EVENING SITTING

COMMITTEE OF FINANCE

General Revenue Fund
Health
Vote 32

The Chair: — I remind committee members that the department was last here on April 12, but that being some time ago, before I call subvote 1, I'm going to invite the hon. minister to introduce her officials.

Hon. Ms. Junor: — Thank you Mr. Chairman. Beside me is Steven Pillar, the associate deputy minister. Next to Steven is Wanda Lamberti, director of budget and financial planning, finance and management services. On this side of me is Roger Carriere, director of program support, community care branch. Directly behind me is Barb Shea, executive director of the drug plan and extended benefits. Next to Barb is Marlene Smadu, our assistant deputy minister. Next to Marlene is Jim Simmons, executive director of community care branch. And at the back we have Carol Klassen in the middle, assistant deputy minister; Kimberley Wihnan, assistant to the deputy minister; and Neil Gardner, executive director of corporate information and technology.

Subvote (HE01)

Mr. Gantefoer: — Thank you, Mr. Deputy Speaker, and good evening Madam Minister and welcome to all of your officials.

For this second in a series of Health estimates in the department that has a great deal of scope and breadth and a pretty significant budget — a matter of outstanding business, Madam Minister, from our last session on April 12. I had asked for — and you had agreed to provide, and you did provide — some information on the SHIN (Saskatchewan Health Information Network) network in terms of summaries of the projects that were undertaken.

It was my understanding that I had asked for a more specific and detailed . . . I appreciate the summary, but I certainly would ask if you could break that down even further in terms of individual contracts that were awarded. This was . . . you know, general categories that you've outlined for me, and I do appreciate that, but I would ask for your undertaking to drill down a little deeper, if you like. And I had mentioned that I'd like it to the standards of the public accounts scrutiny which indicates contracts above a pretty minuscule level, and I'd like those kinds of bits of information if I could, Madam Minister.

Would you like to respond to that on record? Can we have that?

Hon. Ms. Junor: — Thank you, Mr. Chair. Yes, we'll provide some more detailed information for the member.

Mr. Gantefoer: — Thank you very much, Madam Minister. I do appreciate that. I think it's important for us to understand all the various components of the SHIN system and where it's at, so I appreciate that undertaking.

Madam Minister, as I indicated to you tonight, the first item that I want to visit tonight is the whole issue of the drug plan and the process of how the drug plan works and how drugs are brought on to the drug plan formulary.

And, Mr. Deputy Speaker, if I could, would it be possible at this stage to introduce a guest in the gallery?

The Deputy Speaker: — The hon. member for Melfort-Tisdale has asked for leave to introduce a guest. Is leave granted?

Leave granted.

INTRODUCTION OF GUESTS

Mr. Gantefoer: — Thank you, Mr. Deputy Speaker. I wasn't entirely sure of the process when I was already on my feet. But this evening with us is Tracy Kuhtz, and Tracy is the executive director of the Alzheimer's society. And certainly as I think members know, and certainly the minister knows, the Alzheimer's society has been very, very diligent in terms of advocating on behalf of people with the most debilitating disease of Alzheimer's, and we certainly welcome her to watch proceeding this evening.

Hon. Members: Hear, hear!

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Subvote (HE01)

Mr. Gantefoer: — Thank you, Mr. Deputy Speaker. I get to start again, thank you.

Madam Minister, as I've indicated, I believe in our first series and certainly it's been my practice in the past, I would like to give an opportunity for you to initially give a brief overview of the drug plan and how it works, a brief overview of the plan and at that stage do that. And then I would like to move on to the formulary process, per se.

Hon. Ms. Junor: — Thank you. I welcome the opportunity to actually do some of that. That's a good opportunity to describe the drug plan. And I also welcome Tracy.

The drug plan . . . the Saskatchewan Prescription Drug Plan is structured to assist families with low incomes and families with high drug costs and those with a combination of the two. And the benefits of the drug plan is targeted to those with the greatest need and the least ability to pay for their medications.

All the residents in Saskatchewan are covered by this except those who are not covered by other agencies, such as registered Indians, RCMP (Royal Canadian Mounted Police), veterans, and the Workers' Compensation Board.

There are specific benefit programs in the drug plan like the special support program, emergency assistance, exception drug

status, palliative care coverage, social assistance clients, and family health benefits. And we also have the Saskatchewan Aids to Independent Living under the drug plan.

Saskatchewan remains one of the three provinces which provides some assistance with drug costs for the population as a whole. And our drug costs, for some examples, in '94 to '95, our government paid 52.4 million in prescription drug costs; in the 2000-2001 government budget, it's 98.9 million. So there's a significant increase in the cost of the drug plan.

We have two drug committees that review drugs which I just want to describe to you the process. The Saskatchewan Formulary Committee is a professional committee which provides technical assistance to the provincial government. Their activities include advice on the selection of drugs to be covered by the Saskatchewan Prescription Drug Plan, an ongoing review of existing products currently covered by the plan, and development of appropriate drug education tools for consumers and health professionals. And the members of the committee represent the special interest groups as shown. And Dr. Bruce Schnell is the chairperson.

And the other committee . . . and there's members on, members at large, a member from Saskatchewan Health, a member from Saskatchewan Pharmaceutical Association, a member from SAHO (Saskatchewan Association of Health Organizations), a member from the college of physicians and surgeons, one from the Saskatchewan Medical Association, one from the Saskatchewan Registered Nurses' Association, and the college of Medicine, as well as members at large as I've said.

The other committee is the Saskatchewan Drug Quality Assessment Committee, and this is appointed by the Minister of Health to advise the Saskatchewan Formulary Committee, which I just mentioned, and outline the membership in the role, in compiling and maintaining of the Saskatchewan formulary which is the list of all the drugs that we have under the drug plan. Their activities include review of scientific reports about new drugs to determine their safety, effectiveness and quality in relation to therapeutic alternatives, the evaluation of reports of comparative bio-availability studies to determine the compliance of different brands of drugs with standards for bio-equivalence, review of new chemical agents and existing products to determine their appropriate role, if any, in drug therapy in Saskatchewan.

Members of this committee include Dr. John Tuchek as the chairperson. We have someone from the College of Pharmacy, two from the College of Medicine — Dr. Bruce Schnell who is the chairperson of the Formulary Committee is ex-officiary member of this one — and another member from the College of Pharmacy and a member representing the departments of medicine and pharmacology from the College of Medicine.

That is the basic overview of the drug plan in pretty much a very sketchy way. But it gives the two committees that determine the drugs that are on.

Also, we can talk about some of the new drugs, and so it gives us an idea of how many drugs would have been approved — say — in a year. And this year we have had . . . I have a list with me, and they'll be included in the July edition of the formulary. There are over 200 new drugs that have been added to the formulary this year, and 70 of the new drugs or . . . there are more than 70 of these that are new drugs or new formats of drugs. And these include important new therapies for arthritis like Celebrex and Vioxx, and therapies for hepatitis, asthma, diabetics, and other diseases. And there are more than a hundred new generic products that have been added. The addition of these products helps to make drug therapy more affordable for our residents. So like I said we do have a list of all those new drugs if you are interested in that, but that's sort of a broad overview of what the drug plan is like.

Mr. Gantefoer: — Thank you, Madam Minister. Madam Minister, before I would like some further discussion on the two committees that you outlined, I would like to talk about the plan itself a little bit. You indicated there's a number of sub-plans, for lack of a better word, within the global plan that address people with special needs and things of that nature. You mentioned that there's a social assistance plan. Does that plan cover a hundred per cent of anything that's prescribed, or how does that plan work for people that require the financial support because they're on social assistance?

Hon. Ms. Junor: — Thank you, Mr. Deputy Speaker. The social assistance clients, those who receive social assistance will pay no more than $2 for each covered prescription and it does only cover drugs that are on the formulary. Certain drugs such as insulin and oral contraceptives are no charge, and if you are under 18 you will receive covered prescriptions also at no charge. During 1998-99 the drug plan paid out benefits of 17.4 million on behalf of 51,797 social assistance beneficiaries.

Mr. Gantefoer: — Thank you, Madam Minister. Thank you for as well mentioning and anticipating my next question was if they're irrespective if they are on the formulary or not. So they have to be on the formulary before that they're covered in any way.

Madam Minister, as you know there is drugs you know, like Aricept, for example, that has been the most recent talked-about drug for Alzheimer's disease. And there are people . . . this drug has been approved by Health Canada for a number of years, I understand. So it is available in Canada as a prescription drug. But individuals who purchase this drug have to pick up 100 per cent of the cost of it.

And at this stage I understand, and we're going to talk about it more, it's not on the approved . . . on the formulary. So people on social assistance, who are unable to pay the cost of Aricept out of their personal well-being or wherewithal, absolutely have no access then to this drug. Is that correct?

Hon. Ms. Junor: — That's true. The drugs, as I said, have to be on the formulary before they are covered.

Mr. Gantefoer: — So I know this is going to be difficult for you, but then it means that the people that have got the money got a different level of potential care than the people that do not have the money. Is that correct?

(1915)

Hon. Ms. Junor: — What we're doing, and I can explain to

you the status of the Aricept review because I'm sure Tracy would like to hear that too, there is a, like I said, the process of the two drug committees which review the submissions. And they definitely have done a lot of work with Aricept. Some of the delay has been caused by new information that has come from the manufacturer as well as some from us asking for more information.

The committee met on April 27 and they considered the information that's been provided since they last reviewed Aricept. And I haven't received a written response from the committee but I understand they're waiting for a report from the Canadian Coordinating Office for Health Technology Assessment, which is called CCOHTA — CCOHTA — before making another recommendation.

CCOHTA is commissioned by the provinces and territories to provide additional information in the area of drugs and technologies and we do value their role. The report will provide us with additional information that the committee can use in their assessment. The CCOHTA report talks about the methodology of how all the drugs that they're reviewing — how they've studied what they've done, the clinical trials, and that sort of thing.

The next meeting of the Formulary Committee is June 15 and I do understand that of course there are people who would rather have a response sooner than that, but in all fairness we want to have all the information that's possibly available before we do make the decision on this.

The Chair: — Order, order. I just wish to remind the hon. minister that references to guests and involvement of guests in answers or in debate is not permitted. I know it was a fairly fleeting reference but it's just a reminder to all members.

Mr. Gantefoer: — Thank you, Mr. Deputy Speaker, and I'm sure that we'll all be very diligent not to engage anyone in the gallery in the debate.

Madam Minister, I thank you for that comment but it wasn't the answer to the question I asked. I used Aricept simply by way of example. There certainly are other drugs that I could pick that takes us off on a different topic to talk about the principle that I was getting at. And that is that people on social services, if they can't afford to pay for a drug that hasn't been included in the formulary, are not going to be able to access that drug. They don't have the money, Social Services won't pay for it, and it isn't included on the formulary — where other people that have the money to pay for the drug, be it any other drug, have the opportunity to do that. So what you've done is created a situation where people that have money have a different level of health care than those that are on social services. Is that correct?

Hon. Ms. Junor: — Thank you, Mr. Deputy Speaker, what happens in Saskatchewan is no different than other provinces. If you don't have the drug on the formulary, it isn't covered by the drug plan and what . . . Many of the drugs that we review are not included on the drug plan because they're not either cost-effective or of value to the health system. So we don't approve every drug that Health Canada brings out nor does every other province.

