Standing Committee on Health Care

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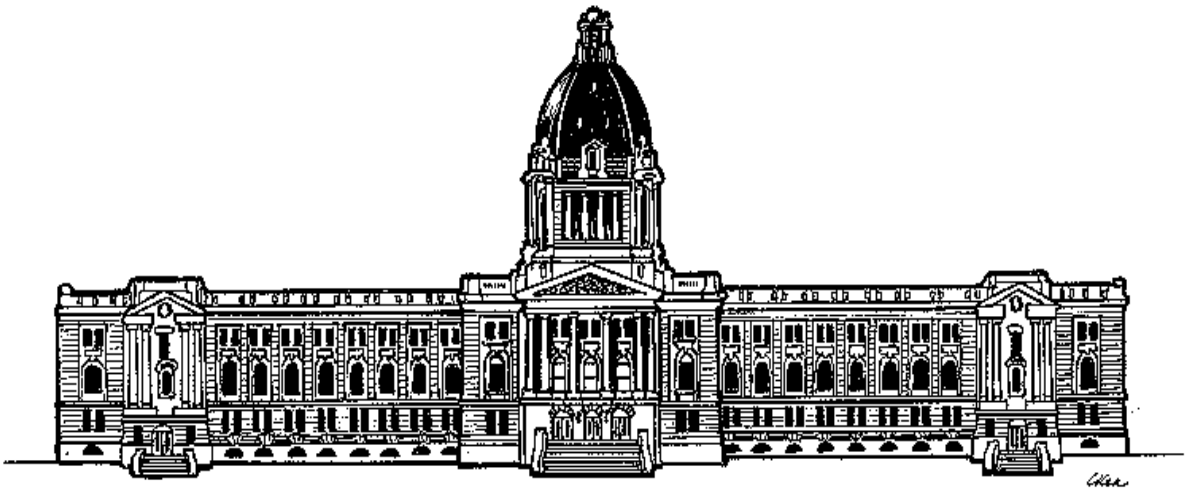

Legislative Assembly of Saskatchewan

Twenty-fourth Legislature

STANDING COMMITTEE ON HEALTH CARE
2001

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

The committee met at 10:03.

The Chair: — Good morning. This is the Standing Committee on Health Care. It's a committee of the Legislative Assembly. Our first order of business is to receive and report on responses to the Fyke Commission.

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

It's an all-party committee and reports its findings of what we heard to the Legislative Assembly by the end of August.

We've given presenters half an hour, and that includes their presentation as well as, hopefully, some question period for the committee members to ask.

So if you want to introduce yourself, where you're from and who you represent, and then you can begin your presentation.

Ms. Lavallie: — Hi. I'm Flo Lavallie. I'm a clinical herbalist. I practice out of Saskatoon and I'm here to present on . . . I wear two hats in the community. I'm on the board of directors of Tamara's House and on the board of directors and a founder of the Saskatoon Health Oasis.

And I really thank you for the opportunity of being here. It's really an honour to be here and to respond to the Fyke report. I perused it very, very orally, and I also have marked some questions, if I have, at the very end and some observations of the report. Very well put together.

I'd like to begin by saying that the pessimist sees difficulty in every opportunity. The optimist sees opportunity in every difficulty. And I really see this is the reasoning for the Fyke report or we wouldn't be here today.

And I have put this report together very briefly. I didn't have much time to put it together and, because of human frailty, I may have not things in order.

But in any case, this presentation, I have a package that I've put together with a letter of support from the College of Physicians and Surgeons. Myself and a colleague of Dr. Melenchuk's actually, Dr. Joe Schnurr in Saskatoon, are going to set up a holistic facility in Saskatoon, the first of its kind in Saskatchewan, introducing complementary therapies and the western, traditional, medical model.

And in 1986, I met with Eric Cline when he was minister of Health and this is when the Saskatoon Health Oasis was founded. And as a result of that we've met with a numerous amount of political people in the community, as well as MLAs (Member of the Legislative Assembly) and MPs (Member of Parliament), and we've received very good response from the community, as well as the MLAs and MPs.

The College of Physicians and Surgeons had asked me and Dr. Joe Schnurr to speak to the Council of the College of Physicians and Surgeons in March and it was very well received as well. Dr. Dennis Kendel has been very supportive to the Saskatoon Health Oasis.

And the motive for the Saskatoon Health Oasis is not to reinvent the wheel but to create a different healing paradigm and a different healing modality, and to encompass . . . to work together instead of work separate from.

And I've . . . basically what I've done is . . . Of course we all know what health is and we know what disease is and I feel personally that the medical system is not efficient by itself. I really feel that together . . . we can work together and help to make the system run more efficiently.

The World Health Organization says that 85 per cent of illnesses that kill us are preventable. And so in working with prevention and . . . prevention, as I see in the Fyke report, is explained differently than we believe in complimentary therapies. And so prevention is basically working with people that are already going through the medical system and assisting them in healing themselves.

Medicine is focused on illness. And we focus on optimum health and also make people aware of how they can help themselves.

Our mission statement is the — and it's been included in the handout — the Saskatoon Health Oasis is a collaborative health centre offering holistic strategies for healing. And again, please find our perspectives in the handout.

We hope to be partners in healing instead of working separately from each other. Families and communities play a major role in the maintenance and enhancement of their health.

And the principles are personal responsibility, accessibility, equity and equality, geographic availability, illness and health, fostering change.

The health system must enable all citizens to live a healthy life in healthy surroundings. Health services must be reasonable and available in all areas of the province. There must be an equal emphasis on health promotion and prevention of disease and accidents. We must acknowledge and maximize opportunity for useful and timely changes in the health care system.

And then again I've listed the letters of support that we've received as we've been functioning for the last five years.

Hon. Allan Rock, Dr. Dennis Kendel, Pat Lorjé, Hon. Judy Junor, the Red Cross, United Way. And Pat Atkinson, we met with Pat, and she's nominated Drew Johnston from the health caucus of provincial government to be our liaison person. And I've communicated with Drew and given him all the information package that you have today.

In closing I would like to draw attention to the full-service hospital cover page where the . . . and this is basically the handout that I've given in Hawaii where they work with hospitals and they have holistic practitioners and medical doctors work together hand in hand in order to make that medical system more efficient.

The Saskatoon Health Oasis has received seed funding from the Saskatoon District Health Board in order to assist this facility to take place. Dr. Joe Schnurr and myself are at the business plan stages of the Saskatoon Health Oasis.

I believe that the year 2001 is the opportunity to realize Tommy Douglas's dream, phase 2 of health care.

In discussion with Pat Atkinson as to how this could happen, and my recommendation for this is to work this in terms of coverage, which is a concern of a lot of people in this province, how these processes can be covered or how these treatments can be covered, and I made a recommendation to Pat Atkinson when we met, is that partial coverage to the client or to the patient.

And the patient . . . say, for instance, six treatments be paid for and then any additional treatments can be paid for from the person's pocket. And that was a way that I thought was fair to everybody. And also the person could take responsibility instead of shoving that responsibility all onto the government. And so people feel equal partnership in their healing.

Inclusion in relationship I think is what I'm asking for here today, and also an opportunity to be heard.

The need for research. Dr. Joe Schnurr and myself are going to look at doing some research, and funding dollars should be really allocated . . . are always allocated for our medical western diseases, which are buzz words of the '90s. Every generation seems to come up with a new disease. And so I really feel that the need for research in complementary therapies and their effectiveness and cost saving, again how we can save the health care system dollars.

I've been in practice for 20 years myself, in private practice. I have two clinics, one in Saskatoon and one in Humboldt. And I see over 3,000 people a year. So evidently it proves to me that there's something wrong, that something, you know, there's something that's not meeting the criteria of the total health care system as we see it or as we have experienced it today.

And then I've included some research that's being done in the US (United States) as a handout. I've also included several handouts as to complementary health care globally, what's going on globally, to give us an idea of where complementary healing is at.

Health care reform by complementary medicine, another handout that I've included. Alternative therapies in health and medicine is another one that I've included. Perspectives of complementary and alternative health care and health policy . . . from the health policy and communications branch, Health Canada.

In terms of making, making . . . of being heard . . . and one of the, probably criticisms, if I have, of the Fyke report, is that we took time out to present a brief to the Fyke Commission and we were not recognized in the Fyke report anywhere except at the very back. And I really took a look at it with a fine-tooth comb, and on page 12 of the Fyke report, it mentions several times other practitioners' health care along with nurses, mental health counsellors, dietitians, pharmacists, midwives and others.

