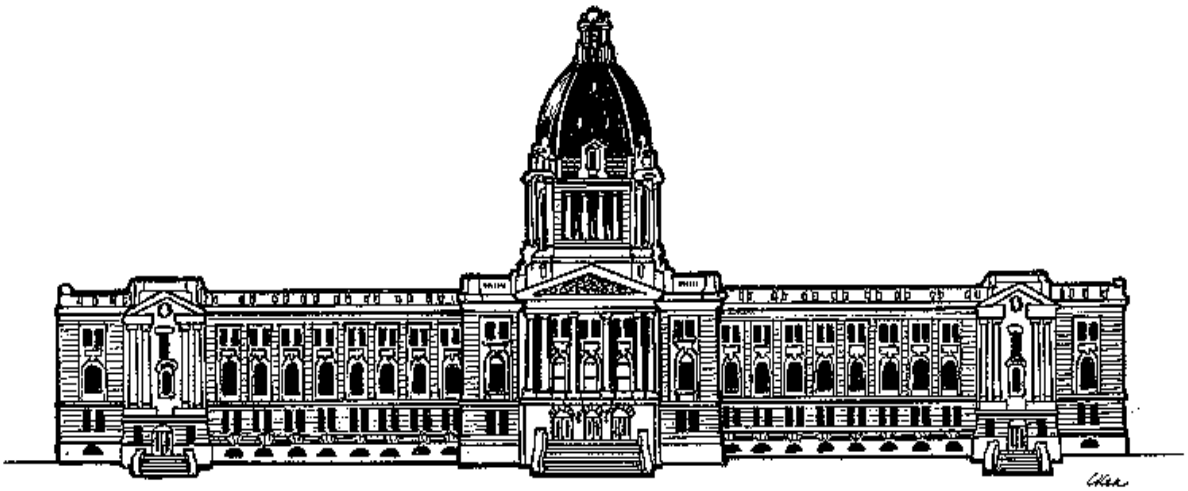
Standing Committee on Health Care

Hansard Verbatim Report

No. 7 – July 10, 2001



Legislative Assembly of Saskatchewan

Twenty-fourth Legislature

STANDING COMMITTEE ON HEALTH CARE
2001

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

The committee met at 10:03.

The Chair: — I think we'll get started since Mr. Boan only has half an hour. Do you want to take a seat up here, Mr. Boan.

Good morning. I'm Judy Junor and this is the Standing Committee on Health Care. Our Vice-Chair is coming — Dr. Melenchuk. We have Andrew Thomson, Warren McCall, and I'm not sure if we're going to have Buckley or not this morning, or someone substituting for him. Brenda Bakken, Bill Boyd, and Rod Gantefoer.

The purpose of the committee is to receive and report on responses to the Fyke Commission and we've set aside half an hour blocks of time for each presenter as either a singular or groups. So if you want to introduce yourself, and then you can proceed with your presentation.

Mr. Boan: — Let me say first of all that I apologize for not having a more comprehensive story to tell. When I spoke to the person who makes appointments, she said that it wouldn't be until late July, and I said that's just fine because that'll give me time. But last week, late last week, she phoned and said could I come today. And I said well I'll be happy to do that but I'll just have to come with what I've got and not with what I'd like.

My name is Jack Boan, legally John Alexander Boan. My academic background began after 63 months with the RCAF (Royal Canadian Air Force) during World War II when I attended the University of Saskatchewan in January of 1946. Following graduation with honours in history, economics, and political science, I attended the Ohio State University where I graduated as a Doctor of Philosophy in agricultural economics in December 1953, having attained a grade point average of 3.95 out of 4.

I was a public servant in Ottawa when I got seconded in late 1961 to the Hall Commission on Health Care where I joined a small, five-member research staff. In September 1962, on leave of absence, I came to teach economics at what is now called the University of Regina and began a career specializing in health economics.

I have brought a copy of a statement of some of the accomplishments in that field while I've been at the university. It's not quite up to date but it gives an idea of some of the things that I've been involved in. I've also attached a short abbreviated curriculum vitae, and I'll leave those here.

Why am I here? I volunteered to come, spurred on by newspaper reports of some of the nonsense that you have been assaulted with, having in mind the aphorism that all that is required for evil to succeed is for good people to remain silent.

I have no axe to grind. My motivation is only to ensure that the people of Saskatchewan get the kind of health care they deserve.

The Fyke report is too big an item to do justice to in half an hour, so I'm going to delimit my remarks.

What I will do is say a few words about the big picture, the national scene, for the sake of perspective. But I want to spend most of the time on the Fyke report. Finally, I want to leave some time for questions because I've found through experience that that's the best way to get information shared.

One pressing problem nationally seems to be a lack of understanding as to what the issues are. For instance, I never see any discussion in the press about how much should be spent on health care. One sees discussions by health experts like Terence Corcoran in a piece, "Calling Doctor Wilt Chamberlain," in which he reiterates the tired old view that the market is the place to decide how health care should be run. Senator Kirby gets space. Why though would a responsible press not want to discuss issues like how much should be spent?

In order to get some debate going within the Presbyterian Church, an article I wrote was published in *The Presbyterian Record*, February of this year. I included it in a brief I sent to Dr. Fyke near the end of his deliberations and I have a copy with me.

Among other things in that article, I pointed out that Canadians need to decide how much of the GDP (gross domestic product) they would like to see devoted to health care. In the US (United States) it is about 14 per cent. In Canada it's something in the order of 9 per cent. In some other industrial countries it's less.

How much is enough? No one knows. Apparently no one cares either. I don't know whose responsibility it is to get information to the public so they can have that debate, but someone needs to do it.

One of the points made in a discussion paper published by the BC (British Columbia) Medical Association is that the public needs more information.

Such a debate would bring people together focusing on what they really want and can pay for. There have been some excellent studies done lately on health care. I hope that this committee has access to them because the Fyke report needs to be seen in light of some of these other reports.

I refer to the publications put out by the National Forum on Health, at the government level, and at the private level there is *Revitalizing Medicare: Shared Problems, Public Solutions* by Michael Rachlis and others, put out by the Tommy Douglas Research Institute.

The former reports cover the entire field and represent a sort of benchmark, like the Hall Commission reports. The Rachlis report is hard hitting and positive in its approach. I commend it to you highly.

I want to spend a moment on that hoary old chestnut, user fees. This has been called a zombie. The latter has been defined as something that is dead and buried but keeps coming back to life. User fees have been shown to be unacceptable by logic and through practice. And I have a couple of studies here that I can show you about this, that go into it in some detail.

And one is called "Why Not User Charges? The Real Issue" . . . this is back in 1993, they're not last week's stuff. "Who Are the

Zombie Masters, and What Do They Want?". And those two papers will convince anybody except those that are impervious to reason, that this is a dead end.

People think that health care is like any other commodity, a loaf of bread, or a can of beans. And these are the people that keep promoting user fees. What is the objective? If the purpose is to bring more money into the system, wouldn't it be more efficient to increase the health budget, so the money could be spent where it will do the most good rather than increase the amount haphazardly?

If it is to deter people from using the system, there is no doubt that it works. Poor people are deterred. In the United States, where between 40 and 50 million people are without health insurance, sick people wait, deterred by not having the money to spend, hoping the illness will go away by itself. In the end however, all too often they are rushed to the hospital in an ambulance, under the care of a doctor at last. Vast sums are spent on them to try to save his or her life, when a stitch in time would have saved bundles.

In Saskatchewan it was found that the space vacated by poor people because of deterrent fees tended to be filled with upper-income people so that the quantity of services hardly diminished it at all.

A far more efficacious way to keep the demand for care down, if that's what's the problem, would be for doctors, who after all are the gatekeepers, to discourage people from coming to the doctor for minor, self-limiting illnesses like the common cold or a questionable specialist's attention.

Now to get to the Fyke report. I think Dr. Fyke has given us an excellent blueprint of how things ought to go. His emphasis on quality and his prescription on how to achieve it is first class.

The basis as I read it would be the community health centre feeding into larger centres where specialists and high-tech equipment are located.

As for the report as a whole, I leave it at that. But I want to spend some time on the community health concept.

I began to be interested in the community health centre when Dr. Hastings in 1972 provided a brilliant analysis for organizing health care using the community health centre in a report in three volumes. The publication of the Evans book, 1994, *Why Are Some People Healthy and Others Not?*, increased my interest as I came to see that the determinants of health can be handled much more efficiently in a properly run health centre than anywhere else.

I spoke about the health centre concept in my brief to the Saskatchewan Commission on Directions in Health Care in 1990 and in my brief to the wellness team of Saskatchewan Health in February 6, 1992. It would be tedious to go into all the details here. I can provide copies of those briefs if they are of any interest.

I was thrilled to see the community health centre advocated in the Fyke report. However, I was dismayed to find that there was no trigger. How we are going to get these community centres established? You have to get the local people to take ownership and it's pretty hard to get this done by fiat.

In my earlier reports on the topic, I mused that maybe there needs to be an incentive. After all, a student of Adam Smith has to be mindful of self-interest. Why would anyone want to be bothered with a health centre if good old Dr. Smith has always looked after them and presumably will do so in the future? Something has to be done to encourage a community approach. I have mused that maybe an economic incentive might appeal.

Suppose a plan were to be conceived where people who organized and patronized a community health centre would continue to get the public support they are used to. Those who preferred to stick with good old Dr. Smith, disdainful of a community approach, would be required to pay an income surcharge for sticking the health system with a more expensive alternative. There are probably all sorts of reasons why that wouldn't be acceptable.

In any event, there are more powerful incentives than money and they need to be explored. It is certain that some systematic approach needs to be adopted. In any event, the future of health care in Saskatchewan looks rosy if the kind of coordination that Dr. Fyke envisages can be put into place.

But be not deceived. There are principalities and powers, as St. Paul put it, who are interested in pulling our health system apart, seeking profit. They have their spokesmen, whether wittingly or not. I cited one earlier. He and his ilk in Vancouver represent the every man for himself ethic. My viewpoint is that we need to hang together or we'll all hang separately and that each of us really prefers to be part of a community rather than playing the role of the Lone Ranger.

There is no reason to be complacent. Possessive individualism is making progress. The continual singing of the same song is getting through, as it did in Germany under Hitler. It is reported that in August 1995 a poll by Ekos Research Associates Incorporated found that 23 per cent of middle-class Canadians agreed with this statement:

> Individuals should be allowed to pay extra to get quicker access to health care.

By January of this year, support had climbed to 38 per cent.

As I said earlier, this is a very hurried piece of work. I have omitted more than I should have because I just haven't had the time to do a more comprehensive report. Nevertheless I hope it will have been found interesting. If you have any questions, I'll do my best to answer them. Also I'm prepared to come back again if you wish.

Thank you for listening. I wish you every success in your deliberations.

The Chair: — Thank you, Mr. Boan. If you do have further submissions or something further to this submission, you could submit it to the committee before July 27. If you have something extra to add to your presentation you could submit it in writing before the end of July, if you have something that you would feel you'd like to add to that.

I think Mr. McCall has a question.

Mr. McCall: — Yes, a couple of questions, and thank you very much, Mr. Boan. It's a real pleasure to have someone who has been there from the Hall Commission on. And certainly colleagues opposite are aware of Chief Justice Emmett Hall and the role that he's played in the history of our country. And anyway, it is a real pleasure to have somebody that's, you know, been on this historic path in terms of this thing that has come to be described as many Canadians . . . as what defines us as Canadian — medicare.

But my question was for you around the . . . in terms of providing incentive in moving towards community health centre models, are you aware of any experience in other jurisdictions where this has taken place and how incentives have been . . .

Mr. Boan: — Well that's one of the things that has been summarized in this study of the Tommy Douglas Research Institute. They cite a number of places across Canada where different kind of community health centre kind of thing have been established and how they were done and so on. And it's in this marvellous study. That's the quick answer.

Mr. McCall: — All right. So I'll certainly leave it off to referring to that report. But I guess my second and last question would be around the question of user fees.

And certainly user fees, in Saskatchewan that was perceived to be part of the initial proposal that was put forward to the people of Saskatchewan in terms of bringing in universal health care in the province and through the '60s, the idea that, you know, user fees being something that make people take the system more seriously when they've got money to put forward and they'll take it more seriously. That gave way to the idea that these weren't so much user fees as deterrent fees.

I was wondering if you could talk a bit more about the evolution of and the thinking around user fees in the '60s and why would you think that user fees are coming up again today as some kind of valid response to what is perceived to be the crisis in our health care funding?

Mr. Boan: — Well first of all, in the Saskatchewan agreement in 1962, there were three modes of billing. And one was the doctor could bill the patient and the patient could recover from medicare, or they could go through the GMS (Group Medical Services) or the one in Saskatoon — I forget the name — you know, those doctor sponsored, or they could bill directly to the government, the doctor could.

So there was . . . the difference between what the government was prepared to pay and what the doctor assessed was not conceived to be at that time a user fee. It was a different mode of payment.

You know, there's a subtle difference here but I think it's important. And when nationally they got excited about user fees, as they call them in other jurisdictions, then Saskatchewan fell under the same broom. But it really didn't belong there, but then nevertheless that was . . . So that's that thing.

The other thing I think you were referring to perhaps is that under the Thatcher government — on the advice of some of the medical profession, by the way — they decided to levy what they called . . . I don't know whether they called it a deterrent fee, but that's what it was popularly known as, a deterrent fee of I think it was $1.50 a visit to the doctor, which would translate to probably be about $10 now, you know, and 2.50 for a hospital visit.

They found the 2.50 hospital visit didn't make any difference to the number of people who were hospitalized. Why would it, you know. But the doctor deterrent did work, they found.

A study was done by John Horne and Glen Beck way back in, I forget, '72 or something. I've got it here somewhere. It showed that although a lot of people were deterred at low income levels where the bite really counted, it didn't affect upper-income people. In fact they tended to use the system even more. So the total effect was minimal.

Does that help? Does that answer your question?

Mr. McCall: — It does. Thank you.

Mr. Gantefoer: — Welcome, Mr. Boan. I'd like to touch on a couple of issues that you raise. You mentioned that there has been in recent polls a fairly significant increase in the people who responded to the question about would it be permissible or acceptable to have individuals pay for medical services in order to increase access or speed up access time.

I'm wondering, is this kind of a shift in people's perception — sort of a result of frustration with increased waiting times that we hear reported, that access for particularly elective, and in our province I think a lot of it is orthopedic kind of work is increasingly long — or cataract or those kinds of procedures — is becoming frustratingly long. Is this kind of a swing in people's perspective about the acceptability of paying for procedures a result of that frustration with waiting times?

Mr. Boan: — I don't know. That's the honest answer but can I speculate a little bit. I would suspect that it has something to do with it. I can tell you that the waiting is pretty frustrating and I have some personal experience along that line because I fell in March and damaged my shoulder. It took weeks and weeks to get an ultrasound. You know, you should be able to get a thing like that for an emergency situation . . . well it wasn't broken but the rotator cuff was gone, you know.

So the frustration level can be . . . I don't know though how that translates into those percentages from 23 to 38 per cent. I'm not sure. I know though that the press has made a lot of . . . shall we say given a lot of attention to this and that's . . . I don't know. I don't know. I'm not a psychiatrist; I'm not a psychologist. I'm not a . . . you know, I'm one of these people that — what do you call them? — a public opinion poll or anything but it strikes me that there could be something to that.

Mr. Gantefoer: — Okay. From your introduction you mentioned that you've done a good number of work in health economy areas.

Are we getting value for our money? Are we spending our money as wisely as we could? You mentioned nationally we're

somewhere around 9 per cent of GDP and other countries are lower. United States is higher. It could be argued that they're not getting as good a value as we are.

Are we getting good value now? Are there better ways we could allocate our resources in this province, focusing on the recommendations of Fyke? And if so, what would be some suggestions you would have in terms of how we can get better value for the money we're already spending?

Mr. Boan: — Again I have to plead that I have no documented data that I can answer your question with. The opinion of the experts in this field of health economics is that we are getting pretty good value for our money but that there could be some improvements.

And the problem is that the improvements are difficult. I think that's why it's not tackled. They're difficult to achieve. It involves getting more co-operation and communication between the different members of the health team, above all. And of course I think that's what Fyke is after in his blueprint, is to encourage the kind of open discussion of problems so that the left hand knows what the right hand is doing.

And so the answer, I guess, the short answer, is I'm not sure myself. I've never done any work on that area. I only go by what the experts have said, and they are of the opinion that we could do better, but we're doing pretty good compared to other jurisdictions.

Mr. Gantefoer: — In terms of . . . you know the reality of our demographics in rural Saskatchewan are such that we have an increasingly aging population; the baby boom demographic bulge is moving upward. And Fyke recommends that we pretty significantly restructure our acute care service delivery model to the tertiary and regional centres for more of the, especially the acute care, and that at a local rural community level particularly, we deal with the community centres and integrated practices and things of that nature.

And I think the ideological bent of saying, well it'd be good if we could do more preventative things, nobody would argue with that. But the reality is, people get sick. People need acute care. And I would think that a lot of the rural communities are not very happy about the idea that acute care is administered in the back of an ambulance. That their concern about needing acute facilities in the demographic realities and also the practical realities . . . our seniors, as they get older, are going to have it increasingly difficult to travel an hour or whatever it is for acute care.

How do you square the reality of the fact acute care is going to be needed right across this province where our citizens are, and that many of our rural people are not willing to easily accept the idea that acute care is delivered in the back of an ambulance for them?

Mr. Boan: — . . . the community health centre would include acute care. And I think that in a large enough centre, there would be . . . you know, let's say a centre involving 10,000 people, there's plenty of possibility for acute care to be built into it.

I agree with you that there's a lot of fear in the rural areas if their doctor goes, or if that . . . if they're facing a situation where they may not be able to get acute care. And that has to be addressed I think in any solution to this question.

The fact is that the people in rural Saskatchewan told the Saskatchewan commission on health in 1990, when asked, well when you get sick I guess you're glad you've got a local hospital — oh, we don't go to the local hospital; we jump in the car and go to Saskatoon or Regina.

And so I think it has be borne in mind that a lot of the people in the rural areas were not utilizing the local system anyhow, even when there was a doctor there, but would prefer to go to the big centres where they can get referred to specialists if need be, and so on.

It's a tangled situation. But I reiterate: my idea of a community health centre would certainly provide for acute care.

Mr. Gantefoer: — One final question. When you talk about a community health centre in a community of 10,000, there's probably less than a dozen communities in this whole province that have more than 10,000 people. What happens to the community that has 2,000 people or 3,000 people? A Tisdale or a Melville or a Weyburn or a Melfort?

Surely we're not suggesting that all the acute care services go to community health centres in centres that have at least 10,000 people. That's what I think rural people are indeed scared of — that ideological approach to delivering of acute care.

Mr. Boan: — I brought this question up at a paper I gave to some group — I forget who they were, public health people in this province or something, I don't remember, a number of years ago — and one of them raised that very question. Well that's all very well for a larger community but what about a community of 500 or 1,000? What are you going to do about that?

And frankly, I was stumped. I didn't know how to answer that question because I hadn't really thought about it.

My son practises medicine at Moose Factory and that's at the tip of the bottom of James Bay. If your geography is okay, you'll know where that is. And one of his jobs is, every week or two, to fly up the coast of James Bay to nursing stations to attend to patients that the local nurse practitioner feels is beyond their competence. And I wouldn't be surprised if something similar to that couldn't be handled here, if you could have a community health centre in an area where there were enough people to sustain an acute facility and so on. And that community health centre could have responsibility for smaller areas, smaller places around there much the same. That would be the only solution I could think of.

The Chair: — Thank you, Mr. Boan. You're very interesting. Now we still have two questions left and we're almost run out of time. So Mr. Thomson and Dr. Melenchuk could be pretty succinct, hopefully.

Mr. Thomson: — Thank you, Madam Chair. I do have a few questions I want to pursue, because I'm intrigued by what you

say about this recurring idea that somehow the ills within the system — and these aren't your views but you've reflected them in your presentation — that the ills of the system can somehow be cured by simply letting people jump the queues, pay user fees, move ahead. And I agree with you that there is this growing sense. In fact, we've heard this in front of this committee now a couple of times, communities saying, just put on a user fee.

The difficulty is, I think, people who have grown up under medicare don't understand the cost of medicine. When we ask people, well, what's an acceptable user fee or premium to put on, people will say $100. That's what this committee has heard thus far. As we know, that raises about 30 million, $30 million, which is virtually nothing. That's less than one-fifth of what we put into the health care budget in new money this year.

I'd be interested in knowing, as someone who has followed the system closely, how do we get people to understand the costs of the system and services they're using? Is this something that you believe we need to work at through medical practitioners? Is this something we need to work at at an ordinary citizen level so that I understand when I go to the hospital to get services that I could simply get at my local medi-clinic, that I'm wasting taxpayers' dollars? I'd be interested in your view on that.

Mr. Boan: — Well it has been suggested that a form be drawn up that people could sign, when they go into or leave the doctor's office, stating how much the fee has been or whatever the cost has been. I don't know how that would work. I don't how you would design it or . . . but it might work. It would give some idea.

For a while here, Saskatchewan Health mailed people a list of procedures that they had had during the year and the cost, and I suspect that that was pretty good from the standpoint of getting people to know how much it costs.

I think that the press could do something in advertising every year when the federal government puts out figures — now it's the Canadian Institute for Health Information — but they put out figures on the cost of health for the year. It can be easily boiled down to a per capita basis and then if people see that it's costing per capita, say $2,500 a year, and if that is generally known, then that's going to make some difference, I would think. It's not free.

But that's something that should be looked into, I guess.

Mr. Thomson: — As I was listening to you and Mr. Gantefoer have your discussion, I was thinking about how we really do need to do more to demystify health care. I listen to this discussion of acute care and I don't know that we'd even come to an agreement amongst the people in this room as to what acute care was.

I'm sure Mr. Gantefoer is not suggesting that you should get major surgeries done in small centres. But how we would come to some better understanding among people as to what the level of care is that I need in my local community, what I need in the next larger community, and what I need in case I need to move across the country to get that very specialized care.

How do you suggest that we start communicating that to ordinary citizens so they have a better understanding, that we get away from this fear factor which is built in this, well I generally agree with the practice or the approach of the report but don't close down my hospital? I think you and I went through this when we saw the Plains shutting down in our community. Some few years now after the fact, six years after the fact, I think people generally feel that their health care is fine. Certainly none of the fears materialized.

But how do we get past that initial approach of fear of change, whether that's moving to the community-based model or whether that's moving to a larger, more specialized version of care?

Mr. Boan: — You've asked a very difficult question. The problem of definitions in this area is a serious one. There's too much loose talk about different things that go on, and better definitions would improve matters I think, improve understanding.

But yes, I don't know. I guess the definition of acute care should be decided on, you know, some acceptable definition agreed upon. We have an expert sitting right next to you that I would imagine has an idea of what acute care is.

Mr. Thomson: — Thank you.

Hon. Mr. Melenchuk: — Thank you very much for your presentation. And certainly it's really engendered I think the base philosophical approach in me in terms of how we look at some of these issues, when we talk about the writings of a Michael Rachlis or a Jonathan Lomas or research and policy analysts throughout Canada, in fact even the Fraser Institute and some of its comments with regard to how to fund a public health care system.

The question I have is that you often hear this phrase with regard to a theme or objective for a public system: the right service at the right place by the right provider at the right time. Would you agree with that sort of base philosophical statement?

Mr. Boan: — Yes, I don't see anything wrong with that.

Hon. Mr. Melenchuk: — The second question I have is with regard to reworking of the language of the Canada Health Act. As it currently exists it is location specific, hospital; provider specific, doctor; and doesn't really define medically necessary. And of course since the Canada Health Act came into force in the early 1980s, we've had a host of other providers and services that have been added to the public system — chiropractors, pharmacare, the home care — all of these that really the language of the Canada Health Act doesn't really address.

Would you see that as an important initiative as well in terms of looking at the perspective across Canada with regard to a publicly funded system?

Mr. Boan: — When Monique Begin spoke to us at the conference of health economics in Edmonton a couple of years ago, she raised some of these questions about the Canada Health Act and said that in reality it ought to be revisited and

amended. But she was afraid to suggest it in case the thing got destroyed out of all recognition. And so she was a little bit hesitant to recommend that the Act be amended.

Actually one should think seriously about amending it, it seems to me, because in my view there ought to be a seamless garment from the intensive care unit right down to the nursing home and home care. It should be . . . One jurisdiction should be looking after all of that. Now it can't be done under the medical care Act as it is now. So I don't know, there's a risk here of losing everything we've got, but it's a question of judgment I guess whether it should be amended.

Hon. Mr. Melenchuk: — The last question I have. It comes down to dollars. How do you pay for the system? We've had a little bit of discussion about user fees. We've also had discussion on a nationwide basis of various other jurisdictions and how they've looked at this. Some of them do have user fees; some of them have premiums.

In Britain, for example, they also went to a fund holder type of system where the primary care physician was the fund holder for the plan.

The Fraser Institute has talked about the dollars following the client or the patient and the patient would become the fund holder.

What do you think about some of those other options that have been thrown out on the national and international scene, specifically fund holding and premiums? What do you think of those concepts?

Mr. Boan: — Well I don't understand the difference between premiums and taxes. The tax we pay is only a premium that's collected by the public instead of having a bill mailed out through the mail. So I really don't understand the difference in that.

As far as the fund holder thing in Britain is concerned, I think that Maggie wanted to try and bring some competition into the system feeling that if people had to face reality, as she saw it, they would do a better job. I don't know how it's worked out; I've read different reports of it. But in any event I think that it was a political and ideological thing more than a health and economically justified approach.

The Chair: — Thank you very much, Mr. Boan, on behalf of the committee. And if there are some things you'd like to share with us, you can certainly send them in. Ms. Anderson will collect some of your material that you were willing to leave with us today. And again, thank you very much for coming.

Our next group of presenters could take the seats at the desk here.

Good morning. I'm Judy Junor and I'm the Chair of the Standing Committee on Health Care. Today the other members of the committee: Dr. Melenchuk is our Vice-Chair, Andrew Thomson, Warren McCall, Buckley Belanger, Brenda Bakken, Bill Boyd, and Rod Gantefoer.

The Standing Committee on Health Care is a legislative committee that its first task is to receive and report on responses to the Fyke Commission. We've scheduled in blocks of 30 minutes for presenters, and that includes your presentation and questions from the committee members.

If you wish to introduce yourselves and say where you're from and then we'll . . . you can start your presentation.

Before you get started, if you're going to share the mics you have to be really close to them when you're speaking into them.

Mr. Warnock: — Warnock.

Ms. Langer: — I'm Susan Langer.

Mr. Ewart: — Garry Ewart.

Mr. Agi: — Fiorindo Agi.

Mr. Warnock: — So I'm just going to start by introducing, distribute our brief. Our brief is too long to read it so we're not going to read it. We're just going to . . . the four of us are going to make a few points that we want to stress on our brief.

In addition to that, Garth Herman, who is president of the party, wanted to come today. He farms at Arcola and he was unable to come today because of work commitments. And so I've submitted a brief of his statement that he wanted to distribute today.

As you can see, Garth strongly supports the principles of local control and democratic participation and he's quite strongly opposed to the whole centralization process, reflected by the reforms that the NDP (New Democratic Party) government has brought in, and the Fyke Commission as well.

So I'm going to start by just making a comment on two aspects of our brief. First of all, on the structure, the Commission on Medicare itself. The New Green Alliance supported the position of the health unions and the Saskatchewan Health Coalition, the one that we needed a commission on medicare, but this was not the kind of commission we wanted. We wanted a broad representative commission, representative of the society as a whole, looking at all the broad aspects of the health and well-being of people.

And furthermore, we supported the principle of having public hearings all across the province so people everywhere could make their presentations, sort of like we had during the Hall Commission and other Royal commissions.

The other thing I want to emphasize here, and it's part of . . . central part of our brief, is the central assumption of the Fyke Commission and the Romanow government is that we have a financial crisis in the health care system and we don't agree with that. If you look at the tables in our appendix you'll see that we believe that there is adequate funding available for medicare.

And you'll see that, for example, between 1991 and 1997 there is actually no increase whatsoever in the spending on health care in Saskatchewan as a percentage of the gross domestic product or in real terms. In fact spending on health care in

Saskatchewan as a percentage of gross domestic product — and the Fyke Commission was supposed to look at this but they didn't — shows that the spending on health care in Saskatchewan has steadily decreased since the last year of the Grant Devine government, from 6.4 per cent of the gross domestic product to 5.4 per cent of the gross domestic product.

And so there has been a conscious decision by the government to reduce the spending on health care.

In addition to that, on table 2, you'll see that, in general, provincial revenues as a percentage of gross domestic product has steadily declined since the period of the last year of the Grant Devine government, where provincial revenues in general represented 24.9 per cent of the real gross domestic product, down to 19 per cent of the real gross domestic product.

So what we're really saying is there's no crisis in funding or available funds. There's a crisis in the government not willing to raise the revenues that are necessary. And our position of course is that you can't cut the royalties and taxes on resource corporations, you can't cut the wealth taxes in this province, you can't lower the income taxes in this province on the people in the higher income brackets, and you can't reduce the taxes on a business and still maintain social programs at the levels that we want them to.

And so what we're saying is there are adequate taxes there. What is lacking is the government's will to collect the taxes that provincial governments in the past have collected in this province.

And so basically we're saying that as long . . . and the most dramatic change in the tax system here has been the reduction of taxes through the Grant Devine period and through the Romanow government, taxes and royalties on resources. You can't have a dramatic reduction of the taxes and royalties on resources and maintain the health care system as it is today.

So I'd like to pass it on now to Susan Langer.

Ms. Langer: — Thank you. I have to do a bit of reorganizing here, sorry.

I have multiple disabilities and, like a large proportion of people with disabilities, especially women, I live in poverty. Therefore I will address chapter 3 of the Fyke report, "Making Things Fair," specifically page 35 where he said:

> Put simply, the biggest cause of poor health in populations is inequality.

A couple of areas I want to identify that come under this heading.

Shelter. There's been no new social housing since the federal government cancelled its program in 1992. Also in that year the provincial NDP administration cancelled rent controls. It is my understanding that Saskatchewan Assistance Plan shelter rates have not increased since 1980 but inflation has increased 70 per cent. The shelter allowance for a single disabled person is $320 per month, and for a single non-disabled person it's $210 a month. However, the average rent for a one-bedroom apartment is $425 a month.

