what's CT and what's MRI, we don't have that information.

Meara Conway: — Can you get that information?

Hon. Jeremy Cockrill: — That would take some time potentially. And you know, I would just say too the SHA has agreements with all these providers in terms of what the per-operation cost . . . I mean that's a commercially sensitive number, so I don't think that's appropriate to table or share in *Hansard*. Because again, you know, there's procurement processes in terms of how we add partners, you know, and add additional capacity to the system.

So we could endeavour to find if there's a reasonable way to get some information, but I don't want to make a clear commitment to you on that tonight.

Meara Conway: — I guess, like not to put too fine a point on it, you've listed volume, like number of services. And of course as opposition scrutinizing the budget, I'm interested in the cost per service. Surely there's a way to get at that.

I know at estimates last year you talked about cost per mammogram, for example, for women that were travelling out of province. We've tried to get that contract. It's not been provided based on the competitive issue, but we were still able to get a commitment from you in terms of the cost that the public is paying per service. So I'm looking for something similar on these items.

And sorry to just pipe in here. It occurs to me that one way of getting around that kind of specific market-sensitive information might be for you to just . . . You know, you've talked about volume for a specific CT or MRI, but a lot of these providers — these amounts in the annual reports — they also provide other diagnostic services.

So perhaps you could just give a global number of services broken down by type of service. And then we don't know what each service specifically costs. We just know ballpark, you know, 14 million and change represented such-and-such amount of MRI, CT scans, and ultrasounds, for example.

[20:00]

Hon. Jeremy Cockrill: — Yeah, I'll just say, we will endeavour to see if there's a way to provide additional information beyond what we already have to you tonight in terms of costs, again without sacrificing that competitive commercial nature. I think that, as taxpayers, we're trying to drive best value in terms of that. And I wouldn't want to risk that on behalf of taxpayers.

You know, you draw the comparison to the publication of the per-unit cost of the Calgary agreement with Clearpoint in regards to biopsies, breast biopsies and diagnostic mammograms. You know, I'd just say that that was, is, continues to be a time-limited endeavour. So slightly different than kind of continuing to build

ongoing partnerships with the providers that are in our province and providing these services. And the numbers indicate some pretty significant volumes, especially on the MRI side.

So just, we'll endeavour to see if there's a way, but I won't commit to you tonight that I'll have that information for you.

Meara Conway: — Thank you, Minister. And of course, you know, all of what you've said may be true in terms of maintaining the competitive advantage, so to speak, but equally important is accountability to the public in terms of value for money. So it would be great to get a breakdown of, based on fiscal year, volume of services by each of these different third-party providers. I don't think that will expose any sensitive information.

On that, when you're making these kinds of decisions, what are your working assumptions in terms of what an MRI costs in the public system, what a CT scan costs in the public system? Is that something that you track? And can you provide those numbers if you have them?

And then I have a question about Clearpoint surgical solutions, just to clarify. Again I'm new to this area. There are funds flowing out to Clearpoint/surgical solutions via the SHA, funds through the Ministry of Health. Is the SHA amounts, which contract is that for? Is that for like the cataracts, orthopedics, general day surgeries, and then the Ministry of Health contract is for the breast care in Alberta? Can you just clarify that?

Hon. Jeremy Cockrill: — So I will maybe answer your Clearpoint question first. Your assumption I think is correct in the sense that any dollars flowing from the ministry are for the out-of-province breast . . . the time-bound agreement we have with them to improve wait times. And then in the agreement with the SHA and Clearpoint, that's for the surgical programs that are delivered — again, publicly funded, privately delivered.

Your question around working assumptions of costs in the public system . . . And maybe I'll start in a different topic but it'll come back. Based on our agreement with CUPE [Canadian Union of Public Employees] 5430, any time there's contracting out that could affect a CUPE member, whether that be here in Regina or Yorkton or North Battleford, there's a process that we go through with CUPE to show that there is similar or better value being delivered for lower cost. And so when it comes to medical imaging, that was done . . . Some were 10 or 15 years ago, and the SHA was able to prove or the ministry was able to prove at that time that there was cost efficiencies to the third-party delivery of medical imaging.

Very similar to, like, one example, you know, that I'm more familiar with is the security services, for example, in North Battleford and Prince Albert. GardaWorld is our provider in those communities. And similar, there was an RFP put out. GardaWorld was the successful proponent as part of that RFP — and sorry, Lloydminster in there as well — and then the process that the SHA goes through with CUPE to show the financial analysis.

So you know, I think that speaks to kind of the working assumptions, I think, were your words around the costs from a public provider versus a third-party provider, whether it be for security or whether it be for imaging services.

Meara Conway: — Is that like a one-and-done process, like 10 to 15 years ago? Like has there been any kind of ongoing process or ongoing work being done by yourself or within SHA to continuously assess the cost of these services provided publicly versus through a third-party private company?

Hon. Jeremy Cockrill: — So the member may be aware that in the fall, this September we signed an updated contract with Clearpoint, or SCI [Surgical Centres Inc.], in regards to extending the surgical agreement that we have with them. Prior to that RFP, the business case was redone in concert with CUPE and, you know, again continued to show the assumptions continue to hold. And CUPE was agreed to that.

And I will also say too, as part of that there was a commitment also made by the Saskatchewan Health Authority to reassess that business case during the life of the contract. So that contract is a five-year contract with SCI with a two-year extension. So that commitment I think is significant because it does go beyond the obligations stated in the collective bargaining agreement that we have with CUPE. But I think the show of good faith to say, yes, this process worked 15 years ago; it worked again here in 2024. And you know, a commitment to do the same thing, to take that step of reassessment again during that five-year contract.