And I really find this very disrespectful. I really feel that we basically are complementary therapists. We are people that work very hard at presenting a paper in terms of health care, and we were not recognized anywhere.

But I also do see some good things that have happened here where I really believe that . . . on page 19 it says: "Less need for services through prevention, early intervention and disease management." And I think that's a very positive statement.

Page 25, interdisciplinary teamwork. And again, are we included in the interdisciplinary teamwork because we are part of a team. I refer to physicians all the time. I have physicians that work with me. The day before yesterday a physician called me and was really concerned about a patient taking an herbal medicine and having a reaction. And she didn't know anything about that reaction and so she called me.

The College of Pharmacy calls me at the university when they have a client that can't take traditional western medicine and seeing if there's an option for them.

And so I'm basically working . . . I've been working for the last 20 years to try and get holistic medicine recognized in this province. And so I really feel that we took . . . you know, we suited up and showed up and made a presentation to this committee and, you know, we weren't recognized.

So the system needs to be . . . I really agree with page 81. It says the system needs to be rethought — an inversion of the pyramid that focuses on everyday, comprehensive services. And I really think that was a profound statement.

Sharing the — end of page 86 — the values. Treat people with caring and compassionate manner. And we do that because of the fact that a lot of complementary therapies are much more gentle and not so intrusive. And so we really feel that we, you know, we can play that companion medicine I call it, in terms of people having to go for traumatic surgery and, you know, and being treated with respect.

The key partnerships between — and that's page 92 — key partnerships between districts and other sectors at the local level. And that's basically what I've done with the Saskatoon District Health Board is I've kept them abreast. They have a submission of the big, thick manual that I presented today.

And I've kept them abreast as to all of the goings on of every symposium that we've had, every meeting that we've had. Where all of our dollars that they have allocated to us — where every stamp, every cent — has gone. And so I've really made sure that . . . And I really feel that we need to be included where a quality control council will be established. And we need to be appointed to health district boards. We need to have some representation in order to be heard.

I think my 15 minutes are done, with the report.

I'm also wearing another hat in the community. And I'm also on the Board of Directors of Tamara's House which is for adults, female adult survivors of childhood sexual abuse. And I was just here three weeks ago presenting to the provincial government a modest proposal that was put together by Sandra

Mitchell. And this modest proposal basically requested financial funding from the provincial government and also from Justice, Health, Social Services, and the Aboriginal Healing Foundation out of Ottawa.

And at Tamara's House we do complementary therapies with adult survivors of childhood sexual abuse. Women that have been ritual survivors of childhood sexual abuse and also women that have been abused by incest and . . . One out of every three women in Saskatchewan have been sexually abused.

We've been on Fairlight Drive for 10 years and a developer from Saskatoon has given me $340,000 to build a brand new Tamara's House at 1605 Victoria. And for that I'm very proud.

And this man basically has no association with Tamara's House whatsoever. He's just a community person. So basically I've promised him that he would be very proud of Tamara's House and that we would . . . we basically practise reiki, aroma massage, and psychodramatic body work. Health Canada has given us $150,000 to do a research grant, which is in that envelope, which is the package that you have received. And there they explain what reiki is, aroma massage, psychodramatic body work. And the research is complete.

And one of the presenters today will be the Healing Co-op, Saskatoon Healing Co-op which received funding from the provincial government to get a co-operative, healing co-operative happening and as a result of the Tamara House health transition fund. Because these women, 100 women went through the research and the cost-effectiveness . . . there's another program that's coming later on that they're doing research on as to how much it's cost the Saskatchewan government in terms of health care, and through complementary therapies it's saved X number of dollars. And there's another report that will be coming out to that effect and the women today from the healing co-op will be presenting that as well.

And Tamara's House has a board that's been represented from the community. We have a woman on the board who is on the National Parole Board. She's an Aboriginal woman. We have another Aboriginal woman who has been awarded several awards from the Women of the Dawn, and she's a doctor of neuropsychiatry. And we have representation of a woman from the Saskatoon District Health Board. We have a nurse on the board and myself, and we have an honorary chairperson who is Dr. Kathy Storrie who is a sociologist from the University of Saskatchewan.

So we basically have done a lot of good work. We've worked on a shoestring budget, $120,000 a year, and with donations from the community, a lot of hard volunteer work, and we've really put a lot of sweat and tears into this project. And so through complementary therapies we basically hope to create a new society and a new form of health care in this province which I'm very proud of.

And after being on the board for five years — this is my last year on the board — we're now going to be launching a million-dollar capital campaign to keep this funding ongoing and to make sure that this facility continues to function, very community-based. And we've been very fortunate; we've had a lot of government people come to visit us and to share our hard work and to hear our pain and to make this a reality.

I've also included, I've also included a newsletter of Tamara's House and we also have a campaign called an Angel campaign where people donate $10 a month; we have 168 angels to date. And that will be ongoing funding to keep . . . you know, for staff positions and just for the daily expenses to keep the place running.

And also we have . . . for instance the elevator in the place cost $24,000 and the developer paid for it. And we've just had community come forward like you wouldn't believe. And this is the first of its kind in Canada, Saskatchewan, and North America. So we should really be honoured to have such a facility in Saskatchewan and to be the first. Saskatchewan always likes to be the first.

And I really believe that the holistic medicine has a place and I think that we've . . . I come from a European background. My great-grandmother was an herbalist in France. And I really belief that our root systems in Saskatchewan come from the European community. And so therefore I think that we need to really seriously take a look at where we came from in order to know as to where we're going.

The Chair: — Thank you very much. Questions from the committee.

Mr. Gantefoer: — Thank you very much, Madam Chair, and thank you very much, Ms. Lavallie, for coming here this morning. You've provided us with a great deal of material and we won't be able to absorb it in this half an hour, but thank you.

I'd like to split up my questions in the two general organizations that you're representing. First of all, Oasis. In the Fyke report he talked very much about primary health care teams at the local level and dispensing primary health. Do you see yourselves as herbal practitioners to be involved with those primary health care teams in a meaningful, collaborative role with other medical professionals?

Ms. Lavallie: — I really do because of the fact that most of the questions that I get from the medical community are concerns with herbal medicines. Allan Rock has asked me to apply to be on the expert advisory committee for Canada. And another medical herbalist out of Europe . . . or out of BC (British Columbia) applied and got the position, which is fine with me. I think that she basically is very, very astute as well.

But these are questions that we're asking the council for the College of Physicians and Surgeons as well.

People come to see us with boxes and bags of herbal medicines. They don't have a bloody clue as to what they're used for. And the medical communities say the same thing. They don't have time to go through their compendiums or through their herbal texts to find out what these herbal medicines are for. So I think there is definitely a place for all of us to work together instead of working under the table or . . . A lot of physicians' wives come to see me and they say, don't let my husband know that I'm coming here. And so, you know, I'm sworn to secrecy. But it's really amazing how this profession has really grown and there's a need.

Mr. Gantefoer: — Are there like training standards or training requirements in order to be able to identify yourself as a practitioner?

Ms. Lavallie: — There's . . . The College of Natural Healing in Calgary and the Dominion Herbal College out of Ontario are the two only practising colleges at this time.

Mr. Gantefoer: — As well, primary health care teams are going to have to be right across the province, not just in the major urban centres. And I heard that you had a practice in Saskatoon and Humboldt as well.

I'm wonder how widespread are personnel in your profession. Would there be the possibility of pretty broad coverage across the province if you were involved with these primary health care teams?

Ms. Lavallie: — There's . . . Regina has several practitioners. There are two, three of us in Saskatoon. There's one in Unity. There's one in Prince Albert. And there's also naturopaths that are being trained in Vancouver. There's a brand new college in Vancouver as well. So they're starting to filter in. They're going to start filtering in as soon as they get the training.

And I think as soon as they understand that the Saskatoon Health Oasis is on its way, I think that they'll come to us.

Mr. Gantefoer: — Thank you. If I could switch to Tamara's House. I just sort of shuddered when you said that one out of three women have experienced sexual abuse at some time in their life. That tells me that there's an awful lot of women in this society in this province that have had a terrible experience in their life. And I imagine a good number of them actually one way or the other require some support and understanding about that whole experience and need some significant support in order to grow out of it or grow through it or cope with it. And I compliment you on this project.

But what is being done? Is very little being done generally in order to deal with the problems of these women?

Ms. Lavallie: — What we're doing is we also have teams that go out into communities and teach survivors or speak to groups. Like we speak to anyone that chooses to be spoken to, in terms of schools, health districts; we speak to various communities about . . . we have teams that go out and speak about sexual abuse.