The roof in the apartment that I live in leaked for several years and mould grew on the ceilings. As a result, my asthma became much worse. This past winter I had severe bronchitis, which required aggressive medical treatment. Because of the high fever I had, my hair is falling out now. So this is the kind of health effect for housing and how I've experienced it personally.

I can't afford market rents, but luckily I'm able to stay where I am because my landlord has not increased my rent since I moved in, in 1992. It's a very unusual situation.

Food. Given these kinds of circumstances, low-income people must use their food allowance to pay for shelter. They beg out of food banks. The poor quality food received does not contribute to good health.

Adding further to the problem, the NDP administration introduced The Good Samaritan Act, which protects food distribution programs for the poor from liability for illness or death caused by their food. This devalues the health status and lives of low-income people and their children.

In the Fyke report, I refer you to page 38, the title, An Equal Chance at Good Health. In the second last sentence, he says:

> Removing barriers to employment such as providing health benefits to low-income families is just one example of how social policies support better health outcomes.

I think this statement is misleading. Prior to 1991, it was possible to calculate medical costs for Saskatchewan Assistance Plan eligibility and entitlement to health benefits. The NDP administration removed that provision. When the federal Child Tax Benefit was introduced, the province reinstated benefits for the children of low-income families only. The parents and others are not covered.

Providing benefits would improve health, enhance one's ability to work, take training, participate in community activities, etc.

Unfortunately there are no recommendations to eliminate poverty and inequality in the Fyke report. In contrast, I show you two other reports. The first one has recently been released, *Saskatchewan's Disability Action Plan*, June 2001. And under the section on income support on page 48:

> The most common recommendation was to raise social assistance rates to overcome the poverty experienced by individuals with disabilities.

And the second report is from the city of Regina, the *Homeless Consultation* document in February of this year. They went to different agencies around the city and asked them to identify gaps in services. And I'll just go through the appendix and comment on the agencies and what they said that's relevant to health care.

Regina Food Bank, they said, need for affordable housing. Regina Open Door Society, raise SAP (Saskatchewan Assistance Program) rates to meet housing costs.

Canadian Mental Health Association, Regina branch, increase SAP rates. Welfare Rights Centre, reintroduction of rent control. REACH (Regina Education and Action on Child Hunger Inc.), SAP rates need to be adjusted to 2001 requirements.

Carmichael Outreach Incorporated, low-income housing, medical care, nutrition management. Habitat for Humanity, affordable and accessible housing. Phoenix Residential Society, SAP rates too low.

Rainbow Youth, affordable, safe housing. Myers Recovery Centre, affordable housing.

Some many years ago, I babysat for the children of Tommy Douglas's less famous daughter while she was teaching nursing in Saskatoon. I don't think the Fyke Commission report is what Tommy would have wanted as a legacy to his descendents or the people of Saskatchewan.

Mr. Ewart: — I was just going to talk a little bit about seniors and how the health care reforms have affected them. Saskatchewan has one of the highest seniors population in comparison to other provinces in Canada, and the health care reforms in the 1990s have caused seniors to bear much of the financial burden due to cutbacks in the health care system.

The Fyke report would create even deeper cuts, I believe, to seniors. And three factors affecting these seniors are drug costs, reductions in publicly funded care homes to private for-profit care homes, and home care due to early releases from hospitals.

The cost of newer drugs to treat certain illnesses associated with aging such as hypertension, diabetic, Alzheimer's, and arthritic medications have increased enormously in the last few years. And even though some people have access to private drug plans, these are very costly and not accessible to all. Many seniors are required to use much of their savings and pensions to pay for their medication. Seniors are finding it difficult to cover the basic necessities of life for such things as food and shelter.

The New Green Alliance recommends a pharmacare program be implemented to alleviate the financial burdens on seniors.

As the seniors population increases in this province and because of reforms, we have seen additional private, for-profit care homes being built in the city and throughout the province at an ever-increasing rate. These care homes charge usually between 2,000 to $5,000 per month, depending on the services provided.

These private, for-profit care homes are not an answer for the majority of our seniors who are required to live on an old-age pension. The provincial government last year increased the cost by 10 per cent for seniors residing in long-term care homes. I understand a senior whose income is $17,000 per year would pay approximately $1,500 per month. This is off-loading onto the individual.

Under health care reform, home care is widely used as a cost-efficient alternative to hospital bed usage. This may reduce hospital cost but the burden is shifted to seniors who are required to pay for certain services such as food preparation and laundry. The charges for these services are prohibitive for most seniors utilizing this service. The New Green Alliance would create a more equitable and affordable home care program.

The changes brought about by health care reform and what the Fyke report promotes is cost efficiency with little regard for the person, and as the folk singer Eric Vogel has said, it's a poor sort of society that doesn't take care of the old and helpless; they took care of us when we were young and helpless.

So I think basically with the seniors issue, things need to be looked into closer. I do not believe that the Fyke report has answered all the questions by any means. Thank you.

Mr. Agi: — Hi, I'm Fiorindo Agi and I'm going to talk on welfare and mental health issues. I'm a mental health client myself. I'm also on the board of the Canadian Mental Health Association, Regina branch. And some of the issues with health care, I remember when they came out with the wellness program back in the early '90s you know, that things were going to have to get better.

And one thing that the people on mental health use is the food banks and I've worked . . . I've volunteered there, and you know they give out a lot of rotten food.

You know when I was there working, they would give out food and I'd be cutting off the rotten part. They would say, well you know we've got to give them something so leave a little bit of that rotten stuff on there. And they give out lots of, you know, bread and buns and doughnuts that is overexpired; too many canned goods with not enough nutrition in it; no . . . hardly any meat. You're lucky maybe once out of a month if you get a piece of meat in your hamper.

And a lot of people are using it because they don't . . . because they're having to take, as Susan has said, they're having to take their money from their food allowance for their rent.

Something that we have talked about in the New Green Alliance is having an annual income; of everyone getting so much a year at either 10, 15, or 20,000 depending on each other's circumstances. And also to add into that is also an annual increase because inflation goes up every year. So we just can't . . . like we have with our social services, we've done really terrible. We've left our . . . it's changes to the fact that there are no increases, and yet everything else goes up.

Also with that, to give a person an incentive to go out to work, our minimum wage has to go up.

Also for people that are on mental health, that they can be able . . . they are able to go out and work, but they aren't able to make very much and they're cut off. So if the premiums could go up so they can make more money.

Better housing. There are a lot of slumlords in the city, and people on mental health and welfare, the low income, have no rights.

The landlords just don't do a lot of their taking care of their apartments. When I've lived in apartments I've always had my mother or father come and help me clean and redo the place

because the landlords will never come and do those things. And it's the little ones that are always get . . . the little people that are always getting taken advantage of, the people that are trying to get into these 350, $400 places. Like my last place I moved into, they had scum all over the bathroom, the tile, you know. And the water taps wouldn't work.

You know, like . . . and better housing for people, you know. When they're in approved homes, that they are taken care of because a lot of them figure in the mental health system, when they're in an approved home, the people are there just for the money. They're not there for taking care of the clients and to help them with their needs.

More advocacy for mental health. A lot more advocacy needs to be done. More and more money needs to be put into Canadian mental health and a lot more programs need to be added so people can live better, healthier lives. You know, there's not enough advocacy for people that are in trouble with the law or that are trying to get out there and get an education or a job.

Like the society really doesn't give mental health people a chance to work. You know, they give them a couple of days on the job and they're booted out because maybe they don't look the same or they don't act the same or, you know.

Really we need the government to be leaders, to get leaders out there in the community saying, these people need a chance to be a part of the community.

Also with our mental health system, our psychiatrists are over-medicating a lot of our members and they feel like they don't have any say. And when you're over-medicated, you can't come out and work in the workforce. It's too hard. You know, if you're on medication, you know and you're all doped up, how can you put in four to eight hours a day at your job?

My last comment is, you know, I believe the Fyke report is a joke to myself. I believe we need to expand services and the only way you do that is by spending money. And yes I know, everybody says there's no money out there. But I believe there is. You know, we have money when we need to do things like build a casino in Regina. We seem to find the money to build things and do things when they don't always need to be done.

Health care is a right, not a privilege. And I know Tommy Douglas is rolling in his grave for what we've done to medicare. Thank you.

The Chair: — Thank you. Is that the end of your presentation?

Mr. Warnock: — Yes. And you can see from our brief that our emphasis is on prevention. Really our thrust of our brief is that the only way you're going to reduce health care costs is through a serious system of prevention.

And we've identified that the research in Britain, the United States, and Canada shows that the greatest cost to medicare is inequality. The greatest increase in the cost is where inequality exists. And the more equal a society is, the less there needs to be spent on health care. And that's sort of the thrust of our report.

The Chair: — Thank you. The committee members have questions?

Hon. Mr. Belanger: — A couple of questions here on your brief. You spoke about water quality being one of the areas that we should be concerned. And I guess one of the points that you raise here was on the trihalomethanes that a lot of the communities . . . And if I could just look at the note here. It says:

> Furthermore simply adding more chlorine can add to the problem. When chlorine is combined with organic acids it produces trihalomethanes which are cancer causing agents.

I guess my question to you is that we often as politicians have been told that in terms of the trihalomethanes they are a by-product of the chlorine that we add to our water. And in fact I remember the exact phrase — a 70-kilogram person consuming more than their allowable trihalomethanes over a period of 70 years have a one in a million chance of getting cancer. Those are the kind of stats that are often presented to us.

So my question on that particular point is: is trihalomethanes in your opinion, is that a far better or lesser evil than not having chlorine added to your water which attacks the bacteria in our water which is a more of an immediate threat to people drinking water in the province?

Mr. Warnock: — Well yes. I mean no one wants to abolish the use of chlorine. But our position would be why don't you clean up the water so you don't have organic matter in the water supply like you had in Walkerton, Ontario. So that would be our position.

But I think we can't dismiss the fact that when chlorine is added to water it often creates cancer causing agents because that's only one cancer causing agent we're exposed to. But we're exposed to a whole lot of other cancer causing agents too, for example, 2,4-D. I've done research on 2,4-D — 2,4-D is an active promoter of cancer in combination with others.

And then you have pesticides in everything else — all kinds of other chemicals we're exposed to — and we don't really look at what is the total impact of that on human health. And this would only be one aspect of it. It would have to be seen in a broader aspect.

But I would say, for example, in the North if you have really bad water someplace, you're not going to eliminate chlorine. But what we would argue is you have to deal with why is the water becoming so contaminated. Why is our groundwater becoming so contaminated? What's it going to do when the hog barns spread enormous amounts of contaminants all over the ground, untreated sewage? You know it's causing a problem everywhere in North America, and in Taiwan, in the Netherlands, in Denmark, etc. We cannot do that here without causing problems down the road.

Hon. Mr. Belanger: — My second and final question is exactly on the diversification of our ag sector. Often the ability to grow food is one of the strong suits of Saskatchewan's ag sector. And we often as politicians are subjected to arguments that in order for us to diversify our ag sector then we have to do certain

things, like intensive livestock operations, that we have to use chemicals, we have to do this and certainly do that. And as we put more and more environmental guidelines and constraints on diversification of our rural economy, so to speak, that boxes in a lot of the farmers.

So I guess my question to you is: how do we as a government in terms of this whole health care thrust begin to diminish some of the threats, as you mentioned, as a result of us using a lot of chemicals and fertilizers and so on and so forth that threaten the water supply? What kind of balance would you see as us looking after both interests?

Mr. Warnock: — I used to be a farmer myself. I grew up on a farm. My father was a farmer. He never used any chemicals. Everybody uses chemicals now. I think that's a product of the corporate control over farming and the removal of so many people from the farm.

But I do think that there's an option today. The New Green Alliance, as a party, supports the move towards ecological agriculture and organic agriculture. And we would point out that all the western European countries now have active programs by the governments that support alternative agriculture. We would support that as well.

But I think for example in hog barns, I mean we don't have to just look at the giant hog barn as the only approach. We can look back to World War II when we produced even more hogs in Saskatchewan on small farms.

But we can also look at what's going on in the United States. You look at Nebraska, for example. Nebraska in 1982 passed laws prohibiting large hog barns, and yet during this period of time the number of farmers producing hogs has gone up, the volume of hogs has gone up. So even within our present system, there are alternatives to these massive hog barns.

And there's lots of examples in the United States and in Canada of people who raise hogs and make a profit at it without using intensive livestock operations, you know. It is possible. It's just that our whole thrust of the society, determined by agribusiness and our research institutions which are linked to agribusiness, is towards intensive livestock operation. But there are alternatives. It's just that the system that we live in, including Saskatchewan, is not willing to look at and give support to the alternative systems.

Furthermore, there's full cost pricing involved here since we're promoting these large hog barns. Who's going to pay for all the pollution that's created by spreading livestock waste all over? Big Sky's one barn spreads more . . . creates more pollution, more waste than the whole city of Prince Albert and is spread untreated on the land. Is that a good way to go? I don't think so. We don't think so.

So we would support looking at the environmental cost. Why should the environmental cost always be passed off to the public? Why aren't the people who are creating the environmental problems have to pay for that?

The Chair: — Mr. Melenchuk, if you want to wrap up this presentation?

Hon. Mr. Melenchuk: — Just one question with regard to health districts. Now I understand from your brief that a majority of your members favour abolition of health districts. And earlier on, you talk about the local autonomy that the previous system had with 485 independent local boards.

The question I have is that if you went to that decentralized a model, how would you propose dealing with things like provincially administered pharmacare, mental health districts on a regional basis, home care districts on a regional basis, and coordination on a more regional or provincial basis, if it was a totally decentralized model? Or are you looking at a mixed model with some . . . (inaudible interjection) . . . Okay.

The Chair: — Seeing no more questions, thank you very much to the presenters for your personal presentations as well as your written submissions. And on behalf of the committee, we thank you for appearing today.

Good morning. I'm Judy Junor and I'm the Chair of the Standing Committee on Health Care. The other members of the committee are Dr. Melenchuk as the Vice-Chair, Andrew Thomson, Warren McCall, Buckley Belanger, Brenda Bakken, Bill Boyd, and Rod Gantefoer.

The Standing Committee on Health Care's first order of business was to receive and report on responses to the Fyke Commission. And we have set aside 30 minutes for presentations, that includes questions from the committee members.

If you want to introduce yourself, you can begin your presentation.

Ms. Biemans: — Good morning. My name is Sheri Biemans. I'm from Watson. I'm the president of the Saskatchewan Association of Licensed Practical Nurses. This is Ede Leeson. She's our registrar/executive director of SALPN (Saskatchewan Association of Licensed Practical Nurses).

As licensed practical nurses we want to deliver two very short messages today. The first message is to both the government and the official opposition through this Standing Committee on Health Care.

Enough is indeed enough. The Fyke Commission report on medicare provided the most public, professional participation of any study or commission before it. Mr. Ken Fyke and his staff had no axes to grind, no baggage coming into their huge task. They sincerely believed in the benefits of the present medicare system that we have all come to expect and in fact, demand. Their findings reflect a genuine concern about how long we can continue to reap the benefits of this system.

While recognizing our system's weaknesses, the report builds on our strengths and provides us with a blueprint plan for enhancing and sustaining medicare for the people of our province.

It is comprehensive, integrated, and reflects quality over quantity, teamwork, collaboration, and co-operation — all attributes that reflect our history and tradition in this province. Licensed practical nurses on the SALPN (Saskatchewan

Association of Licensed Practical Nurses) council want to help. We want to reach out to our members via our newsletter expressing our thoughts and urging their support to show how, in practical terms, we can fit into the Fyke plan.

We present the Canadian Practical Nurses Association paper, "Primary Health Care: What is it and Where do . . . LPNs Fit?" We believe that all regulatory bodies and all unions have supported the Fyke Commission report. We urge the elected members present to go beyond the present model, to step outside the box, to include all health care providers in a collaborative primary care model.

Further we encourage the view that regulatory bodies are legislated to regulate the respective members only. When putting the Fyke blueprint into place, welcome the advice and the input of regulatory bodies but do not lose sight of the intent of primary health care.

Primary health care is based in the community and based on the needs of the community, offered in an atmosphere people can accept and in ways that they can understand. Clearly the commission understood this. On numerous occasions Mr. Fyke alluded to the control some regulatory bodies had in our health care system, and the fact that such control had prevented full utilization and maximization of services.

Many reports, commissions, studies in the past have been completed and ignored. We cannot afford to have this happen to the Fyke Commission report. The longer we wait the harder it will be to deal with. We need the government and the opposition parties to join forces to collaboratively facilitate the Fyke report recommendations now.

Let's make Saskatchewan not only the birthplace of medicare, but also the preserver of medicare.

Our second message is to the citizens of the province. The message is, read it yourself.

The past president of our council, Noella Hart advised LPNs (licensed practical nurse) attending our annual meeting in Saskatoon that the Fyke Commission's report on medicare is well worth the read. She said, and I quote:

> The Fyke Commission Report is an easy read. It is an important read for everyone in our province. Don't count on the fifteen-second clips on the television or the interpretation of the newspapers or radio shows. Count on yourself and share it with others. Urge everyone to read to before they decide how they feel about it. The Commission Report allows us to be informed and to make an informed judgment in an easy way. I believe that we have a responsibility to our grandchildren to ensure that we make our comments about the future of health care in this province knowledgeable comments.
>
> The Commission's report allows us to be informed. I think you will enjoy reading it, my husband and I did.

Noella and her husband are reflective of many Saskatchewan residents. They found time to review this report in spite of their busy jobs and lives. Many of us can and should take the time to do the same.

I live and work in rural Saskatchewan, and had I not read the report, I too might have been concerned about the implications for my area. However, the recommendations for providing everyday health care services in rural areas through primary care service model eased my concerns. Often we mistake quality care for convenient care. And the recommendation to beef up our regional hospitals would be a bonus for proper utilization of services. The enhancement of the Prince Albert District to a more tertiary role is a plus for the needs of the North and the South alike.

I could go on and on about the many good recommendations I found in the report. Everyone will find good points and points of concern in their areas.

If we want to ensure a collaborative environment for the delivery of health care services we must, as both providers and receivers of these services, be informed and aware of what the system can and should offer. Please take time to read it yourself; it will be well worth your effort.

Thank you very much for allowing us this opportunity to express our views.

The Chair: — Thank you. That's the end of your presentation? Committee members have questions?

Mr. McCall: — I was just wondering if you could state for the record how many members you represent.

Ms. Biemans: — Twenty-one hundred LPNs in Saskatchewan.

Mr. McCall: — They would be distributed throughout rural and urban Saskatchewan fairly equally, or what would the breakdown be?

Ms. Leeson: — The majority of LPNs of course would be in the larger centres because of the larger hospital facilities, but definitely distributed throughout the province.

Mr. McCall: — And you yourself being from Watson and working and living in rural Saskatchewan, you make some very . . . and again, thank you for the brevity of your comments. It's often stated that brevity is eloquence and you certainly do pack a punch with your report.

But I just wanted to, I guess, focus on the fact that as an organization that has a fair number of the people you represent working in rural Saskatchewan and you yourself being from rural Saskatchewan, contentions are often made about the possible impacts on the quality of health care for rural Saskatchewan should Fyke go ahead. I was just wondering if you could expand on your thoughts on that part of the discourse that's presently going on around Fyke.

Ms. Biemans: — In my health district, it's actually quite good. We have two hospitals half an hour east and west from my community, and we have a health centre in my community and most people are quite used to driving the half hour.

We have a doctor come into our community five days a week.

We do minor ops. We do a lot of things when the doctors are there. We don't have emergency services, but they know they have to go to Humboldt or Wadena. Actually it goes well there. But I'm speaking for my area only.

Mr. McCall: — So the status quo would seem to be serving the people in your health district quite well?

Ms Biemans: — Very much so. That's my opinion.

Mr. McCall: — Fyke improving that situation not . . .

Mr. Thomson: — Thank you, Madam Chair. I want to thank the Licensed Practical Nurses Association for the presentation. It is indeed brief and to the point.

The one question I had concerns the communication message that you make in the second half of your presentation. One of the things that we hear from health care providers, or certainly at least I have heard talking to nurses in my community, is that people are tired of change. They're finding that the change is often moving too quickly.

Now whether that's a case that it hasn't been communicated well, or just that's there's too much of it, I'm not sure. I'd be interested in knowing how you feel within the nursing profession and within the health care system, how we should communicate, communicate the change.

Ms. Leeson: — It's interesting. I sit on the . . . they have a subcommittee in the Department of Health dealing with the quality council; and I sit on that council and we were talking about this and I was jokingly referring to the fact that perhaps every licensed practical nurse should be required to read Fyke and pass an exam on it before we allow them to practise here or issue their licence every year. Of course that would require a massive bylaw change and I'm joking when I say that.

But I feel, having reviewed right back to 1986 some of the reports that we have had done, either government or previous administrations — and I think of the Murray Kish Commission and on and on. Regional hospitals, what we do with them, was 1986, and there have been so many reports. And I think that's why our council felt that enough is enough. We have looked at this over and over and over. And I think we've kind of tabled these reports, taken bits and pieces out of them.

Some of them dealt with just specific areas. And all through this process, nurses of all ilks, all three nurse practitioners, have had to deal with these changes.

And you're right; it's difficult to deal with them. But there has been no concrete final plan. And Fyke, in our mind as a council, has put that in a blueprint form. And he's put it there with the kind of attention to the public that we serve that we approve of. He's looked at primary care and made it the important part of the package. And he's been very comprehensive.

So I think the need to do it now and our theme of enough is enough would be helpful to make those changes. Because people are indeed, as you point out, worried about change. It's never going to be easy but it's always going to be there, especially in health care. It's always going to be a factor.

So when we say, enough is enough, we're saying the blueprint is there and we're saying, we think you can do it now and you can do it by including nurses. You can do it by making their jobs easier with this blueprint plan. And I think it would be helpful.

Yes, there needs to be the usual education, which I heard you speak about in an earlier presentation as we were listening. And that's always difficult. We also said laughingly at this subcommittee that maybe everyone who receives health care has to read the Fyke report and pass an exam before they get their health care, but you and I both know that wouldn't do it either.

But I really believe that some kind of advanced education program for the public, where the change doesn't become so overwhelming, where it isn't so frightening, where you don't read those 30-second clips and all you hear is, my God, they're going to close another hospital . . .

Because I mean I was a person who went to one of those hospitals and couldn't be served when my son had a tractor accident. So I know they're not meeting the needs now, and I know that we needed to do something about that and make it so that this mother knew where to take that child when that tractor accident happened. And that was partly my fault for not understanding that as a member of the public, but it was also partly the system's fault that had that big green H there that didn't do anything for me. And so I think when we say enough is enough, all of those things apply to that.

Mr. Thomson: — Thank you. Those are quite thought-provoking comments.

The second question I had is how do we work with communities and ordinary citizens to give them a more, perhaps a better informed view of modern nursing? One of the concerns I hear, particularly from seniors that I talk to, is that they still like to see the doctor.

I don't think that they understand in many cases, or maybe I don't understand either, the kind of new role that nurses are taking and playing in the health care system and the new type of ability we had.

I know we saw that even in this legislature as we dealt with the LPN legislation — I think that was last year — that there were still a lot of questions about how do these people fit into the health care system. When would I want to see a nurse; when do I want to see an LPN, an RN (registered nurse), an RPN (registered psychiatric nurse), whatever we may be dealing with; and when do I need to see the doctor?

Is there a way for us to build a greater confidence within the local community about the new role for nurses?

Ms. Leeson: — We're trying that. Certainly the nursing groups in Saskatchewan are doing a more collaborative approach to nursing, and we're travelling the health districts, presenting what we call our NICE document, nursing in collaborative environments. So they see a lot of nurses.

But I don't think it's as hard a sell as you might think. Because

I lived in rural Saskatchewan, and if we had kind of an accident on the farm, I called the closest LPN or RN who was a nurse and said, what do I do with this?

We've always done that. We haven't paid them for it, and we certainly haven't acknowledged their ability to help us there.

But it's not a hard sell in the North. The northern nurses are doing it. It's not a hard sell in the area that I came from. And certainly yes, it's always nice to have a doctor, but I also heard earlier today that those doctors are being bypassed in cases of acute need and they go into the physicians in the tertiary centres that Fyke is talking about.

And I think that nursing can best sell that themselves with a collaborative approach, with the advocacy that they do for patients and continue to do. The advanced clinical nurse is a really important phenomena now. And we strongly supported that as practical nurses because we think that could be very helpful, and help that happen. It's an education process. It's time for a new approach process.

Mr. Thomson: — I'm sure that the Chair would agree with me, now that she's moving to the office next door, that tends to be where I pop into for my health care advice. But I have no other questions.

Ms. Bakken: — Thank you for your presentation. I just have a couple of questions.

You stated that the status quo is working in your area now and that you are happy with the way things are. But under Fyke that will not be the case in your area — things will change. So how do you see that endorsing the Fyke report will improve health care in your area?

Ms. Biemans: — How will it change?

Ms. Bakken: — Well we are going to be . . . We are talking about you have two hospitals and you have a health centre in the middle. If we adopt Fyke's report we will not have those two hospitals or probably neither of them or maybe only one of them because he's endorsing 20 acute care centres.

So how do you see it — the service being provided in your area and improving?

Ms. Biemans: — Well people are used to health centres for one thing. They're used to . . . and we have a lot of doctors in our area. I think they'll probably just . . . it's just like it happened back in '93. People are going to have to get used to the downsizing. I'm not sure how people will react. I don't know.

Ms. Bakken: — Well I guess I find it, you know, I find it interesting that you say that what you have today is good and it's working well, and yet you're endorsing a downsizing further to what we have in rural Saskatchewan. And that has been our concern, is how are we going to provide adequate accessible service when we are going to downsize further?

And I guess, you know, this is what I'm asking: how can you endorse Fyke when this is one of his proposals? And how do you see it enhancing service in your area and throughout rural Saskatchewan?

Ms. Biemans: — Well it is a recommendation, the Fyke report. We don't know for sure that that's what's going to happen.

Ms. Bakken: — But you're endorsing what he is recommending. That's what this is all about, is he has made these recommendations, the presenters that we are hearing are here to tell us whether they agree or disagree with these recommendations; and if they do, why they do.

And you are endorsing this report from what I hear in its entirety. And yet I'm asking you this question of how service is going to be enhanced in your area —and your area's no different than other parts of rural Saskatchewan — and I'm not hearing an answer.

Ms. Leeson: — Perhaps I can help. I think that Fyke's primary health care concept — everyday services where the people are — is going to enhance that kind of thing.

And certainly . . . I mean the other things are already happening. They're already leaving the community to go for the kinds of exceptional treatments that perhaps you're referring to.

So I'm not so sure that even if there was a difference in the number of facilities, that would change anything as far as the people in the Wadena-Watson area.

Our concern . . . because that's already happening. It's already there. They're living that now. They're living Fyke almost now because they're used to health care centres. And yes, the hospitals are there. But they're in many ways . . . I think of the hospital that I approached, for example, with my son. It was a long-term care facility; it wasn't a hospital.

And everyone there knew that. I was a newcomer to the neighbourhood; I didn't know it. And everyone else did. They took their emergency problems with their kids to Regina. And I didn't know that. I thought a green H meant a green H, meant you could get those kind of services. And that's worse in my mind than what Fyke is presenting because that's misleading.

And with Fyke you would know it was a health care centre. You would know you could get that patient stabilized or you would know you could get advice there on where to go. I mean his, his blueprint includes information for mothers like me who could deal with that. And I think that's not downsizing. I think that's improving what we have now and making it clearer.

Ms. Bakken: — Well I think that's debatable, and we're not here to debate.

The other question that I have is, you've also . . . because you've endorsed the Fyke report, you've endorsed the EMS (emergency medical services) report which he endorses in his study. And I would like you to just tell me how, how you see that will enhance service in rural Saskatchewan by implementing the EMS report.

Ms. Leeson: — Well I think I have to disagree with you. He didn't endorse the EMS report in its entirety. Some aspects of it, he certainly did. But I looked at both of those reports, and I

believe he changed some of the EMS report. Maybe Sheri can answer that more specifically vis-à-vis rural.

I saw some improvement in EMS. But I have talked to, to rural people who are worried about that. I don't, I don't know how I can answer that for you.

I agreed with what he said, as did our council, vis-à-vis the EMS approach because they indeed are enhancing it with the information number alone. The ability to communicate is much better, and that's what we looked at. We didn't look at specific locales; we looked at the general blueprint and felt it could be applied and could be beneficial.

Mr. Gantefoer: — Thank you and I'm glad that you're here. And we've certainly met a number of times over the last year too.

I'd like to focus on one particular aspect, and that is the whole question of collaborative practice. I think that everyone agrees that collaborative practice is an ideal that we should strive for. But certainly out of the LPN legislation last year there was an undertaking by the three nursing groups, if you like — the LPNs, the RNs, and the registered psychiatric nurses — to come up with a working paper as to how that collaborative practice would happen. And you've done that and you're now embarking across the province in a collaborative team approach of explaining it to people in the health districts how this is going to work.

I'd like a bit of a report card on how that's going because I think that it's important to understand, first of all, are nurses going to be able to work together, if we're going to understand how primary health teams have any chance of working together where you involve all kinds of other medical professionals.

Ms. Leeson: — I guess I'm the best one to answer that because I've been on the travelling road show. And we're doing it by invitation only. And we've had probably 10 meetings over the last year and we've moving into our third and fourth final meetings. We broke for the summer because of the needs of the districts who have holidays to deal with.

And we ask the districts when we go out to have all three nursing practitioners present. Their human resource people join us. We have nurse managers and district boards — elected people — as well as CEOs (chief executive officer). So it's been good.

I guess if there's anything disappointing about it, it would be that we can't cover as many as we would like. The districts are large and therefore when we go out for a meeting we'll get 20 to 30 people. And they will be representative of what we want. There will be psych nurses and LPNs and registered nurses there but we're not able to get as many because they can't have everybody at our meeting and still be looking after patients.

But I think it's been good. I think that the registered psychiatric nurses are probably not as pleased with it because they're finding that there isn't a recognition of their people as much as they would like. But having said that, the exercise is helping them make that recognition too. So we haven't had . . . I don't think we've had any really sort of negative . . . maybe one negative problem in Saskatoon from the degree program. It was a little feisty. It was our very first meeting.

And so as far as collaboration goes, I'm kind of excited about it. Maybe I'm looking through rose-coloured glasses but it seems to be working from our point of view. We're also able then to talk about collaboration in a broader model because we're not just talking nursing when we're talking primary care. There's so much more than just nursing.

