# Standing Committee on Health Care

## Hansard Verbatim Report

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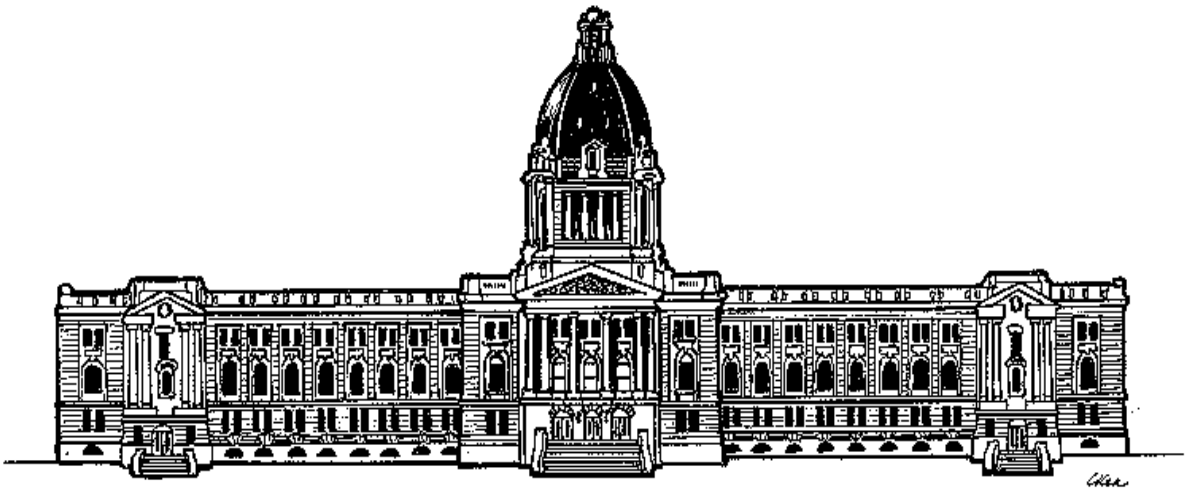

## Legislative Assembly of Saskatchewan

**Twenty-fourth Legislature**

**STANDING COMMITTEE ON HEALTH CARE**
**2001**

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Saskatoon Eastview

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Saskatoon Northwest

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Andrew Thomson
Regina South

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

The committee met at 09:32.

**The Chair**: — Everyone has received a copy of your presentation, thank you. I'll introduce first the committee and then I'll ask you to introduce yourselves, and any titles or where you work or who you represent you could add in also.

I'm Judy Junor, I'm the Chair of the committee. Dr. Melenchuk is the Vice-Chair. I have Andrew Thomson, Warren McCall, Buckley Belanger, Brenda Bakken, Donna Harpauer, and Rod Gantefoer.

You can introduce yourselves.

**Ms. Shellhorn**: — I'm Patricia Shellhorn and I'm medical radiation technologist at the Pasqua Hospital.

**Ms. Garner**: — Donalda Garner, medical radiation technologist at the Pasqua Hospital, also serving in the Regina Health District.

**Ms. Glasser**: — Lorna Glasser, medical laboratory technologist for the Regina Health District, centred mainly at the General Hospital.

**Ms. Seiferling**: — Joetta Seiferling, ultrasound department at the Regina General Hospital.

**The Chair**: — Thank you very much. You can begin.

**Ms. Glasser**: — First of all I'm here to represent not only laboratory technologists, but technologists in general. And I've brought with me a professional profile of the medical laboratory technologist.

We feel that there is a general lack of knowledge or understanding about what we do, not only in the general public but even amongst our peers in the workplace. So I'm just going to highlight a few things from the profile to start with.

The medical laboratory technologist practises all skills incumbent in carrying out laboratory investigations relating to the diagnosis, treatment, and prevention of disease. The practice of medical laboratory technology is the performance of laboratory investigations and the evaluation of the technical sufficiency of the investigations and their results. The definition includes practice in the areas of laboratory administration, laboratory education, medical research, specimen collection, handling, and exsectioning, and laboratory information systems.

The ever-increasing complexity of medical science places a growing importance on the skills and resources of the medical laboratory technologist. Contemporary medical diagnosis requires sophisticated laboratory tests to accurately pinpoint and identify health problems. An accurate diagnosis enables the attending physician to prescribe the appropriate treatment. Laboratory tests play an important role in monitoring the success of the treatment.

The MLTs (medical laboratory technologist) are essential members of the health care team, working with the other health care professionals to enhance their knowledge and ability to use the laboratory's growing capabilities.

Because of its diverse nature, the practice of medical laboratory technology cannot be defined in one neat, simple package. Laboratory technology is actually a family of technologies that has developed over the years. Most large medical labs are divided into five major departments — one being clinical chemistry, clinical microbiology, hematology, histotechnology, transfusion science.

When working in smaller centres, the technologists would be required to do a little bit of everything. But as you can imagine, in the larger centres you must become specialized and you do. You become very expert in one particular field.

In addition some large medical labs include specialized departments of cytology and clinical genetics. The scope of practice depends on the type of employing institution and whether the technologist holds a general certification or a specialty certification. And the scope is continually changing as new techniques are developed and old ones become obsolete.

I've left a copy of this profile with you to read in more detail. And there's also a section on education and accreditation.

So in response to Mr. Fyke's report on health care we would like to say that first we are very pleased to be officially recognized in this report. And it's nice to know that there are some who recognize that health care includes more than doctors and nurses. There are many other providers that bring a vital service to the system and are also in high demand.

The big question for us in responding to this report is to address the question, how to deliver specialized services in a better way.

The laboratory systems of the province have recently undergone amalgamations and extensive re-engineering to become more efficient and cost effective. This process has included changes in instrumentation, a new laboratory information system, and more support staff so that the professionals can maximize the use of their skills. Many of these points were brought forward by Mr. Fyke in his report.

It would be hard at this time to find more efficiencies in this area. We don't feel that adding any more support staff at this time would be of benefit as it does require a trained technologist to deal with the increased complexity of advanced instrumentation. We think we've gone about as far as we can in that avenue.

The big area for improvement as we see it is in utilization. It's very important as he suggested in his quality control program to have statistics and information comparing usage patterns, patient outcomes, waiting lists, costs of programs, etc. But the big thing, as we see it, is to make sure that these recommendations and statistics are acted upon.

Our experience is that as soon as a test is made available, it is overused and in many cases inappropriately ordered. Our own laboratory medical staff scrupulously develops protocols that are nationally accepted as for the usage of certain procedures. And we find that many physicians and residents in the hospitals

either ignore these protocols or find a way around the rules.

Some tests are intended to be used only by specialists for a certain specific situation. As soon as the information is out, many practitioners feel that they need and deserve access to the same diagnostics. This should not be the case if they do not have the background education to know how to interpret the results or if it would not change the course of treatment depending on the result.

A Utilization Committee with the power to enforce the decisions that are made is vital.

The second topic that we have some input toward is the electronic health record. Our experience with information systems in the lab has shown us that we need an absolutely huge database to store the volume of medical information necessary.

On our system, for example, we are only storing information for the laboratory of the Regina Health District and we can only keep up to six months material and we have to archive it. So that doesn't give the doctors a lot of history if they're looking back to compare results of a patient.

So the size of the database when you're looking at a provincial health record is a very important thing. In order to avoid duplication of testing, double doctoring, and other causes of unnecessary health expenses, the physician must be able to access all pertinent information on any given patient.

We must decide in advance how long the information will be stored before it's archived. We must know if there's a system available that can handle that kind of volume and we must overcome the confidentiality concerns in order to give access to the right people.

If all of these conditions can be met, a provincial health registry would be a major help. The bottom line is what is the price tag and would it be cost effective?

The third suggestion that we respond to from Mr. Fyke's report is the primary health network. The report makes reference to the fact that doctors work in isolation from the rest of the system. In large centres this is also true of different professions, working in isolation from one another. So his plan that integrates staff from different specialties would encourage an expanded knowledge of each other's contributions to the system. And I believe with that would come a growing respect and co-operation among health care workers.

A travelling team of professionals would provide this type of integration of staff and would also give rural people more convenient access to many medical specialities.

Technology. Of course this is the part of health care that is the greatest concern to this group today.

In reading through Mr. Fyke's report I detected an underlining theme that expensive technology may somehow be a waste of money or not necessary. I agree that there is some unnecessary usage of all technology. But for the most part, the advanced technology can save health care dollars.

It can eliminate the need for several preliminary tests, which may be invasive or not definitive. And these tests are also linked . . . or eliminating some of these preliminary tests would also reduce a number of repeat doctors visits. And you've probably heard of patients being referred for one procedure, come back, see your doctor, didn't tell us anything; let's try something else, come back, see your doctor. So we're saying if we have access to using the advanced technology, which is more diagnostic, more specific, that we can reduce the cost of all of the lead-up conditions.

If diagnosis is made earlier it prevents the worsening of the patient's condition which again . . . if the condition is worsened it requires more, more health care treatment. Surgeries can be performed with greater accuracy and better outcomes which means faster recovery time. So from my perspective it's better to use this technology and discontinue some of the old outdated techniques.

Specialized testing requires practise to maintain expertise. This same analogy applies to doctors who must perform a certain volume of procedures to be good at it. Consequently there is some testing that should only be done in the tertiary centres.

As Mr. Fyke said, quality is what we're after; and we don't want to water down the expertise of our technologists.

For patient convenience I believe that collection sites for laboratory specimens should be available in all the community centres, with an adequately linked feeder system to the appropriate analysis centre.

And finally, addressing the problem of workplace morale. It's very difficult to maintain morale and keep staff when there are shortages, heavy workloads, and excessive on-call hours and overtime. In order to stop this vicious circle of people leaving and making the workplace situation worse, we must concentrate on retaining the experienced staff that we have. This eliminates the cost of recruitment incentives and the prolonged orientation period that it takes to bring someone up to a level of proficiency.

Some of the targets that we feel must be met are for the employers and their peer groups to recognize each other for their contribution to the health care team. There must be educational opportunities offered for all professionals, and probably all health care workers in general. People need to feel that they can grow in their jobs, that the interest remains there, and that they have advancement opportunities.

On a personal level people feel that they must be able to get time off work if they need it. There must not be excessive work hours or the expectation to handle unmanageable workloads.

Our wages we know can never match some of our neighbouring provinces, but we must be competitive, and we must be able to bargain with like-professions.

In conclusion, we all want quality medical care, and we want to know that the diagnosis and treatments available will increase the desired health outcomes. It's our feeling that the physicians are the gatekeepers and controllers of this system, and they generate most of the cost. So in order to make substantive and

sustainable change, it is the physicians that must buy into this plan, and they must co-operate and establish controls on their own system.

I thank you for my time.

**The Chair**: — Thanks very much. Is someone else going to present also? Would you make sure that you're very close to where your button lights up, your mike there. Thank you.

**Ms. Garner**: — My name is Donalda Garner, and I've been asked to represent the medical radiation technologists and other medical professionals throughout the province. We don't have a 100 per cent consensus on this but we've certainly have talked with many of them and have come up with some suggestions.

In the long run, we believe that health care dollars can be saved and that the system can function more efficiently. The Fyke report was comprehensive but somewhat generalized.

Saskatchewan people may indeed use the health care system at a higher rate than the rest of Canada, but I think it has to be realized that we are the oldest average age province in Canada aside from Newfoundland. So our average age is about 58 years. And we also have some very specific diseases that are the highest ratios in the world — multiple sclerosis and diabetes, things like that, skin cancer. So it does mean that we are going to have to be concentrating more people with getting medical care.

We have a few suggestions that we thought we'd get just a little bit more specific about. We must provide more in-province procedures, saving the cost of sending patients out of province — specifically MRIs (magnetic resonance imaging). Right now SGI (Saskatchewan Government Insurance) and workman's compensation routinely pop people on an airplane and have a contract in Calgary with the MRI there.

And so we are daily sending people to Calgary, getting their MRIs, sending them back. We've got the cost of all of this out-of-province and air and food and that. Whereas if we brought in two more MRIs — one in Regina and one in Saskatoon — we would be able to handle these people.

And when you sit down and figure out the cost to send them out of province, total that up, and put it beside the cost of an MRI, I think that we would find that in the long run there would be a cost savings.