So we're no different than that, than the other provinces, when we talk about which drugs do come into the formulary and which don't. We have the two committees which I think is fairly unique that we have a rigorous screening process with these two committees of experts that look at the clinical trials, the medical evidence, and they give us their best advice.

And those committees, as I've read to you, include members of the professional groups from the Colleges of Medicine and Pharmacy and a wide variety of professionals who deal with drugs, that their best advice to us is what we follow.

Mr. Gantefoer: — Thank you, Madam Minister. I guess the point I was making is that for all the protesting that you do from that side of the House, you have to acknowledge that in the instance of the availability of certain of these drugs there really is a two-tiered health system in this province depended on if you have the money to purchase this drug or not. And so that's the point.

The other point is, Madam Minister, while we're briefly on people that require help from the province by virtue of the fact that they're unable to provide for themselves and are on social assistance, what is the cost to them for ambulance services?

Hon. Ms. Junor: — Thank you, Mr. Deputy Speaker. For ambulance trips into the North, we do pay for those for social assistance clients. For details about southern trips, you'd have to ask Social Services estimates because we don't have that detail.

Mr. Gantefoer: — Thank you, Madam Minister, and I appreciate that. We certainly will direct that then to Social Services.

But I want to, I want to move back to the formulary. And I will use Aricept as the example, but please . . . I want to illustrate a point here and use Aricept as an example.

You've indicated that there are the two committees of the drug plan that review the drugs that are approved by Health Canada and are reviewed to see if it's appropriate for them to be included under the formulary plan.

Madam Minister, when they review these drugs, what criteria or what terms of reference do they use? And I'm thinking in terms of, do they use the actual hard cost of the drug? Do they balance that out against the efficacy of the drug and how well it's performing? Do they look at other costs that are going to be incurred by society or the health system?

And I'm thinking of things that if even a fairly expensive drug, on its own merits, is able to save money in the long-term care budget or the budget that needs long-term hospitalization or things of that nature, how broad is the mandate or how narrow? And how thoroughly do they look at the total ramifications of including any drug in the formulary?

Hon. Ms. Junor: — Thank you, Mr. Deputy Speaker. The Drug Quality Assessment Committee which is the first committee that looks at the drugs, it actually looks at . . . has a very broad criteria — broad range of activities — that they take into account.

They look at the scientific material and they review these scientific reports about the drugs to determine their safety, their effectiveness, and their quality in relation to therapeutic alternatives. They evaluate the reports, like I said, of the comparative bio availability and they do that to determine the compliance of different brands of drugs. They also review new chemical agents and existing products to determine their appropriate role, if any, in our drug therapy in Saskatchewan.

This drug quality assessment committee does not look at the cost. They then refer to the drug . . . to the Saskatchewan Formulary Committee, and the Formulary Committee takes into account exactly what you said — a very broad look at the impact of having this drug on the formulary. What does it do to the acute care costs or long-term care costs. They do look at all of that exactly as you have described.

Mr. Gantefoer: — Thank you, Madam Minister. Madam Minister, certainly you would appreciate that the whole field of technology and drugs is changing very dramatically. And I noticed that from your numbers and your opening comments that from '94-95 I believe it was 52-odd million dollars that was spent on the drug plan to this current year something in the magnitude of $98 million.

Madam Minister, I recognize that's increased costs. Can you . . . does your department have a breakdown on — is this because more people are taking drugs, that the drugs are more expensive, or is there a breakdown as to . . . or you're covering just more drugs for more people so the base is much expanded? Do you have any breakdown in terms of why these costs have gone up so much?

Hon. Ms. Junor: — The increase in the drug plan this year is all of the things that you mentioned, actually. The utilization increase this year is . . . 14.8 million of the increase is just utilization increase. And we do have 6 million prescriptions in Saskatchewan a year for a population of a million.

And our new therapies account for $4.6 million of the increase in this year's budget. For example, the new medications that have been added and some of the costs — I'll just give you an example of how much one drug will cost the system: Rebetron for hepatitis is $1 million; Celebrex, as I mentioned, for arthritis, is $1.3 million; the new agents for asthma are $.5 million; and new patients added to the approval list for MS (multiple sclerosis) drugs is $1 million; and cholesterol-lowering agents account for $.8 million. So $4.6 million is for new therapies, and that just gives you an example of what one drug can cost the system.

Mr. Gantefoer: — Thank you, Madam Minister, but I assume that people that would have conditions where these drugs are appropriate would have been being prescribed other drugs, so it isn't as if it's all a new cost. There probably is . . . because they're being prescribed one of these new drugs that have been approved, the older drug that it replaces is probably not prescribed in the same frequency.

Madam Minister, as you're aware, there has really been relatively recent discoveries of drugs in some categories, and Alzheimer's is one of them, where Aricept has been on the market for some time, and now there's a new drug — Exelon or something, I believe — that has been very recently licensed or approved by Health Canada for inclusion and availability in Canada.

Madam Minister, when a drug is fairly new . . . and I have to tell you that I am, I've been deeply touched, and I can share with you some of the stacks of cards that I've received, and letters, from people who anecdotally have described to me what the impact of Alzheimer's disease has been on individual families. And I'm afraid to get started in terms of reading into the record some of the comments, but you know, it really strikes me that there is a tremendous anecdotal at least evidence . . . and I believe increasingly scientific evidence . . . that has some interesting things that I've detected out of even these comments where people that are saying my mom or my dad have been on Aricept for a year or more and they've seen very significant results by virtue of the fact that they've been on this drug.

(1930)

And I understand that, you know, we can read this into the record and certainly I know that it's important, but there is so much hurt, there's so much desire, and so many of these people's stories that it touches me deeply that the system is not giving people that have Alzheimer's disease any drug at all really that works.

And I appreciate that there's a broad base of drugs that are there for some categories and other diseases, and I'm not trying to minimize the importance that those drugs be properly considered; but from what I understand that there really has been no major drug that has provided significant benefit — not to everyone, I understand that as well. There are a significant number of people who have advanced stages or early stages of Alzheimer's where Aricept has little or no positive effect. I understand that.

But for the people that do respond to it, they generally respond pretty significantly and the benefit, from the anecdotal evidence that I received over the last few weeks, is pretty significant for those people and those people's lives.

And, Madam Minister, it strikes me is that something needs to be done in order to address a very serious segment of our population who increasingly are coming in contact with the problems of Alzheimer's disease and what it's doing to their families.

And, Madam Minister, it also strikes me, as I understand, is that the companies that are actually applying for these drugs to be included in the formulary — and Aricept is Pfizer I believe — have put a program in place or offered a program and I understand, but I also could be corrected that the company that is proposing this new drug that's just been licensed is going to have a similar program, where they're saying that they will cover the cost for an initial 12-week period of time.

And if that 12-week period of time is a critical time where the medical professionals — the doctors — can determine if a patient is going to respond positively to these drugs or not, and certainly and surely, Madam Minister, if it can be demonstrated at no cost that a drug either is going to be effective or not, for those people where it is shown to be effective, that we could

even put those kind of caveats on it that in those instances where it is demonstrated at no cost and virtually no risk to the drug plan, that Aricept would provide potential significant benefits to a patient.

Surely that's an important consideration to address the concerns that people are saying right across this province and the absolute frustration and hurt and pain that they're going through wondering how they're going to cope with the issue of Alzheimer's disease in their families.

Madam Minister, many times as well the cost — and I doubt if the Formulary Committee considers it, they may consider the cost to the system — but do they consider the cost to the families. In many instances these people aren't institutionalized in the initial stages of the disease. They're kept at home. They're kept at their children's home. They're looked after by their families. There is a tremendous social and emotional and personal cost involved with this, Madam Minister. And I challenge the drug committee to say that they've actually considered all of these issues rather than just considering the hard dollars that are involved with the health system.

Madam Minister, I'd invite you to comment on the issues that I've just raised.

Hon. Ms. Junor: — Thank you.

A lot of times we do also get a lot of the cards and the anecdotal evidence and a lot of times people express their frustration that you don't know what it's like or you don't have any idea of what it's like for families that are suffering through this. And I in particular know. I had an aunt last year who died and she had Alzheimer's so I know exactly what it is like.

And it's difficult to deal with the emotional side of many of these issues, so that was why, about three years ago, we did put the two committees in place, so that we have good scientific evidence from the medical community that does look at all of the issues, even including how long people will stay out of nursing homes and the impact on the health system, like I said before, of the benefit of that. And they base their decisions on clinical studies and evidence and they give us their best advice.

And we have to make difficult decisions then in a health system that has many things that are pressuring us to add more money here or there, and that's why we rely on those two committees of experts to give us that advice. So when we make the decisions, we look at the system as a whole and the good of the whole.

And they have said that there is some modest benefit for some people. They don't disagree with that. But when we make our decisions, we have to base it on what the good of the whole is and the good of the system, and to maintain a drug plan that we can still operate and offer to people.

Mr. Gantefoer: — Thank you, Madam Minister. But the point I was trying to make is that there is really no other drug that I'm aware of that provide even modest benefit for individuals with Alzheimer's disease. It's really been a disease that has escaped the ability of the medical profession to treat it effectively, and that's what makes it so frustrating and debilitating is the fact that there's really been no tools until relatively recently for people to deal with this.

And the other thing of course is is that, is it somewhat unique with the offer of the two drug companies for them actually being willing to cover the cost of the drug for an initial 12-week period while the medical professional can determine in that period of time what the proposed or prospective efficacy of this drug is going to be. And it seems to me that that is in some way significantly changing the equation here because it does minimize the risk and potentially the cost because if there is no benefit then certainly I would agree, Madam Minister, that it doesn't much make sense that the formulary would cover it for a person where there's really no benefit.

But certainly it would seem to me that if the drug company is believing enough in the value of the drug that they're willing to cover the first 12 weeks while that's determined, then the Formulary Committee would have to admit that you're really starting to narrow down the potential people where this will be no benefit to. And so that if you put on the caveat that this is only covered where that initial trial occurs and it's demonstrated that there be a potential benefit, is that not a similar caveat, if you like, for the prescription of Aricept in Alzheimer's patients as exist in other provincial jurisdictions that they recognize this dilemma, if you like, as well. Where it works it works pretty well but it might not work at all and therefore it would be inappropriate to have continued prescription of that drug or have it covered under that circumstance.

Does this not change the equation and is that not the logic of why other jurisdictions indeed do include Aricept under their formularies?

Hon. Ms. Junor: — Thank you. I did have that on my list to respond to and I'm sorry, I forgot it.

The three month coverage that Pfizer is offering, we still have to have a commitment to those people who it does benefit to continue the coverage, if it does benefit them. We still have to have had a commitment at the beginning, going into this, to cover — if it does benefit them — to continue the coverage. So I think it would be unfair to people to say we're only going to do it three months and then, whether it benefits you or not, we have not made a commitment as promised to put it on the formulary and cover it.

What we also . . . the benefit that the drug . . . the Formulary Committee and the Drug Quality Assessment Committee — they do look at how much the drug will benefit the system and how much it will benefit people. For example, it takes five people to find one that it will benefit. So they look at all of these things. They look at the trial. They looked at the offer.

Ontario has found that they've had less than . . . significant people dropping off of the program, so the criteria may not be as rigorous as it could be. There's other provinces who have decided not to cover it, like BC (British Columbia) and the Maritimes. So it is a mixed response across the country.