And victims' services; we're starting to work with police, judges. We have a CASAC (Canadian Association of Sexual Assault Centres) worker now that's working with Justice in terms of getting some of the information out. We do a lot of public information to anyone that would like us to come out and speak.

Going back to your initial comment, is I have five survivors in my family alone. And so that's why I took on this mission. Pat Lorjé basically supported me through the justice system with my daughter who's disabled. She has a disability; she has cerebral palsy. And so Pat was my support system and encouraged me to take this to the limit. And so when I start something I don't . . . go till I'm finished. Yes.

Mr. Gantefoer: — That certainly is very commendable. But what worries me is that it strikes me if the numbers are as high as you identify, that there is certain amount of social stigma to this also. A lot of these women who are quietly internally hurting terribly do not have a easy access point to find help. And your house is certainly one, but it's one house in Saskatoon; it's not a provincial program. And 30 per cent of women is a tremendously significant number of people that are experiencing some level of pain.

And I just wondered if there is some real recognition of this, in that agencies — Health, Social Services, Justice, whatever — are not just sort of saying, well there are things here, but that there are meaningful programs in place that people can access in a non-threatening way. Because it would be a very terrible thing to deal with.

Do we have enough support to deal with this issue in this province?

Ms. Lavallie: — Well I really don't think we do. But I think we're on the cusp. I think what we're doing is we're educating. And it's about education; justice system needs to be educated. I think we all need education. I mean I don't know everything there is to know. I've learned through my own pain and through my own experience. And I think that we are doing the best that we can.

But I think that by having the support, I think, in one community, then there's going to be an avalanche throughout the country. And I think that if we do it properly and with the proper support systems, we can continue to do our work. There's a lot of work to do.

Mr. Gantefoer: — Thank you and I wish you well.

Hon. Mr. Belanger: — One question on some of the premises that you have in reference to the emotional development of people that are impacted by some of the negative encounters in their life. Whether it's physical or emotional, it's all interconnected. People use the medicine wheel in the Aboriginal community as kind of the four points of concern when it comes to health.

And you made an interesting comment in terms of the exercise that you're undertaking. It's a new way of doing health. Because we know if somebody is traumatized or if somebody is emotionally not stable, it has a physical effect on them. So you're right in the sense that there is a lot of interconnection between one's emotional self and physical self.

That being said, what is your relationship with, say, the psychology profession, because you work with a lot of the ladies that are traumatized, and what kind of interrelationship do you have, if you have one?

Ms. Lavallie: — What I normally do as a practitioner, first of all, is I network within my community, and so therefore through Social Services. And I'm a former RN (registered nurse) psych nurse, so therefore I have a lot of leads in the community from 34 years ago. And so therefore as a result, we network within our community.

But the women themselves have a network within their own community. They know where they feel comfort. And this is patient/client centred. I think we have to remember that the client, the patient themselves know what they need, that they've never had the opportunity to tell us what they need. And this is what we would like to offer to these women.

Also I think that not everyone connects when you see a therapist. So therefore they can make their own choices if we make them available. And I think it's all a matter of freedom of choice.

Hon. Mr. Belanger: — My final question is: in terms of the psychodramatic body work, could you give me an example of what that entails? And also the aroma massage and the reiki treatment. Just very briefly, just for those that may be watching and not understanding what this is. And I'm certainly one of them. I looked through the information but there wasn't a very thorough explanation.

And the second part — this is my final question — is: how much of the work is necessary? Obviously given the different degrees of work that is necessary for different patients, but on average how much . . . how many treatments or how many times is the person that needs your type of care come to see you? Is it a short stay or is it a long stay? Thanks.

Ms. Lavallie: — Thank you very much for the question. And the women from the healing co-op will be able to answer that. They did the research and so therefore they're probably more . . . they're more in tune with how to be able to explain that to you. I don't want to double-up on the question or the answer.

Hon. Mr. Melenchuk: — Thanks very much. Just a couple of questions. First off could you, just for the record, give me examples of what you would consider your complementary or alternative practitioners in the province of Saskatchewan today, some examples?

Ms. Lavallie: — Some examples?

Hon. Mr. Melenchuk: — Yes.

Ms. Lavallie: — Okay we're looking at incorporating reflexologists, herbalists, massage therapists, aroma massage therapists, some psychologists, social workers, people that basically work . . . and medical physicians of course. Everyone is implied in the process.

And also what we're doing at this point is sending a survey to every client that I have in my practice, and Dr. Schnurr is doing it in his, and bigger people that are coming to me. You know people from every part of the province are basically filling out this survey and telling us what they need and what they would like to see.

Hon. Mr. Melenchuk: — Okay. Second question related to that is where do you see First Nations involvement in the holistic approach or complementary medicine?

Ms. Lavallie: — What I've basically done is I've done presentations to the First Nations community. And also the Aboriginal Healing Foundation out of Ottawa is working very closely with us in terms of assisting us in terms of setting up a program.

We have an elder at Tamara's House, she prefers to call herself a spiritual teacher. We do healing circles at Tamara's House and we also do various sweat lodges for the Aboriginal women. And we also are very sensitive in terms of working with Social Services and have women that are Aboriginal working on the premises as well.

Hon. Mr. Melenchuk: — And another question in terms of Saskatchewan's population. Do you have any estimates in terms of what per cent of the population would be accessing complementary or alternative medicine in today's world?

Ms. Lavallie: — The Angus Reid poll has basically done a survey but I think that might be a bit outdated, but Dr. Michael Epstein who's on our advisory board at the Oasis basically feels it's 80 per cent of people using complementary therapies.

And I see on the average of 18 people a day and I have two clinics and I also . . . I see on the average of almost 3,000 people a year.

Hon. Mr. Melenchuk: — A final question. Of course in the Fyke report the emphasis for Mr. Fyke was quality. He talks at considerable length about evidence base. Can you tell me in terms of complementary alternative medicine what progress has been made in terms of monitoring and evaluating in terms of performance measures?

Ms. Lavallie: — I think that the evidence base basically was . . . That's why I brought some of the handouts that I brought that have a lot of that documented, as well as I brought a copy of the *TIME* magazine, which has the science of yoga explained as well, and various other modalities.

And traditionally, Chinese medicine has been around for thousands of years and herbalism has been around for thousands of years and First Nations people have been around for thousands of years.

And so therefore . . . You know, when I met with the Health caucus provincial government, one of the issues that they had difficulty with is how do you legislate Aboriginal medicine, for instance. How do you legislate oral traditions, for instance; you know, from grandmother to grandmother, you know. I mean I'm the fifth generation and this has come down five generations. How do you legislate this kind of thing? And so these are the kinds of issues, I think, that we're going to have a lot of difficulty with.

Hon. Mr. Melenchuk: — Okay. Thank you.

The Chair: — Any further questions? Seeing none, then thank you very much, on behalf of the committee, for coming and presenting for both organizations and good luck in both of them.

I would ask the next presenters to come and take seats at the table.

Good morning. Welcome to the Standing Committee on Health

Care. The first order of business of the committee was to receive responses to the Fyke Commission and report back to the Legislative Assembly.

I'm Judy Junor, Chair of the committee. Dr. Melenchuk is the vice-chair. Andrew Thomson, Warren McCall, Buckley Belanger, Brenda Bakken, and Rod Gantefoer are members of the committee.

It's an all-party committee of the Legislative Assembly and it's to report back on this task to the Legislative Assembly by the end of August.

We've given presenters 30 minutes and in that time we've allowed for some questions from the committee if we have that time.

If you would like to introduce yourself, where you're from and who you represent, and you can begin your presentation.

Dr. LaPlante: — I'm Garth LaPlante, the president of the Chiropractors Association of Saskatchewan. To my right is Dr. Alex Grier. He's the past president. He's in Saskatoon. Mr. Jim Stewart, our executive director of the Chiropractors Association of Saskatchewan, and Dr. John Corrigan from Weyburn, he's our vice-president.

So what we've done is we've prepared a submission and I believe you have it in front of you.

Madam Chair, hon. members, thank you for allowing us the opportunity to present a submission to the Standing Committee on Health Care. What I was going to do is just touch on a few points here, and then we'll have ample time for any questions that you may have.

So the mission of the Chiropractors Association is dedicated to ensuring the provision of quality care of neuromusculoskeletal system by competent caring doctors of chiropractic use in proven and effective methods.

Chiropractic has been a self-regulating profession in Saskatchewan since its initial legislation which was enacted in 1943, and currently we're governed by The Chiropractic Act, 1994 and its bylaws.