Meara Conway: — Thank you, Minister. I guess just some context for this next question. I think one of the anxieties around this model of publicly funded, privately delivered care is it all sounds great in theory, but of course we have a finite number of staff and professionals that can staff, you know, the public or these third-party providers.

I FOI'd any material that would speak to kind of an analysis that some of these third-party providers would have on the public's ability to recruit and retain a workforce, and how the expansion of this private service was impacting that workforce. And I didn't get anything back, suggesting that isn't being considered.

Can you speak to the analyses that you've done in terms of looking at the impact this has on the difficulties you're having recruiting and retaining in some of the areas that draw on this workforce?

[20:15]

Hon. Jeremy Cockrill: — You know, it's an important question because I do think it's something that, as we provide confidence to the public in working with third-party partners, is very important. I'll talk on the medical imaging side and then maybe I'll flip over to the surgical side, because I think the point on the surgical side is very important.

So the contracts that we have with our medical imaging third-party providers, it stipulates in those contracts that the vendors are not supposed to be targeting SHA employees in terms of recruitment. And that's in the contracts. That was written right into the last round of procurement documents I understand. So you know, again that doesn't . . . Maybe not a perfect solution but I do think it speaks to, hey, as a third-party provider you need to go find, you know, go find additional human resources capacity.

The surgical side though I think is very important because . . . I'll speak to some hard and true fact and then I'll speak to maybe some anecdotal evidence that I've gathered in my travels. The reality is the scheduling of these surgeries is fully integrated within the SHA. So when the SHA is scheduling surgeries for you or I — so say we both have cataract surgeries — the SHA is determining if you're going to go get it at Prairieview in Saskatoon or if it's going to happen at RUH. So functionally the privately delivered surgeries essentially just act as another operating room, just in a different building in a different part of the community.

And if you think about the cost differences too between, you know, setting up a very purpose-built or purpose-designed surgical facility . . . And I don't know if you've had the opportunity to tour Prairieview in Saskatoon, but the layout of the building, you know, they procured a building and have made it fit their function. And so they've been able to be incredibly efficient in terms of delivering high volumes of surgery in a lower time frame.

You know, from an HR [human resources] perspective, again I've had the opportunity to tour SCI's facilities, both here in Regina and in Saskatoon. This isn't a hard and fast rule, but typically the staff that we see at these facilities may be towards the end of their career in health care or have retired and decided to come back and work in one of these surgical centres for SCI. And again really what we're talking about here is delivering more surgical volumes.

And I think, you know, from a patient perspective and as we put patients first, I think what matters to the patient is . . . I don't think they care if their cataract surgery is at Regina General or two blocks away at the Regina Surgical Centre. They just want to get it done as soon as possible. And I think that's what these contracts I think are really delivering in terms of surgical output.

Meara Conway: — Yeah. And I don't want to get into a debate on here but I think, you know, I think what the patient cares about is how long they're waiting. They don't care about volume expansion, for example; they care about those wait times coming down, which is I think what we need to be laser focused on.

Do you have any proof . . . Like the cataract example you gave me, that sounds great in theory. But like are you and I able to get those surgeries happening parallel because there's enough staff to support both parallel systems? That's where the question comes in. Or is one . . . Are we robbing Peter to pay Paul, so to speak.

So to that end, like do you have any proof that, you know, it's retired nurses that are staffing these private third parties? I appreciate the clarity in terms of the stipulation in the diagnostic contracts, but do you then follow up and track how many of those staff members were previously employed by the SHA within a time frame? Is any of that happening, anything you can point to in black and white?

Hon. Jeremy Cockrill: — I'll just say, I mean as I said, it's not a hard and fast rule in terms of . . . You know, I made it clear it was anecdotal in terms of . . . And again I've had family members, even in my own family in other provinces that, you know, have finished long careers in health care in operating rooms and then gone to work in private surgical centres in other jurisdictions. So it's not a hard and fast rule. I'm just sharing what I've noticed in terms of the folks that I've spoken with as I've toured through those facilities.

I do think though you make a comment. And again I'm not trying to get into a debate here but you talked about parallel systems. I think the reality is it's actually kind of one system if you think about it. Because with the integration of scheduling and managing which surgeries are being done where, it's not like, hey, Ms. Conway's in the lineup for a cataract surgery at Regina General and Mr. Cockrill's in a lineup for a surgery at Regina Surgical Centre, and we're both travelling along and, you know, who's moving faster or not. It's actually integrated in the sense of the SHA's looking at who needs to be booked for surgery, and then able to allocate cases to different facilities.

But I appreciate your question on black and white. We'll see what we can provide to you.

Meara Conway: — Thanks, Minister. And yeah, the integration piece, the degree to which that matters is just, are the wait times being positively or negatively affected and the value for money. So I'm just wondering, do you track . . . I appreciate that stipulation. This is something I can kind of hold onto, this term in the contract. Do you then follow up and monitor that or track that in any way?

[20:30]

Hon. Jeremy Cockrill: — Maybe I'll make some general comments and then try to provide some numbers. And again if the answers don't meet your satisfaction, maybe a more specific question might kind of lead us to a more direct answer.

You know, I would say, just from O.R. [operating room] staffing, it's very important to note that across the province our teams in Regina and Saskatoon and elsewhere are meeting on a weekly basis to again evaluate where we're at from a capacity perspective when it comes to surgery.

And you know, I think it's fair to say, speaking with folks here from the Saskatchewan Health Authority, that . . . So you've got the Saskatchewan Health Authority working with SCI, you know, trying to balance where we have capacity. If O.R. staffing was a pressure, a significant pressure in the public system, you'd hear about it in those meetings and you'd be talking about that. And that hasn't . . . Or you know, seeing staff leaving the employ of the Saskatchewan Health Authority to go to SCI, and that is not a theme of those discussions on a weekly basis, as I am to understand them.