Mr. Gantefoer: — Thank you. The area of concern that was expressed in some of this is that health districts would take the opportunity to minimize the standards of people providing care for fiscal imperatives. And I look at the reorganization of nursing service at the Wascana Rehab as an example of where the Regina Health District has eliminated a number of registered nurses' positions and have chosen to fill them with licensed practical nurses. And there are those that would argue that this is a diminishing of the qualifications and service that is provided in that kind of an environment.

Is this the beginning of a trend, even in these primary health models, of diminishing the roles of the higher-trained professionals in a fiscal imperative to try to put the minimum possible qualifications before the people?

Ms. Biemans: — I think they're starting to utilize all health care providers to their full scope of practice and I think it's great that they're finally starting to do that with us. They're putting people where they should be working, moving people around to where it best suits their qualifications and their scope of practice.

Ms. Leeson: — I don't think that you can argue that utilizing, fully utilizing someone to what they're educated to do is downgrading anything. I would disagree with that 100 per cent.

It's not unlike the advanced clinical nurse who are having the same kind of problems getting utilized. If we utilize the advanced clinical nurse to her full potential, that's not downgrading by saying well, you can't have a doctor and you're going to have an advanced clinical nurse who's capable of doing it. I don't see properly utilizing people as downgrading.

Certainly, I understand the change thing that Mr. Thomson talked about and that's what a lot of it is and that's what's, you know, going to probably happen.

But there is so much work out there and there are so few people to do it that proper utilization is just going to become a fact of life. But certainly I don't consider that downgrading.

Mr. Gantefoer: — Well again, not to be argumentative, but I think that if you are having services provided by people with greater levels of training and then that is no longer done because of a fiscal imperative, then that is a concern. And that's not to say that people aren't able to deliver a satisfactory service, but it might not be to the same level of training and competency that has been what has been expected in the past. And that is a concern if that is done not to utilize people's abilities or scope of practice, but because of a fiscal imperative as opposed to a clinical or a training imperative.

Ms. Leeson: — I think I would agree with you. If it's done because of a fiscal imperative, I think it's wrong. I just don't happen to think that's why it's being done. And I also think that it would be a very wrong move to remove one-third of the nursing team for a fiscal reason, or two-thirds.

When we talk about our collaborative practice document, we mean team nursing. We're not talking about one nursing practitioner replacing another. That's not the intention at all.

Hon. Mr. Belanger: — Just a couple of questions. Again I enjoyed your presentation and I think one of the keys that is often spoken about in the Fyke, it's all about vision. And we can call it anything we want to. We can call it rationalizing an overworked system or you can talk about the new way to deliver health or to maintain health in Saskatchewan. There's all kinds of different terms that are often being used.

I guess my question to you . . . I've got a couple of them. My first one is, in terms of the Fyke report and what it entails with coverage of the province as a whole with health services, is there any specific area or region that in your opinion is not served enough?

Ms. Leeson: — I'm sure the psych nurses would tell you that it would be mental health, and I heard the person earlier speak about mental health today. And when I think about the collaborative team that we're dealing with as we travel the province, this gentleman before us was asking for advocacy for mental health patients. And I just can't imagine anyone being more apt to do that than registered psychiatric nurses. And we're having fewer and fewer of them with their specific psychiatric training. I don't want to get into the NEPS (Nursing Education Program of Saskatchewan) program in education.

I also heard you talk about Michael Rachlis and the kinds of things he's doing, but I think that we can even look at advanced practical nurse clinicians, you know, because we really need that. And this gentleman at the far end of the table, in the previous presentation, when he was talking, all I could think of was we're losing more and more psychiatric nurses and that there's the need right there. So certainly mental health would be one.

I'm really excited about the stressing of the public participation, what primary health care's all about. And I would be really concerned if public access, public participation was ignored. Had a little bit of a kafuffle on the subcommittee about having public representation on a quality council, right on the council, doing it there, as well as doing it at the community level. And I think that Fyke meant for that to happen.

And that goes once again to change in how you educate people. The more public you have in there, the less educating you're going to have to do. Because there's a spin-off effect. Ontario's legislation and regulatory bodies are required to have almost, I think, 50 per cent public representation.

And we have benefited immensely just by the three public reps that we now have on our council. So that would be an area I would really want to see strongly, strongly represented on any structure.

Those are just the two that come to my mind.

Hon. Mr. Belanger: — Second question and my last question. And I could be corrected on the number but I think the number that I was given several days ago, that we're doing something like 10,000 more operations since several years ago, and we have an aging population. We also have a very expensive health care system — $2.2 billion — and the costs keep going up and up. It isn't a sustainable system. And that's the purpose of having a Fyke Commission done up, is how do we rationalize the overworked system?

And I guess my question to you is: how would we, as not only the caregivers but the politicians as well, how do we . . . how would you suggest we communicate the vision of Fyke so that we're able to maximize the quality service that you speak about? Those people out there have to know what Fyke is saying. So I guess suggestion wise, how would you like to see it communicated?

Ms. Leeson: — Well the drastic ones we talked about at that subcommittee won't work. So I don't know. It's a hard one. I think that you have to be very careful to stress the public participation that I talked about, because that gives them access and gives them voice. And it also says to them, loud and clear, this is not going to be yet another Department of Health or yet another layer of bureaucracy. It is in fact going to be the thing, the access, the avenue where the public can come in.

When you talk about the cost factor with citizens, it was interesting. I was at a seminar with Michael Rachlis not so long ago and he was saying that some of that cost factor related to seniors is magnified somewhat because seniors are much more healthy today than they've been in many, many years.

Yes, they live longer, and yes, they have more problems. But they've also learned how to deal with those and they're much healthier than, say, his parents were or their parents before them. And so it might not be as expensive as we think, and certainly the preventative part of the Fyke Commission would allow for some cost savings in that end.

I know you're going to struggle with how do we educate the public on this because we do that on a regular basis with the nursing . . . (inaudible) . . . I wish I could be more helpful there.

Hon. Mr. Melenchuk: — Just a couple of points and thank you for your presentation. It is your understanding, having read Fyke and discussed it at your council, do you see the recommendations of Fyke as not diminishing services, but the delivery of services in a better way that utilizes the skills of current health care providers? Would you see it more along those lines?

Ms. Biemans: — Yes, we do.

Hon. Mr. Melenchuk: — The second question I have. Would you see the new primary care model and the, for everyday and specialty services, the way that Fyke has integrated this model, would you see this as improving the recruitment and retention of health care providers in Saskatchewan?

Mr. Biemans: — Yes.

Hon. Mr. Melenchuk: — The third question that I have was with regard to the comments you made with regard to regulatory bodies almost in a turf-protecting way. Would you see that there needs to more co-operation in terms with the various regulatory bodies in developing this primary care coordinated network?

Ms. Leeson: — Very much so. I think that that has to happen because you're working in a primary setting with pharmacists, social workers, all of the regulatory bodies. We have a group which we call NIRO (Network of Inter-Professional Regulatory Organizations) and it's the network of inter-regulatory . . . anyway, it's all of the regulated bodies and we meet on a volunteer basis. We exchange information on regulatory issues and it's very informative. We talk about issues that reflect on everything from dentists to social workers to nursing to physicians to the whole gamut.

And that kind of a body has been very helpful at recognizing what one another does, the kinds of national things and issues that regulatory bodies face, the reason for regulatory bodies. And so I see that as an important part of the primary health care thing that Fyke is talking about.

And it, so far, has only gone . . . we had the physicians as the gatekeepers and now we're getting a little better. We're looking at registered nurses and, in some cases, even pharmacists.

But we can't seem to get out of that close-knit mould that, you know, the gatekeepers are so narrow. And I think once we get out of that mould and develop the team kind of thing that primary health care calls for, it will take a lot of that away.

Hon. Mr. Melenchuk: — One final point that may be a teeny bit controversial, but Fyke's recommendations for 6 tertiary and 14 expanded regional centres, 20 to 30 community health centres and 20 to 30 primary care centres, specifically with regard to the 20 to 30 community health centres he's talking about with 24-hour access, do you think it's important that in those community health centres, and I guess these would be . . . are smaller and larger community hospitals, that it's important to have acute care beds at those locations?

Ms. Leeson: — Well some of them already have acute care bed for stabilizing. They have the ability to deal with that immediate need and then get ambulances on. And Sheri can probably talk better to that than I can.

Ms. Biemans: — In our community, we don't have any 24-hour emergency services because we don't have physicians living in the community. When we did have, then we did have 24-hour emergency and we had one bed, as you said, for stabilizing for 24 hours and then they were sent out if needed to be.

But things work well with our ambulance services and we have stabilized and then called the ambulance for people and sent them out, and we still do things like that.

Hon. Mr. Melenchuk: — The reason I was asking that, obviously, is because there is some, I think, misperception in terms of the recommendations on community health centres. Certainly in Mr. Fyke's response, when he talked about community health centres, he said you could call these hospitals if you wanted to call them community hospitals or community health centres and the terminology wasn't all that important to him, but he did say that there would have to be 24-hour services provided at those locations.

And when he talked about primary care, he talked about 24-hour triage by telephone. But you wouldn't have 24-hour services, that the services would be more in a primary care setting and they wouldn't deal specifically with acute management. That would have to be dealt with elsewhere. Okay. That's all I have to say.

The Chair: — Seeing no more questions, on behalf of the committee, thank you very much, both of you, for presenting today and for leaving us with your printed information.

The committee will stand recessed until 1 p.m.

The committee recessed for a period of time.

The Chair: — Good afternoon. I'm Judy Junor the Chair of the Standing Committee on Health Care. The other members of the committee: Dr. Melenchuk is the Vice-Chair — he'll be along shortly — Andrew Thomson, Warren McCall, Buckley Belanger, Brenda Bakken, Bill Boyd, and Rod Gantefoer.

This is an all-party committee and its first order of business was to receive and report on the responses to the Fyke Commission.

We've set aside 30 minutes for presenters, and that time includes questions from the committee members. So if you can introduce yourselves and where you're from, and then you can begin your presentation. Thanks.

Mr. Bradley: — Mayor Don Bradley, town of Moosomin.

Mr. Miskiman: — Councillor Larry Miskiman, from the town of Moosomin.

Mr. Matheson: — Gale Matheson, mayor of Wapella.

Mr. Newman: — Murray Newman, from the town of Moosomin.

Mr. Miskiman: — Well first of all, thank you for allowing us to make the presentation today. We want to make a point that all of us here have been very, very heavily involved in the health sector for about the last 30 years, that we've been trying to get a new facility within our community, and certainly have been very, very active in the last 10 years.

The mayor has been very active. Murray Newman, a councillor, is also on our Planning Committee for a new integrated health care facility. I'm on the . . . Chair of the Finance Committee. So we are . . . have been very, very much involved. And we feel we're very much in tune with what our residents in our communities require in health care in rural Saskatchewan.

We have some very good success stories, and certainly we want to concentrate in our presentation today you'll find is on a very key area and that's on the regional centre recommendations that

Mr. Fyke had made. We didn't . . . we don't respond to very many areas because we are unfamiliar in that territory and we believe the overall . . . Mr. Fyke's report has certain benefits in some areas, certainly the one we want to . . . we believe we have a success story happening in Moosomin and we want for you to know about it.

When we speak here today, we're actually speaking . . . we've brought Mayor Gale Matheson from the town of Wapella. This is a very regional group of people. We also have had very active involvement from the town of Rocanville, the town of Wapella, the town of Welwyn, the town of Fleming, RM (rural municipality) of Moosomin, RM of Martin, RM of Maryfield, RM of Rocanville, RM of Silverwood, which is close to the Whitewood area, the RM of Walpole, which is close to the Wawota area, and also the RM of Archie, which is our partner across the border in Manitoba. So they all have contributed to our integrated health care project that we're planning.

So to start the presentation, certainly it is an honour to be here today and we want to thank you very much for taking the time to hear our presentation on behalf of the people of Moosomin and area.

The residents of Moosomin and area are proud of the health care services provided in our community, and as the hometown of Ken Fyke, we regret that we didn't ask Mr. Fyke to come to our community when he was conducting research for his commission on medicare, as we believe Moosomin's experiences may suggest a different model for rural health care than laid out in Mr. Fyke's final report.

Mr. Fyke suggested a radical degree of centralization of health care services in Saskatchewan. Well our experience shows that a wide range of services can be provided in a medium-sized centre like Moosomin with a high degree of efficiency and at little cost.

While much of the report is very good, we feel in some areas the report is not realistic, such as in the degree of centralization of acute care services. His report recommends the closure of many hospitals in Saskatchewan, with many becoming primary health care centres which involve 8- to 12-hour service, and 25 to 30 becoming community care centres which are the 24-hour service for convalescent, respite, and palliative care.

The next level of service would be regional hospitals of which there would be 10 to 14 providing acute care and emergency care. This degree of centralization would leave many people a long distance from an emergency room and create higher individual costs associated with travel, accommodations, and of course we can all relate to out-of-pocket expenses such as meals.

It would also make it very difficult, as we can attest, to recruit and retain physicians in rural Saskatchewan. It is almost impossible to recruit doctors to work in solo practices or a two-person team because of the hours involved and the toll those long hours can take on physicians' personal lives.

We believe there is room in the health care system for a larger role to be played by mid-sized centres, and we believe Moosomin's situation is a model that could be applied to mid-sized centres across the province. Moosomin is in a unique position in two key areas: physician retention and the scope of services provided, and these two issues are interrelated.

While many communities the size of Moosomin — which our population base is around 2,500 — and even much larger centres sometimes have a tough time attracting and retaining physicians, Moosomin has not had such a problem in recent years. At present we have six resident physicians who work together, including a GP (general practitioner) surgeon, a GP anaesthetist, and a GP oncologist. Our physicians are young, most in their early to mid-30s. Most have been there for several years. And when we talk to them, they're very much involved in our community and they want to stay there.

The six doctors of the Moosomin Family Practice Centre serve five part-time satellite clinics in small towns in our area, including two in neighbouring Moose Mountain Health District and one in Elkhorn, Manitoba, as well as a separate walk-in clinic in Moosomin which makes physician services available to the public outside of normal clinic hours.

We want to stress a point. I just talked to one of the doctors yesterday and I quizzed on how many patient files they administer through their offices, and as of their last count, inventory which was done in early spring, they have over 15,000 patient files that they service in our area.

Having several doctors work together and operate satellite clinics in surrounding communities solves some of the problems that physicians often face in small towns. One or two doctors working in isolation, on call 24 hours a day, face a real danger of burnout, and sometimes physicians in these situations face difficulty covering weekend calls.

With a large enough group of physicians working together, there are lifestyle advantages for the physicians which makes practising in the community an attractive option and they can serve part-time clinics in smaller towns that might otherwise not have services of a physician.

I want to quote just from a couple of documents that we handed to you in support of our presentation and just highlight a couple of areas. One is from the town of Wapella. The highlight, it says:

> The Moosomin medical staff has greatly improved our medical services for our communities. They have reopened the operating room in Moosomin. They hold a clinic in Wapella one day a week (and my understanding is that those clinics are booked basically solid). All these facilities are used and appreciated by our residents. It seems that the operating room has been a success for the area and the health district.
>
> There are a lot of people in this area that work in the oil industry and they, and any other workers in this area are hurt, they need immediate medical attention. Thanks to the ambulance service we have and the fact that we have medical services a short distance away, these needs can be easily met.
>
> Also in rural Saskatchewan there's a need for more and

> more travel to other towns to acquire services needed. With more travel there is more risk of accidents, and for this reason also there is a need to have facilities close at hand.
>
> We know that it's not possible for a town the size of Wapella to ever be the home of a new hospital facility, so the people of our community have put time and money towards the hospital facility at Moosomin as we feel that we would be quite fortunate to have such a structure so close to us.

Also I enclose a report that's from the community of Elkhorn, Manitoba. And it just emphasizes again:

> For many years we had a small hospital and a doctor in our community. However, like many small rural communities, the ability to recruit and maintain a doctor in town is impossible. Our last doctor left in 1989, leaving the community with no medical services in town.
>
> Our committee met with the Moosomin Family Practice Centre and arranged for a satellite clinic in Elkhorn one day a week beginning in December, 1995. The service was well received and proved to be very successful with most days totally booked.

So those . . . I enclose the letters in there. Certainly, hopefully you will read all the content but I wanted to highlight those sections to you.

We believe that there's several reasons that physician retention has not been a problem in Moosomin. The physicians themselves have been very active in recruitment. The town has co-operated to help them practise in the community, make it financially attractive for them, and the wider range of health care services made available locally provides for a wider scope of practice for the physicians. And we emphasize — when we talk to each one of our physicians, they say what keeps people in a community is the scope of practice.

If services provided in centres like Moosomin are reduced as Mr. Fyke has suggested — he's also commented in our local media that Moosomin should be very well pleased and should be content with a community care centre — it would be difficult if not impossible to recruit and certainly retain physicians in our communities. The key to recruitment and retention of physicians is the scope of practice available to the physicians.

While the long-term trend in small communities across the country has been toward a more limited scope of health care, more services are now available in Moosomin today than were available just two years ago. I want to highlight a couple of key areas, which we believe, are very much appreciated by our residents, and that's elective surgery and also we have chemotherapy.

In November 1999, elective surgery began to be offered at Moosomin Hospital simply because we had an anesthetist and we had a surgeon. And procedures performed include pediatric dental work under general anesthesia — I'd better not read these, I'll get tongue-tied — but certainly a wide scope of minor surgeries, including the dental end of it. And I can't overemphasize the dental end of it has been very successful.

The surgery service began as a one-year provincial pilot project. The Health minister at that time, Hon. Pat Atkinson, said the Health department would be following this pilot with extreme interest and would provide ongoing provincial funding pending a positive evaluation. I'm very, very pleased to report that in February 2001 a very positive evaluation of the pilot was submitted by the Pipestone Health District to the government and requested ongoing funding by the government for this. To date, they have not received a yes or no from the government.

However, they took it upon themselves saying, it was less than $50,000 to keep that operating room running for a year and so they have taken it out of their budget to date, hoping to get it refunded by government. But they seen it was so successful that they continued it on out of their own local budget.

More than 160 procedures have been performed to date for patients across southeastern Saskatchewan and western Manitoba. The service was initiated thanks to the co-operation of the community, which raised the capital cost required to open the operating room, the health district, which administers the program, and also the provincial Health department, which funded our anesthetist's training.

Chemotherapy has been offered as a satellite service of the Allan Blair Cancer Clinic here in Regina since September 1999. The major capital cost for the special purchase of a special hood for the pharmacy department, training of medical, nursing, and pharmacy staff was also a part of the start-up procedures. And patients must come in to the clinic for the first time and after that, they can get that service right at Moosomin Hospital. Again, very pleased to report that over 21 clients have benefited from this with over 106 treatments performed within the local hospital.

Having these services available in Moosomin saves the health system money because procedures can be done at less expensive in a small centre than in a larger centre. It saves the patients money because procedures can be done closer to home without the added expenses of transportation to and from, and sometimes accommodation in a larger centre.

It benefits the physicians by allowing for a broader scope of practice, giving them the opportunity to use more of their skills. It benefits the patients because they can have minor surgery or chemotherapy treatments in familiar surroundings and cared by people they know. It benefits the health system by taking the pressure off larger centres where there are long, long waiting lists. And certainly I think we all know what the waiting lists are in Regina and Saskatoon.

Another key area is in Moosomin. I'm sure you all know where Moosomin is, but if you don't, we're in a unique geographic position. We're right in the eastern corner of the province. Our nearest city in travel is 150 kilometres away, and that's in Brandon, Manitoba. Moosomin is located 235 kilometres from Regina, 165 kilometres from Yorkton, 235 from Estevan. This distance is further emphasized by the present highway conditions in our area, in rural Saskatchewan as a whole.

Just as a point, I know that Mr. Fyke made a comment in the report saying maximum 60-minute travel time for 88 per cent of the population, maximum 80-minute travel time for 98 per cent

of the population.

Well in our geographic range, we're an hour and a half to two hours; we're two hours to two and a half hours; we're two and a half to three hours — depending on the road, the traffic, whatever. So we certainly are out of that geographic limitation that he identified.

We are located, of course, on a very busy two-lane stretch of Trans-Canada Highway, and the number of accident victims who have to be stabilized at the Moosomin Hospital before being transported to a tertiary centre continues to rise.

Our medical professionals have been commended by the head of the emergency department at the Regina General Hospital for their work in this area. And to quote, I've also given you a copy of a letter received by L. Vandervelden, manager of the RGH (Regina General Hospital) emergency centre, commending our physicians on the work that they have done in a recent trauma that was sent into the emergencies. And they have a very, very good reputation with the emergency department at Regina General Hospital.

We believe that the Fyke report recommended too many community care centres and too few regional hospitals. We believe our experiences in Moosomin prove that the services Mr. Fyke envisions in regional hospitals can be provided efficiently in smaller communities like Moosomin.

We believe there is room in the system for smaller regional hospitals in centres the size of Moosomin where reasonable pools of physicians can be maintained and a wide range of services can be offered. Physicians will only get the scope of practice they desire if there is a hospital located in that community where they have their practice.

The Fyke report recommended a radical reduction in acute care services provided in rural Saskatchewan but did not address the number of tertiary hospitals in Saskatoon, which there are three, and of course in Regina, which are two. With the population of Saskatchewan versus these two cities, we're just asking: is it economical to have five tertiary hospitals in these two centres, and are they being operated efficiently for the benefit of all Saskatchewan residents?

We realize that the terms of reference for the Commission on Medicare did not include the economic impact on rural Saskatchewan. However, in our talks with government people, and certainly within ourselves, we believe that approximately 40 per cent of the provincial health budget could be considered economic development.

In Moosomin's case, our health sector employs more than 200 people who live in 15 different communities in this region, making health care a major employer.

With this in mind, if the recommendations of the Commission on Medicare are implemented, it will not only mean fewer services available in rural Saskatchewan and greater distances to access those services, but it could mean the economic death of many communities in this great province of Saskatchewan.

To finalize our report, we want to again thank you for listening to our submission. We understand that your task in reviewing the representations on the final report of the Commission on Medicare and putting forward recommendations is a difficult one. And we appreciate that.

We hope that using, by using our community examples — and we firmly believe that Moosomin has some success stories — that of what is already working can assist you in finding solutions to the issues facing our provincial health care system. We challenge you to find solutions that will improve service standards and access to all Saskatchewan residents — and we emphasize that in both in rural and urban Saskatchewan — to a quality health care. Thank you.

The Chair: — Just one point, Mayor Bradley, before you move on. Your second to last paragraph talks about the commission . . . the standing committee putting forward recommendations. We're not charged with doing that. We're going to listen and report on what we heard. So we won't be putting forward recommendations.

Is there anybody further that wants to present?

A Member: — I don't believe so.

The Chair: — No? Okay. Then we have Mr. Thomson. Questions?

Mr. Thomson: — Thank you very much for the presentation. I suspect that what you've told us today in large part is very true; that I think when Fyke wrote his report he did not think about a situation like Moosomin's, which is very unique. Uniquely situated within the province; unique in that it deals with people on both sides of the border; and unique in that in the last few years you've obviously done a great deal of work in terms of attracting new physicians.

I guess part of what I want to know is — and excuse me if the question sounds naive — what was the secret to that?

Mr. Bradley: — Twenty-five thousand dollars over three years, and they had to stay the three years.

Mr. Thomson: — That's actually quite amazing, given that it's such a small amount of money for three years. So the idea is that $25,000 contribution and then they would stay for three years.

Mr. Miskiman: — I think if I can just add to that too is that certainly . . . It started off with two young South African doctors coming into our area. As a community group we met with them. They decided to come. We've made them feel a part of our community. We involve them in everything. They now are married; they now have children. Some of our doctors now have children going to school. So to make them feel very much a part of our community, and certainly they like the lifestyle.

Mr. Bradley: — And I think they've all bought homes in our community and we think they're going to be permanent fixtures.

Mr. Thomson: — Can I ask a question about district reform. I know that you didn't comment directly on it.

One of the recommendations in the Fyke report is moving towards larger districts. Listening to your presentation, you talk about obviously providing services to people in the Pipestone District, some in Moose Mountain. I assume there must be some of that perhaps as far north as that Esterhazy area.

The idea of a larger district, is there merit to that from the perspective you see, or not?

Mr. Miskiman: — Certainly we didn't speak to that, and certainly we see some efficiencies probably within larger districts. Again our district is a very . . . we are in Pipestone Health District which is a very long, narrow district. And the Moose Mountain one which takes in Wawota is very much more a neighbour to us than certainly, for example, Montmartre is, which is in our district.

So we see the Moose Mountain Health District and the Pipestone Health District having very, very similar needs and requirements and one that we can access both ways.

Mr. Thomson: — I have two other questions. One concerns how people access the services and just the way that the patterns work. Obviously minor surgery is able to be performed in Moosomin. Where is the centre people go to after that for the more major surgeries? Do they go to Yorkton or Brandon, or do they come directly into Regina?

Mr. Miskiman: — I think it's a combination of all three. They're given, the patient is given where their choices are. The doctors have specialists in all three centres that they'll refer to, so it's really the patient's choice.

Mr. Thomson: — My final question concerns a comment that you had made about the health care budget as an economic development tool. This is a debate that I've had for some time with our former mayor, Doug Archer, here in Regina who certainly shared that view, that health care can be and frankly should be an economic development tool.

I guess what I worry about is as we look at it, as we try and allocate resources provincially, I just want to make sure that what we're not advocating here or what . . . I don't think you're advocating is that we should maintain hospitals simply to maintain employment in local communities, that they have to be there to provide services.

Ms. Miskiman: — I know in our community it is a very high economic factor because it's one of our larger employers.

But certainly to justify that, scope of practice has to be made available. And again, when we talk to our physicians, always they say they don't have the scope of practice.

They get offers from Alberta daily, weekly; from the United States. They've got to make a comfortable living. They've got to have a scope of practice so that they aren't just sitting in there giving prescriptions. They've got to exercise their skills, right? And they've got to like the community they live in.

And our doctors to date, thank goodness, have quite enjoyed it. And when you get satisfied doctors in there, they build their practice and bring more people in.

Mr. Thomson: — Let me just conclude by saying thank you very much. I was very impressed with the presentation. It's obviously good work you're doing.

The Chair: — Thank you.

Mr. Gantefoer: — Thank you. And thank you very much for coming.

I wanted to pick up a bit on your recruitment and the retention of your physicians. I believe you're up to six physicians now and you indicated, as I understood it, you started with two South African doctors.

Are the other four members of the practice South African, Canadian, or a combination thereof?

Mr. Miskiman: — They're all South Africans. Yes.

Mr. Gantefoer: — Thank you. I had thought that. For a couple of reasons, I believed that to be true.

But the other thing that I found interesting is when you listed the GP specialists, if you like; a GP surgeon, a GP oncologist, a GP anesthetist, those sorts of things. Do you find that that is more common with South African-trained physicians, that they do a broader scope of practice, they're trained to a broader scope of practice?

Quite often I hear of Canadian trained or more urbane doctors that they get into almost a specialty mindset as general practitioners instead of having that broad scope of practice. And I heard you talking about that that is a real important dimension of their practice, that they get to experience that wide scope of practice and are challenged by it.

Is that a part of the secret of your success?

Mr. Miskiman: — Yes, I believe that certainly the South Africans, besides what we found in our . . . being excellent doctors and they're well trained, certainly they do come with . . . for example, we have one more doctor that has taken quite a bit of anesthetist's training over in South Africa; that if we can get this Commission on Medicare dealt with and laid to rest to a certain amount and assure that there is going to be facilities in Moosomin, he's prepared to go to Saskatoon and upgrade his skills and come back as soon as there's guaranteed that there's going to be scope of service there, and all of a sudden we've got two anesthetists, you know.

So they do come well educated, certainly want to upgrade their skills, and want to really provide good quality health care to the people they serve.

Mr. Gantefoer: — I wonder if that's part of the piece to the puzzle, if you like, of delivering quality health care and a wide range of practice. Because I think it strikes me as that in a number of communities, not just your own, where there are rural family physicians, general practitioners, they tend to be most satisfied because of the broad scope of practice.

And that maybe differentiates them a bit and maybe there's some work that needs to be done in our College of Medicine in

terms of the kind of training we do to rural practice. And maybe we're missing the boat in that part of the real dynamic of a viable and dynamic smaller centre that offers a wide range of services is this training component and maybe that's part of the puzzle.

Mr. Miskiman: — That could be. Certainly I can't overemphasize it and our doctors say a six-person practice is almost a minimum because what that does allow them to do is still have a life. They aren't on call constantly; they get weekends off. They can afford to — because they are busy all the time — they can afford to take a month's holiday and just get away from it, and there's still ample doctors back there to serve the people.

So certainly the number of doctors dictates lifestyle benefits and is an attraction to other physicians.

Mr. Gantefoer: — I think in a broad scope of practice there has to be the support service as well. There has to be access to laboratory testing in a timely way, radiology, some of those sorts of things as well.

Has your community been successful as well in making sure that you have the, you know, the technician support, the lab support, and things of that nature so that they can get the tests that are necessary for their scope of practice to happen in a timely way?

Mr. Miskiman: — Yes. We've always had a very active lab there. And we have two pharmacists — or one right now and we are trying to recruit another pharmacist. We've had X-ray there. So we have qualified technicians really which is kind of what Mr. Fyke refers to as that team of . . . requirements. And I can't agree with that more.

Mr. Gantefoer: — Finally, doctors can't practise without the support of a good team of nurse professionals. And in some communities that is getting increasingly difficult. There may be spouses of people that are in the community or people that indeed want to practise. But how are you making out in terms of keeping an adequate supply of nurse professionals as well in order to make sure that the whole package fits together?

Mr. Miskiman: — Again I guess we're maybe fortunate in that area, that we have good nursing talent.

Certainly we're concerned by the age. Certainly the nurses' ages are escalating up there with fewer younger nurses coming in. But we have had a number of younger nurses come.

But it takes . . . When in our hospital it doesn't allow for full-time work necessarily right away and usually it starts off with part-time, and that's where it's extremely difficult to attract somebody from a city or somewhere to come for part-time work, for example. So it has to come from a spouse or somebody moving to the community.

But we're very fortunate to have an excellent core group of nursing staff. Actually with the reopening of our operating room, it's necessitated them to go away and get further training which has helped their attitudes, I guess. They also want to learn more. So we've been fortunate in that area.

Mr. Gantefoer: — Thank you very much.

Mr. Newman: — We've been able to recruit doctors. And if we're able to figure that one out, we should be able to figure the rest of it out. And really it takes a little bit of money, but more than anything else it's pride in what they do and it's the variety of the job, you know.