Our scope of practice — chiropractors deal primarily with the neuromusculoskeletal conditions. As primary health care practitioners the public may contact them directly without mandatory referral or other health care professions. The primary goal of our treatment or adjustments is to correct areas of decreased mobility within the spine and peripheral joints that have created dysfunction or discomfort.

Our treatment is essentially concerted holistic hands-on type therapy. It doesn't generally cause . . . or have additional cost to the health care system through the use of high-tech ancillary services. We're a relatively low cost form of treatment.

Chiropractors in Saskatchewan are part of the interdisciplinary continuum of care and perceive their role as complementary to other health care disciplines.

The doctors of chiropractic are trained to provide a differential diagnosis, refer patients to the appropriate care of treatment of conditions that are outside of our scope of practice. We're also an integral component of the interdisciplinary secondary and tertiary assessment teams used by the Workers' Compensation Board and SGI (Saskatchewan Government Insurance).

We are a self-regulating profession and primarily responsible for setting the enforcing of standards to ensure the public's safety. So just some of the comments that we had for the recommendations of the Fyke committee.

Number one, everyday service. The CAS supports the recommendation to provide primary health services by interdisciplinary teams of providers integrated into a primary health care network. However, we would add that these services must be evidence based.

What are the right services to provide and by whom? This is the fundamental question that must be answered if there is to be true health care reform.

The CAS (Chiropractors Association of Saskatchewan) submits that evidence-based care is both the engine of health reform and the foundation on which tomorrow's health system is built. There's no advantage to simply delivering the same services in a more efficient manner if it's not been established by science that these are the appropriate services to provide. Finite health care funds should only be provided to those practices and practitioners that have proven their worth in the scientific arena.

The CAS contends that if chiropractors were used in an evidence-based manner, significant cost savings would occur. Unfortunately, chiropractors are prevented from making a full contribution in the current health system due to the cost barrier of partial coverage by medicare.

The following quote is instructive in this regard:

> Simply put, many people are doing the things that others could do, while many professionals are unable to contribute to the extent of their skills.

We refer the committee to the publication, "Chiropractic Care in Saskatchewan: A Case for Greater Coverage Under Medicare." Many of you will be familiar with this document as we presented it at our meetings. This was prepared by Dr. Pran Manga. He's the University of Ottawa professor. And he made an analysis that illustrated if an additional $7 million were provided to allow chiropractors to be fully covered, he estimates that there may be savings of direct costs of up to $65 million, or alternatives, as you can read through.

Dr. Manga explains that existing research strongly supports the cost effectiveness, efficiency, and safety of chiropractic for highly prevalent, extremely costly, and poorly managed neuromusculoskeletal dysfunctions involving back and neck pain. He advises that greater evidence-based use of chiropractic has the unique advantage of simultaneously satisfying the three objectives of health reform: number one, saving in the health care costs; improving health; and equitable access to essential health care services.

Dr. Manga also makes an interesting point in that the current inefficient use of health human resources is economically wasteful, and as such, imposes an unnecessarily high tax burden to the citizens of Saskatchewan.

Based on the evidence, it is essential that the artificial barriers to chiropractic care be eliminated for these savings to be realized.

In the area of specialized care, we agree with the recommendations proposed to this provision. The specialized care, specialized services are particularly supportive to the establishment of the quality council that sets standards.

On page 5 of the commission's preliminary report, "Thinking about the challenges ahead," the comment is made:

> . . . develop standards based on research and clinical evidence so that surgeries and tests are provided only when needed, and waiting lists are based on need.

Implicit in this statement is the recognition that evidence does not support excessive reliance on expensive high-technology care. This reliance is one of the major factors driving up the costs of health care. The delivery of services on the basis of scientific evidence is the only way to ensure that the right service is delivered at the appropriate client at the appropriate time. The setting of objective, evidence-based practices should permit a substitution of low-cost, conservative alternatives such as chiropractic, for high technology care where appropriate.

Making things fair. Prevention must be an essential part of the health system. It must also be recognized that the determinants of health — education, employment, adequate housing, and so on — exist outside the system. A strong argument could be made that increased funding in these areas will more positively affect population health by preventing health problems, than increasing funding for health care.

The only realistic way of potentially reducing spending on health care is to provide services on the basis of evidence. The money saved could potentially be targeted toward preventive services to high-risk populations such as Aboriginal, seniors, and children living in poverty.

Accordingly the CAS concurs with the proposed recommendations.

Getting results. This section of the report may be the most important as it goes to the heart of health reform — accountability and sustainability. This section of the report:

> Health care in Canada is under measured and under managed . . . The most talented committed individual can neither overcome bad system design nor compensate for the absence of timely and comprehensive information.

The CAS concurs with these statements and the recommendations proposed.

To have a sustainable health care system accessible to all, it is essential that it is not only evidence-based standards but to regularly measure performance through such instruments as health report cards. Using performance indicators is an effective way of making all aspects of the health care system accountable for performance and should be used to determine future funding.

In this regard we recommend to the committee the article provided, *System Performance Indicators: Toward a Goal-Based Health System*. This appeared in the August, 2000 edition of the Health Services Utilization and Research Commission publication *Issues and Directions*.

No health care intervention has been analyzed and held accountable to the extent of chiropractic manipulative therapy over the past decade. As a result the profession has a large body of excellent research and much of it which is produced outside of the profession, supporting the cost efficiency effectiveness of its care for neuromusculoskeletal disorders.

The support of change. The CAS agrees with the sentiments expressed in the recommendations in this area. We are particularly supportive of the recommendation to increase funding to the health care research by objectively linking it to the health link expenditure. We believe that research is essential for the viability of a health system in the same manner that research and development is for private industry.

And finally, paying the bills. Most health care analysts agree that there is more than enough money in the health care system to meet the needs, but only if it is restructured in an evidence-based manner. Without fundamental change in culture it is doubtful that this system is sustainable. Even if more money was available, and it isn't, fundamental change in the delivery system would still be needed.

At present, 40 cents of every tax dollar goes to health care. Funding beyond this point would seriously jeopardize the provision of other essential services. Indeed, the case is made that there are some services that have been negatively affected by health care funding in existing levels.

It is obvious that unless the committee, on a priority basis, to reconfigure the health system on an evidence-based manner and immerse it in a culture of quality and accountability, a publicly funded and administered system accessible to all would not be sustainable. All the participants in the system must be willing to introduce the concept of zero-based budgeting; a commitment to submit all health care interventions to evidence-based analysis to determine if they are worthy of retention. If this action is not taken, it will assuredly mean that many valuable evidence-based services presently covered by medicare will have to be eliminated.

In our conclusion, while the report on the Commission of Medicare puts more emphasis on the issues of quality and accountability, conceptually it is little that is unique in the previous analysis of the health care system. The problems identified and recommendations proposed by the Fyke Commission are remarkably similar to the predecessors.

The reason for this similarity and virtually everyone knowledgeable in the health care system knows that the structural changes that need to be made if it is to become cost efficient and effective.

The CAS believes that if the health system is reconstituted on an evidence-based manner, that health care outcomes will provide . . . will improve, and that the health care spending over time will be reduced. We believe that chiropractic will have an integral role to play in a system structured on this basis.

If these changes are not made to the inertia of the increasingly prevalent in the existing publicly funded system, they will all prove fatal.

We urge the committee to recommend the government that the changes proposed by the health care . . . by the commission on medicare be implemented.

If you have any questions . . .

The Chair: — First of all, I just want to comment on your last statement. You urge the committee to recommend to the government. The committee's mandate is to report on what we've heard. We are not going to be making any recommendations as such. Our report will be a compilation of what we've heard from people like yourself, who have come and presented your response.

Questions from the committee. Mr. Gantefoer.

Mr. Gantefoer: — Madam Chair, and thank you for coming, doctors and sir. I would like to ask you in terms of the existing relationship, Mr. Fyke talks a lot about primary health care teams, and collaborative practice in order to have an effective and efficient medical service delivery system in this province.

What would be your experience about working in the current environment with medical practitioners in communities across this province?

Dr. LaPlante: — In the individual practices it'll vary depending . . . we've enjoyed a very good relation with the College of Physician and Surgeons and the SMA (Saskatchewan Medical Association) in this province. We are definitely getting more respect, I would imagine, compared to the other provinces. So we do have a good relationship.

One of the best things that's occurred is these interdisciplinary teams with the WCB (Workers' Compensation Board) and SGI, where secondary and tertiary assessments include a physician, chiropractor, and physiotherapists. They, you know, look at a patient, identify the needs and access . . . make recommendations to access the appropriate care.