The other thing is things like AAA which is abdominal aortic aneurisms and the vascular stinting where we put a stint to sort of protect that area from exploding on a patient, right. This most often was always sent to either Winnipeg or Calgary. Just in the last month have we started doing it here in our own province.

I think a little bit more money and effort has to be put into getting our physicians who have that ability to do it here and again save us the cost.

We have to give the Utilization Committee, as Lorna suggested, a little more teeth. They have to have a little more bite. When they say to a doctor, boy you are ordering way too many lab tests or way too many routine chest X-rays just to pacify your patients — stop it. They have to have that backing that says, yes, we better not do that because we're going to be in trouble. I mean it's the same as with pharmaceuticals. Right? They track the narcotics and antibiotics that are handed out, and they can follow a doctor and make sure that there is no excess on their part.

Physician education — choosing the correct studies for diagnosis rather than pacifying patients with a quick test. And I know it's really difficult for doctors and especially when you look at breasts and mammography, patients now because of the media coverage are far more aware of breast lumps and they are not satisfied with a doctor saying, no this is an innocent cyst or something; they want everything. And it's very hard to sort of keep a limit on these types of tests or to just give them some initial smaller things to pacify and then head on. It's like MRIs of cervical spine rather than going to a CAT (computerized axial tomography) scan first.

Multiple tests are ordered leading up to the appropriate tests, as Lorna was mentioning, they'll start with . . . because the patient admits with abdominal pain, they'll go to a barium enema, they'll do abdominal X-ray series, they'll do an ultrasound, they'll do a GI (gastrointestinal), and finally they'll head for the conclusive test of a CAT scan that usually gives them the answers. And if that was done in the first place we would have saved multiple dollars.

Repeating kidney studies within days of each other — and that's not just kidneys but other ones — the doctors will order a test. It's invasive; we're giving X-ray contrast. It includes the cost of doing it within a hospital setting, the films, the technical time, and they'll repeat it again a few days later to see if indeed the stone is gone and everything is feeling better. Well if the patient's feeling better, he's better. Let's just leave it at that. Let's not put him through all of this kind of a procedure again.

Routine chest X-rays on patients that are being admitted to hospital. These are very, very common and, I mean, they range from the age of six on upwards. If these patients don't have anything that would indicate they have a chest problem, why are we doing that at that kind of an expense? The doctor could say . . . could simply cross that off. It doesn't need to be done, and maybe there should be a criteria set for when a chest X-ray would really be needed or maybe leave it up to the anesthetist if it's a pre-op procedure. It's quite an expense and I don't think it's necessary radiation for a patient either.

MRIs in six months to follow up MS (multiple sclerosis) cases. If a patient has MS, they are going to have it six months down the road and we're not really making any significant difference to that patient's treatment or to their lifestyle. But we are backing up the waiting list and we are inconveniencing that patient. They're already suffering. Why are we putting them again through another procedure?

Another CT (computerized tomography) scanner is definitely needed at the cancer clinic. At the present time there is one CT scanner at the Pasqua Hospital. We do all of the requests for the other physicians, neurologists and the surgeons and that, but we have to do all of the cancer clinic ones too. And if you get three or four of those in one day, that can almost use up the entire booking time for the CAT scan machine.

If we had one available, we certainly could help on the waiting list within the, within the cancer clinic itself, and we could certainly cut down on the three- to four-month waiting list for routine CAT scans.

A triage desk would be a wonderful idea in emergency. I was in the United States, in Oregon, and did indeed have to appear at an emergency room. And there's a desk there, sitting with little business cards and little maps. And the nurse there has the authority to speak to them about their illness and their problem and ask them if maybe they wouldn't be better served to take this card and this little map that's close to their home and attend that doctor's office, because of the costs and because this is . . . truly isn't a medical emergency.

I really think that that aspect should be looked at. I know that they're using it to a certain degree in Ontario and that it is working — $40 to see your doctor; $180 is the starting cost to walk through the door of emergency. And when we have people coming in that are suffering from a corn on their feet and they want to be able to wear their new shoes to the dance tonight or they've had three months of back problems and, you know, tonight was the night, I'm not sleeping through another night — well no, there are physicians and there are facilities to handle that type of problem.

Carotid ultrasounds are used to detect the possibility of a stroke. Now compare the cost of a study, an ultrasound study, to the statistics that state that in the first year following a patient having a stroke, it is going to cost the health care system approximately $100,000 in treatment and care. That's not including the cost to family and that they are not working, that they are not bringing in a taxable income. It's a real problem that we have to take a look at and get that early diagnosis in.

Far better that we spend those extra dollars bringing in another machine and another ultrasound technologist to do that than to take the chance on not . . . on having a patient have a stroke, just down the road.

User fees are a possibility and I know that they're a bad word with politicians. But certainly if you put that little bit of extra money upfront, maybe then the people of Saskatchewan might be a little more aware that there actually is a cost. We've begun to believe that it's free and that we're not looking at the fact that it indeed does come from our pocket.

A possible $5 fee when you visit your physician or a $10 service fee when you come to emergency might make people think twice; rather go to their physician than show up in the emergency room.

Without realizing . . . Saskatchewan people have come to expect medical services without realizing that abuse is what will eventually deprive them of this fantastic privilege. Of course you'd have to be very careful and do the exceptions; you'd have to check on people that are on social services, that are in welfare, elderly people, that don't have that money in their pocket. Certainly they already have cards and those would be presented and you could use that very effectively.

Statistics recently released show that Saskatchewan's educated and professional people are leaving the province at a greater rate than any other province. And in fact this morning I heard that 9,000 people have left, and you can bet those are doctors, nurses, paramedicals, people that are highly educated and are looking for a better opportunity.

We are in crisis, very, very especially in the medical profession. We are having a problem attracting and keeping professionals and paramedicals. We are suffering from a shortage of staff, leading to work overloads and burnouts. Our equipment is becoming outdated, making it hard to attract personnel.

And we fall further behind other provinces that can attract and recruit our newest medical graduates. Even within our province there are bonuses offered in rival health districts and pay discrepancies.

The recent union strike brought the public's attention to how crippling a strike in that sector is to the people of Saskatchewan. We as health care paramedicals within that union voted almost unanimously against a strike. We would like to work with the government to rectify this situation in the future, and we have certainly put several suggestions there.

But I'd just like to skip ahead to the fact that we would be prepared to meet separately with the Health minister or other personnel to determine the best way to handle proposed alternatives.

And we greatly appreciate this opportunity to offer suggestions and to give you some alternatives that may save medicare in Saskatchewan. We work within the system and we see many ways to increase the service and decrease waste, and this forum has provided us a very welcome opportunity and we thank you.

The Fyke report says that technology is our greatest expense. But without being on the cutting edge, we do a disservice to the people of Saskatchewan. Spending a little more, taking a risk, means fast treatment and sooner back on the job or caring for yourself and not having to rely on the health care system. Wellness doesn't work if we are not there to ensure it.

I'd like to thank you and if there are any questions, we would be very happy to answer them.

**The Chair**: — Thank you very much. We will have time for a couple of questions. I have Dr. Melenchuk and Mr. Thomson on the list. Mr. Thomson was first. And Ms. Harpauer.

**Mr. Thomson**: — Thank you very much, Madam Chair. I want to thank the presenters. This was a very informative presentation this morning. It's always interesting to hear how things are working within the system.

I want to address or ask your . . . a little bit of elaboration on one of the points which both presenters have raised and that's the utilization question. From the presentation, I would understand that utilization, part of the problem with the waiting list is that we are over utilizing the services. We are having unnecessary procedures ordered. Could you tell me to what extent you believe that that's a problem?

**Ms. Glasser**: — Image wise or how do you mean? Well that would be hard to quantitate. It really is. There are specific

situations where like it's a sore thumb that pops up and you see it.

I know that Dr. Bahera Mali, the chemical medical biochemist at the General Hospital, has been working closely with the existing Utilization Committee and she has identified a number of areas where improvements should be made. But she's pretty much run up against roadblocks in trying to implement those changes. So any statistics could be garnered through that Utilization Committee.

**Mr. Thomson**: — I was interested in reading a report from HSURC (Health Services Utilization and Research Commission) some time ago saying that perhaps as many as 75 per cent of the cases walking through the emergency rooms were not emergencies.

And I'm very interested to read your report in terms of suggesting that protocols that have been established to make sure our technology is well used are being circumvented. And I just want to thank you very much for bringing that to our attention. I agree with you, the technology is important but so are the protocols to make sure it's well used.

So with that, I won't ask another question except to say, once again, thank you very much.

**Ms. Harpauer**: — I want to thank the presenters for being here and want to touch on the area of utilization as well.

From my past experience from working in a laboratory, I couldn't agree with what you've written more. That's been ongoing for a number of years.

The one thing that you didn't touch on and I was just wondering if you were still finding this, which falls under utilization, is the duplication. When I worked in the labs, did you find . . . or I found that patients from smaller centres would have tests done both in the X-ray and in lab. And rather than their results coming with them or even if the results did come with them, they would be repeated. Is that still ongoing and happening?

**Ms. Glasser**: — I believe there have been improvements made in that area and different medical institutions will accept results from others. We do still see duplication, most often now it's because they're not aware of orders being placed.

But I've identified a number of situations. For example where thyroid testing was ordered in emergency on a patient, they've gone up to the ward; possibly another doctor, resident or someone has come along, ordered it again. The next day it's ordered again. I mean this is something that does . . . it's not going to change from day to day. And we'll see we have three samples on the same patient when we go to run them Tuesday morning. So those types of things need to be watched more carefully.

**Ms. Garner**: — I'm afraid I missed no. 9 on there, speaking about pre-operative X-rays and we do run into that just horrendous numbers of times. I can put a very large percentage on that where they have indeed had an X-ray and then they're sent on to the hospital to be admitted and they come without those tests. And that is a very, very large cost.

And it's something that physicians as well as the staff probably have to be made more aware of. I mean it's just . . . even when a patient is coming in or something, you could certainly . . . they're being booked, you ask if they have any pertinent X-rays, please make sure that they are informed to bring them or could your office please have them forwarded to us.

So that is a very big expense and it's repetitive and again it's radiation more than once and that's . . . medically, ethically for myself, that's a problem. I don't like to do it and yet they have to be there for the surgery or things. So it is a very big problem.

**Ms. Harpauer**: — The other area I wanted to question was the education. I know when I graduated there was between 40 and 60 graduates at the time. For the record, do you know how many are graduating from the area of laboratory technology at this point?

**Ms. Glasser**: — The intake into the training program is on an annual basis and they admit 16 laboratory technologists and I think an equal number of radiation technologists for Saskatchewan. Before the program was revamped in the early or mid-1990s, the lowest intake that they had taken at that time was in the neighbourhood of 35 to 40 per year. So we're graduating significantly fewer technologists now than we used to.

**Ms. Harpauer**: — My understanding is there, and again there used to be a degree program for technologists as well. Do you feel that that should . . . or we have a purpose to have that back in existence?

**Ms. Glasser**: — I'll let Donalda answer that question because I believe the radiation technologists are moving toward that.

**Ms. Garner**: — Nova Scotia already has their Bachelor of Science degree initiated with their MRT. We will be unanimous across Canada by 2005 where you will have to have your Bachelor of Science along with your degree.

This year we have eight graduates in the Regina area in radiology, and absolutely not one of them has accepted one within the Regina Health District . . . has accepted a position. Almost all of them are moving out of province. There are a couple that have been offered very good bonuses in Prince Albert and they'll be headed that direction.

So there's a real problem with a shortage because they in fact, for a couple of years they suspended the radiology program in Saskatchewan. We got a terrible shortage, then we have a few graduating, and now we'll be going to a degree program. And it's becoming more difficult to attract people when they have to have a degree also, and all of this . . . the 27-month-training program for X-ray, it becomes something that they're not attracted to. And they're certainly not going to stay here because we are not competitive with other provinces, and we aren't centralized in a professional union. Dorsey has put us into a supportive group, and that has become a real thorn to keeping even the people that are here. We're not being recognized as paramedicals.

**The Chair**: — We're running overtime, if we could . . . is this your last question?

**Hon. Mr. Melenchuk**: — Just very quickly I'm pleased to have your presentation especially the perspectives you provided on the overall system as just opposed to the area of expertise that you have.