It's like any other job. If you're putting a bolt here and putting it into the same spot every day, how many people . . . you know, and it's better off if you get a little bit of variety. And that's why our doctors, they've emphasized it to us many, many times, that it's the variety of the practice, it's the scope of the practice that is the main reason why they're staying in Moosomin. Thank you.

Ms. Bakken: — You indicated that this was a one-year pilot project that you were involved in. Is there . . . was there any contact from Mr. Fyke asking you how this project is going and is it working and how did you make it work? Was there any input on . . .

Zero. There was no contact by the department or . . . I would have thought that it would have been a starting point.

Mr. Miskiman: — . . . Mr. Fyke, Moosomin is his hometown. And he just happened to be home during last summer to a reunion, high school reunion. And certainly the mayor and I know our reeve, Sinclair Harrison, certainly made him aware of that, you know, come and see what we're doing here. He didn't come.

Can I just make one point on the operating room too — is that that operating room, again, we had to fight tooth and nail to get that up and running. The community had to raise the dollars, which was around $100,000 worth of community monies had to go in to get the operating room up and running. Okay.

We didn't get any help from anybody else, except our doctors wanted to do it, the community wanted it to happen. We did it ourselves. You know, the Minister of Health allowed it to happen, took a look at it. Very, very, very, very successful.

Mr. Bradley: — And at little cost.

Ms. Bakken: — And this . . . (inaudible) . . . that you have for operating costs, is that administration? Is that what you're indicating there?

Mr. Miskiman: — That's for nurses' salaries, and most of the training's been done and . . .

Ms. Bakken: — That's including salary?

Mr. Miskiman: — Yes. Mind you, it's only open half a day. It's open Thursday mornings.

Ms. Bakken: — Just half a day a week?

Mr. Miskiman: — Half a day a week, so there's usually about four, maximum five surgeries done in a week out of there.

Ms. Bakken: — Is there a call for more than that?

Mr. Miskiman: — We believe there is. Our doctors say there is.

Ms. Bakken: — But this is . . . you're limited to this amount of time. You've been . . . this has come down from your health district or from the department, or who has given this direction?

Mr. Miskiman: — Basically direction, as far as I'm aware of, comes from the health district.

Ms. Bakken: — My one final question is, the recommendations made in the EMS report, have you looked at that and what the impact that would have in your community — emergency, medical, for ambulance, that report — and what the impact that would have on your community, have you looked at that at all?

Mr. Miskiman: — No, we haven't. We stayed in an area that we were very, very, very familiar with.

The Chair: — Thank you.

Hon. Mr. Melenchuk: — Sure. Just a couple of quick questions. How many acute care beds do you have at the Moosomin Hospital?

Mr. Miskiman: — Right now we have 33 acute care beds.

Hon. Mr. Melenchuk: — And the next question is, what is your average daily census for your beds?

Mr. Miskiman: — You're asking me a tougher question.

Mr. Newman: — We're not qualified to answer that. You can get that from the health district. But I think right now it's running at 20.

Hon. Mr. Melenchuk: — Yes, that was the understanding that I had was roughly in that range as well.

So you believe with the initiatives that have come forward with practice location grants, the on-call stipends that have been negotiated between the Medical Association and rural physicians, that this has enhanced your recruitment and retention of physicians in Moosomin?

A Member: — No question about it.

Mr. Miskiman: — Yes. Can I just make a point, Mr. Melenchuk.

We are very, very actively . . . we're in the planning stages of the integrated facility and what that bed number is that we've basically . . . it has been suggested is 27 acute care beds.

The Chair: — Thank you. Seeing no more questions, on behalf of the committee I thank you very much, all of you, for coming and presenting today. We have our next presenters ready to go so we'll say good-bye to you and thanks again.

Good afternoon and welcome. This is the Standing Committee on Health Care. I am the Chair, Judy Junor. The other members: Dr. Jim Melenchuk, is the Vice-Chair; Andrew Thomson, Warren McCall, Buckley Belanger, Brenda Bakken, Bill Boyd, and Rod Gantefoer. It's an all-party committee of the Legislative Assembly and our first task is to receive and report on responses to the Fyke Commission.

Our presentations are limited to 30 minutes and that includes your presentation and questions from the committee. If you want to introduce yourself, where you're from, and what office you hold perhaps, then you can begin your presentation.

Mr. Rourke: — Yes, I'm Brian Rourke. I'm the Vice-Chair for the Saskatchewan Health Information Network.

Ms. Lipon: — I'm Shelley Lipon. I'm the CEO of the Saskatchewan Health Information Network.

Dr. Kendel: — I'm Dennis Kendel. I'm one of the members of the board of directors of SHIN (Saskatchewan Health Information Network).

Mr. Rourke: — Our Chair, Jack Grossman, had hoped to be here today but unfortunately he's tied up in business so he sent Dennis and I along as a couple of pretty faces to support Shelley, although I guess if you look at us you realize maybe just a couple of thorns on either side of a rose. Anyway Shelley's going to make the presentation.

The Chair: — We also have your written submission. Thank you.

Ms. Lipon: — So good afternoon. I'm pleased to be able to make a presentation to this committee today. The SHIN board and management team believe that SHIN can play a significant role in addressing many of the recommendations that are contained in the Commission on Medicare report.

SHIN was originally created to address the need for effective and efficient services within the health sector and to help ensure Saskatchewan has a sustainable health system.

Across the province 33 different health regions are providing care to Saskatchewan people, but currently we have no way of looking at how we might do a better job or how we might ensure that we are not duplicating effort.

We also have no way of ensuring that providers treating patients have all the information that they currently need. One of the significant areas, in particular, is around the drug area, and the fact that there are no drug profiles available to many of our providers at this point.

Because we have no way of consistently comparing at how services are currently delivered across the province, we have little ability to contain those costs. An integrated health network will provide the province with a better picture of Saskatchewan's health sector and ensure patients have the highest quality of care. All the provinces have started to realize this and there's tons of work being done right now at the national level, which I'll talk about in a little bit in the future.

I think Saskatchewan has taken some really significant steps in this. And I'm going to go through six of the recommendations in the, in the — I like to call it the Fyke report — but the Commission on Medicare and talk about some of the things

SHIN is currently doing and some of the recommendations we might have in areas that we currently don't have in our budget, but the various parties might want to consider.

With regards to recommendation 1 around primary health services and the 24 on-call service. When we looked at that, we started to look on the various projects that we're currently working on. And I think the biggest one that we're doing right now has to do with the rollout of CommunityNet.

One of the areas around things you have to think about with regards to primary care is whether or not the primary care team actually sits all in one location or whether they're actually across the continuum of care and still out of multiple locations. And SHIN is leading the rollout of CommunityNet right now. This particular rollout will ensure every health facility has adequate bandwidth within three years.

Right now, SHIN, together with the districts decide where the priority facilities are in the priority communities. And if primary care sites were put on as a priority by the government, we would be able to help facilitate the moving of those locations up the priority list.

One of the areas where we're already doing some work in the primary care area is with the Department of Family Medicine in both Regina and Saskatoon. They currently have hosted at the central host site in, for SHIN, a practice-management system, which not only has the business side of what you do in a physician's office but also has the clinical side. So on the business side with regards to scheduling and those types of things and then the clinical side with regards to charting. That particular system is hosted centrally from SHIN and to roll that out to other primary care sites would not be a large capital investment at this point.

On the physician side, we are working with the Saskatchewan Medical Association right now. And what they are looking at is a way to get physicians but could easily roll out to other types of providers as well. How do you get them to actually use information technology? What do you do to get them to be able to bring it into their everyday workload?

And they're looking at what's called a common desktop right now. And it includes a whole bunch of different types of resources. It includes the business side of how they do business. It's includes the clinical side and it also includes the knowledge management side.

Right now if you go into the Internet and you went on Yahoo! and you put in diabetes you would come up with an astronomical amount of hits on the sites. What these knowledge-based tools that are built for health care providers do is they streamline the search engine to go to just credible sites that you would actually use and you'd be willing to give the information to your patients.

That particular pilot's going to roll out with 75 to 90 physicians across this province to look at how they might integrate information technology into their everyday work. We are of the opinion that, frankly, that type of a project or that type of desktop could easily be used well beyond physicians and into the nurses and the other types of providers that we have.

One of the things we've found to date has been that we figure you get three tries with regards to health care providers. If they get frustrated three times, they'll go back to using manual processes and they won't use information technology tools. So SHIN has spent a lot of time and effort in building the support that goes behind the deployment of information technology tools and have built a health desk that eight of the districts currently use. We hope to have 20 on by the end of the year.

What this does is it gives the place the 1-800 number. It gives the user the ability to call that right up and find out how they can quickly rectify their problem. This support . . . the processes and the capital investment made has already been made in this. And really adding on extra users is just a matter of adding on extra staff to answer the phones. So I think it would be quite easy to do.

On the call centre side, we currently have a master services agreement with SAIC (Science Applications International Corporation), an integrator out of San Diego. They have extensive experience in the call centre area; have deployed a health call centre for the veterans in the States.

And when we talk about call centre, we're not just talking about telephones. We're talking about all types of media coming in. We're talking about the Internet and the ability for whoever's answering those calls to go in and get the information they need through the Internet and the search engine that have it at their fingertips. SHIN is certainly positioned well as a project management office to handle that type of a role of any type.

With regards to recommendation two around specialized services, I think the key to around specialized services is if you're going to have specialists only in certain areas of the province, you need to be able to pass the information around so that they can actually make the diagnosis. The electronic health record is crucial through any type of rollout that goes out with regards to specialized services and positioning that.

SHIN is positioned well in a couple of areas. We are currently in the second stage of procuring an integrated clinical system for the five mid-sized districts — or what we call the five mid-sized districts. That includes Yorkton, Prince Albert, Swift Current, Moose Jaw and . . . (inaudible interjection) . . . North Battleford, thank you.

This particular system will be an electronic health record. It will include information around registration, lab, pharmacy, home care, operating room scheduling. And it will bring it all into a common view. It'll be deployed as a district system, no longer a facility system. It'll go across the continuum of care and the information will be integrated across that.

We expect implementation to start in October. The idea is that this system will be the platform that is chosen for all of Saskatchewan except for Regina and Saskatoon. And the reason that the two large tertiary care districts have been left out is that they've already got huge investments in a lot of those feeder systems. And all you really need to do is pull their systems together into an electronic health record. A lot of those mid-size districts don't have these investments, and therefore we're going out and looking for a totally integrated system.

It is thought that this will be rolled out to the entire province within three years, depending on funding of course.

The speed at which this rollout can happen . . . Obviously if you get more funding, it can happen quicker, but that's not always the case. What we're finding in many cases is that you need resources, you need nurses and physicians and people who use the system to help you implement the system. And because they're taxed with time right now, it tends to make things a little bit slower.

The other area, certainly around specialized services, is in the Telehealth area. Some of the provinces, particularly Nova Scotia has had great experience with the Telehealth area. And not necessarily with the Telehealth really sophisticated tools. What they've had really experiences with . . . it's just basic videoconferencing has been one of their greatest successes. And they've used it for specialists such as dermatology, psychology, etc.

And what we would suggest is, as CommunityNet rolls out, we would suggest that the province look at basic videoconferencing to support some of the decisions made around specialized services.

The scheduling and co-ordination and support could be handled out of the SHIN health desk, and I believe that there are some partners at the table such as SaskTel that would be willing to look at some of those investments.

Included in the district integrated clinical system is a module for operating room scheduling for those five districts. Now whenever we talk about that, people right away start to think about waiting lists. And I think this is a tool that will help you be able to manage the waiting lists. But one of the things we'd have to point out is that in order for any of these tools to work, the standard protocols need to be put in place.

The Western Canadian wait list project has established a framework for this, and those types of rules would have to be in place in order to make an operating room scheduling actually be able to have any impact at all in a waiting list system. So the tools are being procured, and then we'll have to look at how the standards go in.

The third recommendation around health goals and health strategies . . . and northern health strategies. SHIN was developed to enable a database and data collection. It was talked about a lot in the original SHIN vision.

One of the things you need to do is, if you've got databases all over the place, it's pretty hard to aggregate data, so we're very much rolling out with a centralized approach to that. It doesn't necessarily mean that everything sits in one database, but at least it sits in separate instances so that you can easily bring that data together.

Without information on the factors affecting the health of Saskatchewan people, it's difficult to plan around the health promotion and disease and injury prevention strategies.

So a lot of the things in the Fyke report that talk about measuring and health goals and stuff, we think there's going to have to be a lot of work done around the databases in order to actually be able to achieve many of them.

There has been a Northern Telehealth strategy and a Northern Telehealth project that's been going on for the last couple of years. It's been quite successful, but it's been focused to the North, for sure. And I've already talked a little bit about how Telehealth actually could be rolled out across the rest of rural Saskatchewan, not necessarily just in the North.

There are some northern areas that haven't been touched at all and we'd recommend that those be addressed. The rollout of CommunityNet, probably using satellite technology in the northern areas, will help that become a reality.

Reports on measurable health goals can only be developed through the access to reliable and accurate data. And I'll probably say this 10 times throughout, is that we can have all these databases, but if they're not standard, it's almost going to be impossible to compare anything.

So that's why it's so important that the province get together and when we buy a common system, not only do we buy a common system but we integrate it and we deploy it the same. So we get business people together to talk about how we're going to enter data and how we enter data similarly across systems so that we can actually compare data.

There's a lot of work being done on data standards. Nationally, we're trying to get some standards on the go, certainly in the pharmacy area and in the lab area and the software vendors whom we buy all these products from, because gone are the days of building. And in most cases, they're waiting for the provinces to get their act together around the data standard area so they can build to those standards and each province doesn't have a different standard.

I would suggest that, once we get the five mid-size districts implemented and we have something in Saskatoon or Regina, we might want to look at HSURC (Health Services Utilization and Research Commission) or some research and analysis area to do a pilot around some data warehousing in mining tools to see exactly how we might de-identify data and be able to use them for research and planning processes.

Number four is talking about performance indicators, quality council, etc. Without SHIN, I'd say it's almost difficult if not impossible to achieve. SHIN will provide the ability to collect the data for health research and measurement. This data will have to be done, like I say, consistently across the board. An annual report on the health system would be difficult without that. We can provide the vehicle for people to be able to do that in the long term.

I've talked about the integrated clinical system. One of the rules or one of the kind of getting everybody in the room and saying okay, we've got five districts here, we're going to implement this thing is it's a common implementation. And that sounds easy to say.

But frankly what that means is that five registration people who are responsible for registration of those districts are getting together to talk about what is the common business process

we're going to use to do this, and five lab people are getting together to talk about that. And we're also bringing in Regina/Saskatoon to talk about how that data would flow.

So that I would say the business re-engineering piece of that is by far going to be the most difficult, but I think is going to be by far the longest term and the ability for a quality . . . (inaudible) . . . to ever be able to measure anything.

SHIN is currently already hosting the MDS long-term care assessment tool which provides RUGS (resource utilization groupings) scores or what they call utilization scores for long-term care patients. It's centrally hosted at SHIN right now. We've got about a third of the districts on and we'll hope to have most of them on by the end of the year.

The idea of moving to that assessment tool was so that that exact thing could be done, so comparison of scores across the province could be done. And we've already started to do that.

The two biggest areas of any electronic health record is probably pharmacy and lab. If you ever talk to any provider, they'll say, you give me pharmacy and lab electronically and I'll use a computer. I've heard that about a hundred times.

With regards to the pharmacy side, Saskatchewan has been pretty open about saying that we're not going to build one. BC's had one running for about five years. Alberta has spent about $50 million building one and are just ready to deploy. We have started discussion with Alberta around getting a licence to use their system.

One of the things around the collaboration and the national efforts that are going on is in fact that you need to collaborate. You shouldn't . . . every province shouldn't go out and build it themselves or buy it themselves. So we plan to implement a pharmacy information system.

We had a three-year plan go last fall to cabinet. In the year 2/3 we talk about beginning that implementation. That particular system will give drug profiles to the providers when they are providing service. Every drug that is dispensed and every drug that is prescribed will be on that system. And there is a whole bunch of benefits to that.

It will allow drug interaction type functionality to happen right there when they're deciding what they should prescribe. One of the big areas that Dr. Kendel has talked about a lot at our board meeting has been about the reduction in errors by having drug prescriptions done on-line versus the writing that goes on right now. There's been tons of research done around that and the numbers are quite astronomical.

SHIN is currently in the process of setting up a steering committee with all the parties in this particular area that will look at the governance around that. Who's going to own the data if it's held provincially? In BC right now the College of Pharmacists is the area that is the control over that data, and so we're looking at those various things.

But the pharmacy information network system is an expensive system. It will require a huge investment. Even if we get it from Alberta for free, the licence, the amount of work for implementation is huge, and that was in year 2/3 of our plan.

The second area is lab results. Lab results are certainly a little more immature across the nation. It is . . . There has been some initial work around allowing lab results to be accessed electronically, but there hasn't been as much work done around the lab standards. There certainly . . . BC has done some work around lab standards and they are moving forward with a western project to look at the standard and hopefully move it nationally.

In year 2/3 of our plan as we talk about the building or the starting to build of a lab results repository which will make all the lab results, regardless of whom . . . who has ordered it, available to the provider, given the appropriate consent and the appropriate security around it, again, that is a significant project and the standards have to be developed before you would go in and spend a lot of money around it.

In recommendation 5 it basically talks about the electronic health record. SHIN was mandated to develop the provincial electronic health record. A three-year plan to achieve this was presented to cabinet. It ranged with operating dollars from 5 to 9 million per year, and development dollars of 7 to 12 million over those next three years. If those are implemented the way that they were recommended, we would be well on our way of a provincial electronic health record.

And when I say provincial electronic health record, I don't mean one big database with all the data in it. What I mean is that there is integrated records where people actually provide their service.

So for instance, 99 per cent of the service you get will likely be in the district that you live in and your data would sit there. There will be some things that will sit provincially such as drugs, such as labs — those will be integrated with those systems. And then there'll be some things that'll sit in your clinician's office or your doctor's office.

And potentially in the long term, I think this will likely be a national minimum data set that will be set across the country. In the long term, there might be some key minimum data set of data that we decide, provincially, it makes sense to have and sit provincially. If I end up in a different district in an emergency situation, they might want to know my name, my address, perhaps allergies, just that minimum data set — it's not my whole record but what they would need in order to serve me.

And in the long term if you kind of read the public . . . or the Canada Health Act and they talk about the ability to go across provinces in the long term, if I end up in Calgary, is there a piece of minimum data that they could have about me if I was in an emergency situation.

That is talked about in our plan in year 2/3 as well. You might say, well you'd need to have the integrated electronic health record across the province before you can do that. But we might be able to start it a little bit earlier if that was the decision.

Around Saskatoon and Regina, we are in the process and ready to go live in . . . we're potentially focusing in October to go live around an electronic health record. Like I said they've invested

a lot of money in their feeder systems like lab, like pharmacy, like registration.

But even in Saskatoon, who we quite often say is very mature in the information technology area, if you go to St. Paul's Hospital today and you were at Royal University Hospital yesterday, they don't got access to the data. They're still phoning over for a chart.

So where SHIN is playing in that area is very much at the integration level or bringing their silo systems together so there's a common view. That particular system has been . . . the interfaces have been built. It's bringing in lab data, transcription data, and registration data. It's going to be deployed in the St. Paul's emergency room. So all of that data from that district will be available to those physicians if you end up in St. Paul's. It'll also be deployed in the health records area.

The majority of the capital investment that has to be made in something like that is in building those interfaces. To deploy that part of that functionality across the district would just mean workstations, if they didn't have any, because you've made that investment already in the interfaces.

The next stages would be looking at adding radiology, adding pharmacy information, X-rays, all of the types of things that physicians will want in moving away from that paper chart.

On recommendation 6, we talk about primary services. We talk about changing sustainability, etc., etc.

SHIN provides better information to health providers. It supports changes in where and how primary and specialized health services are provided. Further investments in research won't provide better information unless we actually put the tools in and we strategically decide how to do it together.

I think we positioned well with the districts. We've got the framework in place to get people to work together. Those five districts have agreed to not go out and buy other systems. They have agreed to play and move ahead in a provincial manner and implement the same. The small districts are all just waiting for when it's their turn to move ahead.

I think we're well positioned to support the recommendations within Fyke. Quality, accuracy, and reliability are the key to making informed funding decisions and that's why I think it's important that we do this very strategically.

I'd recommend in this area that once you've got your clinical systems in, you need to integrate your clinical systems with your financial systems. We right now very much have . . . you know we have our clinical systems, lab, pharmacy, all silos. We're trying to bring them into an integrated system.

And then we've got the administrative system sitting over here. We have no way of knowing how much our services cost because our financial systems sit over here and our clinical systems sit over there. So the next stage will be integrating those so that you know so-and-so came into the hospital, had this type of a diagnosis, and this is how much it cost the system.

It doesn't mean that we're comparing or changing the same way that the States are going but we still need to know, in order to have a sustainable health care system, how much each service is actually costing us.

The information gathering tools and the IT (information technology) tools I would say are all there. Everything that you need to do around the information technology is already available and has been tested, but it requires a lot of collaboration, it requires a lot of buy in from both health providers and senior management in all of the districts and the various agencies in order to make this work.

It also requires a Health Information Protection Act that not only protects the privacy of individuals but also allows the most efficient health care to be provided. And currently there is a review been going on around the regulations and the Act, and from a SHIN perspective, the way it can be interpreted at the way it's written right now would be quite costly to implement and hard to ensure compliance. And we very much support the review that's going around the Act right now to ensure the regulations are put in place that we can actually have an Act that protects the individual and its rights to privacy as well as the ability to receive quality care.

The SHIN board recommends that information technology be considered for all of the work plans that are currently being developed for the Commission on Medicare, and we would be available for any assistance that any of the work groups need as they move forward. Thank you.

The Chair: — Thanks very much. Questions.

Mr. Gantefoer: — Thank you, Madam Chair, and thank you for coming and talking about SHIN. I think that in Fyke and in some of the presentations we had today, the need for an electronic network to sort of link all of the services between communities, between various practitioners, has been stated as one of the priorities that needs to be looked at.

I think there are, as you will know better than I, detractors of SHIN who've said we've spent a whole whack of money so far, and we have little tangible results other than pilot projects, and maybe better defined ideas.

I heard you saying two to three year go-forward plan. What are we . . . is the two or three years going to be when we have an operational system in place in its broad sense? Or where are we going to be in two or three years, and how much more will it cost to get to that stage?

I think people are really looking to say, when is this system going to be up and running and beyond the pilot stage?

Ms. Lipon: — If we . . . the way the strategic plan went into cabinet, it talked about having an operating budget of 5 to $9 million for the next three years, and a capital investment of 8 to $12 million.

If we had that investment, there would be an integrated electronic health record across the province by the end of three years, assuming — now I'm going to put a caveat on that — assuming that the provider resources are available to implement it because that has been a huge issue for us as we move

forward.

You need nurses and physicians to do this, and they've got regular jobs. So they can't just work on helping to develop and configure the system. So that tends to slow us down. But if that investment was made and the resources were available, we would be three-quarters finished and you would just be adding on the specialty types of things on the end.

The thing with SHIN is that we have built a huge operational side of it. You don't just put in these systems and then walk away. You need to operate them, you need to support them, you need to upgrade them. And that's very much where a lot of our budget and resources end up going.

But in particular we will begin implementation of that integrated system in a . . . one of those mid-size districts this year. And I hope to have something completed by the end of this fiscal year. Those will actually be systems that are in the hands of providers.

Dr. Kendel: — One of the unfortunate misperceptions, I guess, when SHIN was launched, that it would be sort of on a big bang concept, that there would be a definitive date at which point we'd all be wired and connected and everything would be integrated. And I guess, as those of us who have worked on the board for some time have come to appreciate, that's not the way those systems develop. They develop incrementally.

And so it's more likely that we're going to see components of a system — for instance, the drug database and perhaps lab database — be operational much longer before you would actually have a system where you could access, you know, the notes that a doctor puts into a record, because that's probably the most difficult thing to capture because you're trying to involve so many different clinics that are at such different stages in terms of their use of electronic technology.

So it's going to happen more incrementally, probably, than people believed at the outset. And I think the expectations that were created at the outset were somewhat unrealistic, actually.

Mr. Gantefoer: — Thank you. The question that falls from that: I heard the response that given the budget support you've asked for, two or three years and the core of the service at least would be up and running on a province-wide basis. And I appreciate Dr. Kendel's comments that there will be incremental additions to that core service as time evolves.

I also understand that it's very important that there is integration interjurisdictionally in the province and also outside of the province and some of the western work that's been done and the national work. You talk about sort of where your . . . and the issue of privacy and where your core records are held. And I heard you saying that basically it's held in your health district.

Is there . . . you know, our society is pretty mobile and I know all of us travel a great deal outside of our home health district and, very often, incidents happen and that there is a need for timely access to more of our records than this core record that you were talking about. How is that going to be contemplated in order to accommodate those realities?

Ms. Lipon: — Maybe I'll just clarify. The difference between where it's held and who controls it . . . (inaudible) . . . something I should have made . . . we're rolling out with a centralized approach so records will be held in a SHIN data centre likely everywhere, except for Regina, Saskatoon in the long run.

The control of them will be the trustee, which is the district. So your main record might be controlled by your district.

And how would you have the ability . . . I guess the question is if you end up in another district that you can get access to that. And I think that'll be built around the processes. I don't think information-technology-wise, that's going to be a tough thing if they're configured the same. It'll be the rules that are made by the providers to allow it to happen is going to be the harder thing.

And so I think we're going to be set . . . if we have all the lines in place and the appropriate security in the lines, we'll be able to transfer that data easily. But the rules behind it will be the more difficult thing, I think, to get in place. So I think information-technology-wise, we'll be fine.

The Chair: — Other questions?

Hon. Mr. Melenchuk: — Just one question with regard to the pharmacy program. How close are you to actually having the Alberta model licensed here?

Ms. Lipon: — We've had numerous discussions with them. And the interesting thing with what's going on nationally is there was $500 million by the federal government put into a separate corporation to invest in health IT, I'm sure most of you are aware. One of the caveats they say they're going to put on the money is that collaboration has to happen.

Now I sit on a national electronic health record working group, and lab and pharmacy are the two priorities that have been talked about for the last two years. There's no question in anybody's mind that Alberta is leading in this.

We've had discussions with Alberta around getting it licensed. I think we're very close to getting that. And the reason is is that they're having problems getting their pharmacy vendors to change their products to work with the system because pharmacy vendors, a lot of them are chains and they're getting a little tired of having Alberta come and ask for this change and then Saskatchewan come and ask for a different change and then BC come and ask for a different one. So I think we're very close to getting it licensed — I would say within the next year, very likely.

But I think, what we're hoping for Alberta and ourselves is that the national are going to come to the table and want to license it across not just Saskatchewan and Alberta but across all the provinces so that we can use it. And they'll use some of that money to help leverage on that. That's what we're hoping will happen.

Hon. Mr. Melenchuk: — And one other question. In terms of the ability to provide the information support to a Fyke-type system, how far along do you think you could have a fully

integrated system? Would it be a year or two or three down the road? And I'm talking pharmacy, lab, personal health record, the information or the accountability and The Privacy Act changes that probably need to happen. How soon would you see that in terms of a roll-up?

Ms. Lipon: — I think the answer I gave to Mr. Gantefoer is that if you had the funding, within the end of three years you'd have a really good core and you'd be able to actually do some analysis for quality in health reform goals for sure at the end of three years given the funding.

The Chair: — Thank you. Seeing no further questions, on behalf of the committee, thank you very much for presenting and for your written presentation.

Good afternoon, and welcome. I'm Judy Junor, Chair of the Standing Committee on Health Care. The other members of the committee are — Dr. Melenchuk is the Vice-Chair — Andrew Thomson, Warren McCall, Buckley Belanger, Brenda Bakken, Bill Boyd, and Rod Gantefoer.

The Standing Committee on Health Care is a legislative committee of all parties and the first order of business that it was charged with was to receive and report on what we heard, our responses to the Fyke Commission. Our presentations are half an hour and that includes your presentation and questions from the committee members.

If you want to introduce yourself and where you're from, then you can begin your presentation. We have your . . . we've passed out your package, and thank you very much.

Ms. McKinnon: — I guess I'll start. I'm Sherry McKinnon. I'm the executive director of the Arthritis Society of Saskatchewan Division.

Ms. Adams: — My name is Donna Adams. I'm program coordinator of client services in the education department.

Ms. Osberg: — I'm Janine Osberg. I run the exercise programs within Saskatchewan. As well I am the Chair of the Arthritis Action Plan Committee of Saskatchewan.

Ms. McKinnon: — I'll start the presentation. First of all I would just like to, on behalf of the Arthritis Society, acknowledge our appreciation and thank you for this opportunity to speak to you today.

In the commission's report, *Caring for Medicare: Sustaining a Quality System*, references to chronic disease were made, examples of health issues were utilized; however the role arthritis plays was not recognized.

Today over 140,000 individuals in Saskatchewan have arthritis. Prevalence rates show that osteoarthritis affects one in ten individuals, meaning that there's a hundred thousand people in our province with that disease. Rheumatoid arthritis affects one in ten individuals, meaning that there's 10,000 individuals in Saskatchewan with that disease. Juvenile arthritis affects one in a hundred, meaning that in our province we have over a thousand children suffering from arthritis.

The number of people with arthritis will increase at a rate of one million more Canadians per decade, at least until the year 2031. Between 1991 and 2031 the number of individuals 45 to 54 years of age diagnosed with arthritis will nearly double.

Arthritis is the third most frequent reason for prescription drug use in Canada. Arthritis is the second most frequent reason for the use of non-prescription medication. Arthritis is one of the most frequent reasons for consulting a doctor. Arthritis is the most common cause of disability in Canada. Arthritis and other musculoskeletal diseases rank second among the four most costly diseases in Canada in 1993.

In 1997 the staggering cost to the health care system indicated that arthritis could be swallowing up more than 10 per cent of the total health care cost.

Arthritis is a serious problem and a growing one. Arthritis ranks high as a cause of illness, disability, and health care use. The incidence of arthritis in Saskatchewan's aging population is poised to become a health care issue of critical importance. It is time to stop treating arthritis as an ache or a pain and make it an important part of the new health care agenda.

The society recognizes the importance of early diagnosis, treatment, and implementation of a disease management program and the major impact they have on the function and quality of life for patients with arthritis. In the case of rheumatoid arthritis, these factors can prevent irreparable damage and major economic loss.

The Arthritis Society would like to see a health care system that no longer sends individuals home not knowing what kind of arthritis they have, but rather employs a pro-active and integrated primary health system which provides the patient with the information and supportive services required for them to become an active participant in their disease management.