Mr. Gantefoer: — Thank you, Madam Minister. I wasn't suggesting for a minute that we should take up the drug

company's offer of a 12-week program and not have any approval on the formulary. I'm asking you to include it on the formulary because I believe that it's an important drug for a whole category of people who haven't had anywhere to turn in terms of medicated relief, the Alzheimer's people.

I mean this disease has been a major challenge to the medical profession for a good number of years, with really no light at the end of the tunnel in terms of anything that will mitigate the severity of this disease. And now we have Aricept that, while I recognize isn't a utopia for everyone, but for the people that it does work for, it seems to work very well.

And I'd like to quote from a letter that I received not very long, and it says, and I quote:

> I'm writing to let you know that I believe the provincial drug plan should cover Aricept. My mom has been diagnosed as having Alzheimer's disease. Once diagnosed by her physician he suggested that a newly approved drug, Aricept, developed for the treatment of the disease, might prove beneficial.
>
> We went ahead with his suggestion and although you cannot scientifically prove its benefit, we feel that it has slowed its distressing effects that Alzheimer's can inflict on not only the person with the disease but the entire family as well. My mom is more alert and much more aware of what is going on around her than she was before. She seems more like the mom I knew.

And that's the kind of anecdotal evidence, Madam Minister, that comes time and time again I'm sure to your desk and certainly to mine. And people acknowledge that this might not work on a double-blind study, but it seems to do the job very effectively for those that it has a positive effect on.

So Madam Minister, what I'm asking you to do is to say look it, let's consider this in a different way. This isn't just another drug to lower hypertension or blood pressure among many. This isn't another among many drugs you're approving in order to lower the cholesterol level or any of the other things that are very important.

There has not been anything available for Alzheimer's people so that they have something to at least try. And in the individual's word it works. It seems to work with a great deal of satisfaction for a great deal of people. And it's especially important because this is a category of disease that has had nothing.

And people have written to me and I quote from other letters where they say, what's here for us? It's almost like discrimination against Alzheimer's patients because we have nothing. We have nothing at all other than Aricept and now this new drug Exelon.

So, Madam Minister, I'm asking you to consider this in a special way because there has been nothing for this whole category of clients and patients, and take advantage of the fact there's a 12-week program that will at least screen out some of the people where it isn't effective. And for those people that are more effective give them something to hold on to, Madam Minister. I think it's a special circumstance and deserves your consideration.

(1945)

Hon. Ms. Junor: — Thank you. I am as anxious as is everyone on this side of the House to offer real substantial help for Alzheimer's patients. We have the committees and the expert committee as I've described to do their job. They have not made a recommendation with the latest information yet. And I'm waiting for that and, as soon as we get that recommendation, we will be making our decision.

Mr. Gantefoer: — Thank you, Madam Minister. Madam Minister, I understand that the committee has the reports from CCOHTA committee that you referred to earlier. I have a question. I understand that the Pfizer company themselves were going to provide a very current 12-month study that they have been undertaking.

Can I ask you if that is correct in terms that there was that undertaking by Pfizer? And second of all, have you received that information yet? And if not, when is it due?

Hon. Ms. Junor: — We're all nodding over here. Yes we have received it. The drug committee does have it, from Pfizer, the 12-month study.

Mr. Gantefoer: — Thank you very much, and I'm assuming that that information will be included in the study of what they're going to do. Is that a confidential study, Madam Minister, or could we request a copy of it?

Hon. Ms. Junor: — You're referring to the 12-month study? Yes, we'll have to ask Pfizer because as far as we know, we don't know the answer to that. We'll have to ask the drug company.

Mr. Gantefoer: — Thank you very much, Madam Minister.

Madam Minister, you've indicated that the next meeting of the Formulary Committee is on June 15. Can you tell us if the issues surrounding Aricept is going to be on that agenda, or is there going to be some further meetings before the issue of Aricept or Exelon's inclusion in the formulary is going to be decided?

Hon. Ms. Junor: — Thank you. Aricept is on the agenda of the June 15 meeting. Exelon, we have no information on at the moment, and the two drug committees have got no submission for that drug yet.

Mr. Gantefoer: — Thank you, Madam Minister.

Madam Minister, to finish the process off, then the drug committee makes recommendation to your office, and then you make the ultimate decision. Is that correct?

Hon. Ms. Junor: — Yes, that's true.

Mr. Gantefoer: — Madam Minister, would you have at your disposal previous decisions that have been made? Has ministerial discretion been used to consider the

recommendations but to make a decision in another direction? For example, was the inclusion of Betaseron for MS sufferers, was that on the basis of the recommendations of the committee? Or was that a ministerial decision that I might say was the right one, but how did that process occur?

Hon. Ms. Junor: — The final decision with the recommendations from the Formulary Committee does rest with the minister. And I would be consulting with my colleagues on the final decision or the recommendation from the committees.

But after the MS recommendation by the Formulary Committee, we put together a task force on high-cost drugs to review our system of how we deal with reviewing and making recommendations for new drugs from the . . . onto the formulary. And they confirmed the validity of the system that we had in place. So that is why we are relying upon them.

And the length of the process with Aricept, we've asked for more information and sometimes Pfizer has said, wait a minute — there's more information we want to give you. So we have done a lot of looking at the very best information we could find to make sure we make the very best decision on this.

Mr. Gantefoer: — So, Madam Minister, at the end of the day, the decision to include or accept on the formulary or not will be yours.

Hon. Ms. Junor: — As I said, it does say the Minister of Health makes the decision. That will be my decision but in consultation with my colleagues.

Ms. Bakken: — Thank you, Mr. Chairman. Madam Minister, welcome and welcome to your assistants. Recently a study was released I believe, maybe as soon as today; I'm not aware the exact date it was released, but it was released by Health Services Utilization and Research Commission. Could you tell us who makes up this organization, who funds them, and who they are accountable to?

Hon. Ms. Junor: — I'm going to give you a lot of information. The background for HSURC was — it's the Health Services Utilization Research Commission — and it was established as a crown corporation in February of 1992, and then The Health Services Utilization and Research Commission Act was passed in 1994. Saskatchewan Health gives 2.108 million to HSURC annually for, and it has done for each of the fiscal years '92 to '93 to '97, and we've increased the funding by a quarter of a million dollars annually for the years '97-98 and '98-99, and because they've been doing some projects that they needed extra money for.

Dr. Liz Harrison is chairperson of the board of directors and other board members include Dr. Barry Maber, who's the vice-president of medical affairs I believe in the Saskatoon District Health Board, Cecile Hunt, Dan de Vlieger, Jean Morrison, Jerry Danielson, who's also a doctor, Marianne Hodgson, James Irvine is a doctor, Robert McCulloch, and Paul Peloso. The CEO (chief executive officer) of HSURC is Laurie Thompson. He's the director of research and grants awards. They have a director of research and grants awards and a communications officer, and four to six research officers, two research transfer officers, and three support staff.

What they have ongoing is . . . it doesn't have any authority to impose its recommendations on health boards or service providers and it does present its findings and recommendations to stakeholders through a newsletter, publications, or presentations at meetings or conferences.

It currently has a number of research projects underway. The home care one we saw today, and evaluation of mental health services, and assessment of the appropriateness of acute care utilization and community services by persons with severe psychiatric conditions. A clinical practice guideline development is a study to assess the effectiveness of selected clinical practice guidelines. System quality indicators is a project to participate in the development of health system quality indicators for use by the health districts. And elective surgery prioritization, a study in collaboration with medical associations, health ministries, and research organizations in western Canada to develop and evaluate waiting list protocols and information systems for cataract surgery, hip/knee arthroplasty, hernia repair, diagnostic magnetic resonance imaging, and access to pediatric mental health services.

And I think that's about all right now and you can ask for any more details.

Ms. Bakken: — Thank you, Madam Minister. When was this study actually completed? I realize it was released today but when was it actually completed? Who set the research question which is, do outcomes for community living seniors differ as a result of receiving preventative home care? And what did this particular study cost?

Hon. Ms. Junor: — Actually HSURC, based on consultation with health districts in 1995, picked three different studies to do on home care. And they've done one already which is the one that was released I believe more than a year ago, as a substitute for hospital care. We've seen that one.

And this is the second one in the series. This is the one as preventive . . . as home care as a preventative service aimed at reducing long-term care use. And the third one will be a substitute for nursing home care. So they started in '95 with the first one.

We've had the first one probably a year and a half ago at least I think. This one has been two years in the making which we just saw released today. The cost is not broken out per project that we know of because they have a global budget that's been determined by their board.

Ms. Bakken: — Madam Minister, when did you receive this study?

Hon. Ms. Junor: — I participated in a briefing with the department on Friday to see it.

Ms. Bakken: — On the first page under methods it states that the study population will be followed over six years, that is '91 to 1996. So is the actual data in this study four years old? Or how do you explain those dates?

Hon. Ms. Junor: — I'm not sure about the dates that you are giving me, but the report itself on page three says they obtained

eight years of anonymous data on all — that's from '89-90 to '96-97 — of anonymous data on all Saskatchewan seniors aged 75 and older as of July 1, 1991.

The data described each person's use of hospitals, physicians, long-term care, special care homes, home care, and prescription medication. And they adjusted for many factors to streamline the process.

Ms. Bakken: — So then you . . . The results of this are just coming out now but they are somewhat outdated. Is that what you're insinuating?

Hon. Ms. Junor: — No. The data that they used took those eight years, and then they compiled all their research and have now come out with the findings almost two years later.

Ms. Bakken: — I find it very alarming what this study is reporting and I quote from the results. It says:

> There is no evidence that light level preventative home care actually keeps seniors alive longer or living independently longer than those not receiving the service.

In light of this finding, Madam Minister, why has it been the focal point of your government since 1993 to make home care one of the main points of this whole system?

Hon. Ms. Junor: — The first study which dealt with acute care, home care as a follow-up to acute care, or taking some of the days that you would stay in the hospital and providing those services at home, showed us that there was an immense value to home care for that substitute for acute care services.

The third part of the study will talk to us about nursing home and keeping people in their own homes as an alternative to a nursing home. This one that they've done in the middle is definitely interesting that what they have found out is that one of the biggest benefits is going to be looking at social housing, seniors' housing, and that the social isolation of seniors contributes greatly to their health and their health outcomes.

And that is something that we're going to see. I think the districts look at it quite closely, as well as the department, as we make policy to look at what we do in home care from now on. But I wouldn't suggest that the districts are going to cut their preventative home care services because the report actually stipulates that what they did find was that the greatest benefit was to the highest-risk people. So the districts should be assessing the highest risk and the greatest need and targeting their services there.

Ms. Bakken: — Well, Madam Minister, I guess we find it a little ironic that prior to this study coming out, you have already made the move to cut a certain level of home care in the health districts. And I quote from a letter from the district CEO at Living Sky Health District. The letter states:

> Those individuals for whom the risk appears to be low will be discharged from home care services and attempts will be made to put them in touch with someone they may be able to hire privately.

You were unaware of this study prior to Friday, yet this press release was on May 5 and this letter had already been received by Living Sky Health District. Could you explain that, please.

Hon. Ms. Junor: — Living Sky have had a review done of their home care utilization, and they found they had the highest utilization in the province of home care services. So they made the decision to target their home care resources to the people there that had the highest need. And that's what the report actually says and validates what Living Sky has done.

Ms. Bakken: — Madam Minister, I guess the people of Saskatchewan would like to know if home care is still a priority of this government or if your plan is to move home care the same way as long-term care has been progressing, where level 1 and 2 has been eliminated from public long-term care. Are you now moving to remove the bottom level of home care so that people have to pay for the services themselves?