And I think, you know — I speak to that integration piece earlier — that really is, I would say, fairly, in my conversations when I've had the opportunity to engage with SCI, I think SCI recognizes that we've got a unique partnership here in Saskatchewan, where we really are kind of delivering the best possible surgical outcomes for folks.

And I would just say too, you know, when we look at the number of surgeries, comparing 2021-2022 to '24-25 — and albeit that '21-22 was a fiscal year where there were some other challenges in the health care system — but going year over year or

comparing those two years, you know, a 7 per cent increase in the number of privately delivered surgeries whereas it's nearly a 26 or 27 per cent increase in the number of surgeries done in SHA facilities.

So it's a significant . . . You know, it's not just growth on the privately delivered side. As well and again, folks waiting longer than six months, comparing those years again, a 31 per cent decrease. So again showing, as this partnership continues to grow and evolve, more services being added, bringing down wait times. And bringing down wait times but in addition to that also being able to deliver more surgeries, because there are more surgeries being performed each and every single year.

Meara Conway: — So I think I did ask the specific question on the diagnostics. If you track that term in the contract, like they're not to specifically target SHA employees, I'm wondering if you track that formally. I'm hearing you don't. You just kind of assess whether this is becoming a challenge kind of through these conversations that are ongoing. Is that . . .

Hon. Jeremy Cockrill: — Yeah. Sorry, you're right. You did ask a specific question. Sorry, I was answering a question more on the surgical side.

When we talk about the medical imaging side, that specific isn't necessarily proactively enforced. Like we're not going to send SHA resources out to our medical imaging partners to see who's working there on any given day and if they are in the employ of the SHA at another facility. If something's brought to our attention, then I'm confident the SHA would look into that and assess.

Meara Conway: — Thank you, Minister. Just before I move on from some of these third-party providers, Prestige Car Service, 1.5 million last year, 1.2 million the year before. What does Prestige Car Service provide?

And while I'm on it, I didn't see an entry in any of the annual reports or volume 2 for something called, yeah, seniors corp care. I understand they provide services, but I don't see it in any of the annual reports. So I'm just wondering . . .

Hon. Jeremy Cockrill: — Your reference to Prestige Car Service, is that in the SHA annual report?

Meara Conway: — Yes.

Hon. Jeremy Cockrill: — Okay. And sorry, what was the name of the other provider that you were referring to?

Meara Conway: — I think it's seniors corp care. My understanding is they provide some services as a third-party contractor but I can't find them anywhere. In terms of the entry, much like Mayfair, I couldn't find Mayfair because it was under a different corporate name. So maybe that's the issue. I think that's the name. I'm just going to confirm that.

Hon. Jeremy Cockrill: — Prestige, you're asking for what those amounts correspond to in terms of service provided. And seniors corp care, you're asking does it fall under a different name and what services are provided.

Meara Conway: — I think it's, yeah, where that entry is. Because I understand they did have a contract with the government of some kind through Health. Just not sure where.

Hon. Jeremy Cockrill: — We will endeavour to find something.

Meara Conway: — Carecorp Seniors Services. And I think it's home care. Carecorp — C-a-r-e-c-o-r-p.

[20:45]

Hon. Jeremy Cockrill: — Thanks for your patience on that. Sorry. We're just trying to confirm specifically.

So the Prestige Car Service, that is our supplier of . . . They essentially provide the shuttle service between facilities in Saskatoon, as well as between staff parking and facility. So if you're a staff member at RUH and you park at the parking lot close to Merlis Belsher Place, Prestige Car Service is the company that owns and operates the shuttle that would be taking you to your site of work, whether that's City Hospital or RUH or JPCH [Jim Pattison Children's Hospital], as well as moving staff in between facilities.

The Carecorp Seniors, I'm not quite . . . I think maybe we need to make sure we're talking about the same company. So maybe if we can defer that question and make sure that we're — maybe in writing over the next couple days — talking about the same company. And then we'll endeavour to find you exactly what services or what relationship the Saskatchewan Health Authority has with that entity.

Meara Conway: — That sounds great. I'll be totally honest. I prepared for tonight in stages, and that was a question I wrote some time ago. And I am not even clear where I found that information, but I will clarify that and make sure I'm not sending you on a wild goose chase.

Moving along, Minister, as a result of the tragedy we saw with Mr. Dubois, my understanding is that there were two kind of prongs that were going to result from that. I think you put this in a letter, I think, or it was reported publicly or both. There was going to be an internal SHA inquiry/investigation. And then the Ministry of Health was also going to undertake a review of security more broadly.

Just hoping for an update from the Ministry of Health: who you've contracted to do that, what you expect to spend, whether there was an RFP posted for that. I didn't see one. So just wondering if you can speak to that as well as the timeline.

Hon. Jeremy Cockrill: — So you're going to get multiple folks treating you to an answer on this question. You know, and again just certainly a very serious incident that occurred at RUH. And I think you saw that from the response from both Andrew Will and myself in terms of some of the commitments made.

So I'm going to ask Ingrid to speak to the ministry review side and speak to where we're at with that commitment, and then Derek Miller from the Saskatchewan Health Authority will speak to what is that internal piece within the Saskatchewan Health Authority, the work that's being done there.

I will just say too, you know, you talk about two prongs. I would say there's really three prongs in the sense of obviously, you know, with any significant incident there's a review process within the Saskatchewan Health Authority. Certainly with this one there would be, and there is.