Through those type of initiatives, you know, we are getting a lot more co-operation and everybody gets a chance to see that, you know, everybody has their role to play. And it starts to put down the barriers of turf protection. And that's one of the big things that we have to overcome.

Mr. Gantefoer: — Are you experiencing more often than not, you know, interdisciplinary referrals and things of that nature? And what would your relationship be with the pharmacy profession because many times, you know, the manipulations that your profession does are sometimes alternatively done in a drug therapy type of thing and there is some difference in terms of the approach under those two regimes. Do you find yourselves having referrals back and forth or how does that relationship work?

Dr. LaPlante: — With pharmacy, as a professional . . .

Mr. Gantefoer: — . . . medical doctors.

Dr. LaPlante: — With the medical doctors you know we're getting more and more where they are recognizing the benefits of spinal manipulative therapy. And you know essentially what we're seeing is 95 per cent of our practice is based on neck and back pain, so you know a lot of times what will happen is that when a patient's in acute distress they will do the therapies concurrently. They will send them to the chiropractor to get the biomechanical; to alleviate the spasm and inflammation they'll be prescribed medication.

And so what I find in practice is that when they are complementary to each other that the people respond a lot quicker, get back to work sooner, and you know they have relief along the way with the medication and they don't have to be on it as long.

Mr. Gantefoer: — The pharmacists, when they met with us, indicated that their members are located virtually right across this province and so are in a very good position to be part of a primary health team.

Would you comment on the location of your members as well. I think I know the answer but I'd like you to put it in the record.

Mr. Stewart: — Chiropractors are located in every area of Saskatchewan as far north as La Ronge; in the northwest, Meadow Lake; and down in Estevan and those areas. A number of practitioners also practise in rural areas. Most of our people are still situated in Saskatoon and Regina, the major centres, as you would expect but we have a number of rural practitioners as well.

A number of practitioners, particularly young practitioners getting started, may have a location in a city but they will go out to surrounding areas like for example in Regina and Balgonie and Sintaluta and other areas. So the coverage of chiropractics throughout the province is excellent.

Mr. Gantefoer: — Thank you very much.

Mr. Thomson: — Madam Chair, I want to thank Dr. LaPlante for his presentation this morning and for the advance copy of it. It made for very thought-provoking reading as the session was going on a couple of weeks ago.

I have three questions. One follows up on what Mr. Gantefoer was asking about these interdisciplinary teams and the primary health teams that are being talked about in Fyke. How would you see the practice, the chiropractic practices' role into those primary health teams? Would you see us moving towards a point where we may have a chiropractor on site working in an interdisciplinary team? Or do you see these maintain themselves as stand-alone practices?

Dr. LaPlante: — It can work in various ways. We participate in the primary health care working group, and that's all the

different nursing disciplines and everybody involved in that. And one of the things that we really would like to strive to attain is getting the appropriate therapy at the appropriate time.

And so whether it's a nurse practitioner that is triaging and deciding on which, you know, intervention or where the person should be going, or that the chiropractor's actually on the team, what we're looking at is evidence-based care in saying that for mechanical low back pain, for neck pain, spinal manipulative therapy is very efficient, cost effective, so they should be directed to getting that type of therapy.

So whenever . . . whatever form it's going to take, that is what we would like to participate in.

Mr. Thomson: — From the answer then, do I understand that perhaps we have not been seeing that happen enough; that there have not been sufficient referral into chiropractic care then, that there have perhaps been other preferred routes?

Dr. Grier: — If you look at the evidence, about 35 per cent of the population in any one year has an episode of neck or back pain for which they go to get care.

Chiropractors see about 10 or 11 per cent of the population annually. So there's quite a room for growth, we think, in terms of providing the appropriate care at the appropriate time.

What often happens is that the person has had the particular problem for quite some period of time and eventually they find their way into our office. What would be better is if they get there sooner.

Mr. Thomson: — So by working with the primary health teams then or working as part of them, you would see a high profile for the profession for this path of treatment?

The second question I had then concerns payments, obviously. You had mentioned in the presentation that $7 million in additional medicare funding would provide full coverage.

I'm wondering whether there has been any consideration given within the chiropractic profession to moving over to a contract-based arrangement with health districts. I don't know whether that's the case currently with WCB's arrangements. But has thought been given to that — to having chiropractors on salary within districts?

Mr. Stewart: — No, it hasn't been addressed at the present time. Chiropractors are paid centrally by Saskatchewan Health. They also receive payment directly from Workers' Com, and from SGI. I don't . . . the CAS wouldn't have any problem addressing this. And some years ago, in 1992, we in fact addressed an alternative payment scheme rather than a fee-for-service scheme.

So while we wouldn't commit ourselves to saying that we would definitely do this, we would be more than willing to enter into any discussion with any district on any type of contractual relationship. That would be fine.

Mr. Thomson: — Actually as I look at my notes, Madam Chair, I notice that my final question was already asked by Mr. Gantefoer, so I will defer to other members.

Hon. Mr. Belanger: — The question that I had in mind was asked by Mr. Thomson, so I'm fine.

Hon. Mr. Melenchuk: — A couple of questions for the record. Can you tell me where the training programs are for chiropractors that would practice in Saskatchewan for example?

Dr. Grier: — There are two Canadian colleges, one French speaking, one English speaking that the . . . the French-speaking one is in Trois-Rivières, Quebec, and the English-speaking one is in Toronto. There are also about 20 US chiropractic colleges.

In order to practise in Canada, you need to first of all go to university for three years, attend the four-year chiropractic program, and then pass national licensing exams, and then provincial licensing exams. In order to maintain a licence in Saskatchewan, you have to attend continuing education on a regular basis.

Hon. Mr. Melenchuk: — Okay. Second question is with regard to the emphasis on your presentation on evidence-based emphasis on research and performance measures. Do you believe, as an association, that chiropractic has withstood the scrutiny with regard to research and performance measures?

Dr. Grier: — I think that when you look at the evidence and look at why people attend . . . the kinds of conditions that people attend chiropractors for, there's ample evidence to show that chiropractic treatment is effective and cost effective for these conditions.

Hon. Mr. Melenchuk: — The final question is do you believe that chiropractors should be points of first contact? That patients should provide self-referral, that there shouldn't be any discriminating factor in between in terms of how chiropractors access the patients that they see?

Dr. Grier: — The short answer is yes. The more complicated answer is that there are a variety of barriers to access — financial in particular — which need to be addressed.

And also I think there needs to be a focus, which is what this committee report is about — is about changing the way that we provide information to people so that they can make effective health care decisions to access the appropriate care at the appropriate time.

Hon. Mr. Melenchuk: — And just one follow-up to that. Do you also believe that it's important for chiropractors to be part of these primary care teams, that they would have access to referral to other practitioners as well?

Dr. Grier: — Yes.

The Chair: — Any further questions? Seeing none, then thank you very much on behalf of the committee for coming today and giving us this overview and your response to the Fyke Commission. It was very informative. Thank you again.

While we're passing out the next written material, could our next presenters please come and take their seats at the table.

Good morning. And welcome to the Standing Committee on Health Care. This is the committee of the Legislative Assembly. Our first order of business is to receive and report on the responses of various individuals and groups to the Fyke Commission. The committee is an all-party committee.

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

Our first task is to receive the reports and respond back to the Legislative Assembly by the end of August.

We've given presenters 30 minutes and . . . your presentation and then, hopefully, some time within that 30 minutes for committee members to ask you questions.

If you want to introduce yourselves and where you're from and who you represent, then you can begin your presentation.

Ms. McGrath: — My name is Darlene McGrath, and I'm one of the co-coordinators of the Healing Co-operative. I am a reiki practitioner and was the main practitioner on the Tamara's House research project.

Ms. Novakowski: — I'm Rita Novakowski, and I'm also a member of the Healing Co-operative in Saskatoon.

Ms. Hellman Pino: — And I'm Kateri Hellman Pino, also a founding member and co-coordinator of the Healing Co-op.

Hon. Madam Chairman, hon. members of this committee, we are very pleased and appreciative of the opportunity to address you today and we are addressing your committee formally on behalf of the Healing Co-op of Saskatoon.

But unofficially and informally, we presume to speak as well for the hundreds of thousands, the 50 per cent or so of Saskatchewan citizens who use complementary therapies, and particularly those who would wish to but can't afford to because they're mostly funded out of our own pockets right now.

All of our members in the Healing Co-op are certified practitioners of recognized complementary therapies. We formed our co-op with a special emphasis on providing services to low-income persons and to adult survivors of childhood sexual abuse — those were our two constituencies of choice — most of whom do not have much money so obviously we have to direct ourselves elsewhere as well.