In the area of specialized services, the Arthritis Society would like to emphasize the importance of the health care system recognizing the specialized services involved in the treatment of arthritis.

The health care system needs to maintain an adequate level of rheumatologists, orthopaedic surgeons, and rehabilitative services to effectively treat arthritis.

Currently the waiting list for hip replacement surgery in Saskatchewan is 61 weeks. It represents the longest waiting period in Canada.

The importance of access to appropriate medical treatment within a reasonable time period without additional financial burdens being placed on the patients cannot be underemphasized. Individuals waiting for joint replacement suffer economic hardship, develop other health-related problems because of their limitations and suffer damage to other joints resulting in loss of quality of life and additional health care costs.

The Arthritis Society would like to see a province-wide arthritis treatment strategy developed that ensures equal access to quality services and long-term sustainability for specialty

services for patients with arthritis.

In addition to access to primary health care and specialty services, it is also important that individuals with arthritis have access to new medications and therapies. It is imperative that arthritis patients have equal access to new arthritis drugs and are not excluded because of limited income. New medications can help improve the quality of life for individuals with arthritis and reduce health care and disability costs.

The Arthritis Society in Saskatchewan was established in 1949. Our mandate is threefold: to support research to find a cure for the over hundred different kinds of rheumatic disease; to help individuals with arthritis today; and to revive prevention programs that will help reduce drug deterioration and damage.

The society is a hundred per cent public funded. It is through the generosity of the people of Saskatchewan that we're able to support research, client services, and education programs.

The society offers a variety of programs to help individuals with arthritis, and they include an arthritis self-management program, which includes a pain management information section; arthritis exercise programs; arthritis information line and referral services — it's an information line which is answered by a registered nurse; lenders' libraries; support groups; Web site; informational pamphlets on types of arthritis, treatment, medication, disease management and coping techniques; displays; workshops; presentations; prevention programs such as sports body basics where our pamphlet addresses osteoarthritis and joint injuries in sports.

We've provided some samples of our information in the package. But the sports body basics is a prevention program to help youngsters, coaches, parents, and officials realize the impact of joint injury and its later risk for development of arthritis.

The Arthritis Society recognizes the importance of a proactive approach to arthritis and the importance disease education and disease management play in maintaining quality life for individuals with arthritis. The Arthritis Society has for many years recognized the benefits of placing an emphasis on the upstream indicator.

The Arthritis Society does not want to work in isolation but in conjunction with the health care system. Many of our services could be valuable tools for health care professionals, such as our Web site for educational purposes and as a source of reference materials for health care professionals. The Arthritis Society recognizes that there is a role for non-profit agencies and we would like to be part of the solution. The Arthritis Society would like to work together with the health care system to ensure that individuals with arthritis receive the quality of care they need and deserve.

In final comment I would like to emphasize that arthritis is serious. The health care system cannot afford to continue to underestimate the impact arthritis has on health care services. It is time to make arthritis an agenda item and develop a coordinated long-term strategy of primary health services and specialty services that will ensure the organizational structure is in place to support a quality health care system.

Again I thank you for this opportunity to make this presentation to you today.

The Chair: — Does anyone else have anything to add to the presentation?

We will then take questions from the committee members.

Mr. Gantefoer: — Thank you very much and thank you for coming today.

In your submission you mentioned that for hip surgery, I believe, the waiting time was 61 weeks and I think there's similar numbers for knee and other joint replacement. From your experience as members of the Arthritis Society and as advocates for people with these diseases, where do you think the biggest impediment is to shortening those wait times? Is it operating time? Is it orthopaedic surgeons? Is it nurse support for recovery? Do you have any insight as to why you think the lists are as long as they are?

Ms. McKinnon: — I would hesitate to sort of answer that question because I really feel that people that work in that area of health care are probably more appropriate to provide information on what the current problems are and what the solutions are. So the orthopaedic surgeons and people that are involved in the operations would be able to give a more clear understanding of the root of the problem and what the solutions can be.

Ms. Osberg: — Being a past patient of having actual hip replacement surgery, I would suggest that all of the above are problems and they all need to be approached.

Ms. McKinnon: — But I think in that area, the individuals that work in that area of health care would be able to really go to the root of the problem and provide the solutions.

Hon. Mr. Melenchuk: — In your closing remarks you stated:

> It is time to make arthritis a health agenda item and develop a coordinated long-term strategy of primary health services and specialized services that will ensure the organizational structure is in place to support a quality health system.

Now is it your intention that we should be looking at arthritis along the lines of a chronic disease model that we have in place for some of our pulmonary diseases along the lines of the Saskatoon health centre, that type of approach? Is that what you're looking at?

Ms. McKinnon: — I think that I would recommend that we need to take a look at the chronic disease area and come up with a long-term strategic plan, because of the impact that it currently has on the health care system. And the numbers are going to increase, which would make us believe that the pressures on the health care system are going to increase as the numbers go up.

Hon. Mr. Melenchuk: — Thank you.

The Chair: — Further questions? Seeing none, then thank you very much for your presentation and for your materials. We

appreciate you coming today.

Committee will take a five-minute break while we change presenters.

We'll resume. Welcome to Mr. Nightingale from Esterhazy. This is the Standing Committee on Health Care, a standing committee of the Legislative Assembly. I'm Judy Junor; I'm the Chair of the committee. The other members of the committee are Dr. Melenchuk, who is the Vice-Chair — he'll be back in a minute — Andrew Thomson, Warren McCall, Buckley Belanger, Brenda Bakken, Bill Boyd, and Rod Gantefoer.

The standing committee's first order of business was to hear and report on what we heard — responses to the Fyke Commission.

The presentations are 30 minutes, and that includes your presentation and questions from the committee if we have time.

And I'd invite you to introduce yourself and where you're from, and begin your presentation.

Mr. Nightingale: — Thank you. My name is John Nightingale. I'm the mayor of the town of Esterhazy. And my comments will be quite short so we should be able to stay on time.

The town of Esterhazy welcomes the opportunity to present to the Standing Committee on Health Care some comments on the Fyke Commission report and the major concerns of our town.

The Esterhazy situation. Four doctors serve our town of 2,800 plus the 11 surrounding towns and villages as well as a large number of farms and acreages. Statistics for the past year show that half of the hospital patients reside in Esterhazy and half come from the surrounding area.

Our medical care facility, St. Anthony's Hospital, has 21 beds, a laboratory, and up-to-date X-ray equipment. The hospital has recently been remodelled for greater efficiency. Services centralized in the hospital are public health, mental health services, addiction services, physiotherapy, home care, pastoral care, and the management of the Centennial Special Care Home which is located adjacent to the hospital. Food services and laundry are centralized for the hospital and the care home.

Esterhazy is the home and major residential centre for two of the largest potash mines in the world, with about 900 employees and about 100 permanent contractors' employees. Also it is the residential community for many employees from a third mine. Steel fabricating shops, service suppliers, and other secondary industries are located in or near the town. One equipment manufacturer employs approximately 80 personnel.

It is interesting to note that frequently patients that should be referred to Yorkton cannot be accepted by Yorkton and so are sent to Regina, Saskatoon, or back to Esterhazy.

Comments on the Fyke report. The Fyke report has consolidated some of the comments of the people of the province, and most notably the comments of various associations of those involved with health care in the province. A one-sentence summary of the report would be to say that it proposes another step along the road of health care centralization that was begun in the early 1990s in Saskatchewan.

We agree that 40-plus per cent of government spending going to health care is enough. Changes are needed in order to keep costs down and yet provide good health care. But let us not jump from the frying pan into the fire. What data did Mr. Fyke have to allow him to state that, or even assume, that significant monetary savings could be made by centralizing health delivery to 10 to 14 regional hospitals?

We believe that maintaining rural hospitals such as Esterhazy is more efficient, and thus better for taxpayers and local residents. Also is there any real evidence that health care of Saskatchewan citizens would be improved by funnelling everyone to a few hospitals?

We do not want to see a further urban/rural split, which will certainly occur if the Fyke recommendations were made . . . were to be implemented. The notion of trying to centralize all significant health care in a few cities is a simplified bigger-is-better approach.

Rural towns, such as Esterhazy is with its present services and health care, provide a quality, a good quality of life that is hard to duplicate. The four doctors and hospital with 21 beds provide good health care for our town and the many surrounding towns, villages, farms, and acreages who are serviced by Esterhazy.

The gap in services provided between regional hospitals and community care centres, as proposed by the Fyke report, is much too large. For instance, if Esterhazy was not declared a regional hospital, we would lose all of our diagnostic ability, including the lab and X-ray.

Without diagnostic services, doctors will not continue to practise. The fallout would be drastic to say the least. We would no longer be an attractive community for seniors. The town would not be able to attract new industry or businesses. No emergency services would be available other than doctors' offices and an ambulance.

All citizens would have to travel at least one hour for any diagnostic service. Citizens may well have to travel one hour even to see a doctor. Many senior citizens can't or do not drive and there's no bus service to Yorkton — which would be our regional hospital — so a taxi or to beg someone for a ride are their only options. Our two pharmacies would probably be reduced to one. Our population would dwindle and the tax base would diminish.

The same could be said for towns across the province. Without expanding further, it is obvious that implementing the Fyke report proposals would strike a near fatal blow to the heart of rural Saskatchewan. This would be moving in the exact opposite direction to the rural revitalization program. The first round of health care reform in Saskatchewan in the early 1990s may have been necessary, but is more of the same medicine healthy? We think a better solution is possible.

Options: place better controls on the skyrocketing drug cost, as the Fyke report suggested; review the funding of core services,

procedures, and diagnostics. Coverage for additional procedures, etc., can be obtained by purchasing insurance as is done with auto insurance. If the federal government want health care to be 100 per cent comprehensive no matter what new procedures are developed, they should pay for the comprehensive aspect.

Consider a credit system or savings account as has been proposed by others. We believe Saskatchewanians would be, or should be, willing to fund some of their medical costs or diagnostics directly or through purchased insurance. There are other options, including a user fee or having certain medical costs treated as taxable benefits.

Who is supporting the Fyke report? A quick review of those who support the major recommendations show it to be all the city-based associations and unions. We are not sure why because implementation would mean far greater congestion in city health care facilities.

Saskatchewan is an interesting place to visit and work because of the wide variety of topography, population density, industry, and so on found in rural areas. Why would we try to centralize our population to a few cities? Revitalizing rural Saskatchewan does not mean funnelling everyone into the cities, does it?

It appears to us that the Fyke report had the choice of at least two major options: funnel all medical services and diagnostics into 10 to 14 centres and leave funding in a status quo situation. Some of the results might be virtually no quantifiable savings, in our opinion; poorer quality of life in rural Saskatchewan, much more stress placed on regional hospitals.

Secondly, they could have said, leave significant medical services in relatively easily accessible locations for rural residents, especially seniors, and recommend one or more funding options. The results might be better medical service to all residents and less financial pressure on taxpayers.

In conclusion, suggestions are: leave the medical beds at their present level of 21 in Esterhazy. Call them whatever you wish but make them available to doctors. Leave diagnostic services in Esterhazy as they are or enhance them suitable to local needs. Reducing health care services in rural Saskatchewan to a walk-in clinic and a one-hour car, truck, or ambulance ride to diagnostic or other health care is not acceptable.

We would also like to refer you to the presentation made by the Society of Rural Physicians of Canada in their letter of May 15 to the Hon. John Nilson.

Thank you on behalf of the citizens of Esterhazy and area, thank you for the opportunity to present our opinion.

The Chair: — Thank you very much, Mr. Mayor. Questions from the committee?

Mr. Thomson: — I'd like to just start by asking a couple of questions to make myself more familiar with what is currently the situation in Esterhazy.

Of the 21 beds that are currently at St. Anthony's Hospital, what are these beds used for, or what is the scope of overall medical services offered? I notice you've listed some. I assume the acute care beds are largely respite and palliative?

Mr. Nightingale: — There's a cross-section of uses — acute care, respite, palliative, observation. I'm not a technical medical expert, so I can't answer exactly.

Mr. Thomson: — What I'm interested in, Madam Chair, is I'm taking a look at the comments you make, and I suspect that you are probably right when you say the gap in services provided behind regional hospitals and community care centres is too large, or at least we've certainly heard this from other communities that there's a sense or maybe a need for another level.

What I'm not certain is how the proposal that Fyke has put forward for community care centres differs from what St. Anthony's Hospital is currently offering in Esterhazy.

Mr. Nightingale: — The difference is particularly in diagnostic services. There would be no diagnostic services — no lab, no X-ray. That's the biggest difference.

Mr. Thomson: — I guess as I read Fyke, I don't know how we wouldn't have at least X-ray and some lab services. I know even when I go to my local medi-clinic that there's an X-ray machine there, that if I break a bone I can get looked at. I don't know how you could offer 24-hour care without some of that.

But if the point you're making is that we need to make sure in these smaller centres that we have the diagnostics and the labs and the X-rays, I think that's a point well taken. Is that largely the point?

Mr. Nightingale: — That's the major point. We don't expect to be a major medical centre — I don't think we do. But it is extremely important to allow the doctors to have some room to manoeuvre and to be able to do the diagnostics and observe their patients.

And if you read the Fyke report, it does state that the diagnostic abilities will be in the regional health centres. And when it lists the services that will be in the community care centres, it doesn't list any diagnostics at all.

Mr. Thomson: — I have two other questions. One concerns the districts themselves. Fyke recommends moving to larger districts. Presently Esterhazy is in North Valley, but it would appear that in terms of regional centre, you would be drawn either to Melville or Yorkton. Which would be seen as the more natural of the regional centres?

Mr. Nightingale: — Well Yorkton is definitely the regional centre for us by far. It's only a 15-minute distance between Melville and Yorkton, and so there's no question about Melville.

And as far as the regional . . . or the districts, whether they're larger or not, I don't think that's something that worries us too much. There's been, I know, there's been some controversy about that. But I personally can't see that that's a hang-up.

The delivery of health care to centres that are as large as

Esterhazy, which is one of the larger towns in Saskatchewan, is pretty critical. But the size of districts isn't of particular concern to me.

Mr. Thomson: — Madam Chair, my final question is at the present time then, the health services being offered in Esterhazy are sufficient to meet the needs of the community?

Mr. Nightingale: — By and large, I think they are. We've gotten used to the way it is and yes, I think they are.

Mr. Thomson: — Thank you.

Hon. Mr. Belanger: — I just want to point out on page 2 the first point that you make, it says that we agree that 40-plus per cent of government spending is . . . going to health care is enough. And that's exactly one of the reasons why we initiated the Fyke Commission is to see exactly how much is enough.

And we see a continual escalation of costs in the health field. And I guess my point in terms of a question here is, you point out that the Fyke Commission . . . you challenged the essential point of the Fyke Commission saying that we need to look at regional centres and you say to us that that doesn't necessarily mean that there's lesser costs. Could you elaborate on that please?

Mr. Nightingale: — Well it's hard for the average person — and I'll consider myself relatively close to an average person — to see how we could . . . how one could save much money by transporting individuals that need to see a doctor, or need to have diagnostics, or funnelling them in any other way to a centre that's at least an hour away. And very often that will be by an expensive ambulance ride. It's pretty hard to see how that's going to save money.

And operating beds in a centre like Esterhazy where hopefully the costs are a little lower should not . . . it's hard to imagine that you can save money by taking people to a bigger centre and putting them in a bed in Yorkton, Regina, and Saskatoon. I mean it's just a common sense approach, I think.

Hon. Mr. Belanger: — And the reason why I asked the question is I just wanted to make sure that while you can challenge the fact that bigger may not be less expensive, you can't dispute the alternative though, that perhaps bigger is less expensive.

If people were to come up to us and say well if we have this particular system in place it will save money and this is how they'll save them, and start rattling off some of the dollars that they would save if they went to a larger centres system.

Mr. Nightingale: — Well if you take a centre like Yorkton which is already overloaded and they're rejecting patients or saying, take them somewhere else or take them home again, and you do that from the Esterhazys, and the Kamsack, Canora, and the other areas that have similar size hospitals, then you have to double the size of Yorkton hospital or in some way take care of those patients. You just can't stop the system. Or you can stop the system, but it's going to be some pretty serious fallout.

So there's a big price to pay to do the centralization.

Hon. Mr. Belanger: — Thank you.

Mr. Gantefoer: — Thank you, Madam Chair, and thank you for coming, Mayor. You talk about in your presentation that you have four doctors, and I'm not familiar. How has the stability of your doctor practice been? Are they Canadian doctors, Canadian-graduated doctors or off-shore? Could you give me a little bit of an oversight of the doctors in your community?

Mr. Nightingale: — I believe that all four of the doctors are South African, from South Africa. But the stability for the time being is good. Who knows how long that will stay. This Fyke Commission report is making doctors nervous in the province.

Certainly I believe as far as I know, and I talk to the doctors on a reasonably frequent basis, they are happy. They like living in a town the size of Esterhazy. There are a lot of benefits, and we don't have a stability problem at all. And we have enough doctors to have a rotation whereby their on call at nights and weekends and so on is not too stressful.

Mr. Gantefoer: — Thank you. Are you aware of . . . Do they do, you know, surgical procedures at all? What kind of procedures do they have in their practice in Esterhazy?

Mr. Nightingale: — As far as I know, and I am not tremendously familiar with the actual procedures, but as far as I know they're minor day-type surgeries.

Mr. Gantefoer: — Okay, thank you. And what about the support nursing staff and things of that nature? Are you in decent shape that way or is that an area of concern for your community?

Mr. Nightingale: — I believe that we are in reasonably good shape nursing-wise. We have fairly good support. There's some strain there. There's . . . I don't know if they're short right now but I know that there's always . . . we're next thing to a shortage but we have enough support to my knowledge.

Mr. Gantefoer: — And a final question. Does your doctor or medical staff of doctors, do they provide any clinic services in other communities surrounding Esterhazy?

Mr. Nightingale: — Yes, there is one doctor that provides clinic service in Langenburg.

Mr. Gantefoer: — Thank you very much.

Hon. Mr. Melenchuk: — A couple of questions, Mr. Mayor. I'm looking at the letter that you provided from David O'Neil, the Chair of the Central Regional Committee for Society of Rural Physicians of Canada.

And on page 2 of his letter he talks about rural physicians for the most part are team players and would look forward to formalizing these relationships. But what I find interesting is that his comment with regard to the Fyke report is that the report does not recognize that rural physicians are multilevel care providers. And I find that an interesting comment from a rural physician in that what he states is that what is normally seen as the inventory of primary care services, rural physicians

are providing more.

Do you find that rural physicians would be probably unhappy or would find a practice location less desirable if they weren't in a situation where they could do the additional services that they are currently providing in places like Esterhazy or Moosomin for example.

Mr. Nightingale: — I can't answer with certainty but from talking to physicians over the years, it seems to me the answer would be yes. They like to have more flexibility and ability to deliver as many services as they possibly can rather than to be narrowed down too much.

Hon. Mr. Melenchuk: — So the point of the question then is, do you believe that part of the attraction of a rural practice is a larger scope of practice than perhaps that physician would have in an urban setting?

Mr. Nightingale: — You know, that's a possibility. They get to be part of the community and yes, they do see a very wide range of patients and they have to make the diagnosis and have the observation and so on and decide where to refer them and so on. I think it is probably a more interesting type of practice. But I am not a doctor, so I can't be sure of that.

Hon. Mr. Melenchuk: — Okay. One final question. You have four physicians practising in Esterhazy right now. Is that a fairly stable physician mix? They've been there for some time?

Mr. Nightingale: — There is a rotation that happens. They're coming and going to some extent.

Right now, we're fairly stable. We had one leave in the last year. But then we had a new doctor replace that doctor quite quickly, so we were not without a physician for very long. So that's why I say that a community like ours is relatively attractive.

Hon. Mr. Melenchuk: — Thanks.

The Chair: — Any further questions?

Ms. Bakken: — Just regarding the doctors. Did you use any incentives in Esterhazy to attract doctors?

Mr. Nightingale: — I wasn't involved in the attraction of the doctor. At the time, I was not in office. And I'm not aware that there was an incentive used, but I have heard that there have been at times. And when I lived in Ontario, northern Ontario, we did use incentives. But I'm not aware that there was in this case.

The Chair: — Any further questions?

Hon. Mr. Melenchuk: — Just one final comment. In terms of the provincial initiatives and the recent negotiations, this past negotiation with the Medical Association and the previous, that there are rural and remote incentive packages. And for jurisdictions with less than 10,000, then they qualify for additional grants, and plus on-call services are now funded in smaller communities as well.

So there are incentives for smaller communities in the province of Saskatchewan for recruiting and retaining physicians.

Mr. Nightingale: — I hope we're taking advantage of them. Thank you very much.

The Chair: — Any further questions? If not, then on behalf of the committee, Mr. Mayor, I'd like to thank you very much for your presentation and thank you for coming today.

Mr. Nightingale: — Thank you.

The Chair: — The committee will take a short recess between presenters.

Thank you very much. Welcome this afternoon. This is the Standing Committee on Health Care, a legislative committee. The committee has been charged with receiving and hearing responses to the Fyke Commission.

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

It's an all-party committee of the Legislative Assembly. And we have . . . this is our first order of business. Our presentations are 30 minutes. And we include in that time, time for questions from the committee if possible.

So if you could introduce yourself and where you're from, then you could begin your presentation.

Mr. Sokalski: — Well thank you, Madam Chairman, hon. members of the legislature, and MLAs (Member of the Legislative Assembly).

Briefly, I'm not here representing any particular group or speaking on behalf of anyone. I live in Wapella. I've been there 45 years. I'm married, a family man, retired officially — unofficially, no. I just completed 30 years with Canada Post. And politically speaking, I am unbiased — no right wing, no left wing — and if I need to fly, I need two wings. I'll leave it at that.

Subject matter: medicare. I have attended public meetings, district meetings, the forum in Regina with reference to the Fyke Commission, and I find that the Fyke Commission final report as being very good, well prepared, unbiased, impartial, and non-political. I'm also told that this report has the support of the professional groups such as the College of Physicians and Surgeons, the Saskatchewan registered association of nurses, and the Saskatchewan Pharmaceutical Association, which in my opinion is great to have that kind of support at this time.

I think that this is a golden opportunity for the present government to set stage, foundation, precedent, platform, whatever, using good, honest principles as I mentioned just past, unbiased, impartial, non-political principles to form a good honest base for medicare in Saskatchewan.

However, first and foremost in order to do this, I am suggesting get the political bull out of medicare. I repeat — get the

political bull out of medicare. Make medicare number one priority. Get rid of the rural health districts as suggested by the Fyke Commission. You do not need 32 CEOs, 32 chair-people, 300-and-some non-professionals to tell you what the provincial health care needs.

I find that rural health districts sometimes forget about the whole — that's w-h-o-l-e — of health care. They're more concerned about the hole — h-o-l-e — their own.

My experience with health district has not been very good. I will not tolerate brainwashing, phoney, falsifying, Mafia tactics, name it — not in health care. I also suggest making a stronger distinction between emergency/acute care and health care. A good majority of the elderly require health care that is long-term care for short-term patients. I shouldn't say this but a lot of them have one foot in the coffin and one on a banana peel — don't repeat that.

I was suggesting here that do not close or make conversions until after you implement a good, solid, properly up-to-date equipment to act as an emergency vehicle. I would like to call this vehicle a mobile acute care hospital — mobile, on wheels, whereby they go directly to A, stabilize on the way to B. No diversions, no delays, direct — it's urgent.

Insofar as small town Saskatchewan, the trend you realize has been, in 1967-68, it was the railway closure of stations, the closing of schools, the abandonment of railway lines, the destruction and removal of elevators, small retail outlets are gone. They cannot compete with the chains of the giants.

So a hospital, in my opinion, alone is not going to save your town. It takes people to save your town, it takes people to make your town; however, those people are leaving. If there's anyone here that can predict rural Saskatchewan's future for the next 10, 20 years, I would like to hear from them. I can't.

I'd like you to refer to the sheet that you have received headed "Viewpoint." Madam Chair, I wonder if I could just spare 30 seconds for the members to read that article on viewpoint which I also . . . don't look at the death notice, just look at "hospital sense."

Now what I would like to ask you, is this what you call good, quality, acute health care? This has been going on for over 30, 35 years living in Wapella.

And I believe if you were to read it over again, or maybe already have received maybe two or three messages within the context of that editorial, number one, Moosomin's economy is more important than that lady's life. The MLA's position of 53 years sitting on the main street of Moosomin — 53 years — that is more important than that lady's life. I don't want to go any further on that because I could get a little more critical.

A year and a half ago I wrote the Hon. Pat Atkinson, minister of Health at that time, and I accused the provincial health, the Pipestone Health District, and the Moosomin regional health for jeopardizing people's lives for the sake of political, personal, and economic gain. And that hasn't changed. The injustice continues.

Now you're deliberating whether to give final approval for this new hospital facility at Moosomin. Why the deliberation? Why the delay in saying no?

And if you read the letter to the Hon. John Nilson, to construct a facility of this magnitude in Moosomin, on the Manitoba border would be the . . . this is what I call political bullshit. And you can also include Melville in that too.

What I may suggest at this time . . . I haven't read the complete recommendation by Mr. Fyke, but I am suggesting even a pilot project immediately, as soon as possible, using district 11. That's 11 districts on your map. You have a map.

For example, consider district 11, southeast Saskatchewan. Now according to the Fyke Commission if he suggests two regional hospitals for that large district, considering rural population, further decline. The highway network, and I want to stress here the north-south road is very important because between the Manitoba border and Regina there's actually only one north-south road and that is No. 9. Eight is something like halfway between.

So the north-south road, considering the population density, the location of the facility is very important. Keeping in mind the motion of traffic, the emergency motion of traffic is destined in that whole area for Regina. You're picked up at A, taken to regional; if the region can't fix it, you're destined to Regina. There's no backtrack, as mentioned in the editorial. You have to go east to go west.

Living in Wapella for 45 years, I'm sick and tired of being treated a second/third class citizen all because of political, selfish, inconsiderate greed, as mentioned in the editorial.

I will conclude at that. If there are any questions, I'd be happy to answer them.

The Chair: — Thank you. Any questions from committee members.

Hon. Mr. Melenchuk: — Your comment that the Fyke report was very good, well prepared, unbiased, and professional, does that indicate that you would support the vast majority of the recommendations within the Fyke report?

Mr. Sokalski: — I would generally speaking support the Fyke report, a very large per cent. There's one exception.

I do question the validity, the necessity of spending big dollars in prevention, promotion of good health. The old saying, you know — and I agree — 1 ounce of prevention is worth 10 pounds of cure. But there is also the other saying: you can lead a horse to water but you can't make him drink.

And if you're looking at dieting and whatever junk foods and all this, just go to a fowl supper and you'll find out or go to a smorg and you'll find out how people are listening.

I do question the validity, the necessity of spending that much money on promotion and prevention. Other than that, the report looks very good to me.

The Chair: — Any further questions? Seeing none, then thank you very much for your presentation and for your printed material. Thank you for coming today.

Mr. Sokalski: — Thank you very much for allowing me to make my oral presentation. Thank you.

The Chair: — We'll take a five-minute break while we get ready for the next presenter.

Seeing that our next presenter is here, we'll invite him to come forward early. Mr. Smith, if you'd like to come forward.

Good afternoon, and welcome to the committee. This is the Standing Committee on Health Care. It's a legislative committee of the Assembly. I'm Judy Junor, Chair of the committee. Dr. Melenchuk is Vice-Chair. The members are Andrew Thomson, Warren McCall, Buckley Belanger, Brenda Bakken, Bill Boyd, and Rod Gantefoer. It's an all-party committee of the Legislative Assembly.

We've set aside 30 minutes for presentations. You're a little early, so we might have more time to spend with you if that's necessary. Thirty minutes for your presentation and then some questions from committee members if they have them.

So if you would introduce yourself and where you're from, and then you can begin your presentation.

Mr. Smith: — Thank you, Madam Chair. Dean Smith from Swift Current. I farm about 25 miles northwest and have been there pretty much all my life. And I have probably some thought-provoking thoughts on health care and have grown up with the system.

I'd like to thank you, Madam Chair, and the rest of the committee, for allowing me this opportunity to make this presentation. By watching a little bit, I have learned. I think what I'll do is talk the most and reduce the questions, because it seems to me that's the easiest way out.

However, I hope that I have enough time for some questions. So I think you have the material in front of you, so I'm going to go through it. I have not memorized this, so I'm probably going to have to read a good part of it.

First of all, I'd like to explain my position on the Fyke report and who I'm representing as I express my view. I've been a member of the Swift Current District Health Board for the last five years, first as an appointed and then as an elected. As a board member I've acquired first-hand knowledge of our health system by being involved in the decision making. However, I'm not making this presentation on behalf of the health board, but rather on the residents of the Southwest who use our health system, and particularly those residents who are familiar with how our health system has evolved over time.

In principle I believe the Fyke report is on the right track. The concept of primary health service teams and regionalized health care delivery systems is most likely the only way we can save our health care system. While some of the smaller details contained within the model may not be appropriate, we must look at the principal components to build upon and promote the rest of the recommendations.

Most importantly, however, is that we encourage public input and we need to start a process of public consultation as quickly as possible. In order to stimulate public involvement I believe we need to create a pilot project on health care reform so that people can give feedback on a pragmatic health care model. I would even go further by suggesting we set up such a project in the Southwest which is the home of medicare and it was Health Region No. 1.

We have a tendency to say as we make changes to the health care system we are doing something new. However I don't agree; I think that the new ideas are often just recycled versions of the old forgotten ideas.

When Health Region No. 1 was created it worked so well that we eventually developed a national program based upon it. Over time, however, we ignored the main principle behind the creation of Health Region No. 1 in medicare and that was ownership and public input. I believe that we can go back to that principle and with the support of the people we can build a regionalized health care delivery system that is effective and sustainable.

Not many people around this table remember Health Region No. 1 so I would like to give you a short history lesson. Under The Health Services Act of 1946, the Health Services Planning Commission was established by order in council being directly responsible to the minister of Public Health and outside the jurisdiction of the deputy minister and the Department of Public Health.

Under the Act this commission was given wide authority over the health services in the province. Among these authorities was that of outlining the boundaries of health regions for the purpose of public health service. If the residents of the region voted in favour of public health services being put into effect on a regional basis, this could then be done with the approval of the minister.

Further, if the region voted in favour of provisional medical, hospital, nursing, and dental services, the regional board could proceed to establish a plan for provision of these services, subject to the approval of the plan by the Health Services Planning Commission.