Hon. Ms. Junor: — Just to reaffirm our commitment to home care, as I said, the first study talked about home care as necessary to relieve some of the days that are being spent in acute care. That is an extremely valid use of home care. And we'll find, when HSURC does their study on long-term care, I'm sure we'll find the same thing — that people that can stay at home and not have long-term care will be benefited by home care in their own homes.

Now our funding for home care between '91 and '92 and 2000 and '01, this year's budget, has increased by 146 per cent. That is a huge commitment on this government's part to home care. We truly believe home care is a necessary service, but what we want to make sure that we're doing is providing the right services to the right people and the highest need people getting the best services that we can provide.

This year's budget increase for home care is 6.4 per cent, which is about $5 million.

Ms. Bakken: — Thank you, Madam Minister. My question again is: are you going to eliminate the low-level services and if you are, are you suggesting then that the people seek out private care?

Hon. Ms. Junor: — This report is useful in showing us exactly where the money is best spent and giving us information on social housing, which is something we have to spend more attention on, but we're not expecting major changes to be based solely on this piece of research. Districts still have to look at their client population, what are their best needs . . . what are their needs and how are they best served. So we're not expecting a wholesale change based on this one report, but it does give us added evidence to look at other types of housing.

Assisted living is becoming something that's very valuable, different housing options for seniors and other people in the community that need assistance with their daily living — we need to pay more attention to that, and this is what this report is showing us.

Ms. Bakken: — Thank you, Madam Minister. On to dealing with long-term care as it relates to home care — when people are no longer able to stay in their own homes and receive home

care and it's not adequate for them, and yet they do not, they are not assessed a level 3 or 4, what is your advice to them or what is available for them to access for care?

Hon. Ms. Junor: — I think what we want to talk about is home care assessment.

It's . . . each district does the assessment of need, and they have criteria that they base that assessment on. We are now looking to collaborate with the other Western provinces — BC, Alberta, and Manitoba — at a new home care assessment tool that is coming available. And we will be testing that so that we'll have some standard of assessment across . . . actually across Western Canada. So we can look at what exactly do people need, and how do we determine that need — which will be very valuable information. And I think that's the key, is that we actually assess people properly and determine what they need and then meet those needs in whatever way is possible with our resources that we have in each facility or each district.

Ms. Bakken: — Madam Minister, is there any process of appeal if they are assessed lower than a level 3, and yet they feel and their family feels that they need long-term care?

(2015)

Hon. Ms. Junor: — Your question about the appeal process — yes, there is a process to appeal if the decision has been made in assessment that you don't agree with.

Your question earlier about level 2's — that we have totally given up on support for level 2's — we still have about 300 people that are assessed as level 2 in our long-term care facilities in the province. So we do still support level 2 if it's necessary, and that again depends upon the assessment that's been done in each district or community.

Home care is available and individuals are assessed individually through, in some places, a coordinated assessment unit and it looks at the need that they have for home care and the risks that they are encountering if they lived by themselves or if those needs are unmet.

Ms. Bakken: — Thank you, Madam Minister. Could you tell me where these level 2 facilities are? I was not aware that there were any still available in the province.

Hon. Ms. Junor: — The level 2 people are actually not in any one facility; they are sprinkled throughout many facilities in the whole province, although Regina has a facility called Qu'Appelle House because they have a critical mass of that type of need so that they can put the people all in one facility. Otherwise they are in different homes across the province.

Ms. Bakken: — Madam Minister, are these affiliated hospitals or health centres, or are they served by the health district?

Hon. Ms. Junor: — They're either affiliated or owned by the districts, some of each, yes.

Ms. Bakken: — Madam Minister, we now have, according to the latest information I've received, that we have 239 personal care homes in the province, and in those 239 homes there are 2,195 beds. Madam Minister, a question to you is, where would these people be if we did not have private, personal care homes?

Hon. Ms. Junor: — Interestingly enough, the current number of personal care homes has not changed significantly since 1992 — the number of homes or the number of beds. So the personal care homes provide an expanded private accommodation and care option for individuals with light-care needs, as you were saying, who do not need or who do not want to make use of the public system. So some of it is personal choice, and some people really do want to stay in their own homes, and some people do need to go into special care homes, but the interesting information is that those numbers have not changed much since '92.

Ms. Bakken: — Well, Madam Minister, I would request a list of the personal care homes that were in 1992 and what they are today because in my constituency of Weyburn-Big Muddy, I believe with the exception of maybe two, they're all since . . . have all been built since 1992.

And I guess the question . . . you stated that a lot of people prefer to go into private care homes. It's been my experience that they have no choice. There is not a bed available in a public facility. And many people that go in there do so at great financial hardship and many cannot go in them because they do not have the financial basis to go in and pay the full price.

So, Madam Minister, is this a goal of your government that we are moving to two-tiered health care in long-term care? And will this continue or what is your plan for addressing the need for long-term care beds in this province?

Hon. Ms. Junor: — Before I give you some information, I do want to comment on your remark about us going to two-tiered health care. And I think I can assure you that is not our intention and it certainly wasn't in my campaign literature. We do have, in Saskatchewan, we have 118 long-term care beds per 1,000 population. The national average is 108 beds per thousand, so we are still above the long-term care . . . (inaudible interjection) . . . I believe I'm answering the question from the member from Weyburn-Big Muddy.

And I believe it shows our commitment to long-term care when we have a significantly higher number of long-term care beds than the national average. We still look at assessing people that have the highest need and the highest risk, getting the first long-term care bed or the first special care home bed so that we ensure people have access to those beds that actually need them.

And still we can't discount that the personal choice of people . . . some people do not want to go into nursing homes. They do want to stay in their own homes or if they've been in another home, a personal care home, they do want to stay there as they age in place or as their assessments increase and they become level 3 or level 4. And then home care does go to the personal care homes.

Ms. Bakken: — Thank you, Madam Minister. Well I guess this debate will continue on to us on this side of the House. We believe that people requiring to go into private care because there is not public care available is two-tiered health care.

Madam Minister, I'd like to ask you a question about the Souris Valley extended care hospital in the constituency of Weyburn-Big Muddy. I would like to ask you how you can justify spending $17 million to build a new facility and yet we are going to lose 40 beds?

Hon. Ms. Junor: — The old facility in Souris Valley needs to be replaced so the provincial share of the new building will be 16.245 million. We will be replacing it to design it to serve people better.

The loss of the 40 beds — South Central District has over the Saskatchewan average of long-term beds per 1,000 of people over 75. So as the demographics has changed and as the district has taken into account the demographics, they have determined that they can do with 40 less beds in long-term care.

Ms. Bakken: — Well, Madam Minister, I think that there's many people in the constituency of Weyburn-Big Muddy would dispute what you have just said. And I know that there have been at least two studies done that show that Souris Valley extended care building is very sound and will be standing long after most of the other buildings in Weyburn are flat.

So I think that this needs to be looked at again and looked at very carefully. The people of the constituency of Weyburn-Big Muddy are not prepared to see this building lost.

And on that note, Madam Minister, if you move this facility out of Souris Valley extended care hospital, what do you propose to happen to this building?

Hon. Ms. Junor: — When we propose capital projects in communities that we work . . . the department works very closely with the community to determine what type of facility will be best in meeting their needs. SPMC, Saskatchewan Property Management, owns the building and will be working with the community when it's vacated to determine the next use for it.

It will cost more to renovate this building which I believe . . . we think it was built in the 1920s. It will cost more to renovate it than it will be to build a new one that will meet the current long-term care service standards.

Ms. Bakken: — Well, Madam Minister, I don't think this issue is going to go away, and I'm sure we're going to have further discussions on this area. My latest information is that will cost a million dollars to dispose of this building. And if it has no use, that is what's going to happen. So I don't see where the savings are going to be here.

But I'd like to move on to something else. As the minister responsible for long-term care, how are you planning to ensure that doctors are maintained in centres where there are long-term care facilities and the population is older and they depend on maintaining a doctor so that they can stay in their communities or access care in long-term care facilities in the smaller towns?

(2030)

Hon. Ms. Junor: — Actually this is . . . Thank you very much for the question because we have pages on incentives that we're doing to recruit and retain rural physicians, and it is a challenge. Many physicians don't feel comfortable going into solo practice anymore. So what we have done is put the following programs in place to help address the challenge of ensuring stable physician services in rural Saskatchewan.

Physician incorporation, we could put . . . the medical services Act is on the floor right now, and physicians were quite anxious to have that. The emergency room coverage and weekend relief program . . . physicians practising in rural Saskatchewan are supported through an integrated emergency room coverage and weekend relief program. We've put $6.8 million in funding to compensating physicians providing emergency room coverage in rural areas and to assisting those communities with fewer than three physicians to access a list of other physicians willing to provide this relief coverage when needed.

And a tripartite committee with representatives from the Department of Health, SAHO, and SMA, the Saskatchewan Medical Association, works with the health districts and the physicians to develop criteria to ensure that eligible physicians are compensated for providing this coverage. And this has been as of January 1 of 2000. Physicians will directly bill the MS . . . the medical services plan for these services.

We have a physician recruitment coordinator and this was an initiative that we announced in '97. And this coordinator is responsible for assisting rural districts and physicians in the recruitment process. As part of this the physician provides valuable links with students and recent graduates of the College of Medicine at the U of S (University of Saskatchewan).

Quite exciting is the rural practice establishment grant program. This program makes grants of $18,000 available to Canadian-trained or landed immigrant physicians that establish new practices in rural Saskatchewan for a minimum of 18 months. It's an ongoing program modelled after a similar offering in 1997 that was credited with assisting in the recruitment of 23 new physicians to rural Saskatchewan.

Six Canadian-trained physicians took advantage of the program in 1998, locating in communities such as Meadow Lake and Kindersley. Currently there are three applications being reviewed and one already offered.

We have the medical resident bursary program which was introduced in June of '98 and provides bursaries of $18,000 to three family medicine residents to assist them with educational expenses. In return for the assistance the applicants must agree to a rural service commitment. Currently this program is fully subscribed.

We have the undergraduate medical student bursary program which provides an annual grant of $18,000 to medical students that sign a return service commitment to a rural Saskatchewan community. This level of assistance was increased in 1997 to recognize increased cost of living and improve uptake. The program is again fully subscribed with more than 15 students currently receiving support. Since its inception in '91 over 60 medical students have received assistance under this program.

We have rural practice enhancement training which was announced in 1997 and provides income replacement to

in-practice rural physicians and assistance to residents wishing to take specialized training in an area of demand in rural Saskatchewan. A return service commitment is required.

To date a number of residents and practising physicians have accessed this program. There were four applicants for the 2000-2001 program.

We have a re-entry training program which was initiated in 1999, and this program provides two grants annually to rural family physicians that wish to enter specialty training. Physicians must have practised full-time in rural Saskatchewan for two years to qualify. Physicians with fewer than five years of full-time rural practice will be required to make a return service commitment. Preference will be given to applicants who voluntarily sign a service commitment beyond the minimum of five years. One physician is currently enrolled in this program.

In addition the new budget, the 2000-2001 budget, provides for an additional two positions for training physicians at the residency level. Details about this enhancement to the medical training opportunities will be announced shortly.