The ministry review just overall is a look at, you know — again that review being done independent of the Saskatchewan Health Authority — really just to take a look at protective services across the whole province. And again, as I spoke to earlier using the North Battleford example, we do have multiple providers of protective services at SHA facilities.

But the third prong I'd say is really some of the more operational response. Obviously the metal detectors — I won't belabour discussion on the metal detectors tonight — but being rolled out at eight different facilities I think has made a demonstrable difference. I know even at my local hospital there's a significant increased presence of protective services officers there. The front entrance looks different than it used to, and that's an adjustment for everybody in our community, but certainly I think it's helped make things safer.

There is also operational work ongoing between myself and the Ministry of Community Safety. And I think you'll see some movement on that very soon, just from some more interim operational response to it. But I'll ask Ingrid to speak to the ministry review, and then ask Derek to speak to the internal SHA work.

Meara Conway: — And maybe we could do one, then the other. Like maybe a back-and-forth about one and then move on to the other, if that's okay with you.

Hon. Jeremy Cockrill: — Sure.

Ingrid Kirby: — Thank you. Ingrid Kirby, assistant deputy minister. So as the minister said, the ministry will be leading a review of the SHA's protective services. We do have confirmation from the Ministry of SaskBuilds and Procurement, the chief procurement officer, that given the nature of the review and the need to move forward in short order, that we do not require procurement processes in this space because there are exemptions under the trade requirements. And I won't go specifically into all of those because I'm not an expert. However we do have confirmation that we can move forward with a third party to do this review without full procurement.

I would note we're currently in negotiations with the vendor, so I won't go into specifics on cost because we're still finalizing that through those negotiations, as well as the full scope and timelines. That said, we would expect to have the review completed this fall for consideration and with recommendations on how to move forward.

Meara Conway: — That has started though, that process, correct?

Ingrid Kirby: — Yes, we're currently in negotiations with a vendor to do the review.

Meara Conway: — The vendor has begun the review though, no?

Ingrid Kirby: — Technically they cannot start the review until we have a signed contract with them, so that is under way.

Meara Conway: — Is the vendor Buckingham Security?

Ingrid Kirby: — Until we finish negotiations, we would not be in a position to confirm.

Meara Conway: — Buckingham Security has begun some meetings, though, with individuals, so I'm confused.

Hon. Jeremy Cockrill: — If I may here, Derek's going to fill in, and this is why it's kind of important to talk . . . I know you wanted to talk about one and then talk about the other, but there's crossover in regards to kind of how the response from the health sector in general is rolling out. So, Derek, I'll ask you to answer.

Derek Miller: — Thank you, Minister. Good evening. I'm Derek Miller. I'm the chief operating officer with the SHA. And just in response to the question that you asked around Buckingham Security, part of the SHA response was to engage a third party to perform a use-of-force review for us to gather the facts of what happened and assess whether the use of force was in alignment with SHA training and policies. And so we engaged Buckingham to perform that third-party review just very specifically for this incident, not related to the broader security review that the ministry is leading.

Meara Conway: — What will you be paying Buckingham Security for that inquiry into this incident?

Derek Miller: — At this point in time, the investigation that Buckingham is completing for us is still in progress, and so we haven't received the final invoice for the total costs. So we don't have that number to share today.

Meara Conway: — Presumably you signed a contract, and was there any ballpark figure that was agreed to?

Derek Miller: — We pay them on an hourly rate, and so they're working towards that. So we have an estimate of where we think it might be, but we don't have the final costs at this point.

Meara Conway: — Are you in a position to talk about that estimate? And can you clarify whether an RFP was put out for this job?

[21:00]

Derek Miller: — We have completed a request for qualified suppliers for investigative services. And Buckingham was one of the proponents that was selected, and they are available to complete investigations for us. And so we picked them from that process that had already been completed.

Meara Conway: — Can you just clarify that for me? I don't understand how that works. So you didn't put out an RFP for this particular review, but you had previously an approved list of vendors?

Derek Miller: — Yes. So as an organization we occasionally require those types of services. So to allow us to be able to have a timely access to a firm that provides investigative services,

there was a procurement that was conducted. And so we have a list of potential suppliers. And so when we have a need, we access that list and select the right vendor that has the right skills to be able to complete a specific incident.

Meara Conway: — From that list of vendors, how many vendors did you have that you chose from? And why did you go with Buckingham Security?

Derek Miller: — I guess the first thing, first part of the question that I'll respond to is just around the process that we use to identify a supplier list. So we've done that for investigative services. There are other services that we do that. And it is a way to be more proactive so that we have the service more readily available when we're ready to proceed.

A larger example of that is our addictions services, where we've used that type of approach. It's allowed us to move more quickly with identification of providers of addictions services.

For this particular investigation, we were looking at the list of potential providers. We do look for the qualifications and the skill set and expertise that a provider might bring. So Buckingham obviously has that type of background and skill set that makes them qualified to assess use of force in this type of incident. And obviously availability is very important as well. We wanted to be able to move forward in a timely way, and they were able to meet that requirement.

We don't have the number of potential suppliers available right now — we're trying to get that — but there are several that are on the list.

Meara Conway: — My other question was just whether there was any kind of estimated cost agreed to or whether this was just sort of a . . . I don't say this disparagingly, but like a blank cheque. Like it'll take as much time as it'll take, and then you just charge us by the hour. Can you let me know the answer to that, as well as when it began?

Derek Miller: — In terms of when we engaged Buckingham to perform the investigation, we contacted them very shortly after the incident in order to have a timely response. We don't have an exact date of when they were engaged, but it was within the week or two after the incident.