When the Government of Saskatchewan created the Fyke Commission we welcomed the initiative and we participated in its work via a brief. We found a lot that is positive in the final report's recommendations: the stress on enhancing the overall health of the population; investing in wellness as key to an effective and sustainable health system; the vision of truly interdisciplinary primary health service networks. All of these are very promising. And of course we feel they address us.

We find ourselves, the complementary health care providers, perfectly positioned to help make the implementation a reality.

Unfortunately and a bit to our dismay we found ourselves completely absent in the report. There was no mention of complementary therapies. And we find this a bit contradictory because we are convinced that without the complementary sector included, those goals, those nice-sounding goals are really unattainable.

We know that the commission was set up because health care has to be bottom line driven to a degree. There's a limit beyond which we can't go. And we're under a great deal of stress.

In the real world, years after the sudden withdrawal of federal funds for health care here in Saskatchewan, we're scrambling to keep in place not the best system we can describe, but the best system we can fund.

And here we come boldly asking for another inclusion. We are asking you, this committee, to recommend in your report to the legislature that Sask Health judiciously expand its inclusion of complementary therapies under medicare funding to include all recognized complementary therapies. And we say that sensitive to the finance question and the many demands, but assured that that way we will meet the goals, we will reduce costs, and improve greatly the quality of life and health of our citizens.

We say complementary — we don't say alternative. Because we are not setting up in opposition or competition, but we see that these therapies used along with conventional medicine greatly speed healing, reduce complications, reduce the need for drugs, and generally increase health and the body's ability to heal itself. All of us in our own practice have anecdotal evidence of this, but there's masses and masses of evidence we are . . . in the handouts we are providing you with, including a bibliography, a selected bibliography of studies.

For example, growing numbers of hospitals in the United States today allow reiki practitioners to give preoperative and post-operative treatments. This is simply because the hospitals work to the bottom line and this enhances their bottom line. They find fewer complications in surgery, they find much speedier recovery. So they'll go to the cost of providing a reiki treatment room. They are for the most part not funding the practitioners. The patients themselves will do that or the practitioners simply work as volunteers. It's not ideal but it's certainly better than nothing.

Currently there are a number of initiatives in the United States to incorporate complementary and alternative therapies into the health care system, notably the White House commission that Bill Clinton launched, and it will report to the President in 2002.

There are many other things. I mentioned a proposal for a pilot integrated medical system. That's being worked out by a think-tank. I didn't give you . . . it's in North Carolina and it's . . . I could give you the fuller reference.

They say comprehensive wellness, complementary coverage, though partially available through an increasing number of health insurance plans around the nation, is largely non-existent in a way that would effectively provide the funding for our proposal. The studies on cost-effectiveness of the complementary medicine are just beginning to be published.

If we look around the planet, complementary health care is all over. In China, what we call complementary here is mainstream medicine and has been for thousands of years. Aboriginal medicine, the same thing, thousands of years of history.

In Europe it's interesting to survey what's going on. There's a tremendous movement toward complementary . . . toward more and more inclusion. England strongly so. And they run the gamut. Belgium scarcely provides any funding for complementary care; to Germany, practically funds it all, or includes it, incorporates it in their system.

So Saskatchewan having been so strong in the leadership in health care in this country so far, I truly hope we're not going to be the last ones to bring up the rear on this question.

The stats on savings, I've provided some. It's very difficult to get the exact stats, though. You notice when Ms. Lavallie spoke of the Tamara's House project, we have partial stats, but you need long-term studies to show how much you're going to save incorporating complementary with conventional.

We know that the biggest drain on conventional medicine is probably chronic care. And that's the one that conventional medicine also does least well. Acute care, conventional medicine is the way to go — nobody has any questions. But for chronic care, that area is not that successful. And that area is a very costly area.

From Tamara's House we found the clients reported quantitative and qualitative improvements, and some of them are listed by the researcher who is also a member of our co-op.

When we get down to just numbers, many of the clients in this study acknowledge that they utilize frequently hospitalization and expensive medications. And one of the results was the distinct lessening of drug use.

And in terms of hospitalization, usually these people were in the psychiatric hospital, Royal University Hospital, Saskatoon. Six hundred per day is the cost. Average stay is 14 days. That adds up. Each intervention then is $8,400.

A series of nine reiki or aroma massage treatments cost $270, and obviously kept them out of the hospital during we don't know how long a period.

Two points. Nine reiki treatments are not going to be a cure any more than one bout in a psychiatric hospital is likely to be the final one for any of these severely traumatized people. But there is a gigantic disproportion in the cost.

We could drown you in statistics of cases. That's probably not necessary. I did include one. Dr. Judith Petry is a surgeon from Vermont and she described her case, becoming acutely ill, going to the hospital, getting quick treatment, getting better, but it didn't deal with the cause. She had recurring symptoms and was advised to go to a surgeon. Being a surgeon herself, that was okay, but first she went to a naturopath.

They discovered the cause, a very simple food allergy — her system reacted violently to corn and wheat. Had she gone for surgery, they would have probably not discovered the cause either, but they certainly would have found out what she looks like inside. And the cost would have been astronomical to her insurance. As it was, her hospital treatment cost $3,800. Seeing the naturopath and going through the whole regime to get well cost $450.

So she is launching a call to Vermont legislature to follow what Washington state has done in one instance. That's the Seattle-King County. They've set up a natural medicine clinic, which is state funded, which incorporates both conventional and complementary therapy.

So to find out how much we really would save by incorporating complementary therapies, we take long-term studies. These are not available because they're not funded. It's hard to get long-term funding since most medical research is done by pharmaceutical companies who have no vested interest in funding this.

We have . . . I quote one instance of a report commissioned by the Governor of Maryland, submitted by the Maryland Commission on Complementary Medical Methods. This report positively identified the cost-effectiveness of alternative methodologies, the report was buried, and never published by the government's . . . governor's office.

And the authors of this pilot integrated system say we don't even have to ask why. It is obvious.

It is true. We have a dearth of information both for lack of research and partly because some that is done gets buried.

Obstacles . . . Oh I should just highlight one other thing, that complementary therapies always work in partnership with the patient or client. That is, you have to take responsibility for your own health if you're . . . Whereas when people just go see a doctor, get a pill, pop a pill, or go to a hospital, they often do not take responsibility. They continue with lifestyle habits that are very detrimental to their health and they want somebody else to make them well, which costs all of us dearly. So this is one other thing that then would help translate into large savings.

Obstacles to the inclusion of complementary therapies, are of course, the sudden cost increase.

When we look at the Tamara's House study, though, and the very swift effects, we feel that quite likely already in the first year we would be . . . that bump would start evening out; that there would be significant savings in hospitalization, drug utilization, specialist utilization, etc., and the, you know, the more invasive therapies. And that saving would already in the first year begin to balance off the cost. We'd love this committee at any rate to wrestle with that concept.

There is another, there is another obstacle and there's a very great urgency for this commission . . . this committee to act boldly. We know the status quo cannot continue. We know that cutting here and there and cutting more and more will not . . . will only reduce us to abysmal health care, and make two-tier health care impossible to avoid. And that's partly . . . and that's in the works already next door.

And we know that under the terms of the North American Free

Trade Agreement, medicare is on appendix 1. That's the list of all the non-conforming measures. Our system is a non-conforming measure in a treaty our government signed on our behalf. That means there's a sunset clause; it has to eventually be phased out.

So your committee has an extremely heavy responsibility of preserving what the people of Saskatchewan will never forgive this government for if we lose it.

I thank you very much for your attention, and I think we'll allow some time for questions.

The Chair: — Before we begin questions from the committee, I just wanted to point out to your members that this committee is not making recommendations to the government. It's reporting on what we hear, and it's reporting to the Legislative Assembly. Thank you.

Questions now from Mr. Thomson.

Mr. Thomson: — Thank you very much for your presentation this morning. I believe a great deal what you've told us this morning is true — that people are . . . There are a large number of people in this province who believe that they want to use — whether you call it alternative, or whether you call it co-operative or complementary medicine — but I know that people are . . . I think of people I know, whether they're practising Tai Chi or yoga or looking after . . . taking herbal supplements or quitting smoking or any of these things, are taking more responsibility for their lives.

I'm not sure now how we move that more into the mainstream. What you've said about Asian medical practices, certainly what we know about Aboriginal practices, traditional practices, I think is all coming true, that we understand that these have a real role to play.