We have rural emergency care, a CME (Continuing Medical Education) program. The rural emergency care Continuing Medical Education program was established in February of 2000 and is intended to provide funds to rural physicians for certification and re-certification of skills in emergency care and risk management such as advanced cardiac life-support, pediatric advanced life-support.

Full cost of Canadian tuition and a portion of both travel and accommodation expenses to a maximum of $250 may be reimbursed. Funds cannot be carried over or accumulated, and physicians must have 12 months continuous licensure and have practised in rural Saskatchewan for at least 12 months prior to applying, and are expected to provide service in rural Saskatchewan after completing the educational activity.

They have resident relief, a weekend relief program, which was introduced in March of this year and it matched the second-year family medicine residents with larger rural communities seeking weekend relief. The communities must have three or more physicians and be ineligible for the weekend relief program that we've described before, under category (a) communities which were smaller ones. The program formalizes an existing practice, provides an opportunity for medical residents to supplement their income, and increases their exposure to the range of opportunities in rural communities.

They have a locum service program which is operated by the SMA and funded through transfers from the department. It's perhaps one of the most popular programs for practising physicians, providing coverage while they take vacation, education, or other leave. This program was expanded during 1997 to ensure that relief was more readily available for rural physicians. Currently there are six replacement physicians employed by the program, and the possibility of expanding the program is being explored.

We have alternate payments in primary health services. We support the development of the primary health services initiative and alternative payment models for physicians. These initiatives support the use of allied health professionals and enhance integration with community-based services. So you can see that we have a vast array of services and programs for rural physicians, and truly they are uptaking on these programs and are quite happy to have them and are using them quite well in rural Saskatchewan.

Ms. Bakken: — Thank you, Madam Minister. One area of concern that has been forwarded to myself is the three-year contract that physicians are required to sign when they come from out of country. This has become a hardship at least in one area that I'm aware of where the doctor wants to be able to sign a one-year contract and not a three-year contract, and it could possibly mean this community losing their doctor. Could I have your thoughts on this, please?

Hon. Ms. Junor: — I'd just like to ask a point of clarification of the member from Weyburn. None of the programs that we find have a three-year commitment. Most of them are 18 months, 12 months. So do you have an idea of which one you're talking about? Which program?

Ms. Bakken: — A letter that I've received from the health advisory board just says that there's concern because they have a three-year . . . the doctor is to sign a three-year contract and he's reluctant to do so. He's new here to this country. He's passed his examination, but he does not want to be tied to three years in case for some reason he decides he does not want to stay in Canada. And they are asking that he be given an opportunity to sign a one-year contract instead of a three-year contract. And my understanding from this letter, if they have their facts correct, is that that is currently possible in Alberta, Manitoba, and British Columbia.

Hon. Ms. Junor: — Thank you. As far as we can tell, we have no program that requires a three-year commitment, so it was likely an arrangement with the district. And if you want to give us the information, we can probably see what we can do in this situation.

Ms. Bakken: — Thank you, Madam Minister. I just have a couple of other questions before there's some other members of the party that would like to question you. They're isolated incidents.

One is about family members looking after other family members in their home and what specific measures is the government looking at to recognize the importance of this care, and for people to be able to continue to do that without causing them financial hardship? Have you looked at anything through the current system or anything to accommodate this?

Hon. Ms. Junor: — We recently had a home care conference in Saskatoon in February and a lot of discussion did centre around caregivers and the burden that caregivers have. So there was a lot of talk about respite, caregiver education. The tax benefits to caregivers has been talked about but never has been acted on. It seems to be more the available respite beds, education and support in the community with programs that recognize what caregivers do. That seems to be more of a concern what has come out in our conversation with caregivers and with home care users.

Ms. Bakken: — Thank you, Madam Minister. I just have one more question. I recently had a constituent who required long-term care and was having . . . had had financial difficulties and was going to find it very difficult to pay the fee even in public care. And she was advised by Social Services to seek a legal separation so that she could go into long-term care and receive assistance. Is this the direction that your government is taking?

(2045)

Hon. Ms. Junor: — Recently we announced a new initiative to look at what we call involuntary separation, so situations where one of a couple is in a nursing home, the other one is left at home. We've looked at . . . in the past it was taking the two incomes, combining the two incomes of the two spouses, and then dividing them in half, and then calculating that for the cost to the person that resides in long-term care.

We recently announced a new initiative where we just would use the income of the resident in long-term care. And that would benefit some 900 families would be paying less. So we no longer will see that sort of a situation. And if that person is still in that situation, we should be hearing about it and give them that new information.

Ms. Bakken: — Madam Minister, if I understand you correctly then, a person can just use their personal income and not have to bring the two together and they do not have to seek involuntary separation in order to access this?

Hon. Ms. Junor: — We call it involuntary separation. What I thought you were suggesting is they would actually have to separate, like legally separate. We call this phenomena that it's . . . that one of the couple goes into a home, we call that involuntary separation. And recognizing the hardship that that does cause some couples, we now have the ability for the couple . . . the person in the nursing home to only use that income and not have the combined income and divide it in half.

You're right. It was just called involuntary separation. The concept is still there, but the way it's paid is not going to be as . . . it's not going to harm the individuals anymore.

Ms. Bakken: — I just want to be very clear on this because this is a recent concern that was brought to me. They no longer have to be — involuntary or however you want to say it — they don't have to be separated. They can just use their own income as the basis. Correct . . . (inaudible interjection) . . . Thank you.

Mr. Hermanson: — Thank you, Mr. Chair. And I just have one or two brief questions for the associate minister. I thank you for being here and for bringing your officials with you.

The question I have is basically is what my constituents in Rosetown-Biggar would like to know. They would like to know for the fiscal year, the current fiscal year 2000-2001, is your department aware of any health care service reductions, eliminations, or closure of facilities in the Rosetown-Biggar constituency? And that would include much of the Midwest Health District, a bit of Greenhead which serves the community of Biggar.

So quite simply, are you aware or can you tell us of any service reduction, service elimination, or facility closures in the Rosetown-Biggar constituency?

Hon. Ms. Junor: — Thank you. As we've said before many times in the House, the Minister of Health has said that the health plans are now in from each district. We're reviewing those and have a timeline of June to have taken a provincial look at them all and will be commenting, then, on the whole of the province. And it would be, I think, a mistake to single out one or two districts now to pre-empt that announcement.

Mr. Hermanson: — Thank you. Mr. Chair, then, could the minister give me some indication of what date I would be made aware of what will be happening to health care in the Rosetown-Biggar constituency?

Hon. Ms. Junor: — As I said, we're looking at June. I'm not sure what exact date in June but that's what we're targeting, to have the provincial review done of all the health plans and announce the either acceptance, rejection, or altering of those plans. And we'll be announcing that in June.

Mr. Hermanson: — Thank you. Mr. Chair, to the minister: I understand that the target was June 15. Are you ahead of schedule or behind schedule? Are we going to know before the House recesses or will we have to wait till July or August to find out?

Hon. Ms. Junor: — Well I'm happy to hear that the House is going to recess by June 15. Actually, we're targeting June and it would probably be in the latter part of June.

Mr. Bjornerud: — Thank you, Mr. Chair, and welcome, Madam Minister, and your officials. I just have a few questions, Madam Minister. And as you know, Madam Minister, I'm from the east side of the province and the East Central Health District is in my area. And I think there's an awful lot of uncertainty in that health district because of the board being removed and a lot of questions that need to be answered out there. And I thought what better time than tonight, when you have the opportunity to talk to these people out there who may actually be watching, to see what is happening.

Madam Minister, maybe we could start tonight by you explaining to us why the board was actually removed in the East Central Health District?

Hon. Ms. Junor: — Basically the department, or the minister, received the resignation of the board Chair, Mary Anderson, and the district had some other resignations and had only two senior managers left of a six-member team so there was some management weaknesses there also. The ongoing deficits and debt faced by the districts — the debt load has equalled 27 per cent of its annual operating budget so it was time to make a decision of what to do with this district and what to do for the people in that district.

Mr. Bjornerud: — Thank you, Mr. Chair. Madam Minister, I'm glad you brought up the deficit and the debt in that district because that was one of my next questions. What is the overall debt for the East Central Health District stand at today?

Hon. Ms. Junor: — The district currently has approval for a

line of credit of $13.5 million and that fluctuates at any given time of the month. But that's their approved line of credit that they operate on.

Mr. Bjornerud: — Well, thank you, Madam Minister, but correct me if I'm wrong, but the projected numbers that I had heard last year, before the board was dissolved, fired, or whatever you want to call it, was close to $20 million. Can you explain where the other $7 million disappeared?

Or was that a number that I was not reading right at that point? That was the number that the past CEO of that health district, Mr. Jim Millar, told me would be there at this point in time with I believe it was 3 or $3.5 million deficit that would be built up after last year. Maybe my numbers were wrong, Madam Minster. Can you clarify that?

Hon. Ms. Junor: — The CEO would not have been aware of a $4 million operating grant that we gave to the district in March of this year which took it down from 17.5 to 13.5.

Mr. Bjornerud: — Well we still seem to have a difference in our numbers, Madam Minister, but I'll let that one sit for now.

I think, Madam Minister, you can understand that the uncertainty and the frustrations out there, not only with the taxpayers in the province or the people that would like to use that hospital when the need arises, but also from the nurses, the doctors, the LPNs (licensed practical nurse), the staff in the care homes, home care workers and everyone else, because I believe that's the only board in the province that has actually been removed to this point.

And I think that uncertainty is grown now when we see examples like Living Sky where there's projections of possibly hospital closures. And the Yorkton people in my area, in the Saltcoats constituency for that matter, and Canora-Pelly, and a number of the areas around there, have great concern. It's areas that have far less debt than the East Central Health District has, are having to, in order to balance their books, projecting the possibility — and again, Madam Minister, I say the possibility — of having to close facilities such as Lanigan and others out there.

What will happen in the Yorkton area? And, Madam Minister, I want to remind you . . . and you are aware of this as I am, but I'd like to get it on the record that the Yorkton hospital should be a well-oiled regional hospital that goes — and you know as well as I do — that goes far into Manitoba, a way up into at times as far as Hudson Bay. It goes down into my neighbouring constituency, passed the Qu'Appelle Valley, down to the Moosomin area, and comes west many miles, Madam Minister.

That hospital, if it had the funding to provide the service that I feel is needed, and I think many out in that area do, could provide a great service to the people of this province when it comes to health care. What we see out there we saw last year with another projected accumulation of another $300 million added to the overall debt.

What do you see this year, Madam Minister, for funding for that health region? Is that going to increase and will that health district, now that Sask Health I believe is actually running that area, what will we see out there? Do we have to have that $300 million deficit disappear this year? And if we do you can imagine as well as I do the cuts that are going to have to take place out there.

Maybe you could give us a broad overview of what's going to happen to the East Central Health District because, Madam Minister, health care is a problem all over this province, but in my area because of the board being removed, I think it's far greater than in any other area.

Hon. Ms. Junor: — I just want to clarify — $300 million deficit you're saying? You said $300 million several times. The district has a $300 million deficit . . . (inaudible interjection) . . . No? Okay.

Mr. Bjornerud: — Well, Madam Minister, we're getting our numbers off a different book, but the numbers that I was gave by the CEO last year — and I believe I'm not the only one that got those numbers, Madam Minister — were in the area of 250 million to 300 million more deficit that they were going to run in the East Central Health District.

Hon. Ms. Junor: — No, three million.