And I think the points you've made with regard to utilization concerns; they've been out there for some time. And I know it's been a difficult area for development of clinical practice guidelines, because oftentimes you hear the concerns with regard to potential litigation, missing a lab test, so there tends to be a blitz approach. And I think we need to look at perhaps how this ties into the coverage of malpractice for professionals and paraprofessionals and providing that protection.

But the question that I really had is with regard to Dorsey. Now I understand that MLTs, MRTs, ultrasonographers are pretty much spread across all five bargaining units in the province, and it was certainly your desire from the start to belong to the health sciences union and you still believe that that is in the best interest of the population of Saskatchewan. Is that correct?

**Ms. Garner**: — Absolutely. When you have all of the professionals together under one umbrella, they have the support of their other groups. They have the advantage of knowledge of what's going on in other provinces. We're able to keep one step ahead professionally and knowing what's new, what's cutting edge. It relieves stress just knowing that you are being accepted as a paramedical. That you're not just in a support group. And we're always concerned about the . . . like being put into one large bargaining group like that. It puts us into a bad situation.

We were extremely unhappy to have to enter a strike situation like that. We are an essential service and we want to be there for the people of Saskatchewan. And being in a professional union, it's less likely to happen. You've got that strong backing in the first place and you don't have all of these problems that you're going to face on a daily basis in just a support union.

**Hon. Mr. Melenchuk**: — Okay, thank you.

**The Chair**: — I'd like to thank very much all of you for presenting and for answering our questions. And we very much appreciate your written submission also. Thank you.

Thank you. I apologize to our next presenters for running a bit late. This is bound to happen when we have interesting presentations. We thank you for your presentation that you supplied to us earlier. And it was very interesting to read.

I'll introduce the committee to you and then I'd ask you to introduce yourselves for the record. I'm Judy Junor and I'm the Chair of the committee. Dr. Melenchuk is the Vice-Chair. Andrew Thomson who's just getting a . . . saying goodbye to last presenters is there. And Mr. Warren McCall, Buckley Belanger, Brenda Bakken, Donna Harpauer, and Rod Gantefoer.

**Ms. Bradshaw**: — Good morning. My name is Janet Bradshaw. I'm president of the Saskatchewan Pharmaceutical Association. I reside in Dysart and I'm a community pharmacist practicing at Pharmasave in Fort Qu'Appelle. And Mr. Ray Joubert is the registrar of our association, and we will both be making a presentation here to you today.

**The Chair**: — You can just proceed.

**Ms. Bradshaw**: — We thank you very much for allowing us to be a part of this process. Under the authority of The Pharmacy Act, 1996, the Saskatchewan Pharmaceutical Association is the statutory governing body for the profession of pharmacy. And in administering this Act we govern pharmacies and the condition of the sale of drugs. We exist so that there will be quality pharmacy care for the people of Saskatchewan.

Our mission includes: first and foremost, public safety; standardized pharmaceutical services; a self-regulated profession; a positive professional image; public policy supporting health; and certainly the optimum public use of pharmacy services. Therefore this submission is presented in the context of our regulatory and our public protective role, and during the course of this presentation we'll focus on those recommendations in the Commission on Medicare report that we believe impact our profession and the public the most.

In dealing with chapter 1 of the commission, the "Everyday Services", we certainly agree with the recommendations regarding the primary care teams, the networks, and the centres in general, and we specifically support the recommendations to more effectively integrate the role of the pharmacist as a member of the primary care team.

Pharmacists provide important everyday services and, for example, these include — as you may well know — providing prescription drugs and certainly the advice that goes to the patients on how to use these medications most effectively. We are certainly there to prevent, to identify, or resolve drug-related problems. We minimize drug abuse. We provide over-the-counter products and a variety of health care aids, along with advice on how to use these products properly in meeting what we consider self-care needs of our patients. And also we refer patients to other health care providers.

While pharmacists work closely with physicians, we believe Mr. Fyke's observations that pharmacists could work more closely with patients and prescribers to make sure drug therapies work as intended can be achieved through a closer collaboration with other primary health care providers. Certainly we contribute the product, but we are also the experts on drug knowledge and, by utilizing this knowledge and expertise, the pharmacist can play an increasingly responsible role in ensuring positive outcomes of drug therapy within this teamwork concept.

Our association will continue to collaborate with government and other regulatory bodies to eliminate any regulatory barriers that may exist. As stated in our media release following public release of the report, the report is consistent with our association values and policies. Pharmacists are available, they are accessible, and they are approachable. So it makes sense to participate in whatever process is established to integrate the pharmacist as a member of the primary health care team.

And a key point that we want to emphasize: our ability to improve the outcomes from drug therapy is enhanced when we can collaborate with other health care providers.

Here's some demographics now. We have 854 pharmacists practising in 362 pharmacies. And this is spread over 128 urban and rural communities; 159 of these pharmacists are in hospitals across the province. And what this means is that we feel we have an adequate distribution of pharmacists to participate in these primary health care teams anywhere in the province.

We will take a leadership role in advancing the recommendation for this enhanced role of the pharmacist, allowing them to apply their knowledge in prescribing decisions. We are anxious to consult with all affected parties to determine how this will work. We reiterate this commitment and the availability of pharmacists to become effective members of primary health care teams.

Now the practical application of this concept certainly raises some important questions and creates some interesting challenges. For example, if this means that pharmacists are to be physically located with other providers, then pharmacists may need to leave the pharmacy to attend the primary health centres. Or perhaps to relocate their business to that facility.

Alternatively the community pharmacy could become the community prime care centre, then requiring changes to the configuration of the pharmacies to accommodate other members of the health care team. Relocation of the providers may be easier to establish in the 94 single pharmacy rural communities where competition with another pharmacy is not a factor.

Whatever way you look at it there certainly would be some economic impact of potential losses and goods of other services if this was a possibility. Therefore in either case, pharmacy owners may need some regulatory support and government incentives to facilitate these changes.

But we have another idea as an alternative. Primary care providers could be gathered together under a virtual structure. Technology could certainly be used to connect team purposes . . . team members for the purposes of communication and information sharing and thus physical relocation may not be needed as team members could be connected with one another through a health information network.

We believe that the best chance of integrating all pharmacists from all communities as a member of the primary health care team can occur with the implementation of the Saskatchewan Health Information Network. Therefore we strongly support the recommendations from the report concerning investments in information systems including the development of an electronic health record under SHIN (Saskatchewan Health Information Network).

At this time I would like to ask Mr. Joubert to continue.

**Mr. Joubert**: — Thank you, President Bradshaw. I'd like to deal with chapter 4 entitled, "Getting Results." And we believe, as an association, that the most important recommendations arising from the report concern the establishment of the quality council.

In our media release following the release of the report we stated, and I quote:

> We continue to believe that optimal drug use is the most cost-effective therapy. When used properly drugs can save the system money. Many strategies exist with the same goal of proper drug use. To maximize their effectiveness we have been promoting a drug-use management framework that would combine all such strategies under the leadership of one body. This role is compatible with our understanding of the quality council.

In that section of the, of that . . . in the section in that chapter entitled, "Improving Quality: The Example of Drugs," the commission argues in favour of the cost effectiveness of optimal drug use and advances a, and I quote from the report:

> . . . a solution centred on a major quality improvement plan for the drug sector.

Our discussion paper on a framework for a comprehensive and integrated drug-use management strategy is attached to our presentation — it's the document that's headed with the blue coloured paper — anticipates this solution as Mr. Fyke has outlined in his report.

By way of example to illustrate the substance of our discussion paper, a number of drug-use management strategies currently exist in Saskatchewan and they include pharmacists conducting drug utilization reviews in hospitals and in community pharmacies, especially in long-term care facilities. What this really means is that the pharmacist in a structured, formal kind of way has a look at the drug use in, for example, a long-term care facility and makes recommendations to nursing and medical staff in terms of what changes may or may not be required.

Secondly, we have the dial access drug information centre in Saskatchewan. This consists of two components: a drug information service for health care professionals — pharmacists, physicians, and nurses in particular — and of course the consumer drug information line where the public, through a 1-800 number, has access to drug information services.

We have a Saskatchewan ADR or adverse drug reaction reporting program that is located at the College of Pharmacy and Nutrition at the University of Saskatchewan in Saskatoon. And this is a very credible and internationally renowned reaction-reporting program that is conducted in collaboration with Health Canada.

We have the academic detailing program under the Saskatchewan district health's pilot program that's being extended to other health districts in Saskatchewan.

We have a triplicate prescription program. And just to simply explain what that is, this is a program where, in collaboration with the College of Physicians and Surgeons, the pharmacist provides information to the college on the dispensing of certain drugs of abuse and the college in turn uses that information to advise their members of potential . . . patients who are potentially double-doctoring, or they use that information for their educational purposes.

There are patient profile release programs under the drug plan.

We have the Saskatchewan *Formulary*, which is a process for determining benefits under the drug plan.

Under Health Canada's non-insured health benefits program, there's a prescription-monitoring program that is currently in suspension because of privacy concerns.

And we also have, finally, the report from the Health Services Utilization and Research Commission advisory panel on optimal prescribing.

So as you can see, there are a number of examples of drug use management strategies in Saskatchewan that exist. There are many, many, many others that for the sake of time we won't get into.

But we collaborate with many organizations in the delivery of these initiatives, but they are fragmented. Duplication exists. For example some health districts have their own drug information services where there is a provincial drug information service that is available to them.

Therefore our discussion paper proposes to integrate the various drug use management strategies and suggests that a governing structure be established to manage, coordinate, and integrate these strategies in Saskatchewan.

To elaborate by way of an example, the government could establish what we call a drug use management centre that could be governed by the quality council. Based on determinants, indicators, and measurements established by the quality council, the centre would use whatever strategies are deemed appropriate to monitor and promote healthy outcomes of drug therapy.

With access to drug use databases such as the extensive database that exists with the drug plan, the centre could identify quality of care issues. It could access our existing drug information and continuing education resources to inform and educate providers of health services. Or it could direct academic detailing where pharmacists provide objective information to physicians on drug therapies of choice.

The centre could also use the data to develop and evaluate prescribing guidelines used and based on best practices.

In this way the government can be assured of the value of funds spent on drug therapy. Our association is certainly interested in taking a leadership role in the development and implementation of this framework.

As another solution, Mr. Fyke recommends . . . recommends, pardon me, and I quote:

> An enhanced role for pharmacists as part of primary health teams, allowing them to apply their knowledge as full participants in prescribing decisions.

And we emphasize here that pharmacists are sufficiently trained to accept this role. For example, we have submitted regulatory amendments for the Minister of Health's approval to permit the pharmacists to dispense prescription medication for . . . without a prescription under certain circumstances such as emergency contraception.

This dispensing without a prescription could also be permitted in other emergency cases where the patient is stabilized on chronic therapy for example, the prescription has expired, and the pharmacist could provide a reasonable quantity to allow the patient to continue therapy until the patient has had a chance to see his or her physician. Or until the pharmacist has had a chance to obtain the prescription.

We will continue to pursue these regulatory changes to permit this in other types of emergency circumstances such as when . . . and this is a fairly classic example . . . the asthmatic has lost his or her prescription medication; needs it but the prescribing physician is not available to obtain the prescription.

The second area where we will continue to pursue change in light of this recommendation from the Fyke report is an area where there could be some delegation of authority. In a growing number of situations, pharmacists engage in collaborative drug therapy agreements or protocols with physicians where they are allowed to manage a patient's drug therapy without contacting the physician on each and every occasion where a change is made to that drug therapy.

A new example is something that is called community warfarin dosage adjustment programs. In this example, warfarin, which is an anticoagulant used to thin blood in certain heart conditions, blood levels are required so that there is careful monitoring so excessive bleeding does not occur. Under these protocols the pharmacist would adjust a dosage of the warfarin based on monitoring regular blood tests.

We are proposing regulatory changes to ensure that these practices comply with all aspects of the law.

Again we emphasis that as the governing body for the profession, we will continue to develop and implement programs to ensure that pharmacists maintain their competency in current and these enhanced roles.