You asked a question around the cost estimate and so on. As I've mentioned, we have an hourly rate. And our team that contracts their service, they have regular check-ins, and they have a very detailed understanding of what the work is. So they're able to monitor their work as it progresses to ensure that it's reasonable and within our expectations.

I will just maybe pull back a level and just note some of the immediate responses to and following the incident. In the day following the incident, our leadership team, we met with the family. It was very, very tragic circumstances and our hearts were definitely with them through what they have and are enduring. We also worked very closely with the Saskatoon Tribal Council, Tribal Chief Arcand, to have a connection with the family and be able to provide as much support as we could.

Following our normal procedure, this was classified as a critical incident and reported to the ministry. And we have a very prescriptive process that we follow to investigate an incident, to gather the facts and understand what were the contributing factors to something happening, and then to identify as a team what should we do to reduce the chance of that type of incident happening again in the future. And we share a report with the ministry and also the follow-up actions that come out of the findings from a critical incident review.

And then obviously, based on the use-of-force review that will be completed by Buckingham shortly, we will use that information as well to make improvements and changes within the SHA. Throughout this, we have co-operated with the police and coroner as they have worked to complete the investigation.

So I just want to emphasize, throughout we have remained in touch with the family and want to support them as well. And we'll be connecting with them as these pieces come together.

Meara Conway: — Thank you for that, Mr. Miller. You mentioned that you met with the family. Was there any engagement with the family on specifically using Buckingham Security? And were there any reservations, given the sensitivity of this event, given the proximity of Buckingham Security to the sitting government?

[21:15]

Chair Keisig: — I'm not sure how that question ties into the budget that we're debating here tonight.

Meara Conway: — Chair, this was . . . It's up to you. If you want to call the question out of order, it's up to you. Or if, you know, government wants to answer it . . . I'll leave it in your capable hands.

Chair Keisig: — Yeah, Minister, I do not see how that question has any relevance to the budget that we are debating this evening. Next question please, Member.

Meara Conway: — How much was spent on overtime in the '22-23 fiscal, '23-24 fiscal, '24-25 fiscal? And do you have any . . . Wait, that's it, right? 2022-23 fiscal up until now.

Hon. Jeremy Cockrill: — So for overtime compensation, this is for the Saskatchewan Health Authority, and we'll go by fiscal years here: 2022-2023, 200.4 million; 2023-2024, 218.3 million; 2024-2025, 249.8 million; and then year to date for '25-26 — this is till the end of February — 288.7 million.

Meara Conway: — Thank you, Minister. I have like two more substantive areas just to ask about, and then I have a couple kind of data points I'm hoping . . . And then I'm going to pass it over to my colleague. In terms of how you . . . It's been kind of identified to me or suggested to me that there's an absence of consistent life cycle reporting for medical equipment, and that this is like a key kind of governance issue, transparency issue.

SHA is obviously managing a diverse and aging portfolio of medical equipment. Of course there are added challenges because of the 12 health regions being amalgamated. You saw kind of a smorgasbord of different approaches to inventory and life cycle tracking.

And I guess I'll maybe just do a spiel and then we can . . . because I'm not sure what you have and what you don't. So my understanding is that like one proxy for like the health of your stock is maybe maintenance. Another proxy would be disruptions caused by equipment issues.

I'm just trying to get at how does the SHA track life cycle management and allocate resources in terms of a strategy around maintaining this equipment? And obviously . . . Sorry. I think it's getting late.

Hon. Jeremy Cockrill: — Can I just ask you a clarifying question?

Meara Conway: — Yeah.

Hon. Jeremy Cockrill: — Are you looking for a specific type of equipment? I mean there's such a wide range, as you can appreciate, right. I mean I don't want to answer questions about beds when you're asking about X-ray machines. Is there any way you can be more specific, I guess?

Meara Conway: — I'm just wondering how you track and therefore prioritize your capital stock. Is there a central place that you track that? How do you make decisions about, you know, ongoing maintenance and replacement? Because of course different facilities are competing for different equipment. So how is the SHA monitoring that and then acting on that?

Hon. Jeremy Cockrill: — So maybe we'll provide this answer, and I don't know if you want to go more specific after this answer. Happy to help there. Now this year's budget . . . And I talked about some of the medical imaging investments being made earlier, you know, in terms of a new CT scanner at the General or a replacement CT scanner at Wigmore in Moose Jaw, update to the interventional radiology suite at St. Paul's.

So I mean in this year's budget we have 43.4 million for base equipment, mostly through the Saskatchewan Health Authority. Some of that is through Cancer Agency. There's also targeted spends or line items I guess outside of that 43, specifically around the genetic and metabolic program equipment this year that I mentioned, some of the advancements that we're making in that program. Very targeted program again to bring some of those services back into the province.

I will ask Derek just to explain the process within the SHA that exists for how they evaluate needs and prioritize.

Derek Miller: — Thank you, Minister. Derek Miller, chief operating officer with the Saskatchewan Health Authority. So the SHA, we operate a maintenance program where all of our equipment is registered as part of our asset program. And when we do that, it's entered into a centralized maintenance management system that's available across all of our sites.

[21:30]

And we also have maintenance standards that define, for a certain piece of equipment, this is the preventative maintenance schedule. So how frequently does the clinical engineering team have to perform inspections on the equipment? And that basically sets in motion how the piece of equipment is maintained over the course of its life cycle.

We have teams, as I mentioned, within clinical engineering. We also have . . . When we procure a piece of equipment, we often enter a service contract with a vendor for them to provide expertise and servicing for the equipment from a preventative maintenance side, but also responding to demand maintenance that may be required if there's a break. So that's our normal ongoing maintenance program.