The Department of Public Health was represented on the Health Services Planning Commission by the deputy minister of Health who, I might add, was not the chairman.

In December 1945 the residents of Swift Current and area voted in favour of the establishment of a health region. The area was then approved by the minister as Health Region No. 1.

A regional board, elected from representatives of all the municipalities concerned, was then formed and directed to draw up plans and provision of complete medical and hospital care for the residents of the region. Upon approval by the Health Services Planning Commission, this came into effect in July, 1946.

To understand the area of concern and the problems presented

by this undertaking, certain information should be understood. Health Region #1 constitutes an area of 15,000 square miles in the southwestern part of the province, with a total population of approximately 50,000 in 1946, 57 in 1966.

Prior to July, 1946, considerable experience with health service administration had been obtained through the operation of five or more municipal medical schemes as well as mutual medical and hospital benefit associations.

The enterprising spirit of the population may be conceived when one realizes that in the economic history of the region only one in approximately seven had provided a sound financial return due to drought or some other conditions.

When the scheme started, only 19 doctors were residents in the region. By July, 1949, the number had increased to 36. At July 1, 1968, there were 44 doctors in the region.

The area of the province provided an ideal locale for the purpose of an experimental regional scheme of health services for a number of reasons. The previous experience as mentioned was useful. Fine co-operation between the doctors and the laymen of the board was evident. The economic picture in the district pointed out problems presented by fluctuations in economic conditions. And a very evident desire on the part of the population concerned to run their own affairs with a minimum of interference or control from the outside.

Since the scheme was started, the regional board and doctors had shown a practical expediency in making change through the advisement in the light of their experiences from month to month. The Saskatchewan Health Services Plan came into effect in January, 1947 and provided hospitalization on a province-wide basis. From that date to July, 1962, the region continued to attempt to provide a complete medical service within the region with the exception of the hospital service and referral outside of the region when necessary.

The regional medical insurance plan was financed prior to 1962 partly by a personal income tax, partly by a land tax, and partly by the provincial government grant. It paid physicians on a percentage of schedule fees with total expenditures being controlled for some years by an agreed monetary pool or funds ceiling. All residents of the regions are insured.

And this came out of the history of the Swift Current regional care. There was a document issued. I don't know if you people have access to it or have seen it, but it's some real good information in it.

Dr. O.K. Hjertaas who attended the historic meeting on January 17, 1946 for delegates passed a motion instructing the 10-member board to provide complete health services to the residents of Health Region #1 when facilities were available.

Stated in Joan Feather's article "From Concept to Reality" in the *Prairie Forum*, Spring 1991, quote:

> It was hard to adequately express the spirit of co-operation and unity of the purpose that prevailed.

Commenting on this co-operation and unity of purpose, Pat Cammer remarked on how the board members had different political views, but they left their political learnings outside the room.

Perhaps those of us who are attending here today could learn something from those individuals who came together more than a half a century ago and radically changed the health care system.

The Fyke report presents an integrated and coordinated model of health care for the province. It is centred on primary health services in the communities across the province which would be linked to basic acute and emergency service in 14 regional hospitals and specialized services in Regina, Saskatoon, and P.A. (Prince Albert).

All of this is facilitated by closing small, underutilized hospitals; reducing the number of health districts; establishing an arm's-length quality council to set delivery . . . service delivery standards; implementing a province-wide human resource strategy to retain health professionals; improving health research and information systems; and introducing a collaborative process for confronting the health status of Saskatchewan . . . of the Saskatchewan Aboriginal people, pardon me. In addition, renewed emphasis on disease prevention, public health measures, and health determinants.

There will be much controversy over these issues as rural Saskatchewan is still angry about the last round of hospital closures. The rural public views a community's existence as having a hospital regardless of whether it services it's needs or not. But hospitals should not be seen as an instrument of rural economic development. The jobs they create in small communities are indeed important, but their primary function has to remain the provision of quality service to those communities.

The key recommendation of the Fyke report is the creation of primary health services teams that would integrate the work of physicians with nurses, pharmacists, and other health care providers in units that can serve the public — especially in rural areas — more effectively. Physicians in these units would be under contract. They would no longer be paid through a fee-for-service system.

We need to use our trained personnel more appropriately. An example, we have approximately 73 nurse practitioners trained in the province and yet we have only a handful that are being utilized.

I have concerns in terms of managing the cost of care. The creation of these teams replaces one kind of incentive . . . incentive problem with another. Still this might be an improvement.

Remember in health care we are looking for the best imperfect solution, but we need to examine in more detail exactly what sorts of problems will arise. With these primary health service teams, there needs to be departmental guidance and direction. These teams need to be co-ordinated to avoid duplication and overlap of services. With these teams in place we need a quality council. Once developed they need to set performance indicators on a provincial basis, and this will drive the entire

system.

As stated in the report, the performance indicators will be the foundation for quality improvement and a guide to resource allocation. They will pinpoint areas in need of support and allow the public to make more informed judgements of both individual sectors and service, and the overall system. The indicators and ratings will replace the antidotal opinion and special interest groups' pressures as they influence on policy and resource allocation.

There must be comprehensive measures in place to optimize the available resources for health care.

I have concerns for the quality councils as to who will be on the council and what powers it will have. Will special interest groups be represented on this council? If so, will this create a conflict of interest thus limiting its ability to do what it was set up to do?

In reference to the Fyke report, I believe the positive recommendations outweigh the negative reviews. As we move forward making changes we must be aware that there will be some resistance and negativity toward some of the changes.

As stated in the report on page 124, under the heading "Making Change", I quote:

> Achieving a quality-focused, accountable and sustainable health system in Saskatchewan will mean change. While the health system has already undergone a great deal of change in the past ten years, it must continue to evolve if it is to meet the needs of the future. Most everyone that participated in the Commission's public dialogue agreed. Everyone also knows that change is not easy, but Saskatchewan's successes with regionalization in the last decade are a testimony to the fact that it can be done.

Again I would like to reinforce this statement by a comparison is how we formed Health Region #1 in the southwest and how effective this health delivery system was in its time.

I believe that the majority of the people in the southwest would be ready to endorse a new approach to regional acute services that should include a new or greatly improved acute facility in Swift Current, new equipment, and a complement of appropriate specialized physicians, and adequate staff.

I think that most people now realize that a lot of small, local hospitals do not and cannot service their needs. We have a good example with the recent addition of CT (computerized tomography) scanning and renal dialysis service in Swift Current.

I am convinced that the public acknowledges the fact that with the high cost of new technologies that small rural facilities cannot be sustained.

We are at a maximum of taxpayers supporting health care and therefore need to allocate our health dollars more effectively. The current 40 plus of our total provincial budget cannot keep escalating.

The implementation of primary care networks requires precise guidelines. This precision is currently lacking. For example, EMS service must be functioning properly prior to closing or restructuring of acute care facilities. This comes from SAHO (Saskatchewan Association of Health Organizations). And primary care facilities must be built before or in tandem with the conversion of existing facilities.

Clear criteria for the placement and/or modification of existing facilities must be developed, and capital projects and infrastructure changes must take place prior to implementing reform. Regional and tertiary centres must be functioning optimally prior to any restructuring at the local rural level. And we must have an understanding of rural best practices to ensure that these will be incorporated into any local level change.

As we make these changes, we need to do a better job of promotion and be prepared to have in place a better system. Example, if we close rural hospitals, let's make sure that we have an effective ambulance service with properly trained EMTs (emergency medical technician) in place beforehand. We should have an enhanced air ambulance service.

And I understand that some of these things are already being talked about. But let's not just talk — let's make it happen.

We need to do a better job of promoting and educating the public about the changes being made. What better way to do this than by demonstrating by example. A good pilot project would be worth more than all the words you could put on paper.

I would like to refer to the operations interactions of the Swift Current Health District and surrounding health districts in the southwest. We, meaning Swift Current, we are considered a host district.

Yet I feel there has been a lack of financial commitment to enable us to properly serve the clients of these other districts. This causes the clients to go elsewhere, which in turn causes them financial hardship as well as valuable time. In turn, they feel the system has failed them and maybe it has.

Swift Current Regional Hospital is a major referral centre serving a southwest area of Saskatchewan, an area of over 40,000 square miles with a population excess of 100,000.

CT scan service is a crucial component of a good regional centre. Regional hospitals have generally been defined as full service acute care hospital serving a geographically defined area related to the trading area in which they reside, and typically, they are located in the major population area of that geographic area and service a widely dispersed population with a large rural component.

Rationale for permanent CT scanning service in the southwest is that, currently, Saskatchewan is below the average of CT service based on population.

At this time, I'd like you to refer to the back, to Appendix A of my submission. And I think this is rather interesting. And again I would like to compare what I'm talking about today as to what we had back in 1947, the size of the area and the population pretty much support one another.

This chart is part of a feasibility assessment for a regional CT scanner, and notice what a vast area there is within the circle of service and distance to travel to tertiary centres. And this can exceed 250 miles if you look at the extreme southwest corner.

This is a huge cost to those taxpayers in remote areas. Not only is there cost of travel and time, but it also caused an overload on our tertiary centres and a backlog in our whole system. We need to lessen the waiting period and what better way to do it than by doing it regionally whenever possible.

We should lessen the load of minor surgeries at the tertiary centres thus freeing up time for scheduling of major procedures. And as you can see from the numbers in this chart, there's justification for a regional service in the southwest.

In the Swift Current Health District, the addition of the regional portable CT scan has been a big boost for the southwest. Although it is shared with Moose Jaw on a 60/40 basis, it has worked fairly well, and it's being utilized as much as possible considering it is in transit a fair amount of the time. In a recent review, it was well documented that it would be used a lot more if it were permanent in the southwest.

It has been well received and appreciated by our clients in the southwest, and this is one example of a service that is needed to support regional centres. Another example is the satellite renal dialysis unit that recently has come to Swift Current. This was an effort put forward and supported financially by the public working in co-operation with the district — the true spirit that is needed to make this work.

As the Fyke report suggests, the major changes that are about to take place need to have considerable resources of capital for infrastructure, new equipment, and an educational enhancement program for the recruitment and retention of professional staffing. This funding needs to be shared federally and provincially with some monies being raised at a local level on a volunteer basis.

We need to realize that when regional facilities are being established, the basic capital funding contribution of the government must be raised from the standard 65 per cent to 90 per cent. The 10 percent needed to be raised by the regional area would be attainable. The long-term savings that would be attained in efficiencies through proper utilization of services would offset the capital investment, not to overlook the improved services for our clients.

I believe that if regionalization is encouraged and properly financed by the Department of Health that as local boards we can sell the principle to the public and get their buy in. This should be the main purpose of a regional board.

To achieve a sense of fairness of a regional planning, we need good representation from all parts of the area. These representatives should be appointed on the basis of their commitment and dedication towards a better health care system. Elected boards have a tendency to be politically motivated and have special interest concerns rather than good health planning.

From the Swift Current Health District's strategic plan towards a healthy future, as a board we identified some of the very issues the Fyke report has outlined as being big problem areas. In fact, in parts of it, it's almost a copy of what we determined that was needed in our three-year strategic plan.

There are still a lot of questions to be answered, but I believe the Fyke report is a step in the right direction. He has pointed out some problem areas and made some recommendations. If we use these recommendations as guidelines and tools for progress, they will become excellent building blocks for the future.

While there could be little doubt that more effective processes and emphasis on health promotion, prevention, the focus of quality and primary care reform may obtain significant improvements in seamless care delivery in Saskatchewan, much must be done to analyze the practicalities of such change.

Health care professionals and the public at large are still dealing with the residual health care reform through the 1990s. In order for any further reform to be successful, it must be based on evidence that all can understand. And this must be clearly communicated. It is imperative to have all the relevant information in place before any significant action is taken.

That there is need for improvements and efficiencies in health care delivery is a given. We can always strive to do things better. How we proceed may make the difference between an innovative and sustainable public health care system for future generations or just another forgotten and expensive public commission.

To make these changes, there needs to be a vision, leadership, and strategic planning at the provincial level to move forward in the development of an integrated care pathways and seamless delivery of services.

At present, each district develops its own strategic plan. These need to be coordinated and moulded together. The government needs the courage to make these appropriate changes and surge ahead and make it happen.

I thank you for this opportunity.

And I've got a few notes that I would like to add before we get into questions, if I may. I didn't talk much about integrated facilities. I stayed pretty much to the acute side of it. And I think those are some things that need to be worked out, and I think the rural areas have a large role to play in the long-term care facilities versus acute services.

However, on a regional concept, I think we should look at how financially efficient an integrated service would be. I guess I'm not in a position to talk about that. We should have our CEO here today doing that.

But an example. And we certainly have been talking about it in Swift Current, and I was instrumental in getting a foundation going and they're looking at what monies are possibly raised when we do capital changes.

And I guess if we look at a regional concept, which we're serving a big area and it's hard to raise money in that area in these times, if we stayed on the 65/35 split and we're looking at

a 50 to $60 million integrated facility, that means we've got to raise 17 to $21 million, which I don't think is attainable in a three- to a five-year period.

However if you look at 90 per cent funding, which I think is needed to support any regional facility, you're looking at 5 or 6 million and I really believe the people in the southwest would pull together and raise that.

And I think the importance of having the volunteer approach by the public is they don't view it as total tax dollars and they feel that that's ownership for the facility and to make it work. And I really think that is something we have lost in health care in the last 30 years. And yet I don't believe in user fees and those type of things, but I like the volunteer approach.

And I guess just to note, certainly the Swift Current Health District is working on many of these options. I guess I'm not as worried about what the district does as how I feel that the people are out there. And certainly my presentation was encouraged by some of the, what I consider, more experienced people in our community. And they really think that there's something we need to look back at and build on from there.

And you know, I think that . . . You know there's lots of quotes in here in the Fyke about waiting lists and I think it's fairly clear why some of those are in place. And certainly we have done studies in Swift Current to show that that is right. And certainly the admission rate, which again is quoted on page 26, is worth looking at.

So with that, have I used up all my time so I don't get any questions? Thank you again, people. It was appreciated, the opportunity to be able to come forward and give you some thoughts.

The Chair: — Thank you, Mr. Smith. Questions from the committee?

Hon. Mr. Melenchuk: — Thank you for your presentation. It was quite a good critique of Fyke. It's your suggestion that part of the buy in from communities in Saskatchewan at large because of the change, we seem to be in a perennial change mode, would be to offer up Swift Current as a pilot for a regional model. So you would like to see some of the implementations of Fyke occur in Swift Current prior to other jurisdictions in Saskatchewan. Is that correct?

Mr. Smith: — Yes. And I guess it looks like it's selfish and deep in my heart I probably am, but also I think there needs to be a model. I think we need to do some good benchmarking. I think we've seen before when we make wholesale changes and it's really hard to back off if you make some mistakes. And there's no doubt in my mind we'll make mistakes. No good progress is ever done without making mistakes.

I really think that we have something to build on and I that it's a sell to our people in that community because they've been through it. There's still some people there that remember it and I think those are the people that have some money that may be prepared to help finance it, and that's my guess. And I think I've . . . I've been there a long time and I think I can read the people as well as anyone.

Hon. Mr. Melenchuk: — Thanks.

The Chair: — Any more questions? Well you are lucky. Thank you very much, Mr. Smith.

A Member: — That's what happens when you baffle them with enough words.

The Chair: — That's what happens when you make a good presentation. Thank you very much for coming and presenting to the committee. On behalf of the committee, I thank you very much for your time.

The committee stands recessed until 7:00 p.m.

The committee recessed for a period of time.

The Chair: — Good evening, and welcome to the Standing Committee on Health Care. I'm Judy Junor, and I'm the Chair of the committee. The other members are Dr. Jim Melenchuk, who is the Vice-Chair, Andrew Thomson, Warren McCall, Buckley Belanger, Brenda Bakken, Bill Boyd, and Rod Gantefoer. It's an all-party committee of the Legislative Assembly. And our first task is to receive and report on what we hear, the responses to the Fyke Commission.

We set aside 30-minute presentations but you have an hour, and you're going to do a nice power point I see, which is set up — working well so far. So if you want to introduce yourselves and where you're from and what you do there and then start your presentation, I'm sure other members will be in shortly.

Mr. Petit: — I'm Richard Petit, acting director of corporate service for the Keewatin Yatthé Health District in Buffalo Narrows.

Mr. Morin: — Max Morin. I'm the Chair of the Keewatin Yatthé Health District out of Ile-a-la-Crosse.

Mr. Rivard: — Al Rivard. I'm from La Ronge, with the Mamawetan Churchill River Health District, board member, and also representative Métis Nation of Saskatchewan.

Ms. Moore: — I'm Judy Moore. I'm with the population health unit for the northern health districts. I work with Keewatin Yatthé Health District and Mamawetan and the Athabasca Health Authority as the manager of the population health unit.

The Chair: — Good evening. So you can start your presentation any time you're ready.

Mr. Morin: — Maybe I can start. First of all, I'd like to thank the committee for allowing us an hour. We've combined our presentation from the North. We have the Athabasca Health Authority, which is the far north, the Mamawetan Churchill River, the Keewatin Yatthé Health District, and the Northern Intertribal Health Authority which represents the First Nations.

So we've combined our presentation to the northern health strategy which we'll be doing. And at the same time, how we want to go by the presentation, and we'll get our Judy Moore, our technician here to do a presentation on the health status, some of the health status out in northern Saskatchewan. And

then Al Rivard and myself will go through the northern health strategy, and Richard will hook up to the power point as we go.

We won't read word by word but just an overview and so it will give time for the committee members if they have any questions.

Ms. Moore: — I'm pleased to present to you a brief picture of the health status of northern people. This presentation was prepared by Dr. James Irvine, the medical health officer for the northern health districts, along with staff from the population health unit.

It serves as a lead-in to the northern health strategy that's going to follow, and it'll give you . . . it's a health snapshot really of northern Saskatchewan that deals with jurisdiction, demographics, and the extraordinary effects that health determinants, services, and access to services have made on the lives of northern people.

The geography of the North. There are about 50 communities spread over northern Saskatchewan over thousands of square kilometres, and some of those communities have no road access. This is the community of Camsell Portage which is located in the far North, the Athabasca area.

A map of the province. Northern Saskatchewan comprising almost one-half. This is a vast geographic area of 317,000 square kilometres. And serving this vast area represents extraordinary health issues in terms of services, access to services, travel arrangements, and hazards that can result from those. We were chatting a bit about those.

The health districts in the North. We have the Athabasca Health Authority in the far North, Keewatin Yatthé Health District on the west side of the province, and the Mamawetan Churchill River Health District.

A memorandum of understanding for the northern co-management partnership is in place, which sets forth the working relationship between the health districts. And it's a collaborative approach taken on programs, projects, and shared positions.

The population health unit, which deals with broad-based population health issues and initiatives, has nine shared positions and provides the legal authority for the medical health officer.

The same organizational structure exists for First Nations. We have four tribal councils in the North — the Lac La Ronge Indian Band, Meadow Lake Tribal Council, Peter Ballantyne Cree Nation, and Prince Albert Grand Council.

The Northern Intertribal Health Authority provides services to the tribal councils, again for shared positions, resources, and projects. Similar to what we have with the co-management agreement for the health districts. The community health status and surveillance unit is a unit of NITHA, or the Northern Intertribal Health Authority, and it provides monitoring and statistical work similar to the population health unit for the districts. So they're quite comparable in what they do.

This map shows the overlap of the four tribal councils and the northern health districts. So here we have the Meadow Lake Tribal Council. In here the Lac La Ronge Indian Band. On this side we have Peter Ballantyne Cree Nation and then Prince Albert Grand Council which is scattered with their different memberships throughout the North. And that's the overlap with the health districts.

The people of the North. There are some 33,000 people living in northern Saskatchewan. And it's a young, growing population. Almost 40 per cent are under 15 years of age compared to 23 per cent in Saskatchewan. It's predominantly Aboriginal — Cree, Dene, and Métis.

This slide is the population pyramid of Saskatchewan — young at the bottom, elders at the top. It shows the age distribution of the population by male and female. The main point is, provincially 13 per cent of the population is under the age of 10. Whereas in Sandy Bay, which is one example of a community in northern Saskatchewan, children 10 and under comprise 32 per cent or one-third of the population.

The change in district population. This slide shows the population study done by HSURC, and James Irvine and Donna Stockdale of our population health unit were also involved in preparing this study. It shows the predicted change in population for health districts over the next 15 years. Note the range is from a decrease of greater than 10 per cent to an increase of greater than 10 per cent. The blue area is showing areas of decrease. The red, mainly the red northern area, is showing an increase of greater than 10 per cent projected for the next 15 years.

The same holds true for seniors or elders, the same prediction. We're looking at an increase of greater than 10 per cent for elders in our northern health districts and other areas over the next 15 years.

Now we'll take a look at the population makeup for each of the health districts in the North. Here we have the 1996 census population for the Athabasca Health Authority and we see that 85 per cent of the population, the maroon areas here, are all on-reserve. So that population is made up of 85 per cent on-reserve.

If we look at the Keewatin Yatthé Health District, we see that 57 per cent of the population is Métis, and we look at a total of 74 per cent here being off-reserve.

For the Mamawetan Churchill River Health District, in this case we have a total of 56 per cent being off-reserve.

So a different makeup between the Far North, and the central area, and the west side.

The determinants of health. There are multiple influences on our health. Factors that affect the social, physical, and individual . . . the well-being of the individual.

Things that determine our health. We look at things of income and social status, education, employment. We look at the environment, both man-made and natural; social supports, early childhood development, health services, and health behaviours.

Looking at some of these aspects, first of all the incidence of low income. And these next three slides come from StatsCanada. So we're looking at the incidence of low income as a percentage of population across the country.

In the North, 32 per cent low income, and in La Loche we're looking at 55 per cent of the population experiencing low income.

The average number of persons per room in a household. And this slide would demonstrate the overcrowded housing in the North, which is also a determinant of health.

The average value of a dwelling. In Canada we're looking at approximately 150,000 as an average. If we look in Jans Bay it's 15,000.

The risks to some of the health for people in the North. We look at psycho-social issues, or mental health issues. We look at addictions and violence; parenting and early childhood development; smoking rates; changes in physical activity; and the cost of food and availability of food and the use of healthy diets, how that's changed significantly over the years.

We've covered demographics and some physical and social aspects and now we'll take a look at some health statistics. First of all death rates and the leading causes of death.

Infant death rates. The infant death rate in the North is more than double the Canadian rate. A healthy baby, we all like to see.

Potential years of lost life or premature death. Injuries and violence comprising the largest leading cause of premature death. And we're looking at things there like suicides, accidents, drowning, fires.

Infectious and communicable diseases. The most significant that we see here are the water-borne diarrheas. And this would be due, these two areas here, this would be due to a lack of access to potable water, inadequate water supply for washing — washing of hands, clothing, personal hygiene, overcrowding in houses as well.

The only other area to note is the area of hepatitis A. That should be noted that recently that statistic has been reduced to zero due to a more recent immunization program in the North started in 1996. So we've been able to make some real headway in that area.

Communicable diseases for 1999-2000. In the North, there was a total for on- and off-reserve of some 700 cases of STDs (sexually transmitted disease). If we look at Regina and Saskatoon, they would face the same workload, the same number of cases. But in the North, we're facing 700 for our population of 33,000. So a tremendous workload in that particular area.

This line shows the rate of tuberculosis for both on- and off-reserve. In the year 2000, we had 43 cases of TB (tuberculosis) in the North; 18 were off-reserve or 42 per cent, and 25 were on-reserve or 58 per cent. One health district community in northern Saskatchewan has had the highest rate over the last five years, of 450 to 700 — like way off the scale.

There are presently four cases of drug-resistant TB in Saskatchewan and all of these four cases are in the North and all of them are off-reserve, and that's certainly a major concern for us.

Here we see the increasing number of cases of hepatitis C in the two health districts — from 12 in 1997, to 24 in 1999, and 21 in the year 2000.

In terms of risk factors for hep C, we're looking at the whole area of injection drug use as being more and more of an issue in the North, the same as we're facing in urban centres, so we're experiencing that as well.

For sexually transmitted diseases, this slide shows the differences in rates for these diseases, and the greater prevalence is seven to eight times greater in the North than in Saskatchewan.

Teen pregnancy. The birth rate for 14- to 19-year-olds in the North is more than three times higher than Saskatchewan. And of special concern is the 14-and-under age group, which is four times higher than the Saskatchewan average.

Now we'll take a look at chronic diseases, the area of diabetes, cancer, heart disease, and stroke.

The rate of diabetes is higher in the North than in the South. This slide shows the rate of diabetes for First Nations over two decades. It is a six-fold increase. The thing to note here though, while this is First Nations; the same pattern exists for Métis people, a six-fold increase for them as well.

Cancer trends in northern Saskatchewan. In northern Saskatchewan we have the highest rate of lung cancer of all districts in the province. Bowel and breast cancer — we've caught up to the Saskatchewan average. And for cervical cancer, that rate is decreasing but it is still higher.

What will the future hold? Some happy smiling faces are nice to see.

Providing health services in the North. We need to address recruitment and retention, a particularly difficult issue in the North, and I'm involved in recruiting and retention in the North. And to try to find dental therapists and public health inspectors, and nurses, and primary care nurses — it may difficult in the South but it's really tough in the North. We know that first hand.

We need to provide training and develop Aboriginal health care providers. And we need to address primary care nursing.

We also need to examine access to services and transportation in new ways. And we need to continue to provide services in innovative ways such as Telehealth.

Accessing services such as the nearest referral hospital is a challenge for northerners. Uranium City to Prince Albert is 834 kilometres. Uranium City to Saskatoon is 958 kilometres. Compare this to Saskatoon to Edmonton at 532 kilometres.

Going west, Regina to Cranbrook, BC, 938 kilometres. Going east, Regina to Dryden, Ontario at 905 kilometres. So lots of distance to travel to get ourselves to the nearest referral hospitals.

Put another way — and correct me if I'm wrong, okay, Max and Richard — I understand that from La Loche to Saskatoon is about a 14- to 15-hour round trip minimum over some interesting and challenging roads. About right? From Fond-du-Lac, a child and escort costs about $1,650 for travel and accommodation.

This slide shows the locations of physicians and hospitals. In the Far North, Uranium City, then La Loche, Ile-a-la-Crosse, La Ronge, and Flin Flon, Creighton.

The blue squares in this slide show the locations for visiting physicians in the North and on-call 24-hour primary care services. And the red squares again show the hospitals, the same as the previous slide.

This one shows the communities that receive public health nursing services, one to two weeks . . . over a one- to two-week period of time.

The strengths in the North. All one has to do is to travel into some northern communities to get a real sense of what a community is. You travel to Pinehouse, you travel the west side, and you get a sense of community.

You feel a desire for change when you travel those communities. You notice the primary care focus. You see the value placed on the environment.

You experience partnerships with Social Services, Education, Recreation, Economic Development, other First Nations, and communities. People want to work together.

You realize the traditional concepts of health and well-being and the importance of those traditional concepts. And you see the focus placed on holistic health, prevention and promotion perspectives. Typically in the North, we spell holistic with a 'W' in front of the 'H', to look at the whole person, the whole being rather than an empty space.

The medicine wheel. Looking at the mental, emotional, spiritual, and physical well-being, meaning the holistic side of things — not a fragmented health service, not a fragmented person, but a whole person and a whole service.

Directions for the future. A northern health strategy which is to follow. Thank you.

Mr. Morin: — If I can start it off, first of all we just figured we'd give you a snapshot of some of the challenges we have in health districts and health authorities in northern Saskatchewan.

The northern health strategy, we've been working on this for over a year and we have partnered with the two health districts, the Athabasca Health Authority and the First Nations communities to Northern Intertribal Health Authority. So it's a joint presentation.

Lionel Bird from the Northern Intertribal Health Authority had another commitment today, so he couldn't make it. But the presentation, we're making it on behalf of all the people of the northern . . . Georgina McDonald and the Athabasca Health Authority also couldn't make this. But we were given the mandate to present this as a northern health strategy, looking at all of the northern authorities that deal with health in northern Saskatchewan.

A little bit of background also with that. We've been dealing on the northern health strategy when the former premier, Romanow, met with the northern leadership two and a half years ago in Saskatoon. He did mention some sort of a northern strategy in respect to looking at the North and how can we deal with the North. If we don't deal with northern Saskatchewan now then the situation is only going to get worse.

And so as northern Saskatchewan people, the commitment was given that the North was going to be seriously looked at and you can't continue ignoring the North, particularly with what the health issues and the status of our people — the high unemployment, lack of jobs for our people, lack of housing, etc. The list could go on — the dependency of our people on governments for the rest of their lives. We'd like to break that dependency. And with that I'll turn it over to Al Rivard to start off the presentation.

Mr. Rivard: — Thank you, Max. The partners that Max just indicated were referred to as the stakeholders — northern health stakeholders. And we believe that there is another way to deliver health services in the North.

As Judy presented earlier, we have some very different and unique, challenging health status. We believe in holistic and community-oriented health delivery services. We believe in building on our strengths and principles. And also because we have developed partnerships to address the broader determinants of health, we believe that there's a northern solution to help delivery. And we believe that change must include northern efforts.

What are some of the options for change? We could stay with what we have and as Max said, we haven't been successful in addressing our major health issues. We could find a breakthrough, do something new within the existing structure. Or we could break from the conventional paradigms and find a new way of doing things — a new way that will work, a new way that will have a positive impact on health status.

And our choice is to break from convention. We're working from the basic assumption that health is the result of individuals, families, and communities learning and applying the natural laws and principles of healthy living in their own lives. We believe that this is keeping in part with the health reform principles as expressed by Saskatchewan government in increasing community involvement; emphasizing prevention, healthy lifestyles, and population health; improving balance; coordinating and integrating client-centred systems; maintaining appropriate services; and financial sustainability.

Ms. Moore: — Can I just interject for a moment. Looking at some of these in terms of the community involvement, I think of the phenomenal job done on the west side in terms of

newsletters and getting information out to the people and inviting their involvement, letting them know what's happening. We do a tremendous job of that. And that's disseminated to how many households, Richard?

Mr. Petit: — 3,600.

Ms. Moore: — So it reaches a lot of people. And I look at the community health educators over on the west side as well, and the effort they've gone to, to actually incorporate those people that work the front line in the communities as part of the health district, which . . . I mean they're a tremendous support and a tremendous help.

And I look at the capacity building workshops we've done in terms of the Northern Diabetes Prevention Coalition hosting those. One was already held over on the west side in Keewatin Yatthé district, and now one is going to be held in September in the Mamawetan district, which is really to build capacity within the communities, to invite community people to take part, to learn about how to make changes in their own personal lifestyle and in their community lifestyle in terms of healthy eating and physical activity.