I'd like to deal briefly with chapter 5 entitled "In Support of Change". Like many other provider groups, we are experiencing a shortage of pharmacists. We are collaborating in efforts to examine the nature of the problem and possible solutions. However, we are also interested in measures to ensure that pharmacists are optimally deployed in the system. Therefore we support recommendations made earlier in the report on this principle and also those recommendations in chapter 5 to coordinate human resource planning and management on a provincial basis.

A key element of a successful drug use management strategy is a strong, supportive information system. Health care providers can make better drug therapy decisions when information systems provide them with comprehensive drug use data on patients. Pharmacists in particular can use the data to enhance drug use, monitoring activities, prevent duplication or inappropriate therapies, and certainly prevent drug abuse. Once again, for this reason we strongly support recommendations concerning information systems.

By way of conclusion, to summarize Mr. Fyke: enhanced health

outcomes can occur when optimization of the role of the pharmacist is combined with appropriate drug therapy. As we have publicly stated, and I quote:

> It is a good report and deserves to be supported. While some recommendations are challenging, we see opportunities to enhance health outcomes. What we need now is decisive government action that sends a message to all of us to plan for implementation. At the very least, government could implement the quality council immediately. Regardless of changes that are implemented, the concept is needed. It could also provide objective information to guide decisions in dealing with Mr. Fyke's recommendations.

Through the Standing Committee on Health we continue to urge government to implement the Commission on Medicare's report. We especially support implementation of the quality council. We support an integrated and comprehensive drug use management strategy. We support an enhanced role for pharmacists as effective members of primary care teams, and all of which is supported with technology and effective information systems.

We will participate in the implementation plans and exert a leadership role in the drug use management strategies.

All of which is respectfully submitted, and we thank you for the opportunity. We'd be happy to entertain any questions.

**The Chair**: — Thank you very much.

**Mr. Thomson**: — Thank you, Madam Chair. I want to thank both of the presenters. This was a very well laid out presentation. I enjoyed reading the advanced copy of some of your views last night. So I thank you for that.

I want to just make sure I understood clearly — I think it was in Ms. Bradshaw's presentation — about the number of pharmacists and where they were located throughout the province. Did I understand that the pharmacists, you say, are located throughout 128 different communities?

**Ms. Bradshaw**: — 128 urban and rural communities.

**Mr. Thomson**: — I think that this is extremely important for us to understand. Many of us, at least I know in my own case, I'm more likely to talk to my pharmacist than I am to talk to my doctor about my health issues. And the fact that this network of pharmacists is so well established throughout the province I think speaks very well to the integration into the primary health teams.

With that comment — I know I'm supposed to ask a question, Madam Chair — so my question is this. How do you see us proceeding with the introduction of the primary health teams? I understand you're saying we should move quickly to do the quality council. How quickly should we move with these primary health teams?

**Ms. Bradshaw**: — Well I think there's a certain amount of . . . The concept that we favour, we see most practical is certainly the virtual structure. And based on that, we need the process in place for health information sharing. And we strongly advise that that has to be moved forward before we can actually go ahead with the concept as such under a virtual structure. That is certainly something that is lacking.

As community pharmacist, I believe that not having the information that I need — something as simple as a diagnosis that I don't have access to — certainly does not do me the best in counselling my patient. And I don't think it's the best for the patient either. We need to have that information sharing if we are going to collaborate with other health care providers.

**Mr. Thomson**: — A quick supplemental on that. And obviously SHIN is a big part of this. The secondary piece, I would assume, is a need to reform regulations to allow pharmacists to undertake more responsibility in terms of managing drug therapy. Is this . . .

**A Member**: — That's true.

**Mr. Thomson**: — Okay. Thank you very much.

**Mr. Gantefoer**: — Thank you . . . (inaudible) . . . that we're pressed for time, but thank you very much for your presentation. It's very, very thorough and very much appreciated.

I have some questions that sort of go around the issue of collaborative practice between yourselves as pharmacists and medical practitioners who actually write the prescriptions. In your experience in the communities in the current situation, you call for collaborative practice and a more meaningful role for pharmacists in that collaboration.

What is the relationship now in terms of . . . Do the medical professionals really respect your expertise? Because I expect that with the changes that are so rapid in prescription technology and all the advances, that I suspect that pharmacists are much more knowledgeable about the details of the ramifications of a drug course or whatever. And so do you have meaningful input currently with physicians in your experience?

And second of all, I know from anecdotal experience and even experience of my mother, at times it seemed as if her whole cupboard was filled with prescriptions that all of a sudden it came to someone's opinion that this was all nonsense. It just sort of built up and gradually built up and all of a sudden a more appropriate therapy would have actually been a lot better for her.

And those checks and balances and relationships with physicians is what I'm interested in.

**Ms. Bradshaw**: — Well first of all I do believe there is a good relationship already in place with most pharmacies and their physicians. And certainly they do rely on us for their expertise. The drug community per se is constantly evolving, so I don't believe that the physicians have the time to look up things. So certainly they are in contact with us all the time.

As far as you were saying about the number of medications that can be a problem, certainly we see that a lot with seniors who are on a number of medications. That is an area of concern.

What we certainly try to emphasize to all people is that they stay with one pharmacy. As you know, our systems are not linked. So if a patient goes to a pharmacy other than the one that they have been attending, we do not have access to those records. So therein lies a number of problems that can occur with duplication of medications. And that is one area where, if we have the electronic health record, the SHIN, that'll help address some of these problems.

But certainly with the drug use management, trying to consolidate the number of medications is a huge issue. Because with that comes more adverse drug effects, more hospitalizations, and so on and so forth.

**Mr. Gantefoer**: — A quick supplemental following up on that. Is there a two-way relationship? So, for example, a client comes in, and again assuming a single pharmacy, and you notice that this is starting to build up, is there the two-way dialogue that you would call the attending physician and say, look it, we think that this is going to be a problem, that all of these different medications are going to have poor results? So that's the first part of it.

And second, I'm told that there are examples where indeed it's necessary for pharmacists to talk to the physician because the dosage, for example, may not be appropriate and actually may be harmful and the physician was unaware of that. What I'm getting at, is there instances where the pharmacists actually initiate a call back to the physician and say, I think there's a problem here?

**Ms. Bradshaw**: — Absolutely. All the time. I mean, these are interventions that take place right when the patient brings in the prescription. And certainly, if we have the entire history of the patient, if they have been, say, with one community pharmacist, then we have access to that whole history. We can see a pattern if there is a problem.

So yes, absolutely, that does go on.

**Mr. Joubert**: — Just by way of a supplementary comment, we . . . that kind of activity and responsibility is incorporated within our standards of practice. So we hold pharmacists ethically accountable to engage in those kinds of activities when they see a problem. And that's what we mean by preventing and . . . identifying and preventing drug-related problems.

Secondly, there's some interesting research that's been done on those kinds of interventions that show that when you spend $1 in compensating the pharmacists for those interventions, you can save the system $2.50. And I'd be happy to share that information with the standing committee in a little bit more detail if you're interested in having it.

**The Chair**: — Thank you. If you could supply that to us, I think that would be very useful.

**Hon. Mr. Belanger**: — Yes, particularly in terms of . . . I've got a couple of questions but I'll just stick to one here.

One other question I have is when you mention that your association, like other associations in the health field do have challenges attracting new pharmacists and getting trained pharmacists in place, my question I guess is in relation to the effort of trying to seek some of those people to take the training. Has your association been active in that regard?

And in particular, has there been any effort made to a fairly large population, or a segment of the population, that being Aboriginal people, has there been any collaboration with the training institutions, or has there been any collaboration with any of the Aboriginally run and operated institutions to try and see if there's anybody in the Aboriginal community that would take up this field?

**Mr. Joubert**: — I may have to defer to my colleagues at the University of Saskatchewan because they more or less control the admissions to the programs. My understanding is that for the 80 or so positions, admissions to the College of Pharmacy and Nutrition, there are at least three or four applicants every year. So there's an adequate supply of people interested in entering the profession.

My understanding is that also at the university there are equity programs that provide opportunities to Aboriginal peoples. I'm not sure of the statistics but as far as I know I don't think we have many, if any, Aboriginal pharmacists registered with the Saskatchewan Pharmaceutical Association. We might have one or two out of the 1,100 or so members we have.

So the short answer to your first questions is yes, there's adequate opportunities. The answer to your second question is maybe we need to do more as an association in collaboration with the university and the Aboriginal peoples.

Part of the problem with us is that most of our graduates from the College of Pharmacy and Nutrition leave the province.

**The Chair**: — Thank you. Dr. Melenchuk, you can wrap it up for us.

**Hon. Mr. Melenchuk**: — A couple of quick questions with regard to the primary health care teams. It would be the preference of your association that your involvement would be on a virtual basis as opposed to actually a physical plant location? Would you see that as preferential than the one recommended by Fyke?

**Ms. Bradshaw**: — I could see that as a concern for rural pharmacies where there is only just the single pharmacy. And that has been expressed to me, that they really didn't . . . they were concerned: where they would practice out of, how would it affect their business, how would it affect the community. I see this as a more workable situation for establishing the team, under a virtual concept.

**Hon. Mr. Melenchuk**: — Now you obviously have pharmacists located in pretty much everywhere in Saskatchewan, so you're obviously in a good position at this point in time to work within these improved co-operative, coordinated circumstances.

The one question that I do have that you didn't address in your report is with regard to the expansion per se of OTCs (over the counter); the availability of non . . . of converting some prescriptions items to non-prescription items and perhaps have

the pharmacy deal with that on a one on one with the patient or client when they came in.

Do you have a particular position at this point in time, your association?

**Ms. Bradshaw**: — It happens on a daily basis; that's a large part of our practice as it is right now. Our recommendations as far as products moving to an OTC status are based on a larger committee that evaluates this. So it's done on an . . . I guess as they are reviewed.

But I feel that that's a big part of the practice right now where we see people coming in looking for self-medication. And at that point there is often a decision made based on the pharmacist to have a referral made to a physician. So it's an initial step but it certainly is there right now and a big part of the practice.

**Hon. Mr. Melenchuk**: — So the question arises, is under this new model perhaps of an integrated primary health care team, would you see an expanded role for over-the-counter preparations that the pharmacist would have control of, knowing that they're going to have the information transfer, a greater amount of information on the patient perhaps, access to the entire patient chart, that they might be in a better position to make recommendations on a wider range of over-the-counter products than is currently available?

**Ms. Bradshaw**: — Possibly, possibly. But I don't see that as changing dramatically.

**Hon. Mr. Melenchuk**: — Thank you.

**The Chair**: — Thank you very much. Thank you, Ms. Bradshaw and Mr. Joubert. And if you could follow up with that information you said you'd share with us, we'd appreciate that. And on behalf of the committee we thank both of you for coming today.

**Mr. Joubert**: — A brand new report, if you're interested as well. We can leave them here or . . . (inaudible) . . . in a little bit more detail.

**The Chair**: — Thank you. Good morning, and welcome to our next presenters. I'll introduce the committee and then I'll ask you to introduce yourself with your title and your organization for the record and for our viewing public.

I'm Judy Junor, Chair of the committee. Dr. Melenchuk is the Vice-Chair. Andrew Thomson, Warren McCall, Buckley Belanger, Brenda Bakken, Donna Harpauer, and Rod Gantefoer.

Good morning.

**Mr. MacKinnon**: — Good morning.

**The Chair**: — Go ahead.

**Mr. MacKinnon**: — Thank you very much. I am here with my colleague, Gordon Barnhart, who is the university secretary, Madam Chair.

Thank you very much for giving us the opportunity to appear before this committee and to comment on aspects of Fyke that we believe touch the activities at the University of Saskatchewan.

I do have a written submission, which was completed yesterday and is available in the 15 copies for distribution to the members of the committee and I believe to the administrative staff as well.

I'm going to take about, really no more than about five or ten minutes, believing that questions will perhaps follow. I do want to talk a little bit about the report in general terms though and I will talk around three themes: the problem, the solution, and the opportunity, because we think that Fyke addresses all three — a problem, a solution, and an opportunity.

Let me talk a little bit about the problem. And I'm going to summarize this in two ways by talking a bit about the mandates of medical education. I think it's fair to say that the history of the College of Medicine at the University of Saskatchewan is one of success in addressing two of the three mandates of medical education — clinical teaching and clinical service.