In 1993 when we undertook the first set of health care reforms, we called it wellness. Now the opposition will tell you that we did so euphemistically simply to hide budget cuts. But indeed a big part of the idea was to start moving money out of the acute care treatments, or at least new money, rather than directing it there, was to start directing it into preventative medical care.

This met, as you probably know, with huge resistance. Now I'm not sure if nearly 10 years later, the public is in any different position. Our budgets continue to be tight. I think you've made an excellent comment in saying that we are now looking for the best system we can afford, not the best system we can dream of. I think that's really a very eloquent statement.

The question is how do we marry these pieces together. How do we convince people that we want to move more towards prevention, that we want to encourage them to undertake these alternative or complementary therapies, but at the same time meet the fears and the concerns that we hear from people time and again in this committee, that losing the doctor out of a small town or moving money out of acute care will mean that they're losing economic development and that their town will shut down? How do we marry those things together? And I'd appreciate your comment on that.

Ms. Novakowski: — I think, first of all, if complementary care is included in this interdisciplinary team approach, then there's more credibility to complementary therapy first of all. And also that there is some funding, because right now the problem with complementary therapy is that there is no insurance, there's no funding for people that often can't afford it.

Also, if you have complementary care personnel available to people that say they have a chronic illness or a particular problem, they can be shown ways that they can help themselves. So that would be a way to encourage it.

It's a complicated issue.

Mr. Thomson: — Is there more that we can do with existing practitioners? I know I used to go to a doctor who, it seemed like every time I turned around he decided I was suffering from stress — who knows why, in the business I'm into — and constantly prescribed yoga. Probably would have been good advice. At the time, I wasn't so sure.

How do we get . . . is there a way for us to work with practitioners currently in the field to expand their knowledge of this?

Is there a way for us to work with . . . Let me use as an example; I'm concerned by a report yesterday that came out that says that our children are basically fat and unhealthy — bad diets, sedentary lifestyles. Is there something we can be doing in the schools, more on the prevention aspect, to convince people or teach them the basics of these things?

Ms. McGrath: — Yes. The beauty about the word complementary, we can fit in anywhere.

What we need, I think, from the existing system, we need opening points where we can enter in. I work with physicians. I work with chiropractors. I work with massage therapists. But how I got working with them is through my clients. They use all these people.

What we're trying to set up from this end is already in existence. It's just not formalized. So to formalize it means that we have to develop partnerships with our physicians and surgeons; with other complementary therapies that are researched, that are acceptable among all of us as being solid and safely delivered. I think that the public expects that of us if we're going to redesign something or expand the system.

Physicians can learn on the job by working with us, with a client. They already have assessed where the client's at. A decision needs to be made, where does this client want to go. And that decision comes from the client.

On the Tamara's House research project, it was totally client driven. The results are because of that nature. Reiki didn't heal them; reiki allowed them to help heal themselves. The energy of reiki helped them to move to a state of well-being where they realized they could do that for themselves. So it's a complement. It complements anything; it can be introduced at any point in time.

But when the main establishment knows so little about the kind

of work we do, the only way they will learn is through education and actually working with us. So we're asking for partnerships. The Healing Co-operative exists because we wanted to be a recognized, legitimate player in the new health care structure; that we're here not to take over anything, we're here to work with and aid in this transition that we're in.

Mr. Thomson: — One final question and then one brief comment.

The final question concerns regulation. Mr. Fyke talks a lot in the report and we've heard a lot of testimony before this committee about evidence-based care and the need for us to have results and to be able to quantify those, especially as we make choices on where the money goes.

As I say, it's strange to talk about it as a new approach to medicine because of course it's thousands of years old, but in this new approach if we try to integrate it in, how do we make sure that we can measure the results? How do we make sure that we can regulate to make sure there's a consistency of care? How do you build this in to more of a . . . I'm not sure and I don't mean anything offensive by the word, but a more mainstream approach?

Ms. Novakowski: — How do you regulate mainstream medicine? I think you do it the same way, wouldn't you?

Mr. Thomson: — Well in many cases the results are easier to find. This is . . . the problem is we start dealing with front-end care, it's often harder because obviously by the lack of it you'll see down the road where the problem is. We can count how many gall bladder surgeries are necessary. We can see how many out-patient treatments, our province versus others.

In many ways it's easier to quantify and to compare the existing medical practice. How do we work on bringing this more into the mainstream?

Ms. Novakowski: — One possibility for instance would be if a person is getting well and needs fewer drugs or fewer interventions, I think it's possible to assess what's happening.

Mr. Thomson: — My final comment is just that I want to congratulate you on the work you're doing. I still very much believe that the wellness initiatives that we had thought about in '93 and really formed the initial part of health care reform are well worth pursuing. I hope we get to a point again in this province where we are able to pick up that cudgel one more time. I fear that we're not there yet so in part I guess I ask you to continue to work and to be patient but there is a great deal more that needs to be done in this province to convince people that medicine is about more, and well-being is about a lot more than simply getting pills and regular treatments.

So thank you very much.

Hon. Mr. Belanger: — The points raised in your document talks about the value and the complementary medicines and the therapies that you offer is of significant value and benefit, and I don't think that there's anyone that would challenge some of the points that you make.

The only question I have is . . . I did have a bunch of questions about what type of treatment that you did have but your documents are fairly thorough and I understand now what I'm dealing with more and more. But my question is that you mentioned that your primary services are to those with low income or those suffering from the after-effects of sexual abuse. I guess my question is, if you want to envision a larger role in society for some of the techniques and some of the methods that you have espoused here, why wouldn't we make these services open to the general public? Why wouldn't, say for example, myself be someone that might want to go and see whether the benefits of these techniques might be of value to me without having to go through the trauma of being somebody that may have been sexually abused as a child? These are some of the things that I have for questions.

Ms. Novakowski: — We're open to anyone. We just have a focus to that area because it's an overlooked area because of their situation. But we're open to everyone.

Hon. Mr. Belanger: — They could basically walk off the street and go into your shop and you'd be able to show them the different techniques that you use.

Ms. Novakowski: — Absolutely anyone can come. That's right.

Hon. Mr. Belanger: — The second question I have is in terms . . . I asked this earlier. Really we're dealing with the inner strength and the power to really make a difference in people's lives, and we do that through your various techniques. I asked a question earlier, what relationship do you have with say the psychologists of the province? Because when we talk about the balance and the power of the mind, this is what you're actually tapping into. So is there a relationship when we talk about the spiritual and emotional and physical well-being of the people of Saskatchewan?

Ms. McGrath: — For the last six months I've been working with a counsellor with SDH's (Saskatoon District Health) approval and SDH is funding this. Our client is under mental health, adult. And we have been able to achieve a partnership, not just in treating the same client but we treat the same client at the same time. This client receives reiki while she's having a counselling session with her counsellor.

In six months time we have produced a better quality of life for this client than she had had in the last 10 years. And this is a long-term client of the system.

We did a presentation to Mental Health about the work we're doing. And it was a very interesting opportunity to meet the co-workers of this client. In the room before we started I asked how many people present had an experience of reiki. Five people put their hand up. Out of that five, three had reiki training. It was very interesting because it was unknown to the counsellor I work with.

The important issue here is that the research project taught us a lot of things about the capabilities of these modalities, and that is why I was contacted to work with him. Because they had tried alternative therapies and other complementary therapies to help this client who was stuck. And he finally decided he

wanted someone who had experience.

The research project gave me the experience he felt was needed. And because it's client directed, our whole approach to treating the client has changed. And together, we have learned from each other, and the client is directing the healing process, which is what the research proved happens.

Hon. Mr. Belanger: — Thank you.

Mr. McCall: — Thank you very much for an excellent presentation. And my question has to do with formalizing the relationship that you make the case for it presently existing. Now certainly in bolstering your case to gaining acceptance and gaining, you know, guaranteed funding, other examples throughout Canada I'm sure would be useful in building that case.

And it seems to me that there was a rather large-scale project undertaken in British Columbia with the holistic health centre that was adjacent to one of the more major metro hospitals in British Columbia, I believe in Vancouver. And certainly from that, and this was a number of years ago that this project was undertaken so I would assume that there's been a fair amount of research built up in terms of evidence-based outcomes and, you know, what the effect . . . you know, is this worth the public expenditure?

So I was just wondering if you've come across that in your research and if that's . . . if I'm possibly off on the wrong path or if that's . . . if you've come across that? Anyway, your comments.

Ms. Novakowski: — I'd like to point out a book that has recently been published and it's soon to be made available from Saskatoon District Health, and it's the *Handbook of Complementary Healthcare* and there is a lot of research on what's going on not just in Canada but also internationally as well. So some information is in here.