On an annual basis we do an intake across the organization where leaders identify their equipment priorities. And they use feedback from the clinical engineering team: the performance of the equipment during the past year, if there have been breaks or other issues. And then they would identify through this process the specific piece of equipment that they would be looking to replace their equipment with. And then we would basically prioritize that list and use the ministry annual funding that they provide for capital equipment to fund the priorities that have been identified.

In addition to this, we also have funding provided from home foundations across the province, which are an amazing resource for us in terms of supporting our equipment needs. And they make significant investments in terms of replacement equipment but also new innovations, new equipment that can help serve our patients.

Meara Conway: — Thank you, Mr. Miller. Can you clarify, that central mechanism, does it track the age and relative health and relative need of that equipment?

Derek Miller: — The system that we are using within the SHA now is new within the last two or three years. So new equipment as it's entered in, we would have the age because we would have the date of purchase. There might be some older equipment that we may not have an age associated with it, but we do have . . . It is the source of the maintenance records, so we would have an ongoing record of the maintenance, the preventative maintenance, the demand maintenance that has occurred on that specific piece of equipment.

Meara Conway: — What do you call that new system?

Derek Miller: — It is the CMMS — not to go into abbreviations — the centralized maintenance management system.

Meara Conway: — Thank you, Mr. Miller. I'm going to pass things on to my colleague, and I will follow up on a few items, Minister.

There is one area I am disappointed I didn't get to. And I'm just raising it because it's come up quite a few times at tables that I've been at, and it's affecting families quite significantly. The 150-kilometre policy around ALC [alternative level of care], long-term care, like moving people within 150 kilometres. My understanding is that this policy has existed for a while, but there's an ongoing pilot, which means this is being maybe utilized a bit more at least, moving folks from urban to rural communities. Hearing lots of concerns from families who are being separated. And then I'm also hearing concerns from the communities where those folks are going. They're unable to then accommodate their local folks.

I don't have a lot of time to go into it because I want to pass things over to MLA Roy, but I will be following up with a letter to both of you. Or maybe we can just have an aside about maybe what's driving this at some later point, unless you want to make some brief comments now.

Hon. Jeremy Cockrill: — I'll just make a couple of comments. You know, I imagine all 61 MLAs hear about some of the challenges in regards to this. There's a reason for the policy, but really I think Minister Carr can speak more to specifically how we're working through that. And I know we have officials in the room here as well who could speak to that if you do want to speak longer. But I'll let Minister Carr make a few comments on this.

Hon. Lori Carr: — Yeah, I guess with long-term care facilities, we try to have enough facilities in each given community to be able to accommodate the population, the aging population that we have. But obviously that's not a perfect system. It ebbs and flows. Sometimes we have less people. Sometimes we have more people. So when we do have more people, we have surrounding communities that have empty spaces.

So we're using the assets that we have in the best way possible. And it's not ideal to move your loved one to a community outside of the home that you're in, but it is a better . . . It is a policy where they go into a home in a different community, but they still have their first nursing home of choice. So when a bed comes available, they will be able to move back to that nursing home that they wanted in the first place. So using the assets that we have in the best way possible with the goal of getting people back to the community that they want.

Meara Conway: — Thank you. I'll pass it over to my colleague.

Jacqueline Roy: — Thanks so much. So moving on to oncology, when we look at full-time equivalent oncologists now versus last fiscal, just full-time equivalencies, where are we at in relation to last year?

Hon. Jeremy Cockrill: — Thanks for your patience. Just making sure we have correct numbers for you. As of last year, so that would be as of December 31st, 2024, we were at 62.9 filled FTE for oncologists. Fast-forward a year to December 31st, 2025, 66.3 filled FTE for oncology. But then fast-forward to today, April 1st, 2026, we've filled one of those positions, so we're at 67.3 filled FTE.

We only have two vacancies in oncology at the moment. And I would say credit to the work done by the Saskatchewan Cancer Agency, again focusing on team-based care so that our oncologists have the other medical professionals on their team manage those workloads. You know, and as well . . .

Jacqueline Roy: — I think we can all definitely appreciate that, and I would agree with you on that. Forgive me, Minister, but I will be trying to go as quickly as possible because some of these questions are very important.

I will be asking for a breakdown for each oncologist and oncology medical professional corporation who has to be listed on the Public Accounts payee disclosure list. And I'll be asking for that breakdown of the amount paid at regular rates and the total paid at bonus or overtime rates. I'm aware that information might not be here tonight, so I will give a grace period for that. And I'll also ask to be included in that how many of those positions are locum, part-time, and full-time. Is that clear?

Hon. Jeremy Cockrill: — You're asking for compensation for the oncologists, what was paid out at regular rates versus bonus or overtime rates?

Jacqueline Roy: — Yes, and for oncology medical professional corporations. For everybody on the Public Accounts payee disclosure list, as well as what positions are locum, part-time, and full-time. I do think that would take more than two or three minutes, and if that's the case, I will just ask for that to be tabled here within three weeks.

[21:45]

Hon. Jeremy Cockrill: — Well let's see what we can provide for you.

Jacqueline Roy: — Okay. Thanks for your patience. If it goes on too long, we'll move to the next one.

Hon. Jeremy Cockrill: — So in your first question regarding compensation, certainly don't have that information here tonight. I understand that that will be quite a process to break that out, to go back and look up invoices for nearly 70 professionals and start to break that out. So we can endeavour to do that for last fiscal, but I would suggest that we would need more than a few weeks to provide that information to you.

In terms of the list that I've said to you, 67.3 FTE, we have no locums as a part of that. Out of that, there are five individuals, like they're all full-time, but there are five of them that do clinical work on a part-time basis. So it means, you know, the other parts of their work might be around research, around a leadership position, teaching program. So most are . . . well they're all full-time, just five of them have other responsibilities, not unlike other specialty groups in the province.