In fact the record in the clinical teaching side is very impressive and has been I think demonstrated to be so in a couple of key indicators. One, the success of our students in national examinations. They've always done very well in the highly competitive national examinations that medical students are required to write. And the success of our students in acquiring residencies of their choice. They were typically offered either their first or second choices. And so these are clear signs of the quality of these young people as they embark upon their professional careers.

We were less successful, I think — and it's the history of the College of Medicine that this is the case — less successful in addressing the third mandate of medical education and that is the research mandate.

The first point that I would really like to make is that the mandates of medical education are generally recognized not as being in conflict, each with the others, but as being interdependent. And so, if you think of a medical school as having three duties, all three are important: clinical teaching, service, and research. And as I say, we were successful in addressing two of these mandates. Far less successful in addressing a third.

Well if that's the history, in 1992, a very critical thing happened, of course, with the formation of Saskatoon District Health. And I would describe the formation of the district as a process of change, which is incomplete to this day, because there were fundamental changes to the status of Royal University Hospital. It had been a university medical school/teaching hospital. It became part of the Saskatoon Health District.

But the significance of this change for medical education was not fully addressed at that time. Indeed, it was not even carefully addressed at that time.

And so we had the medical school at the university on the one

hand. We had the Saskatoon Health District on the other hand with the three Saskatoon hospitals. But we did not have the kind of integration between the activities of the College of Medicine and the Saskatoon Health District that was required for there to be effective medical education in the city in all respects.

The fact that the idea of an academic health science centre was not addressed in 1992 has lead to a fair amount of tension, I think it's fair to say, that exists at least very nearly to this day. I think that there is a fair amount of optimism that is developing around some of the ideas in Fyke that have allowed us to give some assurances, I believe, to our medical school faculty and, indeed, to the medical community of Saskatoon and, indeed, of the province that we're going to be able to address some of the issues that have arisen and we are going to make the successful transition that is called for.

Given that that is the case and that is our appeal, it will come as no surprise to the members of this committee to hear me, on behalf of the University of Saskatchewan, say that we warmly endorse the recommendation of Fyke for the creation of an academic health science centre in Saskatoon to complete the process of change that was underway or began in 1992 and to bring about an integration within the city, with important links, by the way, to the rest of the province, including to Regina where we do have a mandate. But the idea of bringing Saskatoon, Regina, the University of Saskatchewan together in the form of an academic health science centre is something that we think is an excellent idea.

We also would like to note that Mr. Fyke made very important recommendations about medical research, underlying the fact that indeed there are three and not two mandates to medical education. In order for any academic health science centre to thrive through time there does have to be a vigorous research community, and it supports the teaching and supports the research.

People who want to do medical science in a university setting, in a College of Medicine setting will want to do some research, or at least will want to be engaged in some way in the research community. If that's not available to them in Saskatchewan, in this highly competitive environment in which we live and work, it will be available to them in Calgary or in Edmonton or in Winnipeg with of course very untoward consequences for our capacity to continue to do medical education at the level that this province deserves and requires.

And so we believe that the Fyke report does point the way to a solution — the call for an academic health science centre and the call for the province to commit itself from 1 per cent to 2 per cent of its Health budget on research. This would provide an enormous stimulus to the development of the research capacity in the city and in the province and I would hope that this would find favour with your committee.

May I also suggest that there's a tremendous opportunity in the situation in which we find ourselves. Health services is described, for some purposes at least, as an industry and I think for a number of purposes it is. The capacity to create a vigorous academic health science centre in this province located primarily in Saskatoon but with very important linkages to Regina is something that should be welcomed. There is no doubt that this is going to be a growth industry in the future.

Certainly the emphasis that we see placed on medical research by the federal government at this time through the Canadian Institutes of Health Research reveals that there is a new emphasis on the importance of research in the health sector, and the capacity of this province to take advantage of that, I think, is a tremendous opportunity. We believe that it's an opportunity which is a natural in this province.

We are, for example, the only university in the country that has the full range of health sciences colleges — the only one in the country — by virtue of having veterinary medicine together with medicine, dentistry, pharmacy, physical therapy, kinesiology, nursing. The only one in the country.

And so the capacity to bring these together in the enterprise of research and teaching is a capacity which we think should be taken advantage of in this province.

So it's an opportunity that is enhanced as well by having the Canadian Light Source Synchrotron under construction on our campus. I have talked to people who are responsible for these laboratories in a number of different settings. They have said to me and they have emphasized over and over again, you are building a world-class facility, a world-class laboratory on the University of Saskatchewan campus in Saskatoon in Saskatchewan. In order to take full advantage of that, there must be a strong base of local use. That is to say Saskatchewan, our two universities, others, must use the synchrotron. And one of the areas in which it's considered to be a vital support to research is in the area of medical research.

And one can readily understand that if you think of the synchrotron, as I think it is most appropriately thought of, as a giant, very accurate, very advanced microscope, and becomes useful for all purposes for which microscopes are useful.

So in summary, Madam Chair, members of the committee, we do support the Fyke recommendations for an academic health science centre. We do support the suggestion that there should be from one to two per cent of the provincial Health budget devoted to research. We think that that would be a catalyst from which there would be enormous benefits following. We believe that this is a direction that should be supported and find wide support in the province, and we are pleased to again come before you and offer that endorsement.

**The Chair**: — Thank you very much, President MacKinnon. Questions, we have Mr. Thomson on the list, Mr. Gantefoer.

**Mr. Thomson**: — Thank you, Madam Chair. Thank you, Mr. MacKinnon. I want to start by saying that this is a very interesting proposal, and I'm pleased to see that the university is supportive of many of the Fyke recommendations.

There are certainly some concerns for those of us who live outside of Saskatoon, of how the university, if we proceed with designating Saskatoon as an academic health sciences centre, how the university will work to ensure that health care throughout the regions is maintained to the quality that Saskatoon has come to enjoy.

Obviously we were all pleased to see Saskatoon Health District ranked third in the nation; somewhat less heartening to see Regina ranked 26. How does the university plan to address . . . to make sure that Regina and the rest of Saskatchewan are able to share in the benefits that quite obviously the university provides?

**Mr. MacKinnon**: — Well I think one of the outstanding questions is: what will be the precise nature of this academic health science centre? I should tell you, by the way, that there has been a good deal of early discussion about this issue. It's taken place already. The district is as interested in talking with us as we are with the district about this. Our acting dean of Medicine has talked about not just an academic health science centre in Saskatoon, but one which would be designated a Saskatchewan academic health science centre with vital linkages and a particular presence, by the way, in Regina.

Again the university's medical school has had a historical presence in Regina. It is officially recognized as entitled to conduct medical education in Regina. It has done so to a greater or lesser extent, often depending upon resources that are available.

But we believe that the capacity to be present in Regina, to work with the Regina district — and by the way, we've had meetings with the district leadership here in this city — we think that this is vitally important and we think it should be reflected in the makeup of this new health science centre.

**Mr. Thomson**: — I have two additional questions, Madam Chair. In 1988 the university, the Royal University Hospital, and the College of Medicine, I guess, ended their linkage with . . . at that time the Plains Health Centre as a teaching hospital. To my knowledge, General Hospital is not recognized as an additional teaching hospital. The only one in the province, I believe, is the Royal University.

If Saskatoon's . . . and the University of Saskatchewan is to be designated as this provincial health sciences centre, would we look at restoring some of those linkages? Would we look at the other majority tertiary care centres having opportunity to become teaching hospitals again?

**Mr. MacKinnon**: — . . . as we continue to have some of those linkages now. A number of our programs continue to be carried on in Regina. Would we be looking to enhancing them? Yes, we would. We would also be looking to take advantage of new partnerships, I think, that would be available to us. Not just in Regina, but obviously, certainly in Regina but as well in neighbouring cities.

We have talked to academic health science centres in Winnipeg, in Calgary, and in Edmonton. And there is a new emphasis, I think, on partnerships, on regional partnerships, on the capacity to emphasize certain things in our different prairie cities. And so we will be looking to Regina particularly, but as well to Edmonton, Calgary, and Winnipeg, for precisely the kind of opportunities you're referring to, Mr. Thomson.

**Mr. Thomson**: — My final question, Madam Chair, concerns the academic health sciences centre. There is some concern that this would be a consolidation of academic training and would mean a loss of a program in nursing education here in Regina that we do enjoy.

Is that the way that the university is seeing this, or would we look to work with regional centres, to make sure that nursing education and other health sciences education continue throughout the province?

**Mr. MacKinnon**: — We have, you will know, a very strong commitment to regional co-operation in nursing education. We have a joint program with SIAST (Saskatchewan Institute of Applied Science and Technology) as you know. That of course is in both Regina and in Saskatoon. We have a nursing program with which we co-operate in the North, in Prince Albert. And so there's a very strong regional dimension to our nursing education. I expect that to certainly be sustained into the future, perhaps even expanded.

**Mr. Thomson**: — Finally . . . I have one final question. The university's had great success obviously with its SUNTEP (Saskatchewan urban native teacher education program) and NORTEP (northern teacher education program) programs for teaching. Has the university given any consideration to similar programs in the health sciences to encourage Aboriginal people to enter into the health sciences professions?

**Mr. MacKinnon**: — Not only have we given some thought to it, we have taken some action with respect to it. In the nursing side, the admission of Aboriginal students into nursing and our co-operation with Prince Albert on this front. As well in the dental education, the training of dental technicians; we have done that through the National School of Dental Therapy. That's co-operation with Aboriginal people in this province.

And so the answer to your question is not only do we intend to do so, we have done so. And do I expect to see us do more in this area in the future? Yes, I do.

**The Chair**: — Thank you very much.

**Mr. Gantefoer**: — Thank you very much. Thank you very much, President MacKinnon, for being here and making this presentation. I think it's very important that you've done that.

I'd like to cover just two areas. And certainly from your presentation we could discuss this at length, so I'll limit myself to two areas.

You correctly identified, I think, that one of the components of the threefold component and priorities of medical practitioners in the College of Medicine is the research component that has been lacking. And Fyke identifies a 1 to 2 per cent of the Health budget as a commitment in terms of medical research. That'd be 20 to $40 million.

Actually your $20 million is the bottom of the range and currently the province is spending $5 million. As well if we moved into that 20 to $40 million range, I believe you're saying that there's a real opportunity for matching federal funds that would be available as that infrastructure to do that research happens.

And finally with the opportunity of the synchrotron, it's a

particularly important juncture in making this kind of commitment.

Is this becoming time-sensitive? Do we have to make this commitment fairly soon if we're going to properly and effectively leverage the opportunities that the synchrotron presents? And if we fail to meet that challenge, do we run the risk of simply having itinerant technicians coming into Saskatoon and doing their week or two or three of raw research or basic research in the synchrotron and then leaving to do the advanced research somewhere else?

**Mr. MacKinnon**: —Well I think the answer to that is that there is much here that is time-sensitive. Certainly to my colleagues in the College of Medicine and at the university I have said we have months to fix the issues that we've identified at the university and at the college. We do not have years.

Now there are some things that are going to take longer than months. We're really talking about a new culture here too, the kind of culture in which everyone working in health science area in this particular health science capacity recognizes that there are the three mandates, they are interdependent, and we must be devoted to all three mandates.

Your comments with respect to the synchrotron are very timely indeed, Mr. Gantefoer, because it is a time-sensitive issue. We have to develop the capacity not two years from now, but now — beginning now — to develop the capacity that will be up and running, that will have the research plans in place, that will participate in the selection of beamlines because one of the key features of synchrotron development is the identification of what beamlines you are going to build.

For example we have the first six identified. The capacity of the synchrotron is to have 30. It's going to take us quite a while to work up to that. But what will beamlines 7, 8, 9, 10, and 11, and 12 be? Will they be beamlines that are identified by potential users at the University of Toronto or the University of British Columbia? Or will they be beamlines that are identified by potential users at the U of S (University of Saskatchewan) or the U of R (University of Regina)? I would very much hope it would be the latter.

So we have to develop the capacity now to take advantage of the synchrotron a few years from now. So it's very time-sensitive indeed.