Mr. Bjornerud: — Three million, Madam Minister, I'm sorry. I'm exaggerating to the degree that it's not even believable and that's really odd for me. Three million, Madam Minister, we're talking. I was having a hard time thinking we're that far off the page here and we can't be.

But 3 million, Madam Minister; the overall debt was 20 million. So let's go back and start from square one and I'll quit exaggerating and I'll get down to the real facts. But I feel I was right when we . . . when I started these numbers, but I believe last year was another $3 million debt and I apologize for saying 300 million.

(2100)

Hon. Ms. Junor: — I was hiding my chocolate bar. We're working with the district to develop a long-term plan that aims both towards quality services and financial stability. This year's budget for East Central is 5.04 per cent increase.

Mr. Bjornerud: — I'm glad to hear that, Madam Minister, but I still . . . I think my concern is the same out there. If the books are balanced out there and we take inflation and everything else and put it in the picture, I think we're going to have to see an awful lot of cuts in the East Central Health District. And I believe, Madam Minister, it's something that's the last thing we need in that area because all that's going to do is push more people coming into the cities like Regina and even in some cases, into Saskatoon, which is not going to alleviate the problem in here.

I think if we did the proper funding out there and took a look at what the problems have been in the Yorkton area, maybe an audit of the health care system would bring up things where we could have a money saving for an example. But Madam Minister, I'd like you to respond. Are there big cuts coming in the East Central Health District? Because I mean you should be more familiar with these than the other districts because you

actually have some input in what will really happen out there.

Hon. Ms. Junor: — The funding to East Central has risen 45 per cent since '93-94, and that doesn't include the 5 per cent from this year's budget. And as I answered the member from Rosetown-Biggar, it would be premature to pre-empt the overall announcement in June of the provincial plan and the provincial overview of the districts' health plans by announcing one or two districts here in this format.

Mr. Bjornerud: — Well thank you, Madam Minister. And I'll guess we'll have to wait and see what comes out when . . . in June when all these things are brought out into the public eye.

Madam Minister, where do we go with the health board in the East Central Health District? Will a new board be appointed or elected? Or are we going to sit there . . . how long is this going to sit there in the state it's in right now? Or is that the direction that actually your government wants to head right now in removing the health boards? Or will we join the rest of the province again with a health board at some point in time?

Hon. Ms. Junor: — Once the district is in a stable position and has a long-term plan that we're all working together with them — the long-term plan to reduce its debt — we do look forward to getting a new district health board in place.

Mr. Elhard: — Madam Minister, I'd like to return to a subject that was raised by my colleague from Weyburn-Big Muddy, concerning the involuntary separation issue. I had a call in a somewhat post-state of panic from an elderly lady who was recommended to follow the procedure of involuntary separation to address the issue of what she would be paying for her husband's care in a long-term care facility. And I asked her for her concerns and she said what it boils down to is, that I've lived with the guy for 60 years, I don't plan to get rid of him that easy.

So having listened to your answer and the questions earlier, I'm still not really clear on what happens here on the involuntary separation. If the involuntary separation designation form has no legal effect, nor any effect on other social safety net programs of either level of government, nor does it affect marital status, really what purpose does this form serve at all that can't be recognized without such a form? Couldn't a simple say-so on the part of the individual suffice as opposed to having them sign a form like this? The worry factor for senior citizens is substantial.

Hon. Ms. Junor: — I am going to try this again because this is something that we are committed to, long-term relationships and recognize people's . . . their commitment and also their fear of what might happen to them. Involuntary separation is a marital status designation for married couples who live in separate dwellings. It has nothing to do with real separation as we consider separation and divorce. This is, they live in separate dwellings for reasons beyond their control, like one spouse lives in a special care home and one in their own home. There is no recognition of involuntary separation in the existing care and rates regulations, so for married residents currently, the resident — as I was saying — the resident and the spouse's income is combined. That was the old method of doing it. Now we recognize . . . they will just use the resident's income.

So this is a benefit to 900 couples that they will pay less and it changes nothing with their marital status. It's just a term that we use. And it's unfortunate. It does have a connotation for some people that somehow or other you are separated legally or as we determine, a separation in the marriage, of a normal marriage.

Mr. Elhard: — Thank you, Madam Minister. Mr. Chairman, I'd like to ask the Minister then, in the case of a couple that have one income, how do you deal with that kind of a situation? You don't have separate incomes for both spouses, you have one income. You divide it between the two? Is that how that kind of a situation would be dealt with?

Hon. Ms. Junor: — I'm not sure what specific case you'd be referring to, but to my knowledge all seniors have an income — the old age security — so there would be two incomes in a family. And the old age security would be the one . . . of the person that is going into the home, that would be what the income is . . . the resident fee is based on, that income.

Mr. Elhard: — Thank you, Madam Minister. Mr. Chairman, I'd like to further pursue that. If there is a situation where one spouse is eligible for government programs of that nature but the other spouse has no other form of income, I guess that's the kind of anomaly we're asking about in this particular situation.

Hon. Ms. Junor: — In any situation, you have the option to choose which one benefits you more, so you would still be able to go in the old way, if that's more beneficial, or take this new way if that would save you some money.

Mr. Elhard: — Mr. Chairman, I'd like to change directions now in terms of my questioning.

Madam Minister, when hospital closures or reductions of service are contemplated or proposed by a health district, does the distance to another full-service facility come into the equation at all, and if so, what distance — in miles or kilometres — is considered safe or optimal for saving lives?

Hon. Ms. Junor: — Generally speaking, what we use is the term . . . when we talk about reasonable access to services, we basically look at 45 minutes to a facility that has in-patient services.

Mr. Elhard: — As you can understand, Madam Minister, distance is a big concern to me, given the fact that the constituency I serve is the largest constituency in the province, outside of the two Far North ones. And the constituents are acutely aware of the distance they have to travel to any health facility.

Mr. Chairman, I would like to . . . would also like to pursue that line of questioning in regards to available services in the Southwest Health District, most of which is in the Cypress Hills constituency, will experience a net shortfall of over $900,000 projected for the upcoming year. And most of that shortfall I'm told is a result of negotiated settlements for staff in terms of wages and benefits. Now with one facility being restricted to a five-day-week service level to help balance the health district's books, they're cutting us pretty close to the bone already. And the facility that is being reduced or is going to experience reduced services is probably outside of the 45-minute time frame that you talked about.

So I guess what I'm wondering is, in view of the limitations that you recommend as minimal, would the district qualify for help from your government's transition fund to maintain services on the weekend to hospitals or facilities that are threatened with closure to help balance their books?

(2115)

Hon. Ms. Junor: — Before I answer the exact question, I do want to clarify some information we gave earlier on the drug plan before we move into the next department's estimates.

When we talked about ambulance services, and I answered that in the North Sask Health pays for social services recipients, the total for the '98-99 budget was 1.32 million that we spend there, and we do pay for emergency medical transportation by road and air ambulance. We do pay for that and that is in our budget in '98-99 at 1.12 million. So we do have those figures to give you.

Now my answer to the specific question from the member from Cypress is that the South West Health District . . . first of all I wanted to say the South West Health District received this year a 4.17 per cent increase in its budget.

And when we're looking . . . and we do recognize that some residents travel further than the 45 minutes, given some of the geographical difficulties and the geographical configurations we have in this province. That's why when we have the health plans that have been submitted we're looking at the provincial overview. So we can tell what impact will happen to people in the whole province when we look at these sorts of things.

And in sparsely populated areas we're looking at a very strong rural emergency service because it's difficult to provide services in sparsely populated areas as well as difficult to provide staff in some of those areas. So we are looking at that when we consider that district's health plan.

Mr. Elhard: — No further questions, I understand . . . (inaudible interjection) . . . One more? Well this won't be actually a question. I appreciated the fact that you mentioned the 45-minute limitation as being what you're trying to achieve. Time limitations are significantly different in rural Saskatchewan right now than mileage because you can't accomplish 45 miles in 45 minutes in rural Saskatchewan.

I'd like to pick up on some of these issues of importance to the rural area, but I understand that time has elapsed and we'll leave it for another day. Thank you very much.

Hon. Mr. Lingenfelter: — I move the committee report progress.

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The Deputy Chair: — I'd like to invite the Minister of Social Services to introduce his officials.

Hon. Mr. Van Mulligen: — Thank you, Mr. Chair. Seated beside me is Dan Perrins, the deputy minister of the department. Seated behind Mr. Perrins is Bonnie Durnford, the assistant deputy minister. Seated behind me is Bob Wihlidal, the executive director of financial management. And seated towards the rear of the Chamber are Phil Walsh, the executive director of income support; Richard Hazel, the executive director of family and youth; Dorothea Warren, the associate executive director of family and youth; Deborah Bryck, the director of child day care; and Larry Moffatt, the executive director of community living.

Subvote (SS01)

Ms. Eagles: — Thank you, Mr. Chair. Mr. Chair, I'd like to begin by thanking the minister and his officials for being here tonight to discuss the estimates for the Department of Social Services.

Mr. Minister, I'm going to focus especially on the report recently released by the Children's Advocate, and I hope that we can gain a better understanding as to the direction your department is taking in implementing these recommendations. On page 44 of this report, and I'll quote:

> We had a baby in our care for two months and hadn't received payment. When we called to ask about payment, the worker was relieved to know we had the baby because they didn't know where he was. The file had only the birth certificate in it and no other information.

Mr. Minister, how could this happen?

Hon. Mr. Van Mulligen: — Mr. Chair, I understand that that particular quotation was an expression that was made at one of the public meetings convened by the Children's Advocate. We've attempted to pursue the details of that for the Children's Advocate, have not been able to do that successfully, and I would suggest if the member has a question with respect to a specific quotation such as that, then she should pursue that with the Children's Advocate.

Ms. Eagles: — Mr. Minister, this isn't a library book or a set of keys we're talking about. Under your administration we're not only losing people to Alberta but we're also losing them within your department. And again, how could it be possible for a child to literally be missing from your system for months?

Hon. Mr. Van Mulligen: — Again, Mr. Chair, this was a statement that was expressed at a public meeting which was convened by the Children's Advocate. We have attempted to obtain the details of that just to see . . . to enable us to verify that information, to check into that. We've been unable to do so and I would suggest to the member that if she wants to get further details on that particular quotation, she should pursue that with the Children's Advocate, in whose report that information is contained.

Ms. Eagles: — As minister, is it not your job to contact the Children's Advocate to find out? You're the minister responsible. Is it not up to you to contact the Children's Advocate?

Hon. Mr. Van Mulligen: — Mr. Chair, we have done so. And I would point out to the member that the Children's Advocate, in

putting forward her report, encourages all of us to examine and deal with the substantive issues that she raises as opposed to dealing with specific quotations. Again we're certainly in a position to answer the member's questions with respect to the findings of the Children's Advocate as far as compliance, for example, with practices and the like and the progress the department has made.

But as to that particular quotation, I really can't help the member and I would encourage her that if she's interested in obtaining further information on that specific quotation, then she should ask the Children's Advocate; because after all, this specific quotation is contained in the Children's Advocate's report.

Ms. Eagles: — Mr. Minister, my interpretation is that you don't firmly believe that this actually happened, so I will ask you this question: if it did happen, what is your department doing to make sure it doesn't happen again? And if this isn't the truth, what steps do you have in place so that this can't happen?

Hon. Mr. Van Mulligen: — Well I thank the member for her question because now she's dealing more with the general substance of the Children's Advocate's report and the direction that we're taking.