I look at the consultations for our community health action process, the needs assessment . . .

The Chair: — Excuse me. One minute, Judy. You can't be heard because your mike's been taken off. So we can't record anything that you've said. Would you put it back on?

Ms. Moore: — I was speaking about the community health action process and needs assessment as well. I mean those are examples of community involvement. And looking at the whole area of prevention and healthy lifestyles, if we look at the community vitality process that we're involved in now in terms of looking at the availability of food and the prices of food and embarking on seeing what we can do to help stores rearrange how they display their food products.

The South Bay youth camp that's taking place, a tremendous involvement of some 400 young people looking at the whole idea of prevention and promotion and addressing some of their issues and having key speakers to work with them.

Suicide intervention, child and youth behaviour workers, sexual wellness workers — lots being done in terms of keeping with these health reform principles that the districts have undertaken. Sorry to interject, but I think those are so special and so important that we need to mention those specifically.

Mr. Rivard: — Thank you, Judy. Why did we initiate change? Why did we get involved in developing northern strategy? I think we've been fortunate in one way, a few ways I guess, is the opportune time.

We have a recent history of development of the health districts in the North. That's just happened over the past few years. And maybe also the timing of the Fyke Commission, I believe, is an opportunity for us.

But some of these initiatives have evolved out of the northern dialogue, which was initiated by former Premier Roy Romanow in the late '90s with the northern leadership — Max mentioned Metis Nation leaders, First Nations leaders, and northern municipalities.

But also northern communities have been involved in health transfer because of the federal government's transfer of responsibility to First Nations communities. And that's been, as you know, evolving over the past 10 or 15 years. And our communities have all been involved and been affected by that transfer.

Over the last two decades northern communities have also been consistently asserting that they require greater health responsibility and control of their health. Keewatin Yatthé Health District, Athabasca Health Authority, Mamawetan Churchill River Health District, despite their major challenges as indicated, have accepted responsibility of health transfer and devolution.

There've been identification of issues and concerns. We have built partnerships. We've sat at common tables. The three northern health authorities as well as the First Nations health authorities have all sat at a common table and built partnerships.

We presented a partnership paper to Ms. Judy Junor in October, the associate minister of Health. As well, we participated extensively in the development of a SAHO paper. We presented to the Fyke Commission in December, and again in January. And finally, the Fyke report came through in the spring endorsing the northern health strategy.

Why a northern health strategy? The partners believe that obviously we have similar geographic and distance challenges. We have similar population growth and composition issues. We have similar disease and health problems, similar historic health services challenges.

The culture of the people in the North is holistic. There have been numerous community consultations regarding health services and these indicate that there is a desire for a holistic approach to health delivery. We believe it is a way to achieve and maintain a sustainable health system.

We believe that the northern health strategy is built on the health reform principles and that the health reform principles provide an opportunity for influencing the broader determinants of health. A northern health strategy will help us to increase self-reliance, and self-reliance is part of the holistic approach to health. Self-reliance is integral to achieving a financially sustainable health system. We have to work together. We've got some shared and common problems, jurisdictional problems. The partnerships that we've created in the North, I think where we can share resources, will be able to address our common problems.

What does the endorsement of the Fyke Commission report, what does it mean? We believe that it advances the former premier's dialogue with northern leaders and the commitment to address northern issues.

We believe that the extraordinary circumstances as outlined in Judy's paper earlier are recognized. We believe that the province must now indicate their position regarding the North's

initiative and Fyke's endorsement of our strategy, and this is an opportunity to build on our work with all of the northern partners and support with government. It means for the strategy to work, the northern stakeholders still have to continue to work towards defining a framework of the northern strategy.

Thank you. Max.

Mr. Morin: — Okay. Thank you. I'll continue from where Al left off. What is the northern health strategy? It must be holistic, must place the individual within the appropriate family and community context, must recognize the North is unique. It has historic . . . (inaudible) . . . resource health services. It has a unique configuration of health problems. It has unique geographic issues. It has a unique population growth situation. And it has a unique language and cultural issues.

What is the northern health strategy? The strategy must emphasize prevention not just treatment. The strategy must recognize and respect the complex jurisdictional issues in the North, First Nations- and Métis-held districts, federal, provincial, and municipal governments.

The strategy must recognize that the health of northern people requires co-operation and support from department and agencies that often don't view themselves as delivering health services. Sask Housing, as an example, or Justice, Social Services, Recreation.

What is the northern health strategy? A recognition that the North is different than the rest of the province and requires a unique approach. A definition of the basic level of health services that a person living anywhere in northern Saskatchewan can expect.

What is the northern health strategy? It includes a funding formula that rewards holistic health approaches, and recognizes the North extraordinary circumstances; a health evaluation system that is based on holistic health criteria.

Goal. The goal is to improve the health status of northern Saskatchewan residents.

The principles. Individuals and communities need to take ownership of their own health. This is more predominant in the North because of the historic context. We need to respect the autonomy of individual health districts and First Nations health authority. We need to build on current strengths and create new ones.

Objectives. Develop delivery frameworks for health care delivery for promotion of well-being and prevention of ill health to increase family, community, and northern region capacity to improve health.

Develop partnerships capitalizing on shared goals while ensuring diversity. Develop, in conjunction with funding agencies, a fair and equitable resource allocation and reporting model. Process to be led by northerners according to the principles identified.

The next steps. Engage the proposed working group including provincial and federal health agencies. Identify immediate issues for action. Develop a work plan to be approved by the northern health stakeholders. Define time frame for immediate, short- and long-term action, and a communication strategy.

The work begins. The northern health strategy should be inclusive of a wide spectrum of interests in the working group. The main element of the partnership model is still intact, although we must find a way to utilize all the other groups that have some determination of well-being for our constituents.

The northern health strategy should be considered as integral element of the overall northern strategy.

Define a flexible, basic, and integrated level of services that would be available to all northerners. Propose a funding formula that recognizes the unique cost of delivering service in the North and reward prevention and holistic approaches.

Continue to build on the efforts being made in recruitment and retention. Develop a co-operative approach to encouraging northerners to train for health careers.

Propose an evaluation system that takes into account holistic principles.

How do we find the common ground, common issues, and how do we collaborate to create a system that maximizes northern health resources?

Create recommendations for effective mechanisms for permanent federal and provincial partnerships . . . participation in the northern health strategy.

Some of the tasks we have are operation/service scan; define roles and responsibilities; human resource capacity; integrated process models; partnerships outside of the health sector; health education promotion; infrastructure, what is there and where and how does to make the best use of them; research, build on the Polypartite R&D (research and development) Committee; accountability/quality, a required element; funding services, strategy to lobby for more financial resources for services; funding strategy, strategy to lobby for resources to assist in development and implementation of the northern health strategy; transportation; information technology; consultation; community strategy.

Enabling factors: federal and provincial governments' endorsement of the northern health strategy, financial commitment to ensure the strategy process is nurtured, and a written commitment by stakeholders through a memorandum of understanding.

Judy, that's our presentation. If you have questions.

The Chair: — Thank you very much. That was a very comprehensive and collaborative presentation. And that was very well done. Questions from the committee members?

Mr. Gantefoer: — Thank you very much, and welcome all this great distance south. When I see the statistics that you release, it's a long way.

One of the questions I have is — I noticed in, I think, one of

your slides that it showed that the three health districts have a lot of joint projects and collaborative association serving 30,000 people — is there a need to have three separate districts, or could one district do that and eliminate the need to set up another layer of collaboration?

Mr. Morin: — Because of the vast area we cover and the unique area — the geographic area of the area — we strongly believe that the three health districts have to remain in the North, because Athabasca Health Authority deals specifically with the Athabasca. And sometimes even they feel that they're being left out when we're initiating initiatives in the Mamawetan or in the Keewatin Yatthé Health Districts.

But the co-management agreement, the one-of-a-kind positions . . . we felt that we would sign a co-management agreement and work collaboratively on one-of-a-kind positions, like we couldn't have all those positions in every, every . . . I think they call those positions in the South, host districts. Instead of a host district, we signed a co-management agreement and all the health districts and the Athabasca Health Authority all work collaboratively to sort of give some direction to the one-of-a-kind position staff that we have.

It works that way, but we still feel strong that the health districts in each of the districts in the North have to be intact so we can specifically deal with the issues confronting our people in that area. But it's too broad the way it was one previously to the Northern Health Services out of La Ronge, and they had one department running everything. A lot of people didn't get the services. That's why we're in the health conditions that we are now.

Mr. Rivard: — Also, geographically the communities that connected north-south. There's the corridor on the west side which goes from Green Lake through to La Loche and all those communities. And those . . . so those communities are all linked together in the Keewatin Yatthé Health District.

The main artery in the central west side or east side, I'm sorry, from just north of Prince Albert through to Southend. And now the newer road through Stony Rapids — that's another geographic, I guess, barrier or boundary. So the delivery of services makes sense along the border lines.

And then in the far North the access — even though there is a somewhat ill-defined, I guess, all-weather road through there — the access to the far North is by air. And the communities are mainly First Nations, too, in the far North. So that's another support I guess for there being three health districts.

Mr. Gantefoer: — In terms of looking at your plan, it talks about the goals and objectives and tasks that need to be laid out. It's still too soon in your formation, I guess, to actually lay out a plan as to how it would work. But have you looked ahead to say we need in addition to all the socio-economic, cultural, you know, lifestyle issues, and the determinants of health that need to be worked on, what kind of service model in terms of acute care service delivery are you looking at?

Mr. Fyke talks about primary health care services, for example, where you would have physicians, nurses, you know, a number of health care professionals working in collaborative practice. Do you see a part of that in the communities of the North, and then some itinerant? Or do you have a model as to how this actual service delivery may happen in your mind?

Mr. Morin: — I don't think we expect a regional hospital in the North, that's a farther recommendation, immediately; maybe in the future. It talks about centres like La Loche being a health centre where the acute care and the long-term care, and Ile-a-la-Crosse being the other centre where we provide acute and long-term care on the west side.

In the east side they have Flin Flon and La Ronge. And then Uranium City is the existing facility for acute services only in Uranium City, but they're planning a new facility in Stony Rapids to look at Black Lake and Stony Rapids where the population is because Uranium City, just about 200 people live there and that's where the hospital was built a number of years ago.

I believe the primary care model is really what we're looking at and also collaboration through the northern medical services.

We have physicians who are hired through the College of Medicine and we have a department called northern medical services where the physicians come to work in La Ronge, Uranium City, and in Ile-a-la-Crosse — and we're working on a similar model for La Loche as we speak — where they're not on a fee for service but on a salary where they can spend more time doing more community health development processes at the community. And they're not worried about if I take time off then that means I won't get a fee-for-service charge or whatever. That's a concern we have.

And we have the primary care nursing and our physicians in Ile-a-la-Crosse as an example I can give, trained these nurses to become primary care nurses and they're situated in communities like Beauval, Dillon, Patuanak, and that's where the primary care nurses in that they collaborate and work with the physicians and the other staff, professional staff.

Ms. Moore: — That's available in La Ronge as well too; a primary care nursing available right at the clinic that works hand in hand with the physicians that are there.

Mr. Gantefoer: — The position of advanced practice nursing or advanced clinical nursing is something that has just really been defined in legislation in this past legislative session. But I believe northern nurses have been exercising in reality that function for a good number of years in many of the communities.

Do you see . . . Is that program needing further expansion and is it meeting a lot of your needs? Or do the advanced practice nurse or the nurse practitioners have an increased role to play in delivery of health services in the North?

Mr. Rivard: — Because of our challenges of geography and isolation in the communities, definitely we'll be continuing to rely on those added expectations, I guess, of our caregivers.

Mr. Gantefoer: — One final question. In terms of training of northern people for these roles, a lot of the people are people from the South that come north to work. Is there some success

and some direction in terms of providing training opportunities for northern people to come back and work in their communities?

Mr. Morin: — There was a program delivered by Dumont Technical Institute in Prince Albert and there was five people from our health district that took that training. The day they graduated I was there recruiting and I hired all five of them back in our district as LPNs.

And we've also supported the First Nations community out of Prince Albert — Northern Intertribal Health Authority — doing the initial nursing access program that they just announced recently, eventually leading to a diploma nursing program. And that area, they also have sent a lot of our northerners to that dental therapy school out of Prince Albert. So it's working. It's gradually . . . and we're increasing the education system.

We're meeting with Northern Lights School Division, Creighton, and Ile-a-la-Crosse School Division to see if they can get more math and science; encouraging the students to take that math and science and biology classes so they can eventually get into health careers because a lot of them were not taking the math and sciences. In some schools it was not available to them.

So we're trying to make that available and we have successfully got a Smart Community initiative from Industry Canada through Keewatin Career Development Corporation.

And we're looking at distance high-speed Internet access to the community. So if it's not available in Jans Bay or in Ile-a-la-Crosse, the student can still take it through the Internet process that we're connecting four to five schools in northern Saskatchewan through this high-speed Internet. So we're making . . .

Ms. Moore: — We also have our summer student program too. I know there's a number of students . . . there's about 12 of them over in the Keewatin . . .

Mr. Petit: — That have been hired, yes . . . (inaudible) . . . students through Sask Health funding as well as centennial funding to hire some summer students. We hired six . . . actually ten grade 12 students that applied to go into nursing, LPN. We've also hired students that are in nursing college now that have come back for the summer.

Ms. Moore: — We have some . . . (inaudible) . . . in the Mamawetan district as well too, so a summer student program for those that are looking at health career professions. So we give them an opportunity over the summer to work in some of those areas, shadow alongside the people.

Mr. Thomson: — Thank you, Madam Chair. I want to thank the presenters for a thorough and an excellent presentation tonight. The questions I want to pursue are really twofold, and then I have a comment.

I am very interested in the comments that you have made tonight about some of the things which are impacting on the health of northern residents, things like housing, water quality, these kind of issues. In the context of a northern health strategy, has thought been given to rolling more responsibilities, perhaps housing authority responsibilities, into the health district? Or is there another protocol or framework that can be worked out to make sure that everyone is headed in the same direction?

Mr. Morin: — I'll just touch on one example. I think what has to happen is the housing authority in most communities are doing a sufficient, a good job in most communities. The problem is with the policies.

I'll give you an example. Because of the shortage of housing, in order for you to get access to housing, you have to have dependants. Why do you feel our young girls are getting pregnant, you know. Might as well have a dependant and then maybe I can get access to housing. That's the only way you can get access to housing. There's no housing for single, employable people. There's no incentive and there's no initiative for them.

So what do they do? You know, they shack up; they get pregnant. And then I'll apply for a house with the housing authority. Maybe if I have one or two dependants, my chances of getting a house is better. That's the only . . . that's the housing situation we're facing in most communities in the North.

And the policies . . . if the northerners were given an opportunity, the housing authorities at the local level were given an opportunity to define their policies a little more clearer and access to housing for a remote housing program that Sask Housing introduced, for example — it's only for families. If a single person wanted to apply and had a job, I'm sorry, you can't apply. The remote housing initiative is only for families. So first, if you get a dependant, maybe you'll have a chance to get access to that program. You know, that's the reality. That's the policies that have to be changed in order for us. And that's part of the northern health strategy.

We want to be involved in designing and sitting down with different departments. How do we change the policy to meet the needs of the community? They've been making the policies out of Regina or Ottawa for us and that's why the health status and the condition that our people are in today.

Mr. Thomson: — In terms of developing the northern health strategy, it seems that, in many ways, it's headed in the same direction Mr. Fyke is in terms of trying to empower more community control.

And obviously things are more difficult in the North because of the involvement of the federal government more actively on the reserves and their relationship there, the unique situation.

Is there an ability through the health districts to bridge some of these jurisdictional issues or are we finding that, in particular, the federal government is jealously guarding its role or do we find that the partners are prepared to work together?

Mr. Morin: — We have partnerships with Meadow Lake Tribal Council and I think Mamawetan has partnerships with Lac la Ronge Indian Band, Peter Ballantyne Cree Nation, and the Prince Albert Grand Council where we have adjacent communities.

I'll use Jans Bay and Cole Bay as example. They're adjacent to Canoe Lake First Nations. The Canoe Lake First Nations provide clinical and nursing services to our people and we sign an agreement with them to do that.

And we have First Nations representatives on our board, sitting on our board, not necessarily representing only the First Nations, but bringing the First Nations issues and point of views to the board table.

And health; we look at it, health affects all of us. It's First Nations, Métis, or non-Aboriginal. It doesn't matter who you are. It affects everybody. And so, jurisdictional issues, when it comes to health, are not that hard to break because, if you're ill or you're sick or you're in emergency situation and you need help, it doesn't matter who's there. If the person is from the First Nations community or from a non-First Nations or Métis community, they're all out there to make sure that the client or the individual gets the help that they require.

And also, because of the lack of resources that we had in northern Saskatchewan, we've collaborated and came together and say, because of the lack of resources, why don't we put our resources together and work together collaboratively so we can improve the well-being of the individuals in our community. So we've been doing that for a number of years now.

Ms. Moore: — . . . either, but certainly it's been a part of the development of the northern health strategy, represents NITHA, the Northern Intertribal Health Authority. So they certainly are committed to this as well. And Lionel was meeting with the federal regional people here in Regina as well to make sure they were well versed on this.

Mr. Thomson: — The second area I wanted to ask about was these . . . the prevalence of some of these chronic diseases, in particular diabetes which appears to be largely out of whack with where the rest of the provincial population is. Is there an ability for us in the northern areas to look at disease-specific strategies to deal with some of these issues like diabetes, or even the high prevalence of lung cancer that you . . . and lung disease that you mention? Or do we need to look at this at strictly a holistic level? Is there an ability for us to take a two-pronged approach there?

Ms. Moore: — The area we're looking . . . we have established the Northern Diabetes Prevention Coalition which certainly has focused on taking the message out to the communities in terms of the focus being healthy eating and lifestyle. We've been able to reach that in the various languages of the North, in Dene and also in Cree, through Missinipe Broadcasting. So we've been able to get the message out to people.

We're also looking at various community projects so we've been having workers out in the community planning different events such as walking trails, nutritional programs in the schools. There's been policies developed at this point in time that different . . . the Northern Lights School Division and recreation associations have taken on in terms of developing their programs, and the food that they offer in their schools, in their machines, and that type of nutrition program. So there's been a real grassroots movement that way in terms of the area of diabetes, to look at what we can do to effect change there in people's lifestyle. That's one I can certainly speak to.

Mr. Rivard: — . . . in that is to make the best of what . . . the resources that we have because the programming to deliver all that is . . .

Ms. Moore: — Yes.

Mr. Rivard: — . . . we're limited in the capacity, the manpower. A lot of this is volunteer at the . . . right at the community level. And we're thankful for that, but still limited resources.

Ms. Moore: — The funding for the coalition actually was a three-year funding program and we're rapidly approaching our last year for the efforts for that.

We have since put in two proposals into Ottawa to continue on under the Métis off-reserve Aboriginal diabetes proposal. So we have two in there in terms of carrying on more grassroots work in the area of diabetes prevention. And we're waiting to hear back on those proposals. So we're hoping we're successful on those.

And that focuses on the west side and the communities of Sandy Bay and Pinehouse which we see as real need.

Mr. Thomson: — Thank you. I just want to conclude by making an observation or a comment.

Of the presentations we've heard so far, we've heard many different views on how Fyke will affect particular segments of the health care sector, different communities. And I find it very interesting that, given the compelling statistics that you've shown us on what is happening in the North in terms of health indicators, in terms of rates of disease, in terms of the strategy that you're working on, I find it interesting that in all that time you didn't once use the word crisis, which I think we have heard in just about every other presentation.

Ms. Moore: — We used extraordinary.

Mr. Thomson: — Because if anywhere I have seen a compelling argument of the need for us to focus our resources and our approach much more in health care, it's in the presentation you've laid out tonight. And if I could say anything, I would in many ways think that this should be required reading for all of us Southerners so that we understand just what the difference . . . of how good we have it down here.

So while clearly you have outlined to us a very significant challenge, I think you've also outlined a good start on a strategy to start to deal with it. And I want to congratulate you on that.

Hon. Mr. Melenchuk: — A couple of quick questions. Certainly I believe Fyke does recognize the unique circumstances of the North in his recommendations in terms of the jurisdictional issues and maintaining the three northern districts. But I think he also recognizes that the focus needs to be on public health prevention and promotion issues.

But the question that I have — and I'm looking to see where you're thinking along these lines because I didn't see it

particularly in your northern strategy — is how, how would you see the access to specialist services and diagnostic services for your 33,000 people in northern Saskatchewan? Where would the improvements be?

You have consultant specialists that will travel to northern communities. Do you see a regional centre of some type providing secondary services in the future? Or do you see a lot more travel for northern residents to tertiary care, secondary care facilities in Prince Albert, Saskatoon? Where do you see that evolving to?

Mr. Morin: — Yes. The first issue is a new health centre will be completed, I guess . . . inspection in La Loche on the 17th of this month. I'll just use La Loche as an example. They were operating out of ATCO trailers and the new centre will be able to accommodate specialists' visits. There's rooms there available for them.

And the facility in La Ronge — anybody . . . you've seen it — has rooms there to accommodate specialists.

And the primary care centre, tertiary care centre, the recommendation by Fyke, for example, in Prince Albert, we don't have any problems with Prince Albert. Right now we're utilizing Saskatoon from the west side, as an example. But if Prince Albert can provide those services to our people, why not? And we did have some initial discussion with the Prince Albert Health District because right now the northern medical services, the College of Medicine, they're connected with the University Hospital and they're referring people to specialists.

In the future, we'd like to see more specialists' visits come to northern Saskatchewan and, through northern medical services, arrangements are being made. We have quite a few visits on our polypartite meeting that we have with northern medical services. On a quarterly basis, reports are given.

And so, a lot of our people . . . also, the expansion of the Telehealth initiative is another one that we're currently working on. And our medical health officer had indicated that the problem we have is in the receiving end, which is Saskatoon. If somebody, a specialist in Saskatoon had access to that technology, they'd be able to receive from Uranium City or from Ile-a-la-Crosse or Beauval. And if arrangements could be made to have that technology in a specialist's . . . access to that technology, then we don't have to refer as many people for a 10-minute or a 15-minute visit to a specialist from La Loche or from Ile-a-la-Crosse when you can use the technology that we have in there right now. But the only access we have is with the University Hospital. It's in one setting and the specialists don't usually go there. So we're trying to expand that to include some of the specialists having that technology within their offices.

Ms. Moore: — The other area might be ultrasound services. I know we have those available now in La Ronge. We have a technician and we have the equipment. So we can actually do them right in La Ronge, at the health centre there. And that might be something we would want to look at or consider in terms of maybe another location in the North, to be able to provide those services rather than people travelling to La Ronge or to Prince Albert to access those diagnostic services.

Hon. Mr. Melenchuk: — I have one other question in terms of follow-up. Do you see a point in time when surgical services on a day surgery basis would be provided say in La Ronge or La Loche?

Mr. Morin: — From my perspective, maybe not major but minor stuff, you know. Because the group of physicians that we currently have, one has to be an anesthetist, one has to be a surgeon, and another one. So there has to be a team of them working together and it's pretty hard to recruit physicians like that. Not like the old days when Dr. Hoffman did everything way up in northern Saskatchewan. He operated on you if you had appendicitis or you had broke your leg. Everything — he did everything. So those days are gone, I guess, for that.

Hon. Mr. Melenchuk: — I was thinking more in the terms of itinerant surgery where a specialist from Saskatoon or P.A. would go up and do a slate of 10 cases there, all day surgical. For example an ENT (ear, nose, and throat) surgeon, a lot of middle ear problems, could do eight or nine kids — put tubes, ventilation tubes and things like that — without having all those children travel to Saskatoon or P.A. to have that procedure done. And they might be just in for a day and then there would be the trained follow-up, you know.

And I think we have the College of Physicians coming in next, and I don't think they have any particular regulations for problems in that area.

Ms. Moore: — It certainly makes sense because we do have, you know, those services coming in in terms of diagnostic — ear, nose, and throat, and various areas. So yes, if there could be some of those day procedures done it would fit hand in hand with the services they're providing right now by coming in and testing them.

Mr. Morin: — We did approve an ENT when I sat on St. Joseph's Hospital Board for those minor procedures in Ile-a-la-Crosse.

Hon. Mr. Belanger: — Just a couple of questions I have. First of all I think some of the examples that you've given us are some of the challenges in northern Saskatchewan when it comes to health care.

I didn't want to say very much and I wanted to give the opportunity to my colleagues to hear first hand and to question first hand some of the challenges that you face. And I just wanted to point out that, you know, when you give us some of those stats it really brings home the point of all the tremendous work that's being done out there in northern Saskatchewan.

So on my behalf, I think I talk for my colleagues as well, is to commend them for their contribution because the North has really got some serious challenges ahead of them. But there is some really good work being done.

My question being . . . there's two very brief ones. And just before that, I have a very small point about Fyke. Fyke recommended and recognized some of the northern challenges, and recommended the three health district system in northern Saskatchewan along with the four hospital system. So he understands the challenges. And the document indicates that. So

there's no question, I think the approach you're taking certainly has his endorsement and some of the work that the committee's going to do will certainly continue pushing forward on that front.

When you talked about the funding formula on page — I'm not sure what page it is — but it says, propose a funding formula that recognizes the cost of delivering services in the North and rewards prevention and holistic approaches. Could you give me some of the examples of some of the holistic approaches that you would talk about?

And secondly, when we do provincial Acts like a smoking Act, the tobacco Act, does that help some of the strategies in the North when it comes to having the young people stop taking up smoking as much as they did five years ago?

And so those are the two questions I have.

Mr. Morin: — First of all, in regards to some of the legislation that's being passed in regards to smoking, it has some impact but not as much as it should in some of our northern communities.

I just read some documents that were faxed to our village officers, a lobbying effort being made about you have to hide, not show your cigarettes in public. They have to be under the counter or some place like that. And there's people lobbying right now saying you should phone your MLA or whatever to not to try and pass that kind of legislation.

I don't know what has to happen. I think more graphic situations have to be given to people and role models have to go . . . and we're working with the schools. We have partnerships with the schools, and we're trying to get healthy public policies established.

Our population health unit and our medical health officer is designing policies that we can implement at the local level. Smoke-free bingos as an example. People play bingo and so we'll try no smoking at this bingo. What alternatives do we provide? We provide them healthy other stuff maybe.

In the schools as an example, we're saying instead of selling pop and chips can you sell juice, milk, and stuff like that — more healthier foods. You know, that's the kind of policies that we're trying to implement.

In regards to Fyke's recommendations in regards to northern Saskatchewan, yes, Fyke understands. We had an opportunity to meet with him twice and also he came on MBC (Missinipe Broadcasting Corporation) in northern Saskatchewan where me and Louise Wiens, the Mamawetan Churchill River Health District chairperson, went on the radio, open-line radio, to hear views from northern Saskatchewan people.

Our strategic plans were also given to Fyke and our strategic plan addresses a lot of the issues that he talks about. We went to 1,100 people in our health district in regards to developing our strategic plan, and the number one issue is holistic.

And examples I can give you in regards to the holistic approach to health, what do you mean?

The way it was before is, I'll use the rehab centre. And we used to laugh at some of the people that used to work in the rehab centres. The more people you have in your rehab centre, the better it is statistically. You know what I mean? The more people that are in the hospital, it's good statistically. It provides good arguments what the funding . . . It gives you a good argument that funding is being utilized to its capacity.

And we're saying if people stay away from the long-term care homes; if people get it, say enrich housing; support, better home care services at the local level, let's keep them outside of the acute care centres. Let's keep the minimum people, the ones that really require an acute care centre. Let's keep the people from the rehab centre. Let's provide programs at the local level so they don't have to come to a rehab centre unless they're in a dire straits situation.

That's the approach we're looking at. That's the holistic approach we're talking about. Instead of giving us funding and saying, your hospital is funded for 18 beds, then make sure there's 18 there. If we have 6, does it mean we're being cut off, we'll get penalized? Is it because we're doing a better job of keeping them away and being healthier at home?

Hon. Mr. Belanger: — The system then is pay to keep people in the hospital as opposed to keeping them out, and that's a fundamental difference that we have in northern Saskatchewan.

So I just want to thank you and I realize and appreciate that an hour and fifteen minutes is not enough time, but at the very least we had a very good snapshot of what's happening in northern Saskatchewan. And again I commend you for all your work as people that are involved with the health district and look forward to some of the approaches that are necessary in the future to make things better. Thank you.

The Chair: — Thank you very much, on behalf of the whole committee. I think it's been said quite well that this is a very good presentation and it's well worth everyone that's watching to have seen it. And I know I've been involved with your issues for several years and I see that you've really come a long way again. And I congratulate you on continuing to do very good work together. I look forward to seeing your strategy evolve and come to fruition. Thanks again for coming.

We'll take a few minutes to get the technology . . .

Mr. Morin: — Just one final comment Judy, is as northern Saskatchewan people we're ready for the challenge. And I just want to say that because there is a lot of health issues out there. But give us the opportunity as the provincial government, and we're working with the federal government also, to deal with the issues that are in front of us — and we're willing to go against the wind if it has to — but we're willing to take that challenge and see if we can improve the health status of our people. Thank you.

The Chair: — Thanks again. And we'll take a few minutes to get the technology removed before the college comes forward. Thank you again for coming.

I think we're ready. This is the Standing Committee on Health Care. I'm Judy Junor, the Chair of the committee. It's an

all-party legislative committee. The other members are: Dr. Jim Melenchuk is the Vice-Chair; Andrew Thomson; Warren McCall; Buckley Belanger; Brenda Bakken; Bill Boyd; and Rod Gantefoer.

We have half-hour presentations — your presentation — and then included in that half hour, questions from the committee if they have any. And I would welcome you to introduce yourself and where you're from, and begin your presentation.

Dr. Morris: — Fred Morris, president of council. I'm from Moose Jaw.

Dr. Kendel: — I'm Dennis Kendel, the registrar of the college, from Saskatoon.

Dr. Morris is a good example of a Saskatchewan physician who has not only served his entire career here but he's now recycled himself. Having been a general surgeon up to this point in his life, he's now retrained himself as a flight surgeon and works at the Moose Jaw air base. So there's a tribute to lifelong learning if you can retool yourself at that stage of your career.

I gave you copies of our written presentation earlier, and I trust you'll have time to read that. And we don't intend to go through that in detail because we'd like to leave ample time for interaction with you in answering any questions you might have. So we're just going to touch on some highlights.