**Mr. Gantefoer**: — Thank you very much. The other area . . . And Mr. Thomson talked about the relationship of the colleges, the health colleges, to Saskatoon and Regina. I would like to submit . . . And I appreciate the concept of the integrated health sciences facility being considered a Saskatchewan resource.

And I would like to go to the other communities, the smaller communities if you like, that still potentially in Fyke have a regional function. I'm thinking of Yorkton, North Battleford, Swift Current, Moose Jaw, Melfort, those kinds of communities in the world and seeing is there going to be an improved relationship with those communities in terms of the health sciences college as well? Maybe some residency programs, some of those sorts of things that deal with rural family practice and some of those aspects that I think are very important.

Do you see a linkage not only being improved between the colleges and Regina as the other major urban centre in this province, but also the smaller urban centres right across the province?

**Mr. MacKinnon**: — The answer to that question, Mr. Gantefoer, is yes. Again part of this move would be a greater integration of our own health science colleges and the opportunity with nursing, with physiotherapy, with pharmacy, with all of these, to talk about ways in which we can have linkages of the kind that you mention with all of the important regional centres in the province; be very enthusiastic about that. And I think it would be warmly endorsed within our health science colleges — all of them — not just medicine.

**Mr. Gantefoer**: — The final comment that I would like to acknowledge is that you state that there is significant and noticeable progress being made through the Health Sciences Advisory Council and trying to define more appropriate relationships between the College of Medicine in specific and the Saskatoon District Health.

I would certainly encourage that body to also look at the broader issues of the relationship not only in Saskatoon, but the relationships with Regina and all these other centres. So it may be expanding the mandate somewhat, but I think they should take that bigger view.

**Mr. MacKinnon**: — Thank you, Mr. Gantefoer. I'll take that back and endorse it.

**Hon. Mr. Melenchuk**: — Thank you and thank you to President MacKinnon for his presentation.

I have two questions with regard to the academic health sciences centre. Now currently in the University of Saskatchewan, we have a separate Vet-Med College, the College of Medicine, the dental college. A new kinesiology building is currently under construction. We have the Royal University Hospital with research facilities and teaching facilities.

Now how do you see the need in terms of this academic health sciences centre?

Obviously there has to be some integration with regards to governance management of that structure. But in terms of additional facilities, where do you see the priority in terms of physical plant that might be added on to achieve this academic health science centre?

**Mr. MacKinnon**: — It's an important question, Dr. Melenchuk. The answer is we don't have a precise shape in mind for the physical resources that will be necessary. We did do some work. We did present some of our work to the departments of Health and Post-Secondary Education. That represented a kind of a first and quick cut at the space issue.

We do know that there is a severe space shortage. There is generally on the campus. That's been documented by external consultants. We know that it's particularly serious in health sciences and medicine in particular, in part because the facilities that are necessary for the research side have never really been

developed to the extent necessary to allow research to be done.

We know too that some of our teaching resources are on the weak side — the physical facilities, that is to say, in support of these resources. Our College of Nursing in particular has complained for many years. We brought in a new dean of nursing this year and she has described our physical plant in nursing in most uncharitable terms. So that we know that there are a number of areas here that we have to address.

Our focus so far, I think it's fair to say, has been on the governance issues which have to be sorted out very, very quickly. We want to identify what the key bodies will be in this academic health science centre and what they will do. I think we're making progress there. We also want to talk about the kinds of administrative arrangements that will be necessary to facilitate working together in ways in which we're not used to. All of that will take place. At the same time we have to identify many of the new academic features of this academic health science centre. And I think when we have worked through those, and we're on a fast track to do that, we will know the kind of refinements that will be necessary in the sort of space proposals that we have already taken a first cut at.

So we can go to work on that very quickly. We've done a lot of the work already. And we do have in mind, you know, a substantial increase to our infrastructure. We know it's necessary.

**Hon. Mr. Melenchuk**: — Okay. So you're really into form follows function. We'll see how this new governance management function might work and then what the space requirements would be for that.

The second question that I have is with regard to your . . . you know, the suggestion that there is a requirement for re-evaluation and change in the relationship between the College of Medicine, Saskatoon District Health, and University of Saskatchewan. For some time, in fact as long as I can remember, there have been difficulties in the relationship between academic physicians and downtown physicians, full-time teaching, part-time teaching, full-time researchers who want to do a little bit of teaching, academic appointments, the mixing . . . the funding mix with the clinical services fund, the amount of funding coming from the Health department and Post-Secondary.

So you see this as a total re-evaluation in the relationships that are currently in existence and perhaps some new funding models. Is that what you're suggesting here?

**Mr. MacKinnon**: — Yes, we certainly have to be open to that Dr. Melenchuk. The benchmark from my perspective has been national standards and we have used that phrase over and over again where there are difficulties in identifying what arrangements would be appropriate or most helpful.

Let's talk about national standards. We have plenty of experience to draw upon. We have already used that experience in inviting Dr. Glynn from Kingston, Dr. Hudson from Toronto, and another gentleman from Winnipeg to join us to help us address the issue with respect to the assignment of operating room space. And there will be all kinds of other examples.

We want to talk about what is necessary with our colleagues in the district. We want to, as much as possible, move towards kind of new arrangements without necessarily at least external support. But to the extent that it's necessary, we have to be prepared to bring in advice from elsewhere to help us make this transition, and we have to do that fairly quickly.

**Hon. Mr. Melenchuk**: — That's all the comments I have and I would concur with the president that I see this as well as an opportunity. There are challenges there, but I think we have some real opportunities here as well.

**The Chair**: — Thank you. Any further questions? If not, then I thank you very much President MacKinnon and Mr. Barnhart for coming and giving your presentation. We very much appreciate that. And the committee welcomes any other input you have that you want to share with us.

**Mr. MacKinnon**: — Thank you very much, Madam Chair and members of the committee, we appreciate the opportunity to appear before you. Thank you.

**The Chair**: — The committee will take a brief recess while we prepare for the next presenters.

**The committee recessed for a period of time.**

**The Chair**: — Good morning. We'll start our next presentation. I'll introduce the committee first and then, Dr. Rajakumar, you can introduce yourself again.

I'm Judy Junor, Chair of the committee; Dr. Melenchuk is the Vice-Chair. We have Andrew Thomson, Warren McCall, Buckley Belanger, Brenda Bakken, Donna Harpauer and Rod Gantefoer with us today.

So if you can introduce yourself again and then you can start.

**Dr. Rajakumar**: — Thank you, Madam Chair and members of the committee; thank you for the privilege given to me to address this committee.

I am an associate professor of cardiology, College of Medicine, and also chief executive officer of Saskatchewan Heart Centre which I founded about five years ago. So what I would like to tell you is some general comments about Fyke's report.

We support, in principle, what Fyke has reported. He has highlighted the problems and challenges facing the health care situation in Saskatchewan. And to a great extent, we support his recommendations.

The question is how to implement this? We have a lot of reports, one after the other, but the problem is how to implement it. We have problems with manpower. There's no champion to lead and there is no one to sacrifice the, the . . . there's no initial sacrifice.

I agree money is not the problem. There is overuse, underuse, and abuse of the system. When I say that, I am, I am in the system. I know what is happening. There is improper management. There's no accountability. This is volume driven and quality is sacrificed. There is no incentive for quality care.

This is based on the fee schedule that we are supposed to use.

I have some agreements . . . disagreements with what Mr. Fyke has said. The only way to do this is to channel the central funding through the health boards. As you know health boards also have their problems. They cannot retain, they cannot appoint, or they cannot recruit people. People are leaving. So the system . . . the only way to channel money for recruitment and retainment . . . retaining staff is not working.

He's recommending a quality council. It's a good idea but who should be in the quality council.

There is recommendation to, to centralize health care towards urban. In a way, that is right. We can't expect to have heart surgery or angioplasties in rural Saskatchewan. But rural Saskatchewan has some infrastructure, which has been built for many years. We should not completely shut down. The technologies are now available, the telecommunication technologies are available where we could develop . . . (inaudible) . . . with the existing infrastructure we could provide what the out-patient care is provided in urban centres, we could with the collaboration of the local people, we could provide this kind of care. I'm talking about telemedicine.

So what is our submission? I was faced . . . when I saw this initiative I was faced with the issue of meeting the standards expected from a university professor. That is scholarly work, research, excellence in teaching, excellence in patient care. But when I looked around, I didn't have all these resources.

The only thing that I could . . . Then I thought, well the only way to do is let me do it myself. So whom I went to? I went to the public. Public should be our target of support. Public is the people whom we try to serve without fear or favour. So that's what drove me four years . . . five years ago. And I'm going to tell you in another few minutes time what we have achieved single-handedly, without any support from the health board, from the university, from the government. We have put together a program which is up and running.

I talk about the Saskatchewan Heart Centre. This is now organized and governed by a board of directors predominantly from the members of the public. We are now in the fundraising phase to raise money — whatever money we can get — to build up the infrastructure and to some extent meet the operational cost.

I'll turn on to the priorities of the centre. We started with two clinics. Patients . . . We need a core of patients, a critical mass of patients, to develop the program because this has to be patient-driven program, which then should lead to research, excellence in care, and development of new technology which we should be proud of. We should be the leaders not the followers.

If you take the history of University Hospital, university was the leader . . . University Hospital was the leader in implanting the first pacemaker and in heart . . . and bypass surgery. But we are not only going to the bottom but being left out of the . . . from the rest of Canada.

We have chosen the most needed program — that's heart failure. Heart failure is an ever-increasing problem. This is what will we do because of our aging population and because of the new treatment and devices available, these patients are living. The final . . . heart failure is the final pathway for these patients to leave this world.

And these patients are neglected. These people are very . . .these patients come out with complex problems. They are elderly, they are marginalized, and they have nobody to take care of them for the simple reason, it takes lots of time.

The fee schedule is not there. These people need to be seen sometimes practically every week, if you want to prevent emergency room visits, and hospital admission. But the fee schedule is such that it doesn't allow a majority of the doctors to follow them, especially in specialist . . . by specialist. You cannot entrust these complicated problems to the . . . (inaudible) . . . family physicians who are not . . . they don't have access to support services, in particular echocardiograms, stress testing, pacemaker reprogramming, to mention a few.

But the cardiologists are not taking these cases. In fact, the fee-driven situation has driven them to — most of us — to engage in activities which will give us more money. That is procedure-driven practice.

We cannot now get cardiologist's consultation. It's pretty difficult because, again, the system that we are in — fee driven, procedure driven, volume driven, not quality driven.

So we have now 145 patients in the clinic with full data and we are part of a national network of heart failure in Canada. And we collect data, which is very time-consuming. There is no fee schedule for that. We collect the data so that we can come out with outcomes how we are performing compared with the rest of Canada.

And I had given you some . . . there's a first report of this clinic which I am . . . (inaudible) . . . and again, this is not funded by health board. It is not funded by the government. It's funded from my initiative; some money I collected from the industry and some money I have from the industry and from the Saskatchewan Heart Centre initiative.

The next one should follow is surveillance and proper follow-up of patient with coronary artery disease. We need to be a provincial centre rather than focused on Saskatchewan . . . Saskatoon, because Saskatchewan has only one million people — 50 per cent is rural, 50 per cent is urban.

The treatment a person gets should not depend where he is, whom he sees; it depends on what he has. The only way to do that is to develop regional centres. That is our number two priority.

So I have in my . . . the information I have given, I have given the provincial plan. Once we develop the Saskatoon centre, we will go out and develop satellite clinics in the rest of the places mentioned in page 2.

The ideal clinic should function as follows: it should have detailed patient evaluation to clinically benchmark disease with the feedback to the referring physician; monitor patients at

intervals closely matched to patient needs; prompt access to clinic staff with immediate response; innovative medical regimes beyond reach of primary care physicians, including new medications in clinical trials; ongoing, comprehensive patient education with the goal of health maintenance and self-care.

These should be the guiding principles for these clinics.

Now I had given . . . I had also included the package on the program that we are up and running. If you . . . I would draw your attention to the budget page in this package that what we need is $210,000 for operating costs and if you look at the average physician earning based on speciality, cardiologists have been leading the whole group — $500,000, half a million. This is an average earning of a cardiologist.

But if you . . . We need some kind of alternate funding system so that we could do a better job for half the money for a cardiologist's services and half the money we could use it for funding the right health people who can work in a multi-disciplinary clinic and provide reports at periodic intervals to show our performance.