And I might say at the outset, Mr. Chair, that this report of the Children's Advocate, *The Children and Youth in Care Review*, is a report which follows hard on the heels of another report by the Children's Advocate into the death of Karen Quill. And as a result of her review of that specific death, the Children's Advocate issued a report and made a number of recommendations that we followed up on.

Since that time, or at that time, we also asked the Children's Advocate to do a more general, broad review of children in care, and she has now provided us with that report.

I venture to say that if we were to do, or if the Children's Advocate were to do a report such as this, if we were to ask her again to do a report in a year's time or in two years time, that the general findings that she might have would be different than what would be contained in this report.

Following on the heels of the Quill report, the department hired additional staff in the area of child welfare, and specifically front line staff and supervisory staff in the area of child protection. We also introduced what we feel were better practices in terms of how it is that the people in child protection work go about doing their work. We also, I believe, improved training for people in the area of child protection.

But before that I guess you might say had a chance to mature and to be fully in operation, we have this other report on children in care which again, I think, caught the department in a period of transition. I am confident that in a year's time we'll be able to show further progress in this area. Having said that, we are at this point, reviewing the recommendations in the report and trying to determine what direction we should go as a department.

There are various directions, I suppose, that one could take. We are reviewing what direction we should be taking in consultation with the Child Welfare League of America, and we are confident that early next spring that we will be able to report progress in these areas and also to be able to lay out in some detail the direction that we are taking.

(2130)

Ms. Eagles: — Mr. Minister, if in fact the situation that I asked earlier did happen, what sort of reprimand is given to the person responsible for that child?

Hon. Mr. Van Mulligen: — Mr. Chair, the question is hypothetical. I'm not really in a position to answer that.

An Hon. Member: — What do you mean? What do you mean you're not ready to answer that. You must have . . .

Ms. Eagles: — You don't have an answer for what happens to people that would be in a situation like this?

Hon. Mr. Van Mulligen: — Mr. Chair, with the other public servants there are a range of measures that can be taken with respect to public servants who do not perform their jobs up to the expectations that are required or err in doing their jobs. And that ranges from reprimands and letters placed in personnel files to suspensions to, if it's appropriate, terminations. There is a range of remedies that can be taken by the employer if an employee is not doing their work, Mr. Chair.

Ms. Eagles: — Mr. Minister, Mr. Chair, the report is entitled *Listen to Their Voices*. As a parent who has raised two children, sometimes we forget that our kids do have a voice. And these children in the foster care program do not have the luxury of having two parents to talk to. Mr. Minister, on page 20 the report states that children have a right to speak. What is the procedure from your department to ensure that a child's complaint is just not sloughed off but is seriously looked into?

Hon. Mr. Van Mulligen: — Mr. Chair, depending on the nature of the complaint, but certainly the starting point for any complaints by a child would be the social worker who is responsible for that child and that particular file. We have, during the course of the last number of years, outlined some very clear contact standards. And the policy is that caseworkers will maintain regular contact with children in care and their caregivers to ensure that all basic and special needs of the children are met, providing and obtaining relevant information related to case planning, providing treatment intervention to support both the child and the caregivers.

And the minimum contact standards include: one, caseworkers must have personal contact with each child in care within two working days of placement unless they were the worker who placed the child, and each child in care must have personal contact with their worker a minimum of twice a month for the first two months of placement and every six weeks thereafter. A majority of these contacts must take place in the caregiver's home, and when age appropriate, each child must be interviewed separately from the caregiver a minimum of once every six months. And caregiver resources must be seen a minimum of once every six months by the caseworker responsible for the resource.

Ms. Eagles: — Mr. Chairman, Mr. Minister, I will read here on page 20:

> As a child, I was asking for help because of abuse at my natural home for nine years. It would be investigated, and then they would listen to my parents who said, everything is all right. Children need to be listened to.

So obviously the children aren't being listening to, I mean, if they're taking the parents' word over the children all the time.

Hon. Mr. Van Mulligen: — Mr. Chair, again it's difficult to be able to react to that specific quotation. It appears that in this particular case — and when this might have happened is not really clear because this is now an adult talking about things that took place in the past — that this child asked for help and the department listened, according to this, and did investigate. But then talking to the parents, who said everything was all right . . . and I assume on that basis that the investigation was not carried forward. It's difficult to know how to react to that specific quote without knowing any of the details or the circumstances, Mr. Chair.

Ms. Eagles: — Mr. Chair, Mr. Minister, would you agree in a situation like that that perhaps contact should be made down the road to ensure that everything is in fact all right or if the kids in fact do have a valid complaint?

Hon. Mr. Van Mulligen: — No, Mr. Chair, we would agree that if a child does raise concerns such as that that it would be desirable to stay in touch with the child.

Ms. Eagles: — Thank you, Mr. Minister. Mr. Chair, Mr. Minister, this report has also done a very thorough job of making some recommendations that would assist your department, and I will just read a few of them. It says here, the recommendations 1.1, and that's on page 22, The Child and Family Services Act be amended to include participation rights for children in care. This includes the right to be informed about their plans of care. An interpreter of language is a barrier to consulting with the child. And they should be informed about and assisted in contacting the Children's Advocate, be consulted, and to express their views according to their abilities about significant decisions affecting them. And be informed about their rights and of the procedures available to them for enforcing their rights.

Is your department considering . . . what is your department doing to actually consider implementing some of these?

Hon. Mr. Van Mulligen: — Mr. Chair, to a very great extent, the specific recommendation reflects desirable practices in the department. As to the question as . . . as to including that particular recommendation in the Act, that is something that we will have to consider. But again, it reflects what we consider to be desirable practices. And I would venture to say that our workers are acting in accordance with this.

But again, including that in the Act is a specific recommendation that we will have to consider.

(2145)

Ms. Eagles: — Mr. Chair and Mr. Minister, regarding the training for social services workers, Mr. Minister, am I correct in understanding that the department has uniform rules and regulations that all case workers must adhere to?

Hon. Mr. Van Mulligen: — Yes, Mr. Chair. To some extent I elaborated on that with respect to the contact standards, but generally speaking we had manuals that attempt to interpret our legislation for the workers and then training is based on that so that they can be clearly guided in the work that they do.

Ms. Eagles: — Okay, thank you, Mr. Minister. We all acknowledge that the workloads for case workers is overwhelming. And there are instances where a child has not seen his or her worker in months. Mr. Minister, what is being done to assist these case workers?

Hon. Mr. Van Mulligen: — Mr. Chair, in the wake of the Quill report, in 1998 I believe it was, the department added 50 new staff in the area of child protection, front-line workers and some supervisory staff because the lack of . . . or appropriate supervision was also identified as a concern. Those staff were added at that time.

We also clarified our expectations of workers in terms of their practices, and we also improved training at that time so that workers heading into the field to do this work would be better trained. Those are the steps that we've taken, oh I'd say within the last year and a half to two years, in the wake of the Quill report.

We are again examining the recommendations of the Children's Advocate to see what implications it has for us as a department.

Ms. Eagles: — Thank you, Mr. Minister. I'm sure you would agree with me that there is a shortage of caseworkers and the recommendation clearly states that the Department of Social Services needs more time and resources so these people can do their job properly and see that children are not harmed or neglected. Do you agree with that?

Hon. Mr. Van Mulligen: — Well, Mr. Chair, I guess it's a question of how one would deploy those resources. We have at this point a model on which we base our practices and we deploy our resources.

But the Children's Advocate, in her introductory comments, also points out that her review team had unanimity on the issue that the department should be doing a better job of preventing children from coming into care in the first place; that it's one thing to enhance the system that you have which investigates complaints from the community and from children and from others about abuse or neglect that is taking place.

We do an investigation. On the basis of that investigation we may take children into care, place them in a foster home, and then we have procedures as we outlined — for example, contact standards to do follow-up for that, and then on the other hand try to see what we can do to repair what is going wrong in that family so that the child can ultimately be returned.

But the Children's Advocate, although she has a great number of recommendations based on her review of the system we

have, again in her introductory remarks says that what we really need to be doing is to find better ways to prevent children from coming into care in the first place.

Now does that suggest that when we receive a report, for example, of neglect of a child, that we should change our practices to work with that family at that point to keep that family together, and so as to do a better job of preventing children from coming into care in the first instance but providing better support to that family at that point in time, as opposed to taking the child into care and improving our foster resources to be able to accommodate that? So those are some of the basic questions that the Children's Advocate raises for us.

Ms. Eagles: — Mr. Minister, I truly believe that children are the most precious thing in the world and we must do whatever we have to to make sure that they are raised in a safe, healthy environment. With that being said, in this report it said that many people, when asked why they became foster parents, said they did so because they simply loved children and they found it very rewarding.

Regarding compensation, can you tell me how much a foster parent receives monetarily for a child?

Hon. Mr. Van Mulligen: — Mr. Chair, there's a fair amount of information here with respect to payments but I'll undertake to send a copy of this information across to the member. But the basic maintenance rates, for example, for an infant are $481.98 per month, and the basic maintenance rate for a 12- to 15-year-old is $504.31 per month. And then in the North, there is additional allowances that are made but in addition to that there is special needs and the like, and other skills for emergency receiving care in the like, but I'll undertake to send a copy of this across to the member.

Ms. Eagles: — It is my understanding that foster parents have to take money out of their own pockets if they want their foster child or children to partake in recreational activities, sports, entertainment. What is your department doing regarding recommendations as to foster parents being paid at an equivalent level to other out-of-home care providers?

Hon. Mr. Van Mulligen: — Mr. Chair, foster care rates have been increased over the course of the years, and we have reviewed this continually with a view to keeping pace with inflation and to also ensure that there is some basis for comparison between foster care in Saskatchewan and what we pay and what other provinces pay. Suffice it to say that we are currently reviewing our rates to ensure that in the future that they will also be appropriate. As to the specific question of the recreational needs of children, we can review these on a per case basis as special needs and provide assistance as required.

Ms. Eagles: — Thank you, Mr. Minister. I've just had a chance to glance at this chart here. And the schedule fee here, that pretty well is what it would cost to raise a child or supply them with their needs. So the foster parents in fact don't really get a wage for looking after these children, am I correct in assuming that?

Hon. Mr. Van Mulligen: — In addition to the basic maintenance rates, the member will also see that there are provisions for special needs. There is also a fee for service that in addition to basic maintenance, if children present physical or behavioural difficulties, the foster parent may receive a fee for service ranging from $100 to $500 per month. That's in addition to the basic maintenance rate. Also, there is a fee of $100 per month per child that is paid to all approved practitioner level foster parents who have completed their training.

Ms. Eagles: — Thank you, Mr. Minister. Do you think that the fees that you have outlined for me is an adequate wage for these caregivers?

(2200)

Hon. Mr. Van Mulligen: — As I indicated earlier, Mr. Chair, there have been increases over the years.

We have been sensitive to the needs of foster parents. We've worked closely with them. I guess it's fair to say that we're not always everything that other people would want us to be, but I think that we've been sensitive. We've tried to respond. And as I've indicated, we're currently reviewing the rates.

Ms. Eagles: — Thank you, Mr. Minister. I take it by your answer that that is a no, that you don't think it is an adequate wage.

I'm going to move on to something a little bit different here, Mr. Minister. A case has been brought to my attention where an elderly lady is receiving the basic allowance for social services of $195 a month and $40 a month for disability insurance. She owns her own home and is required to drive to Saskatoon at least twice a week for health care services, which your department pays her $18 a trip.