But at the outset, I think it's important to clarify that we aren't here on behalf of physicians because the College of Physicians and Surgeons is not an agency that represents the interests of physicians. That's the responsibility of the Saskatchewan Medical Association. The college is an agency created by this legislature to regulate medicine in the public interest, and that is our job.

We're governed by a 17-member council, and as we point out in the paper, five of the members of our governing council are public representatives appointed by the Lieutenant Governor in Council; 11 are doctors elected by their peers around the province; and the dean of medicine, or his or her designate, sits on the governing council.

The council actually has a number of explicit values that it wants to achieve and some organizational goals which I've outlined in the paper. As we went through the Commission on Medicare report, it was encouraging actually how many of the recommendations are actually aligned with our organizational goals. In many instances actually, we believe that although there's much work that needs to be done to flesh out the details, that many of the recommendations are aligned with those goals.

I'm going to comment very briefly on a number of key recommendations in the report prepared by Mr. Fyke. And the first I want to speak on is the creation of a quality council.

We certainly strongly support this recommendation at the College of Physicians and Surgeons. Frankly, there's probably no other area of human endeavour where people would spend $2.2 billion of their money without putting more effort than we have historically into actually making sure that we're getting quality and value for that huge expenditure. And I would point out that we see value as an inherent part of quality because certainly if we're spending money on things that aren't effective, that's a waste of public resources.

So we think that many of the recommendations in this report are interrelated and we discourage cherry-picking.

On the other hand, the quality council is probably something that stands on its own merit; that in fact to move the agenda ahead we think we need an agency that has some independence, some credibility to actually measure what we're doing on a day-to-day basis and to report, we suggest, as Mr. Fyke did, to this legislature directly and also directly to the public.

We think the quality council needs to be insulated from inappropriate influence by, frankly, health service providers, by interest groups, by the government itself, or the official opposition of the day. It needs to have a sense of independence but very accountable to the legislature and the public.

And we feel that the quality council should not be an academic agency that isolates itself from the people but engages the public in dialogue about options that the public needs to make decisions on.

So we do strongly support moving ahead with the council and we believe it does deserve funding of the level that Mr. Fyke actually recommended.

In terms of information management in the health care system, you heard earlier today from the Saskatchewan Health Information Network, and we would concur with many of the observations made by that agency.

The Fyke report describes the situation as one in which the health system is data rich but information poor. And those of us who work in the system find it very frustrating often that there's data collected for very isolated functions, but the data are not sufficiently connected to actually make judgment about whether the system as a whole is working as effectively and as efficiently as it should. And so we think more investment in information management is an important public priority and we would support that.

In terms of restructuring of primary health care services, we make the observation and report that Fyke's comments on this issue were hardly novel. Almost any group that has recommended or studied this issue in the recent years has recommended fairly similar things.

And there's three points on which we strongly agree, it's that primary health care services need to be much more deliberately planned and organized, rather than just hoping they'll happen. And right now, frankly, in many areas of this province, it's by hit or miss whether in fact primary health care services do happen because they are not organized and coordinated.

We believe that all health care providers who play a role in meeting the public's need for primary health care services need to work collaboratively as members of a team. You've heard that time and time and again, and yet, quite frankly, short of the few pilot projects that have been underway, teamwork really isn't happening right now and we need to find ways to connect

people to work more effectively as teams.

Now some of those may be virtual teams because of Saskatchewan's geography. It might not be possible that all of those people are co-located, but at least they need to share information and they need to be working to the same purposes.

And the team approach to health care . . . primary health care needs to be structured to maximally harness the skill set of all the health providers involved. As we sat and listened to earlier presentations, we heard questions about whether advanced clinical nurses are being used to their full advantage at the current time — and quite frankly, they're not being used as fully as they might be.

Indeed nurses with regular education, quite apart from ACNs (advanced clinical nurse), are not used to their full advantage. There are many health workers, I think, that could be used to greater advantage if in fact we organized the system more logically.

In terms of the history in Saskatchewan . . . and I was a relatively young person in 1962 when the tumultuous debate occurred in Saskatchewan, but I did live in this province. I've lived in this province all my life.

And it's interesting that back in 1962 Tommy Douglas actually had a vision of a more organized approach to health services, and I must say it was our profession that to some extent opposed that because of a fear that there would be loss of professional autonomy. And it was that fear that actually caused the medical profession of that day to withdraw its services for 26 days. And that was resolved ultimately through mediation by Lord Taylor.

And the saw-off that was achieved was an agreement that government would fund services but physicians would remain essentially autonomous entrepreneurs as it were.

And it's not our position to say whether in fact any particular group in the system should or should not function in a private practice way, but the system does need to work more coordinated as a system. And currently it doesn't.

And so in bringing to the table all the stakeholders who need to get together in primary care, it's our concern that it probably won't happen in earnest until there is a serious public policy commitment to that on the part of whoever the government is at any particular time.

And so we hope that on the primary care piece that the government will make a public policy decision in the near future to actually try and implement integrated primary health care teams, and that that will stimulate the dialogue necessary to bring all of those workers together.

In terms of health human resource planning and management, there are some activities already underway, including the recently created Health Human Resources Council. And we support that. We think it's illogical to try and plan for human resource supply each profession separate from another, because there's so much interrelatedness that you can't logically plan the physician workforce unless you have an anticipation as to what role other groups will play. And so a more integrated approach such as the Human Resources Council is taking is one that we favour.

In terms of consolidation of health districts, we mentioned at the beginning of our paper that we believe that form should follow function. And there's compelling reasons to try and keep decision making as close to home as possible. We recognize that. We have empathy with that. And for some services, primary health care services, there's no doubt that having community-level involvement is critically important.

But there can be ways, we think, to engage the community in decision making that doesn't necessarily mean having these head offices at the number of sites that we currently have them and all the redundancy that goes with that.

As one of the agencies — and there's many in this province that try to work collaboratively with the districts — we also have to tell you that it's just a daunting task to work with 33 different agencies. The truth is then that you give your best probably to perhaps a third of those because you can't frankly maintain meaningful relationships with 33 different agencies.

And so we do think there is good reason to have some consolidation of health districts. The precise number obviously might require some more study.

It's interesting also that the relationship between however many health districts there are and the government does need to be clarified. It's easy for anybody to make decisions that are popular with the public. But when you make decisions that are unpopular, the worst thing is to be blamed for the decision and not have control over it.

So it's our perception that sometimes when health districts would be inclined to make decisions that are unpopular with the public and the public reacts, they tend to blame central government. Conversely, sometimes when they're inclined to make a decision that would not make the central government pleased, they're prohibited from doing so.

And so there has to be some clarification of where the decision making actually lies. And wherever the decision is based, those people have to be accountable for the decision.

In terms of Mr. Fyke's recommendations on restructuring the hospital system, it is quite a drastic change, I'm sure many people perceive, to move from the current supply of 70 hospitals to potentially as few as 20. And I think to some extent what is missing in the report is dialogue about what actually would happen in those other communities. What is it possible to do through these other facilities? And the report was quite skeletal in that extent.

And I think it does take more dialogue as to whether you can assure various important diagnostic services in these communities and point of access in terms of emergency care without necessarily having a hospital.

I think when we reviewed the issue of hospital supply, there was little doubt that if you were starting *de novo* in Saskatchewan today with a clean slate, you wouldn't build 70

hospitals — no one would do that. But you also have to recognize that there are 70 hospitals on the ground and therefore, in terms of coming to a pragmatic solution, there probably does need to be more study in terms of how many hospitals do we need to actually deliver true acute care and then what structures do you need to deliver the full range of services, many of which no longer require a hospital base.

We made brief comment in relation to the College of Medicine. We regard the College of Medicine as a very important institution for the future of this province. We recognize that there has been considerable conflict about the appropriate role of this institution. There is continual claims from the institution that it's underfunded. In turn many external observers feel that the institution is not adequately responsive to the actual needs of this province.

It is our sense that Mr. Fyke felt that the institution deserves to be more generously funded if in fact it focuses its mission on the needs of this province. And certainly providing people for health care in the rural parts of our province, dealing with Aboriginal health issues, and providing generalized specialist education would seem to us to be the logical mission for this relatively small medical school, rather than trying to be a smaller version of the University of Toronto.

In terms of future affordability, this is probably the issue that we have least jurisdiction to make any meaningful comment on. Our only comment is that whatever rethinking or restructuring might occur in terms of funding, I guess we would plead that we remember that the fundamental basis of the system is to try and spread risk across the entire population and to help those people who might be most disadvantaged by disease.

And we would therefore caution against any changes which would in fact shift the financial burden more to those people who can least afford to bear the costs.

So with those preliminary remarks and trusting that you will read the paper in its entirety, we would prefer to answer any questions you might have.

The Chair: — Thank you. Questions now.

Mr. Thomson: — I have a couple of questions I wanted to ask and you touch on it a little bit in terms of HSURC and the question of the quality council. You make the comment on page 4 of your brief, saying that HSURC . . . I'm looking at the third paragraph:

> HSURC has had some limited success in transferring its research findings into public policy and clinical practice.

How would we go about making sure that the quality council had a greater success of this? I think about some of the good work that HSURC has done in terms of looking at how the emergency rooms have been improperly utilized in many cases — I think the stat is 77 per cent in the large tertiary centres — and yet we seem to have not dedicated much of our time in figuring out how to move these people out of the emergency rooms and into other more appropriate areas.

How could we make sure the quality council was more effective or built on the work of HSURC?

Dr. Kendel: — I think when we've discussed this at the college council, one of our views is first of all, Fyke assumes that HSURC would be subsumed within the quality council. In other words, what HSURC now does would continue but there would be a much larger role for the quality council. And where that larger role would probably have its greatest impact would be on influencing public policy in terms of how the system would actually be structured and run.

Right now a huge proportion of what HSURC has been doing is trying to influence the hearts and minds of individual health care providers, most notably physicians, to change practices in accordance with the best available evidence. And that's a very slow process.

But the reference that was made to one instance in which the utilization commission was particularly effective was in terms of changing the practice for testing thyroid function. It's a somewhat esoteric example but hard evidence that we waste a lot of money by ordering a sequence of tests when in fact one screening test will give you a good indication as to whether there's good reason to order the other test.

By simply changing policy overnight that if you are testing thyroid function you would do the sensitive TSH (thyroid-stimulating hormone) test first and only if that test is abnormal would the other tests be run, we've saved over a million dollars per annum every year thereafter simply because the evidence suggests that's the way it ought to be done.

And increasingly an agency like the quality council, I think if it did its work well, could in fact influence public policy so that you wouldn't necessarily be having so much variation in practice based on whether people want to buy into the evidence or not. In some instances, since this is public money we're using, I don't know that there ought to be quite so much unfettered freedom for people to use it without greater accountability.

Mr. Thomson: — Let me build on that answer then because I'm interested in that also.

It seems that the utilization issue on the health care is driven by two forces. One is the patient obviously who decides they have an ache and a pain or something else and decide they have to go see the doctor rather than perhaps seeking some other way of dealing with it.

The second is, and we hear this frequently, concerns that particularly where people have dealt with specialists, that there's a duplication or an unnecessary set of visits back; the specialists report directly back to the GP, the GP then calls in the patient, and obviously bills for an additional visit. Is there a way for us to find mechanisms to streamline to bring down costs within the system?

Dr. Kendel: — I'm sure there's mechanisms to find streamlining but when you look across the world, systems that actually expect citizens to contact first a primary care physician or a primary care nurse as the point of contact are much more cost-effective than models where people access concurrently

whatever number of specialists they believe their symptomatology is related to. That is the most expensive system on the face of the earth. It's the model in the United States prior to managed care — very expensive. And I don't think you would want that model, quite frankly.

But having a person who coordinates the care, whether that be a nurse or a physician, is still probably the most cost-effective way to go about it.

Mr. Thomson: — Yes. I want to be clear about this. I'm not advocating that people have direct access to specialists. I'm thinking in terms of the reporting back though, once the tests have been done. People are then required often to go back to their GP and the GP simply reads them off the letter that was sent by the specialist. Is there a reason we can't cut out that second visit?

Dr. Kendel: — Well perhaps in many instances we could if we used information technology more in accordance with the way it's used in other sectors. If it's just getting the information to the person without a need to explain the implications of it and some further action, it's hard to imagine why that information can't be conveyed by telephone, or, you know, by e-mail, secure e-mail, or other methods.

To some extent also you need to realize that practices are driven by payment mechanisms. And you know, in a fee-for-service system a doctor doesn't get paid unless he or she sees the whites of a patient's eyes.

And so you have to actually then ask yourself, do you need to restructure a system where if you are spending time on the phone conveying information, you're compensated. And to some extent the medical association is moving in that direction, but perhaps not as extensively as might be appropriate.

Mr. Thomson: — Commissioner Fyke told us that there was some appetite — and I realize that the college is different than the SMA (Saskatchewan Medical Association) — but told us that there is, he believes, some ability for us to move beyond fee for service with many, particularly specialists.

I'm interested as to whether or not that would be your perception also.

Dr. Kendel: — Well the only observation, we would have to temper by saying it would just be our observation about what we perceive to be the mood of the profession — we don't speak for the profession.

But generally I think younger physicians are inclined to simply want to practise medicine and be paid fairly for their work. They don't want to invest in buildings. They don't want to be managers of staff. They don't want to be entrepreneurs. They don't want all that hassle. They simply want to practise medicine.

But there is a generational gap. We have a significant number of older physicians who were raised in a different social context and they have invested in what they consider to be small businesses.

And so I guess you have to work out a way that you can accommodate the changing expectations of the new cohort of physicians, which may be more aligned with societal objectives, but deal fairly with the people who are near the end of their careers who began their careers on a different premise. And that's to be worked out with the Medical Association. That isn't our business.

Mr. Thomson: — Final question, Madam Chair. I know other members have questions also.

I'm looking at page 13 of your written brief and, second last paragraph, I'd be interested in hearing additional comment on. The paragraph reads:

> The assurance of continuity of medical care to defined populations combined with the assurance of reasonable lifestyles for primary care physicians makes solo practice a non-sustainable anachronism.

While I'm not in a position to doubt the validity of it, it's certainly provocative.

We've heard other communities talk about how their single doctor system is obviously something they want to maintain.

How do we look at squaring this belief that this is a non-sustainable anachronism with the desire for these communities to maintain a doctor in their community and the services that go with it?

Dr. Kendel: — You know, if you read back in the records, many groups have studied this issue.

I practised medicine now for over 30 years in this province in one way or another. And back even in the early part of my career, the Medical Association, the College, SHA Saskatchewan Health-Care Association) as it then existed, and the Department of Health at that time were all on record saying that we need to move away from solo rural practice to groupings, we used to say at that time, of at least three physicians. I think it's now moved to perhaps five as the workable number.

And I have to tell you and it's mentioned in the succeeding paragraphs, if it wasn't for the tragedy in South Africa that drove so many physicians from that country, we wouldn't even be talking about this here today, because we could not sustain the model of repopulating each of these doctors with solo practice if you depended on Canadian supply.

Because Canadian educated physicians from all of the 16 Canadian medical schools will not go to that environment. Most people wouldn't go to that environment except the countries they're coming from, they're coming to a situation which was infinitely better than the situation they're leaving. So they're willing, at least for some years, to actually accept those arrangements.

But observe how long they stay. They don't stay long. So many people in rural Saskatchewan are served by a revolving panorama of doctors that are there a year or two. And there's no potential to establish long-term relationships which are

incredibly important in primary care for physicians, nurses, and everybody else.

And so we think that if you had groups of physicians of at least five who would travel out — it does mean that physicians need to travel out to communities to serve the people where they are, to actually give the visits — that in the long run this would probably provide better continuity of care to those communities than they're now receiving.

Quite apart from . . . As long as we aren't dealing with countries that close their borders to immigration, we'll probably continue for a while to get physicians from South Africa. But we just came from a meeting where the High Commissioner from South Africa pleaded with us to stop depleting the physician supply in that country because the population of that country is in infinitely worse condition than we are.

And, you know, he vigorously objected to situations where governments, most notably the government to the immediate west of us actually, the government itself went on a recruitment trip to South Africa. And he regarded that as unconscionable that a rich, developed nation like this would actually send its government to take more physicians out of South Africa.

South Africa in turn gets physicians from Cuba. And even then they don't have enough to meet the needs of their people.

So when I met with a former high commissioner from South Africa, he said that everybody from Saskatchewan should visit one of the large black hospitals in South Africa and that we'd probably quit trying to recruit doctors there if we did that.

Mr. Thomson: — If I might just ask one supplemental to that. I think that that's a very astute observation as to how we have dealt with particularly recruitment. The retention issues are different in the areas. But I know certainly listening to the town of Moosomin, I think reported today that all six of their physicians were South African. There's no doubt that that is in large part how we're dealing with it, is through the benefits of living here in Canada.

I'm interested though in returning to the earlier issue about the solo practice. We had heard, last week I believe it was, from people in Porcupine Plain who I think are in a single physician practice there, and talking about the concerns that they had with the possibility of losing that.

How do we deal with that? How do we, as the former premier would say, square the circle to create both better health care and — frankly I'm a politician — a politically acceptable solution also.

Dr. Kendel: — I grew up on a farm in Saskatchewan and I still have ties with rural Saskatchewan. And I understand the whole dilemma around sustaining small rural communities. And the argument is if you lose the local doctor you lose the pharmacy and then there's a cascade of, you know, things that move out of the town.

I think if we have a vision to actually establish the teams we're talking about so it isn't just the solo doctor . . . if you look at the way Dr. Tony Hamilton works with ACNs in three different communities now. I don't know if you've yet heard from those communities but the people in those communities feel that they are as well served as they ever were before when they had a physician in each of those towns.

But the physicians and advanced clinical nurses take call interchangeably. In other words, you know, at 10 o'clock at night when your child is ill, there's nothing wrong with contacting the ACN on call. And a high proportion of the problems can be dealt with quite competently by the ACN.

So that if you had groups of, say, five family physicians and whatever number of ACNs, perhaps physios, other people working as a team so that they shared the burden, I think you could actually provide better sustainable care to people in these rural communities.

You might not have a little pharmacy in every one of the towns that now have one, but you would have the pharmacy service. I think you can still deliver the service.

It's not an easy thing. You know, it's hard to say that perhaps not every one of these communities will be sustainable, but I think that is the reality. And you have to consolidate it into a way that you can give the best possible service to the people who are there.

The other tough social question is, is whether you use health system resources to do economic sustenance. I mean if you want to sustain rural communities, you can do it through a variety of budgets and vehicles. But at least be honest then about what you're doing. It's not delivering logical health services; it's trying to prop up an economic structure where it's under strain.

Dr. Morris: — The use of the physician assistant . . . another way around this is with the solo physicians working together in different communities. I mean they don't have to necessarily be living in the same town. And if they share call then this takes some of the burden off the solo physician.

Mr. Gantefoer: — Thank you very much and welcome this evening. I want to touch on a couple of areas that have been in some part at least been dealt with in your answers to Mr. Thomson.

In talking to some of the communities that either by coincidence or design had some of the South African practitioners here, they commented on the fact that it seemed that there was a great appreciation for a wide scope of practice in rural Saskatchewan practice. And it may not be a correct observation, but some people have said to me that our Canadian medical system tends to do much more, even on the family physician level, of specializing in terms of their training, and that the wide scope of practice is something that we're losing from our domestically trained physicians.

Is that a fair observation and do we need to have a revisiting of what we need in terms of scope of practice credentials for rural family practice?

Dr. Kendel: — I think some of it's a fair observation and some of it's a distorted perception, actually.

One of differences about the educational background of physicians who come through the Canadian education system and that in South Africa is that, because of the high level of violence in South Africa, literally every physician is involved in treating trauma. You can't be educated in South Africa without being exposed to huge trauma practice.

And so when it comes to dealing with road accidents and farm accidents, which are a cause of great concern in rural Saskatchewan as to how you would care for people in that circumstance, I think it's an accurate perception that South African physicians tend to feel more comfortable dealing with those circumstances than perhaps people who come through our standard family medicine residencies.

Our family medicine residency program of two years duration is designed to prepare a physician to practise a broad range of family medicine skills but it doesn't confer any sort of advanced surgical skills. You have to do additional training to acquire that. In the South African system, as I say, because of the violence in the country, it just is an inherent part of their experience to date.

The other thing is — I don't know how to say this diplomatically — but some South African physicians just have a greater measure of chutzpah, if you like, in terms of saying, gee I can do that. And they aren't subject to the same litigation realities often that people are in North America. And when in fact they first encounter a situation where they got in over their heads and all of a sudden they're subject to litigation, they tend to pull in, you know, their head a little bit.

But it's a culture difference in which, if you practise in a country in which you're much less likely to be sued, you are more inclined to be somewhat more aggressive in terms of doing things.

But I think the point I made earlier about the College of Medicine— indeed all of the 16 Canadian medical schools — having educational streams that prepare people for rural practice is important.

In Australia there is what they call vocational training for rural medicine. And it acknowledges that you need a different skill set to practise in the rural communities. And so they actually have a vocational program where if you're going to practise in rural Australia, you go to that program. And you would acquire the skills, you know, to do the surgical things that we were talking about. And that has been lacking.

There's been debate in Canada about starting another medical school in Canada specifically to prepare people for rural practice. I'm not convinced that would be a rational thing to do, but I think schools that are based in provinces like Saskatchewan should actually direct their mission more to that, to that purpose.

Mr. Gantefoer: — Thank you. When you talked about liability, that sort of leads me to another question. I've heard comment made that one of the pressures on physicians to over-prescribe or overcall for tests is the issue of the potential, first of all, of liability in case that there is some subsequent event that isn't desired. And so that rather than take a chance and say, as HSURC did, in the example used, of saying that this one screening test is sufficient, a battery of tests are ordered. And that there is the concern because of the potential of liability.

Is there some process that potentially could mitigate against this liability issue? Are there any discussions going on? Or is it not a perceived concern?

Dr. Kendel: — The practice of so-called defensive medicine — which is the term used to describe what you are talking about — is real. It's hard to quantify how much resource it consumes. Some people estimate it may consume in the neighbourhood of 15 to 20 per cent of total expenditure.

The truth is if you actually practise in accordance with published guidelines that are evidence-based, you're on pretty firm ground in terms of litigation. It doesn't mean you can't be sued because anybody can register a lawsuit against you, but the chances of success in that litigation would be pretty minimal.

In Saskatchewan now all physicians are required to carry professional liability insurance and most do so through the organization known as the Canadian Medical Protective Association. The Saskatchewan Medical Association, on behalf of doctors, has negotiated a reimbursement strategy in which you as, we all as, citizens pay for that liability coverage. It's quite expensive.

But frankly, short of moving to a no-fault system such as existed for a while in New Zealand and exists in some Scandinavian countries, there are no other mechanisms I know of to actually sort of dampen that, other than encouraging people to follow so-called best practices where they have some shelter. And usually those best practices are less expensive than what's done when you practise defensively.

Mr. Gantefoer: — One further question and that is about the demographics. We talk about the demographics of citizens but what about the demographics of physicians? Would your college have a sense of what the demographic situation is in terms of the long-term need for replacement of physicians? And does our level of training at the College of Medicine come adequately close to meeting that potential need down the road or are we going to face a real potential problem sometime in the future?

Dr. Kendel: — Well first of all, contrary to the perception that we actually have been experiencing a net loss of physicians, we've actually experienced a slight gain in physician supply in this province each year in the last five or six years.

Mr. Gantefoer: — Outside of South Africa?

Dr. Kendel: — Yes. But I'm talking about the actual number of physicians on the ground in Saskatchewan has actually been a net gain.

The medical education system in Canada, as you likely know, was significantly downsized in the last seven or eight years, and now that trend has changed. And of course an announcement was made yesterday, I guess that was, to actually increase the educational capacity from 55 to 60 in Saskatchewan. And most of the other schools in Canada are doing that.

If in fact you use those projections, in the short term there still is going to be some physician short supply. We won't meet it through domestic supply; we probably will be a net importer. Saskatchewan could never be totally self-reliant on its medical school because we don't educate the full range of specialists that are necessary, so we'll always depend on some of the other schools who have the broader range of educational programs.

We hope to retain more of our students here, though. And retention in family medicine has actually improved quite remarkably in recent years, and that's encouraging.

Hon. Mr. Melenchuk: — Thank you very much, Dr. Kendel, and Dr. Morris. Just a couple of questions. On page 18 of your brief, right at the top it says, while there may be sufficient evidence to support almost immediate consolidation of some rural hospitals, it is less clear that 20 hospitals would be adequate to service the acute care needs of all Saskatchewan residents.

And it's . . . you then go on to say that you see that the role of the quality council would be one to determine how that rationalization of hospitals within the province of Saskatchewan would occur. Is that correct?

Dr. Kendel: — Well that's one possible way to do it, if the broad . . . if the mandate of the quality council would extend to that. Now given the fact that we don't support the quality council having actual enforcement powers of its decisions, it would simply advise what the, what the probably the complement of hospitals ought to be. And it would still be the matter . . . responsibility of government to either accept or reject those recommendations.

Hon. Mr. Melenchuk: — The second question with regard to the quality council is, have you or your council put your minds around what the membership of this quality council would look like in terms of representation from communities, from public stakeholders? Do you have any suggestions along those lines?

Dr. Kendel: — Well we haven't had a great deal of opportunity at the council itself, the 17-member council, to discuss that in detail. The Health department does have some working groups looking at issues and options and there has been some discussion at that level in which we've participated.

Quite frankly, I think the one thing you want to guard against is making this agency governed by some sort of a board that is a representative board. Because you would have no end of territorialism as to who's going to have control and power over it.

When we spoke earlier about it having to be an agency that's very closely connected to the public, I think there are many ways to build in public input. But that doesn't necessarily mean that you actually have public representation, if you like, at the governance level.

Some people have suggested that this agency should be structured much like the Provincial Auditor. There is no board. And frankly there are some aspects of that we find quite appealing, because the Provincial Auditor tells it like he or she sees it, we hope.

If you look at some of the reports even from the Auditor General for Canada, for instance if you look at the stinging report from the Auditor General for Canada on the non-insured health benefits program for Aboriginal people, that's a very detailed report and it pulls no punches in terms of saying what a mess that program is.

And you have to have an agency that has the courage to stand up and actually say to whoever the government of the day is, we have a problem here, folks, and this is exactly the way we see it. So the agency has to have a fair measure of independence.

But recognize also in a democracy you can't take away the decision-making power from the elected people. So if it has a strong advisory role and public awareness raising role, we think that would be an appropriate way to go.

Hon. Mr. Melenchuk: — Okay. Just to move on a bit next. Your comments with regards to Fyke as providing more of a macro perspective with lots of fleshing out on the micro and operational side, with regard to your specific role as the College of Physicians and Surgeons, do you see any imminent changes or potential changes in terms of the licensing requirements that might improve recruitment of physicians in the province of Saskatchewan?

Dr. Kendel: — It's something we review regularly, Dr. Melenchuk, and in fact we've relatively recently made some modification in licensing requirements for one category of licensure. We don't see any immediate changes out of what's in the Fyke report. Quite frankly, we think first and foremost our responsibility is to make sure that the quality of care isn't compromised by lowering standards of licensure. On the other hand, we probably already have the most flexible licensure options in this country for people to come in on short term to meet needs, to spell people off.

And if we actually suddenly reverted to much more rigid policies as there are, for instance, in Ontario, we would essentially shut down rural health care overnight because you wouldn't be able to get doctors into this province.

Hon. Mr. Melenchuk: — Just one further question. Again, this is more on the standards side. Your policy with regard to itinerant surgery — is there any plan to look at perhaps expanding that beyond the day surgery modality?

Dr. Kendel: — It's not beyond the realm of possibility, but the reason at the moment we tie it to day surgery is this logic. When people drive in from the country to have day surgery in Saskatoon or Regina and they go back to their home communities the same day, if something goes wrong they're as distant from their surgeon as they are . . . as their community is.

And if we believe it's safe for people to drive in from rural Saskatchewan and have day surgery and then not have the surgeon immediately accessible, then it's equally logical that if you can move the surgeon out to a community where the human resources and equipment are the same as you have in the city, it's not unreasonable that they should do day surgery out in outlying centres. And quite a number of centres, as you know, do that right now.

But if it's a condition for which at the present time it's believed you need to keep a person in hospital, and that means that the surgeon's close at hand, we're less comfortable with saying that it would be safe to do that surgery in the country and then have the surgeon come in and the person stays in the rural hospital.

Now the question then comes is, could the rural doctors provide some of the care that's necessary? And to some extent we think they can. However as you well know because you have walked in those shoes, there is the fundamental principle that you're accountable for, you know, covering your own risks you create in medicine. So when you do the surgery and if you do the surgery where there's a risk, for instance, of life-threatening hemorrhage afterwards, it's not responsible to be at such a distance that you couldn't go back in and deal with the bleeder.

I mean Dr. Morris is a surgeon and he's also lived in this province long enough to know the era where there was really unhealthy itinerant surgery. I mean surgeons went around the country operating just like custom combining, you know, and moved through a swath and moved on. And there were tragedies as a consequence of that. We don't want to go back to that era.

Hon. Mr. Melenchuk: — There is no working group to develop potential guidelines that might fit the Fyke model with his teamwork primary care, or perhaps training rural physicians on location to manage post-op complications, or perhaps transfer times that might be similar to a surgeon in Saskatoon who lived on the north end and had to get to University Hospital — it might be a 25-minute drive away. There is no working group looking at that particular aspect at this point?

Dr. Kendel: — There is no working group focused on that particular, perhaps narrow issue, Dr. Melenchuk. But certainly there are working groups at this moment that are looking at all of the key aspects of the Fyke report. And inherent in that is the question of where is it safe to perform surgery.

In fact the question is somewhat bigger than that. It's rethinking what constitutes a hospital. What do you actually need to have? What can safely be done outside a hospital?

When you think back just 10 years ago to how dependent we were on hospitals, we're doing much outside of hospitals now that we thought would be fundamentally unsafe to do outside those hallowed walls. And now we do it. And so I think the envelope could be pushed further. But you also need to remember the data in Fyke showing that we are still more dependent on hospitals in this province than any other place in Canada. We use hospitals more. So even for that reason we need to get ourselves less dependent on hospitals.

The Chair: — Thank you. Any further questions? Then on behalf of the committee, Dr. Morris and Dr. Kendel, thank you very much for coming and presenting tonight. We appreciate your written and personal submission.

I'll entertain a motion for the committee to adjourn until tomorrow morning. Dr. Melenchuk, thank you. We're adjourned until 10 a.m. then.

The committee adjourned at 21:07.