Now I'll turn to my position in the University of Saskatchewan. I just wanted to initially give you the constitution now and opportunity that we have.

Currently there's not going to be a single member in the academic division of cardiology. I was the last member to survive, and three days back I sent a letter to my chairman of the Department of Medicine. I just cannot continue to stay in this because there is no resources. For me to progress in my professional life, the demands that are placed on me for my promotion to a professor, they want six papers, periodical papers to be published. Ninety-nine per cent of my time is spent on coronary care unit and wards.

How do I find time? I don't have even a single colleague of mine to work with me. So I was left with one person. Dr. McMeekin has left; Dr. Wells is being allowed a no-pay leave. And then I am the one who has been there for nine years. And there's another person who's in probation. So I just couldn't. I just sent a letter saying that I am leaving. Give me one year's time to develop up the infrastructure and come back to the university.

University's the way to deliver evidence-based medicine. Universities should set an example and encourage best physician practices to the rest of the medical community.

And that is the mandate of the university. University's mandate is province based. It's not regional based. I think . . . I told the president before he left, this is what I have done. And I hope with the support — at least with the support of the committee — I think I could achieve. I want to stay here. This is . . . We have a crisis and we have an opportunity. The question is find all the right people and work with them.

So that's all I wanted to say. But this is the right move. Health care should be non-partisan. We should be able to meet people like you, the politicians. We need to have the political power, political goodwill, and then we'll do our work. Without any favour or fear, we should be able to deliver.

And this is a good move. And I hope you'll continue to meet. This should not be a one-time deal. We should continue to meet so that we have a line of communication with the political system.

With that I wanted to say one word, a phrase — Coming together is a beginning; keeping together is progress; working together is success. We all have to work together — the politicians, the front-line caregivers, the public at large. We have to engage the civilian society in this process.

Thank you.

**The Chair**: — Thank you very much. Also thank you very much for your package of additional material that we can all share.

Entertain questions now.

**Hon. Mr. Belanger**: — Thank you very much, Dr. Rajakumar. I just wanted to point out that some of the points you made were very, very solid points.

I thank you for your service to the people of Saskatchewan because certainly the calling that you've taken has been a sincere calling and has been a very demanding calling as well.

I picked up on one of your points when you mentioned in terms of the service to the people, that it can't be rural or urban. It's got to be on a province-wide basis. I most certainly concur that . . . I am from northern Saskatchewan and sometimes access to these services, which other areas take for granted, sometimes are not provided in the North and we can certainly appreciate the challenge of providing those services.

So with that being said, in terms of the Fyke report, my question being that Fyke did recommend in terms of the western provinces, that we have centres of excellence between Alberta, Manitoba, and Saskatchewan. We're able to coordinate better centres of excellence in terms of heart disease or cancer treatment, etc., etc.

My first question would be, based on the provincial use or the provincial prevalence of heart disease, where are most of our patients coming from?

And secondly is, how do you see a provincial centre of excellence being coordinated with Fyke's vision of having a regional centre of excellence model between the western provinces?

**Dr. Rajakumar**: — First of all, I started my life in Ile-a-la-Crosse — that's your riding. I worked as a family physician for three and a half years. My son was born there. I know the issues there.

In fact when I was there about 10 or 15 years ago, I could hardly count on my fingers the number of heart attack patients I managed. But because of the development of diabetes, there is significant increase in heart disease. I know the issues very well.

And also I have worked in other rural Saskatchewan as a family physician before I became a cardiologist. So I'm not speaking from the ivory tower. I know the whole issues.

Now your question about how, I think once we develop a centre of excellence which could be . . . To me, a centre of excellence is a knowledge delivery enterprise. You have to have knowledgeable people to deliver. That means nurses, doctors, pharmacists, and other health people. And then you have to have a system of delivery with good governance, and then an enterprise. You may call it a university or you may call it a health centre or institute or a heart centre — that's what we need. Once we have that and then have a critical mass of patients, then, then we can get linked to other institutions.

We are already doing it. Once you have, say 150 heart failure patients, if the leading centres want to do some clinical trials, they come to us. In fact I was approached by Harvard — in fact I got a letter; I can show you later on — is interested in linking, because they need people to come up with new ways of treating, new way of providing devices. They need that. Once you have a system in place, then linkage will be easier.

We don't need to go; they will come to you. And we will, as I said, this heart failure clinic, now we are already linked. What is being done in Saskatoon, they are doing in Ottawa or Toronto. So we follow the same map, care map. We collect the same data. So this is the way to go.

I mean I understand the big problem that we have for long-term sustenance, about developing a true academic health centre, but we have to do something to serve our people tomorrow.

This is not a multi-million dollar project. It may be, may be, may be half a million to start with. But once we do that, we will be talk of rest of Canada. That's how you start centres of excellence.

Major things have been done in the past, not by tens and hundreds of people; two or three people get together and make things happen. Mayo Clinic is a good example. Two brothers and a nun started it. Cleveland Clinic another example — four people. That's why the symbol four, that four boxes are there.

So the way to do it is, enough of all these reports, get back to work, do it, and set an example. That is the key. We can have all these things. We can have big projects and planning and all those things.

My simple question is where are you going to find people. Fyke is telling this, you know, where are you going to find . . . There are no people, everybody's leaving. Be in a competitive environment. Unfortunately we are next to a very rich province. They can grab. Money will buy anything.

But there are some people who want to stay here and enjoy the clean air and the beauty of Saskatchewan. And there are other reasons, for family reasons. I'm here, my children are here. They don't want to leave. They are in the university. There are reasons; so use them, and try to develop it, whatever you have. Otherwise we'd be in big trouble.

The centre of excellence is not a thing that we cannot achieve, we can achieve.

**The Chair**: — Thank you.

**Mr. Gantefoer**: — Thank you, Madam Chair, and welcome Dr. Rajakumar. And I want to thank you for your presentation, but mostly I want to thank you for your commitment and your enthusiasm and your passion for your field of work, and your plan for providing I think a significant improvement into service delivery in this province. I think it makes a lot of sense because it's practical and pragmatic and it's not ideological. It just is looking at what's needed and how do we get the job done.

I appreciate your plan very much but . . . and I'm not being critical when you talk about the regional centres and looking at your map of your provincial plan. I guess I would point out what I think is maybe a small deficiency in that area, in that the northeast is an area — and the communities broadly represented by Nipawin, Tisdale, Melfort, in that area — I think would be another area that would be worth considering. And also in the southeast, the Estevan-Weyburn areas are significant communities.

I would encourage you to add those two circles to your map if that's appropriate because I think those areas have a significant population base as well, and some pretty significant resources in terms of medical professionals in those areas that may be worth considering.

But other than that, I certainly very much appreciate your plan; and I wonder if the idea of adding those two circles to your map is indeed a possibility or if it takes anything away from your plan?

**Dr. Rajakumar**: — You're absolutely right. I thank you for pointing out. And it was an error on my part. Absolutely right. When you say northeast, that is Nipawin area?

**Mr. Gantefoer**: — Nipawin, Tisdale, Melfort roughly — those three tri-district communities.

**Dr. Rajakumar**: — I think Nipawin has some infrastructure. In fact the surgeon who's — Dr. Bala, he's my batch mate; we studied together; I brought him to Saskatchewan — he's there practising now. Because of him their surgical program is up and running.

I think that is, it is an omission on my part. Thank you for pointing it out, it's important.

**The Chair**: — Thank you.

**Hon. Mr. Melenchuk**: — Thank you very much, and thank you, Dr. Rajakumar. And I think that there's a couple of questions and points that I'd like to make.

One of the points that was accentuated by yourself in your presentation is the lack of recognition of the management of chronic diseases in the current fee schedule. Do you see replacing the fee schedule with some other type of alternate payment arrangement, or do you see the management of chronic diseases more on a contractual basis in addition to the current

operation and fee-for-service?

**Dr. Rajakumar**: — Absolutely right. I mean, because of my time commitment I didn't want to touch on it. I'm very glad you brought it because you were a family physician, you know; it's easy to relate to you and to Madam Chair.

The only way to provide care for chronic diseases is the . . . (inaudible) . . . model — multi-disciplinary team, is not fee driven. Maybe you have to have some kind of an alternate way of payment, sessional basis.

I can't get my colleagues — except Dr. McMeekin who is part of my division; he has to support me because otherwise, you know, what is the mandate of academic division — I could not get any one of them to come and help me. I cannot go on. I lose money on this.

I cannot go on because the fee schedule doesn't permit this management of this complex patient. The patient needs to be seen every week sometime, based on what the blood chemistry is. When I change the medicine they have to come. And if you don't, if the potassium goes high — sudden death.

And the fee schedule is 25 or 30, I'm not . . . I don't even bother about fee schedule. I don't know. It's about 25, $30 for a specialist. They're asked . . . For the time I spend I read an echocardiogram which takes about 15 to 20 minutes. I get $90. So how can I get people to come and help me.

But this is a needed program which these patients are trying. You are going to hear first-hand information from a person who has — in the next presentation — who has benefited over this.

Absolutely right. I think there should be an alternate way of funding this, this kind of thing — program. One, I would say is, one way, is to give a block funding and it should be central. I don't think it should be through the health board because this is a provincial plan. I think it become too bureaucratic. We need a simple administrative structure. We make decision and we implement it. It should be either on a sessional basis or some kind of a central funding and then contract it out.

**Hon. Mr. Melenchuk**: — The second question that I have is with regard to the academic setting with regard to cardiology in Saskatoon. And it's more of a question in terms of what you would see as the appropriate mix in terms of research, teaching, and clinical services.

In your academic setting, after Dr. McMeekin left, you were looking at 95 per cent of your time, or more, spent on wards or coronary care unit, providing no time for research or teaching. What would be a satisfactory mix in today's standards between the amount of clinical time, research time, and teaching time to attract an academic to a cardiology centre like Saskatoon?

**Dr. Rajakumar**: — Again it depends on what other support I have. If I have few clinicians who are well tuned with the research program, I can collaborate. Then collaboration won't take much time, see. That is another point. So we need a critical mass of academic cardiologists to spearhead this and set an example and then come up with the innovative program.

So I would say again, about at least 25 or 30 per cent. I think when we sign an agreement with the university, I think we were promised I think 10 per cent or 25 — 10 per cent for time research — but we never take it because the demand is so much. But without research, how can we lead? I mean we'll be the followers or we'll be left out.

**The Chair**: — Thank you very much. Dr. Melenchuk, is that it? Thank you very much, Dr. Rajakumar. The next presenters will come forward and you can be their resource, I understand, after their presentation. So we may see you back again.

I also want to thank you for your willingness to be involved in the continuing process of dialoguing about the delivery of health services in this province. Thank you.

And welcome to our next presenters. I'll introduce the committee again and then have you introduce yourselves and where you're from.

I'm Judy Junor, Chair of the committee. Dr. Jim Melenchuk is the Vice-Chair. Andrew Thomson, Warren McCall, and Buckley Belanger, Brenda Bakken, Donna Harpauer, and Rod Gantefoer are the rest of the committee members. Thank you.

**Mr. Wawryk**: — Thank you, Madam Chairman. Good morning to both yourselves, the committee members, and Madam Chair.

I am Len Wawryk. I'm the Chair of the Saskatchewan Heart Centre Board. We are presently addressed in Saskatoon but it is a Saskatchewan entity. And I want you to know that first of all because it is very important to us that people realize that this is meant . . . although we are in Saskatoon at the moment, we do have membership from other parts of the province and it is a province-wide organization.

Thank you very much for giving us the opportunity to speak with you this morning. The Saskatchewan Heart Centre is very thankful for that opportunity.

It has become increasingly evident to the public, and in particular those of us on the Saskatchewan Heart Centre Board, that the provincial government and the district health boards should not and cannot be saddled with the full responsibility of health care in the province.

We believe that the community also has an important role to play in the provision of health care.

A community-based organization such as the Saskatchewan Heart Centre can offer significant benefits to the health care system. We may have a slightly different method or approach, but our goal is the same — to nurture a sustainable, quality, accessible system for all the people in Saskatchewan.