Jacqueline Roy: — Indeed, agreed. Yeah, I am limiting it to a very specific region in order to control the time it will take, so I do appreciate that effort.

Hon. Jeremy Cockrill: — Sorry, were you talking about a geographic region or a . . .

Jacqueline Roy: — No, no. Specialty, right? Yeah. Okay. When can I expect a return on that then?

Hon. Jeremy Cockrill: — Can I just ask for clarification of the report that you're specifically looking at? You're looking at the payee disclosure report or the Sask Cancer annual report? Is that your kind of . . .

Jacqueline Roy: — I'm looking at all oncologists.

Hon. Jeremy Cockrill: — But just the numbers. So the numbers that you're looking for clarification on, are those in the payee disclosure report or in the annual report?

Jacqueline Roy: — Both are officially accounts that need to be published under the payee disclosure guidelines.

Minister, I can actually clarify if I may, if this would help. I guess what I am looking for would be people employed through the SHA, through the Public Accounts volume 2, and through the Sask Cancer Agency. Right? If that makes sense to people.

Hon. Jeremy Cockrill: — Makes a bit more sense, yeah. I'm just working to figure out exactly what we can commit to providing for you, just so we're clear on this.

So we're just getting all on the same page here. So like Public Accounts for executive government, I think you're talking about the Sask Cancer payee disclosure report in terms of the individual physicians and the prof corps on there. Is that correct?

Jacqueline Roy: — Sask Cancer Agency.

Hon. Jeremy Cockrill: — Sask Cancer Agency. Yes. So we will be able to get you a global number across all oncologists in terms of what was paid out at regular rates and then what was paid out for extra clinics. We won't be able to break that down per physician or per oncologist. But we won't have that number for you tonight, but we will endeavour to get that number to you as soon as we can.

Jacqueline Roy: — So my understanding is that you can't break that down per medical professional corporation? Okay, could I get the reason for that then? Specifically for the Sask Cancer Agency, where I mean the numbers are obviously there, right? So is there a reason we can't provide them publicly?

Hon. Jeremy Cockrill: — So again we can provide that number on a global level in terms of dollars paid for additional work. We don't break out the payments to medical professional corps in any other specialty and not in this case either.

Jacqueline Roy: — Okay, thank you. Moving on. So with the Regina General Hospital unit 1D, been in code burgundy a lot, a lot of over-capacity issues. I'm wondering how long has it been in code burgundy or over capacity this year? And does any part of the budget reflect a solution to that?

[22:00]

Hon. Jeremy Cockrill: — So as I understand, you referenced Regina General 1D. That's adult mental health, correct? Correct.

Yeah, so currently, I know I just did the point-in-time check. I mean as of this morning, we had five available beds there as of this morning. Just looking at our average daily census and occupancy for the '24-25 year — which is the last information that I have over a longer period of time — 50 beds available in adult mental health at Regina General. The average daily census is 44, pardon me. Average length of stay over that time period, 18.47 days.

In terms of what's in this year's budget to address capacity pressures specifically there, and really generally across Regina, there are funds in this year's budget dedicated towards Regina master planning, as there are in Saskatoon. Same discussions happening in Saskatoon in terms of understanding what is available with existing assets in the city, understanding how we utilize those and where we can find additional capacity. And then looking at what are the capital needs in the future.

Jacqueline Roy: — Definitely understood. And I appreciate getting the average daily census. I'm just looking for clarification for my own tabulations as to how many days we were in over capacity or in code burgundy.

Hon. Jeremy Cockrill: — Okay, I have some more current numbers for you. So this is for the '25-26 fiscal year, so hot off the presses. The Regina General Hospital mental health over capacity, 209 out of 365 days. However there's caveats to this number which need to be noted. That's the 8 a.m. census. So maybe there's 52 admitted at 8 a.m., but then there's discharges throughout the day. So that's using the 8 a.m. census.

I would just also note too code burgundy is actually kind of legacy wording from the old RQHR [Regina Qu'Appelle Health Region] days, I guess. If there is a situation where a unit is over capacity, then there's surge protocols in place. And then that's obviously utilizing other space and other capacity within the hospital building to accommodate those additional patients.

Jacqueline Roy: — Thanks so much. Appreciate that. And could I get those numbers for the equivalent unit in Saskatoon in Dubé hospital?

[22:15]

Hon. Jeremy Cockrill: — So again the caveat on these numbers is it is based on the 8 a.m. census every day. The equivalent number for the '25-26 fiscal year at Saskatoon Dubé for adult mental health, over capacity, 325 out of 365 days.

Jacqueline Roy: — Thank you for that, Minister. Appreciate it. Moving on I guess to a different area here, just looking at the contract that was just extended in order to deal with biopsies and mammograms. What was the procurement process used this time before extending that contract? And in the event that there was no procurement process, I guess what was the justification for not using one?

Hon. Jeremy Cockrill: — So the extension of the current contract again, just essentially rolling over our contract with the existing supplier, I mean, with the decision made just in recent weeks after evaluating where we're currently at in terms of wait times.

You know, there's been significant progress reducing, you know, since this contract was brought into place, reducing biopsy wait times in Regina by 87 per cent. That's fairly significant. Obviously we've opened the breast health centre, added a couple breast radiologists specifically. So good progress.

My personal belief that I think while there's been good progress, we want to keep the momentum going and not . . . You know, as we get the breast health centre, you know, really kind of going here after its first year of being in operation, I didn't want to lose momentum. And so we saw an opportunity here to extend a current contract with an existing supplier.

Jacqueline Roy: — Okay, so therefore a tendering or procurement process wasn't used because of what you just explained, correct?