Mr. Minister, this lady would like to put licence plates on her own vehicle so she can drive herself, because she cannot afford to plate her vehicle. And my question is: is there a policy in place that would allow her the necessary money so that she could plate her vehicle without selling any of her property?

Hon. Mr. Van Mulligen: — Mr. Chair, the member raises an interesting question. I might say, as a matter of practice we do not licence vehicles. That would . . . to undertake to do so would present some, I think a number of requests that would be difficult for us.

Having said that, there may well be one or two cases from time to time where in hindsight we might have been better off to licence a vehicle than to provide support for transportation. But as a matter of practice we do not licence vehicles, Mr. Chair.

Ms. Eagles: — So if the information, Mr. Minister, was delivered to your office regarding this woman, would you agree to look into this case on a specific basis?

H**on. Mr. Van Mulligen**: — We'll certainly look into it, Mr. Chair. I'll ask my officials to do that. The difficulty for us is when you're confronted with the request, for how long this might continue, but we'll certainly take a look at the case that the member raises.

Ms. Eagles: — Mr. Minister, as well another situation. A person has contacted my office and I apologize, I do not have all the

details. But this person is on social assistance and she has just gained employment — albeit part-time, as well as minimum wage. And it almost . . . according to this person it seems that she is being penalized for being productive and trying to get off of social assistance.

And her initial report is that now that she is working on a part-time basis, and again for a minimum wage, Social Services has discontinued payment of her SaskPower and SaskEnergy, and she feels that is vital to her survival at this point.

And she feels that monetarily she'd be better off to forget about entering the workforce and just to stay solely on social services. Could you give me your views on a situation like that?

Hon. Mr. Van Mulligen: — Well, Mr. Chair, without knowing the details of the case, I don't know if this, for example, is a single parent or a . . . the member is signifying yes.

We have made substantial changes to our social assistance programs precisely with this type of case in mind. We wanted to ensure that there were incentives for parents to work and that they would always be better off working than remaining on social assistance.

As a general rule we believe that is the case. What we've done is, one, is that even though a person might be on social assistance, because of the National Child Benefit and the Saskatchewan Child Benefit, they still retain the benefit — that is their benefit whether they're on social assistance or not on social assistance.

In addition there too, that person may also qualify for family health benefits so that there will continue to be coverage for her child. So that if there are extraordinary medical expenses, health expenses, that by itself won't trigger a need to fall back on social assistance where they might obtain that assistance.

And finally we set into place the Saskatchewan employment supplement which is something that the person we speak of would have to apply for. And there's a 1-800 number that he or she can call . . . she can call. Without knowing all of the details and the salary levels and so on, depending on a person's circumstances a parent might receive up to $2,500, $2,600 per year from the child benefit, and approximately a further $2,000 per year from the Saskatchewan employment supplement. And then of course whatever health benefits their children may require.

So we've tried to provide significant financial incentive so that a family will always be better off working and supported in doing that, than simply to remain on social assistance.

Ms. Eagles: — Thank you, Mr. Minister, and I do apologize. It was probably a bit unfair of me to question you on that without myself knowing all the facts, but I will get them and I will contact your office; but I do apologize for that.

And with that I will turn it over to my colleague and at this time I would like to thank you for the time that you and your officials have given me this evening. And I'm sure I'll have some more questions for you at another time, but thank you.

Mr. Toth: — Thank you, Mr. Chair. Mr. Minister, just doing a couple of follow-ups with regard to some of the questions that my colleague, the member from Estevan, was raising. And it's an issue that we have discussed before but certainly I think I need a little more clarification on it.

The member talked about when a child complains about abuse or neglect, it's brought to the department's attention. The question I have is the process that is followed to indeed determine that the complaint is a reasonable complaint where action must be taken, and the department would feel that maybe at the time, until they do further research, then maybe they should remove a child from the home.

The concern I have is there are times, I'm sure, that social workers may find as they do further research into some of the accusations, that some of the accusations or complaints that have been brought forward have been made in anger, fits of anger, a child against a parent; especially if a parent sets down some guidelines and sets down some rules and a child rebels against those rules. And also situations where parents themselves may make accusations against the other spouse because of their anger over certain positions that one or the other spouse may have taken. And as a result, when an accusation comes forward, then of course the concern for the children and their safety comes into play.

And, Mr. Minister, the question I would have is, what are the safety features and the steps that are taken to ensure that proper attention is given that, number one, the workers don't just walk in and remove children. Because one of the concerns raised by the Child Advocate is the fact that there is seen to be too many children in care and in some cases maybe children removed from the home too quickly. What steps are taken and what . . . how do workers really now begin the process of determining whether or not they should be actually removing a child from a home because this may be a situation that is volatile, or leaving the child in the home and trying to work with that family to address the concerns that have been raised?

Hon. Mr. Van Mulligen: — Well, Mr. Chair, the member with his question points out the essential difficulty that our department faces and that social workers face. Even as we listen to one voice that expresses concern about having raised complaints with the department about abuse and that child being interviewed and the parents being interviewed and then, according to the child, that nothing is done.

But now, in this case, the member points out the other end of that continuum, and that is to say children who might make allegations based on anger, that it might be an act of rebellion, that there's also the issue of one parent trying, especially in custody matters, trying to make accusations about the child-raising practices of the other parent as a means of, I guess, trying to get some favour in the courts or in the court process that they may be involved in. That then becomes the essential difficulty for social workers, Mr. Chair.

When we receive a complaint, we do an investigation. If there are immediate safety issues, then we must act. For example, if there's a call and we find a child wandering the streets with no apparent caregiver, then obviously we need to act and we must ensure the safety of the child. If we enter into a home and it's

obvious that the child has been abused or molested, then we must act to guarantee the safety of the child.

(2215)

But in any event, Mr. Chair, we undertake to do an investigation. And we speak to the child and we hear from the child. And if the allegations are based as simply as a matter of rebellion, then we might be able to find out from the child that there's something else troubling that child apart from an allegation of abuse or neglect. We will undertake to interview the parents. The interviews might extend to the child's school. It might extend to other professionals that the family has been involved with.

Following our review of the situation, and if the child is in care, we have a period of seven days to complete that review and then to determine our next course of action. That course of action, in some cases, results in a voluntary . . . involuntary arrangement where the parents agree that that family may be experiencing a crisis and that in terms of working through their crisis it might be better if the child were to be taken into care by the Department of Social Services.

In other instances, our review leads us to conclude that we should be going forward to the courts to apply for a form of guardianship — if you like — to take the children into our care and to ensure that they're placed in a foster home for a period of months until we're satisfied that the family situation has been resolved and, if appropriate, the child can be returned. But after a period of seven days, we're obliged to make an application to the courts unless there's been some earlier resolution and to be able to satisfy the courts that the action that we are proposing is the correct action.

Mr. Toth: — Mr. Chair, Mr. Minister, I appreciate that because I feel very strongly that we certainly need to have guidelines in place that are followed very stringently so that we do not put families really at risk. And I think that's one of the points that the child advocate is bringing out and really trying to work with families rather than always removing children from the home.

Another area that I think and I believe possibly your department is becoming more aware of . . . certainly it's brought out in today's paper: "Fetal alcohol problems cost taxpayers". And I think there's a growing concern. We had, some of my colleagues and I had the privilege of talking to a group in Saskatoon. They're trying to reach out to a drug and alcohol problem within the inner city. But they pointed out the fact, too, that one of the concerns they have is there is a problem even coming that we really haven't quite gotten into the middle of yet, but they are concerned about the fact that in the very near future — even the police are talking about it — that we're going to be dealing with young people who have unfortunately during their formidable years while they've still been . . . before their birth, their parents or their mothers have been constantly on drugs and alcohol. As a result it's affecting the mannerism then, the actions of the children.

And this I think, Mr. Minister, is going to be something that is going to affect each and every one of us. It's going to be a cost, as the headline indicates, it's going to be an actual cost to the taxpayer. And just putting an individual behind bars isn't going to address the problem that that person is facing.

And, Mr. Minister, I realize that this problem is something that basically over go . . . or it was within the realm of three different departments: Justice and Social Services and certainly Health care.

I'm wondering, Mr. Minister, what your department is doing to raise this concern? Because there's no doubt, I would believe that many of the workers out there right now in their dealing with young people and dealing with some of the concerns and the accusations that are coming forward and being brought to their attention, are finding out that they are actually beginning to deal with or are dealing with children who are exhibiting many of the problems that are arising of fetal alcohol syndrome.

And so, Mr. Minister, my question to you is, what is your department doing to begin to address this problem that could be a major problem in the future? But I'm not sure we can nip it in the bud because there's probably too many young people out there already who are affected by it, but I would think if we begin . . . we are going to need to begin to tackle it and address this major problem so that young women realize the consequences of their actions if they proceed to drink and take drugs while they are pregnant.

So, Mr. Minister, my question to you is, what is your department doing to begin to address this concern, and working with other departments where this is an overlapping problem, in coming up with a long-range strategy and plan so that this doesn't become a problem that consumes us in the future?

Hon. Mr. Van Mulligen: — Well, Mr. Chair, I agree entirely with the concerns that the member has expressed. This is a horrible problem for our society. I don't know what to compare it to. The situations that you find are sometimes beyond comprehension and seem to be beyond treatment.

As a department, we work with the Department of Health. The Department of Health is the lead for Saskatchewan in the area of fetal alcohol syndrome. We have formed a partnership with Alberta, Manitoba, and most recently joined by the Yukon, Northwest Territories, and Nunavut. The purpose of the partnership is development of a common strategy to address FAS (fetal alcohol syndrome) and consider both the prevention of and support required to those affected by FAS, and to allow the jurisdictions to learn from another's shared expertise and best practices and resource material.

FAS presents us with two major challenges, broadly put. One is for the children that are born with FAS, to ensure that all the relevant departments and government agencies and also community agencies that have a role to play with children and later with adults, so that all those who come into contact with children who have fetal alcohol syndrome, and later adults, are in a better position to understand the nature of the condition and therefore be able to provide more appropriate resources and appropriate care or appropriate services, whatever that might be.

Whether it's in our department in trying to understand the problems that are raised by a child or whether it's in education, in the area of special needs, we have a lot to do to educate ourselves and all of society about the conditions so that, one, we

can deal appropriately with the needs of those that have fetal alcohol syndrome.

But there's a more fundamental question, I believe, when you consider that fetal alcohol syndrome is 100 per cent preventable. And if it's 100 per cent preventable, what can we do to prevent it so that we don't have it happening.

Again we are sharing our experiences with that of the other provinces. We are also at this time working with our partners in the other department to examine a broader, early childhood intervention strategy that might see us being able to provide more targeted intervention with moms who we suspect have alcohol or drug problems, and where there is a risk of bringing forth a child with fetal alcohol syndrome. We are very interested to see the steps that Manitoba has taken in a stop-FAS program. My discussions with their officials in Manitoba a few months ago leaves me encouraged that yes, there may be things that we can do to ensure that prevention is more effective in the future than it is today.

But again the details and the specifics and the devil is always in the details as to how we go about doing that . . . is something that we're trying to sort through now. But again I agree entirely with the member; this is a terrible problem for our society, and we must double our resolve to put an end to it or to do what we can to prevent it from taking place.

The committee reported progress.

The Assembly adjourned at 10:27 p.m.

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