Our board is presently comprised of 15 members of the community, people who come from various walks of life. The Saskatoon District Health Board and the College of Medicine are also represented on the board.

As a non-profit organization, we are registered for the purpose . . . we have registered a non-profit corporation for the purpose

of raising funds for the Heart Centre. And while we hope to collaborate with the health boards, the university, and the Department of Health, we do not wish to lose the community-based nature of our Heart Centre.

Our approach is patient-centred, meaning we want to put the needs of the patient first and foremost. The people who live with chronic heart problems and the people who have suffered an acute cardiac health problem face many challenges in accessing the range of services they require.

A simple example is an elderly person, whether they're in the city or a rural resident who has to come to the city to access this care. These people may be very nervous about travelling in the city. They may . . . And I recall my own father coming to the city and wanting to stop at the edge of the city and have me come and drive him around. And I've heard this story many, many times.

Rural residents are just generally not accustomed to driving in the city, let alone being . . . having a health problem at the same time. And now they have to not only go to see the specialist, but they may have to travel to another location to see a nutritionist or a psychologist, or go to another location for physiotherapy.

Travelling around is a difficult problem for them and our interest is to . . . our vision is to create a one-stop centre for the patients. A place where they can get treatment for their immediate needs as well as health education programs to support their long-term cardiac health care needs.

And these education and promotion services will also be available to the public. As well our centre will provide professional education and support to members of the medical profession, and it will be a place for cardiovascular research.

It is clear that this has become increasingly difficult to retain highly skilled health care professionals here in the province. And we at the Saskatchewan Heart Centre are prepared to assist in this regard.

We truly believe we will only be able to attract and retain qualified health care professionals if the proper environment exists in which to practice. And with our aging population, Saskatchewan offers an ideal setting for cardiac health care professionals.

The Fyke report has indicated that specialists must work where they can consult with their peers and have access to special diagnostic equipment and treatment facilities. Quality must come first and the quality for highly specialized techniques depends on the critical mass of skills and cases. And that can be provided in centres such as we're discussing.

The Saskatchewan Heart Centre is a community-based initiative and we are prepared to raise funds to provide the type of environment which will be enticing to qualified professionals — an environment that will not only encourage people to come here, but would also encourage them to stay here.

And we know the patient basis here. In fact every one of us, particularly me, are getting into that space where I may be lying on one of these beds waiting for Rajakumar to wake up and come and help me out. It's important for all of us. No question about it. No one in this province, I imagine . . . I can truly believe that virtually no one has not been affected in some way by a heart problem, whether it's themself or a relative or a friend. We all know someone who has had a heart problem.

As Dr. Rajakumar has pointed out, the need is great but the present circumstances are not encouraging. Our goal is to do something about that.

What we require is support. We are happy to work with the health districts and the Department of Health in order to do our part in providing a sustainable, quality, accessible treatment system for heart patients.

Our experience to date has shown us that the community is behind this concept. Already many individuals and groups have come forward to offer their financial support. And we believe once we go public with the Saskatchewan Heart Centre we will receive overwhelming support.

We are presently speaking to individuals — to select individuals and corporations — in our efforts to secure major sponsorships for the centre. We believe this approach will help build even stronger community support and commitment for the quality health care approach that our centre will provide.

We have non-profit organizations who are working very hard on our behalf right now to raise money. The Rotary Club and the Knights of Columbus, just to name a couple.

Our commitment is strong, and at present we are looking for a sustainable location for the Heart Centre. Although the Saskatoon District Health Board has indicated that at present they do not have sufficient space available for our needs, we will find that in the private sector. Once we have a Saskatoon location fully established, we will secure a location in Regina as well.

And I think as questions have arisen about the other areas of the province, as Dr. Rajakumar has stated, telemedicine will allow us to bring high quality care quickly and effectively to outlying communities. Our hope is to eventually construct a special facility designed for the comprehensive health care needs of Saskatchewan people.

What we need from the government and the district health boards is support for our efforts. As well, we would expect funding for shared operational costs. We believe that this is distinctly possibly. It may require some revamping of the conditions of that at the present. It may be that it has to be a pilot project to make it happen. But we believe that this is distinctly possible, and it appears to be the only way to assure our goal of quality care is met.

I thank you very much. Before we can go to questions if you wouldn't mind, if I could ask that Tor Kamaka who is with us today — he's a patient and a private citizen — would like to make a personal statement.

**Mr. Kamaka**: — Good morning, Madam Chairman, chairman of the board. It gives me great pleasure to be here and hear my statement. And I thank you very much, Madam Chairman,

chairman of the board.

As a resident of Saskatchewan as well as a patient, the help, the heart failure clinic has been very educational for both my wife and I. I was well informed of my condition. The clinic is a good way to prevent episodes from happening.

As far as build-up fluid, the clinic also helps to keep the patient motivated and positive. It showed that there was care in this method of treatment. Regular blood tests help to show if medication are working; with regular visits it was easy to adjust medication and correct problems before they occur.

Before, I was fortunate if I saw a doctor every six months and by then it could be too late to do anything.

I started with this program two years ago while I was in the hospital for heart failure and I was introduced this program, the heart failure clinic, to my wife and I. And since then I have not needed hospital care and I have not been inconveniencing the government for health care in this way.

I feel that this program is a very good program for the residents and citizens of Canada and Saskatchewan. I have been benefit a great deal from them.

Thank you, Madam Chairman.

**The Chair**: — Thank you very much. We now have some opportunity for questions. Ms. Harpauer, I believe, had . . . you wanted to ask one first.

**Ms. Harpauer**: — Thank you. And first of all, I welcome you here. I commend you for your presentation and again your remarkable enthusiasm and your initiatives that you are working on. You are a testimony to the power of community and what you can accomplish if you're not restrained by government control and restrictions.

You must have some idea — you've obviously gone to a great deal of work and planning in your fundraising as we speak — of what your initial start-up costs will be for such a centre in Saskatoon. And what might that be? And what are you sort of projecting as an annual operating amount of money that you're going to need?

**Mr. Wawryk**: — Yes, our initial goal is actually $3 million. But a portion of that, 1.6 million, will be a fund that would then stay in an investment opportunity to provide ongoing funding for us. Our actual operating costs for the first year I believe will run just over $200,000. I think those figures are in Dr. Rajakumar's report as well.

It's not substantial truthfully, because we don't believe we need a lot of other physical elements. We truly believe that there should be space available in the present hospital facilities. There are beds. There is equipment there that is not in use at the present and that we could put the centre in a location like that.

An example of that is that in Toronto, for instance, the Peter Munk heart institute took an entire wing of the Toronto, I believe it's Toronto General Hospital and renovated it to become the heart institute.

We don't need an entire wing, but certainly the facility is there, the beds are there, a lot of that infrastructure is there. What the Heart Centre can do is provide the other elements of the infrastructure that makes it much more convenient for cardiologists and cardiac surgeons to have a practice in this community.

**Ms. Harpauer**: — Thank you. And how co-operative and responsive have you found the — I'm assuming that you're working with the Saskatoon Health District at this point — are they co-operating with this concept and looking into providing or finding space within their present facilities?

There is definitely rumours out there that there are beds available and areas that are in use in the Saskatoon Health District. How are you finding them to work with as a partner? Are they receptive to a community-based clinic within their facilities?

**Mr. Wawryk**: — Well presently we have membership on our board of the health district and the university College of Medicine. The difficulty is that it's a slow process to get access to a significant amount of space. We do presently have a small space next to Dr. Rajakumar's electrocardiac facility, and that's where the heart failure clinic is.

To get more space, it's a challenge. There is no question about that. We just met with both the . . . with the Saskatoon district and a member from St. Paul's Hospital, looking for space. And there's a lot of shuffling around of facility. We certainly believe that there is enough space for us, and I think it's a matter of time till we would get that.

There is some renovation coming down the way when they move family medicine out of the RUH (Royal University Hospital), but at the present it looks like we're going to have to go to the public for that. We'll go to landlords, private entrepreneurs who hold property who will be willing, we're sure, will be willing to donate space to a facility such as the Saskatchewan Heart Centre. And in the interim, I believe that's the route we will go.

We expect that we will end up in a hospital facility, preferably one that has the cardiac surgery capacity, that has the other elements that are useful, and that's RUH primarily at this point. Now in Regina the same would occur. We would expect to be in a hospital facility.

But none of this is easy. It is a long, hard grind. We have been doing this since 1997. We have a number of people, like myself who work full-time who take off work, you know, to come and do this and they go to other sessions. And as I say, our last point is we need support. And we hope that this group can help encourage that.

**The Chair**: — Thank you.

**Mr. McCall**: — Thank you very much for your presentation. It was certainly informative. You may have touched on the answer to the question I'm going to ask a little earlier, in your answer to Ms. Harpauer's question.

But I was just wondering with the centre, do you draw your

inspiration from any particular model or institute that's already in existence? I know you'd mentioned the Peter Munk heart institute, but is there a particular model that you're taking as something of a blueprint for your endeavours?

**Mr. Wawryk**: — Yes there is. Maybe I can just let Ruben speak to that because Ruben has been to a number of these facilities and in fact can speak to them directly.

**The Chair**: — Dr. Rajakumar, you have to speak quite close to the mike.

**Dr. Rajakumar**: — If we want to look at locally, the cancer centre is an ideal model. It is again a chronic disease, it is centrally funded, and also it has its own funding mechanism from Cancer Society. If it is good for cancer, why not is good for heart disease?

Looking at outside the province, that is Ottawa heart centre . . . Ottawa Heart Institute. The first institute dedicated to heart in this country. And it has shown remarkable outcome results. And there are new innovations coming out of that. That is a leading example of that.

Then British Columbia, BC, has a heart centre, recently, about two years ago when we were starting this. And then you have in Winnipeg, the Cardiovascular Institute. It's run by Naranjan Dhalla is one of the scientists there.

And these institutes are drawing quite a bit of competitive dollars from government funding. If you don't have this kind of an enterprise, we will not be able to compete.

And now also in Alberta, there are some private physicians that got together and called an institute. But these are things that come to my mind.

**Mr. McCall**: — Thank you.

**Hon. Mr. Melenchuk**: — I just have one quick question. Certainly a concept of a multi-disciplinary centre to deal with chronic diseases and congestive heart failure, in particular, is very good.

But in terms of your knowledge with regard to clinics of this nature and patients that have become members of the clinic itself, have you . . . can you determine a percentage in terms of correlation in — prior to becoming a clinic patient — in terms of their admission rates and after they become a clinic patient in terms of the prevention and the benefits, in terms of acute care interventions required?

**Dr. Rajakumar**: — Actually that's the purpose of this database. Actually this database is exactly supposed to do that, but it's now . . . it's about two years now, the number is not that adequate to analyze, and then eventually we will be able to show because in our database we collect this.

When the patient is registered in the clinic for the first time, we ask them how many times, from today back one year, how many times you had entered emergency room, how many times you were admitted to hospital. And then from that day onwards we continue to take the data and then it is available, but just a question of analyzing it. I mean that's very important.

I think in the short term we can prove this kind of a collaborative approach will definitely reduce emergency room admission, visits and admission. Mortality — well it might take a longer time but . . .

And also not only that, we can also show what is the . . . we can narrow the gap between what is best care and what is available in the community especially with regard to proven drug usage.

For this type of thing the pharmaceutical industry is very much interested in it. This is one issue to where there will be an increase in pharmaceutical cost but you get a benefit from preventing hospital admission. There is a, there's a net gain.

And for this reason this kind of a clinic is being now funded by pharmaceutical industry. I mean, I've been successful with . . . exactly I did the same thing. And pharmaceutical industry is pretty difficult to get money from because they are very knowledgeable, they are in the marketplace. They won't fund it unless this will fly, and we were . . . (inaudible) . . . to get it.

**The Chair**: — Thank you very much. I'd like to thank all of you, the presenters, including the personal testimony. And we thank you also for the printed material that you supplied and we welcome the suggestion that you are open to any further conversation that we may have with you. And good luck on your future endeavours.

**Mr. Wawryk**: — Thank you very much, Madam Chairperson, and thank you committee members.

**The Chair**: — I'll now entertain a motion to adjourn. Mr. Belanger. The committee will adjourn till 10:30 on Tuesday, July 3.

The committee adjourned at 12:06.