Hon. Jeremy Cockrill: — Correct. We're extending an existing

contract. And our procurement process originally on this, the procurement process used was approved by the chief procurement officer with the Ministry of SaskBuilds.

Jacqueline Roy: — Thank you for that. Okay, moving on here to yet another area. I know we've talked about this a little bit more. To my understanding, HPV [human papilloma virus] at-home testing kits that were promised in November of 2024 haven't been distributed. Do we have a price and estimated time that that promise will come into effect?

Hon. Jeremy Cockrill: — So as you mentioned, this was an election platform commitment during the last election campaign. You know, fairly significant project, just because it does require, you know, changes to lab equipment, lab processes. So there has been investments made last year, over $2 million, to add six FTEs to support the transition to HPV testing. And you know, that's funding to Sask Cancer Agency.

This year again, continued funding in this year's budget. We are on track. There's still some negotiations going on right now in terms of the provider for the laboratory equipment. We are in early stages of an RFP process for the self-sampling kits. The planned launch of HPV primary screening is March 2027 and aiming to have self-sampling kits to follow just a couple months after that is rolled out.

Jacqueline Roy: — So then June 2027-ish, right?

Hon. Jeremy Cockrill: — That's the goal. I mean the target initially is to make sure that we have the HPV primary screening set up, and then that really will set the table for the self-sampling kits.

Jacqueline Roy: — Okay. Thanks for that. And one that we always ask each year, basically just wondering once again how many patients are in queue for mammography in Regina. And then along with that, if you could just provide an update: globally how much money has been spent on travel and accommodation with respect to, of course, the Calgary project?

Hon. Jeremy Cockrill: — So I'll just start with your question on the Calgary part of your question. So as of February 17th, 2026, the ministry has processed approximately $151,000 of travel expense claims for 632 patients that travelled to Calgary. And just to clarify — I know I clarified it last year; I'll take the opportunity again — they are travelling specifically for breast biopsies. If a diagnostic mammogram is necessary, that also occurs in Calgary.

Just when it comes to screening mammograms and wait times or the folks waiting for an appointment — again this is in the screening mammogram program — as of March 24th we currently have nobody waiting for an appointment. So that means everybody has been booked into a time slot. We expect 34 per cent of those on the Regina list will be scheduled within six weeks, and we expect the remaining 66 to be no longer than four months.

Jacqueline Roy: — Fantastic. I just need to know exactly how many are in queue. I fully, though, understand . . .

Hon. Jeremy Cockrill: — 2,517. So again all of those women have booked appointments: 34 per cent within six weeks, the remaining no longer than four months.

Jacqueline Roy: — Awesome. Thanks so much. I'm just going to add one more question here, looking at the time. I know we canvassed this a little bit earlier today when we were looking at SANE [sexual assault nurse examiner] nurses. So the SHA asked for 1.8 million. That does seem . . . I'm wondering were there discussions around that number that you might have needed more money than that?

[22:30]

Hon. Jeremy Cockrill: — So in regards to the sexual assault nurse examiners working in our system, as I have said earlier today, we do have these services 24-7 in both Regina and Saskatoon currently. There's also coverage in Prince Albert, not currently 24-7. The coordinator in Prince Albert provides forensic examinations to survivors of assault who present to the emergency department during core hours, 7:30 a.m. to 4 p.m. And after core hours the service is currently supported by emergency departments' physicians and staff.

The member asked about discussions in regards to budget. You know, through every budget process that I've ever been a part of in this ministry and other ministries, there's discussions that occur at multiple levels in the process. And so I can assure the member that anything that is brought forward is discussed at various levels within the organization and considered in that process.

Chair Keisig: — Thank you, Minister.

Having reached our agreed-upon time for consideration of these estimates, we will now adjourn consideration of the estimates and the supplementary estimates no. 2 for the Ministry of Health.

Minister, would you like to add some closing comments?

Hon. Jeremy Cockrill: — Thank you, Mr. Chair. And we really, I thought, did a great job of limiting acronyms this evening. I hope you appreciate that. I just want to thank all members of committee for being here tonight, certainly the building staff who are willing to stay here until 10:30. Ms. Conway and Ms. Roy, thank you for your questions tonight.

Most of all though I'd like to just thank the many officials who have joined us again from the Ministry of Health, the Saskatchewan Health Authority, the Saskatchewan Cancer Agency, the Healthcare Recruitment Agency, 3sHealth, eHealth as well. I think I got everybody.

These folks do an incredible job in terms of helping myself and Minister Carr really over the last several months as we prepared for budget, but really more importantly developing the patients-first health care plan and really refining our focus, ensuring that Saskatchewan patients are at the heart of every decision that we make when it comes to health care in this province.

And so not only helping, thanks to these folks for travelling, some of them to Regina for last night and tonight, but the work they've done over the last several months, and I know the work that we've already embarked on to execute and deliver on the 50

next steps that we outlined in the patients-first health care plan. I enjoy working with these folks, and lots of work ahead. Thanks.

Chair Keisig: — Thank you, Minister. MLA Conway, would you like to have some closing comments?

Meara Conway: — Thank you, Chair. I just want to echo the comments of Minister Cockrill and thank the officials that made it out tonight. Budget is hard enough, then you have to come out to estimates, throw on a tie. And I know I'm the last thing between you and your bed, so I'll keep it brief and just extend my thanks and gratitude.

Chair Keisig: — Thank you, MLA Conway. And thank you to the minister and his team and the committee for all of their hard work this evening. And thank you to *Hansard* and the building staff.

This committee stands adjourned till the call of the Chair. Thank you, everyone.

[The committee adjourned at 22:35.]