But I've put one sheet in here that gave a few quotes from here because I think it's very . . . a valuable resource because it's focusing on if we want to bring complementary care into the health care system, what do we need to do, how do we need to educate people, and what are the questions we need to ask. And it's a beginning point and like I said, it will be available soon, so I recommend that this could be a resource broader than Saskatoon.

Mr. McCall: — I just bring that up because we certainly do in Saskatchewan take no small amount of pride in the pioneering role that we've played in health care in Canada, but we also at the same time like to point to precedents where this has been proven successful and beneficial.

And so I was just wondering if you . . . and British Columbia of course is a provincial jurisdiction so there would be many of the same challenges being faced there in terms of decisions relating to public expenditure in health care. So I was just wondering if you were familiar with that model.

But I did note the cover that you included in the package and I'll take a look. Thanks.

The Chair: — Thank you.

Hon. Mr. Melenchuk: — I just have one question, and thank you for your presentation. Looking at your little handout here, it states certified practitioners. And I would just like to know what does it take to become a certified practitioner in reiki, aroma massage, and reflexology?

Ms. Hellman Pino: — There are very different requirements, all three. We have a reiki master right here who can address reiki.

Ms. Novakowski: — For reiki there are several levels of training. A person can learn to do that for themselves in just a weekend course, which helps them to treat themselves. This is self-care. But if a person wants to be professionally prepared, that takes longer training. So there's more for professionals . . . so there's actually two levels.

And then for those who teach and train like I do, there's further education necessary.

Hon. Mr. Melenchuk: — Just where would that education occur? Would it be from a master like yourself? So that's the sort of . . . there's no school that you would go to per se.

Ms. Novakowski: — There are some reiki masters who have started schools in the sense of formal institutions, but most do it on a smaller scale.

Mr. Hellman Pino: — To address the other two, the training for aroma massage therapy is . . . well the training of the aroma therapist and master in our co-op has been extremely intensive and long. And she studied in Paris, because there are sort of almost pseudo or slightly suspect routes to go here.

And for reflexology, perhaps you know more.

Ms. McGrath: — Reflexology has a national body as well as a provincial body. Kelsey Institute offers the classes as well. You can go to Calgary, Edmonton, their institutions also offer this.

And the reflexologist in our co-op has studied and practised for 18 years. Like it's a growing, ongoing education process. It's not just a . . . you go once and . . . if you want to be professional, you're going to continue your education.

Hon. Mr. Melenchuk: — And my final question is, in terms of funding your healing co-op, what per cent of your funding would come from sources other than what the client pays on a fee-for-service basis?

Ms. McGrath: — I didn't hear all that.

Hon. Mr. Melenchuk: — The question is what per cent of the funding to support the healing co-op would come from sources other than a user-pay client paying his fees.

Ms. McGrath: — At the moment we are funding part of our process ourselves by doing complementary therapies complimentary. Other than that it is the agreement with SDH. For the client that I work with, SDH pays for that service. And at this point, people are paying for the service out of their own

pocket.

Ms. Hellman Pino: — We are in the process of seeking funding because the idea is to provide a sliding fee scale for the preferential two groups, and the only way we can do that is with additional funding.

Hon. Mr. Melenchuk: — The question that I'm trying to get at: do you receive a government grant in any way? I think there was something initially from Economic Development to get the enterprise started. But there is no operating grants provided from any source? Okay. Thank you.

The Chair: — Seeing no more questions, then on behalf of the committee I'd like to thank you very much for appearing today and sharing with us your views and your views on the Fyke Commission. Thank you again for coming.

The committee will stand recessed till 1 p.m.

The committee recessed for a period of time.

The Chair: — I'd like to welcome you today, to the Standing Committee on Health Care.

I'm Judy Junor. I'm the Chair of the committee. It's an all-party committee. And the other members are, Dr. Jim Melenchuk is the vice-chair; he'll be here in a moment. Andrew Thomson, Warren McCall, Buckley Belanger, Brenda Bakken. We have Glen Hart there waiting for a name tag, and Rod Gantefoer.

The committee is a legislative committee and its first order of business has been to receive responses to the Fyke Commission and to report back to the legislature on what we heard. And we are to report back to the Legislative Assembly by the end of August.

The presentations that we've scheduled are 30 minutes. We've given presenters the 30 minutes, and that includes time, hopefully, for the committee to ask you questions if they have any.

So if you want to introduce yourself and where you're from, or if you represent something or somebody, and then begin your presentation.

Dr. Wiser: — Thank you very much, Madam Chairman. My name is Dr. Larry Wiser. I'm a family practitioner here in Regina. I spend most of my time assisting surgeons in the operating room here in Regina.

I've included a bit of a curriculum vitae with you — I've passed out three documents — and that tells you a little . . . something about me and my background, some of the publications I've done.

I think the thing that I would point out on this is that I also hold a master's in health service administration from the University of Alberta, which is the same degree Mr. Fyke holds. I believe he was the class of '70 or '71. I'm from the class of 1989. And I think that gives me a rather unique presentation on this.

It's a pleasure to be here today. And thanks very much for granting me this opportunity to present to you.

The topic of my presentation is The Fyke Report: Finesse or Fiasco? I won't keep you waiting, ladies and gentlemen, as for my opinion.

The Fyke report and its recommendations are a fiasco of the highest order. It will cause unprecedented damage to the health care system of this province if implemented. The Fyke report is an expression of faith. It is not an expression of experience nor of science. It's like jumping off a cliff into thin air.

The Fyke report falls down because of its three A's. And I'll go through them for you. Of these three A's, the first are its assertions, the second are its assumptions, and the third is its apologies. Now let's deal with these individually. And I'll quote some from the Fyke report to show you what I mean.

Well what is an assertion? We'll deal with the first one first — assertions. I define an assertion as a positive statement made without any visible proof or means of supporting evidence. And I'll give you some examples of these.

Page 5 of the Fyke report. Ken Fyke:

> Primary health services are the foundation of a system that promotes and maintains health . . . The foundation is cracked, with many gaps . . .

Ladies and gentlemen, I'm a family practitioner. I've practised both here and in California. I don't see these cracks; I don't see these gaps.

Assertion no. 2, page 5, Ken Fyke:

> There is no doubt that the province embarked on the right road for the right reasons in the early 1990s.

Well ladies and gentlemen, I beg to differ with that. And I have in front of me right here, a report . . . a presentation by Dr. Richard Plane, who is associate professor of economics at the University of Alberta. And he made this presentation in front of the Donner Foundation Conference on November 13, 1998. And I would like to read for you some of the things that Dr. Plane noted. Now this is three years ago. And he noted, and I quote:

> It has been shown that Saskatchewan developed the prototype model for the rapid and successful reform of provincial medicare system. The combination of a fiscal crisis, coupled with a reasonably well thought out needs-based health reform plan allowed the provincial government to radically transform the institutional and governance of a large and well-entrenched health care delivery system, and to achieve major economies in the delivery of integrated health services throughout the province.
>
> Alberta followed a similar course of action. Its cuts were deeper and more long lasting during its downsizing phase.
>
> Saskatchewan has seemingly paid a price in order to buy more fiscal room for its treasury.

> The drop from above average to the national level on three measures of health status, that in the short run the province moved from a position of excellence to one equal or slightly below the norm as far as the health status of its population is concerned. The decline of infants is measured . . .

Let me just do that again:

> The decline in the health status of infants as measured by a marked increase in the infant mortality ratio, associated with health care funding cutbacks, is particularly troublesome and deserving of much closer scrutiny than can be afforded in this paper.

Ladies and gentlemen, the cuts that this government made as Dr. Plane notes, on three parameters of health — one of the others was personal years of life lost — moved this province from a position of excellence in its macroparameters to one of the norm or slightly below.

So as far as Mr. Fyke saying that this was the right course that is highly debatable.

Assertion number three, page 60, Ken Fyke:

> Research suggests that, whether elected or appointed, board members have very similar views and behave quite similarly in carrying out their duties as board members . . .

Well that simply is not true, ladies and gentlemen. It's just plain wrong.

To prove that Mr. Fyke and his commission clearly don't know what they're talking about here, I have given you a copy of a letter I sent to the former minister of Health, the Hon. Pat Atkinson, at her request. With reference to the above statement of Mr. Fyke, please look to page 2, if you've got that letter in hand, the third paragraph down.

I'm speaking about the absolute contempt with which I was treated by the appointed board members of the Regina Health District Board in my application for privileges. And this is something all recent University of Saskatchewan medical graduates should be fully aware of before they decide to settle here, in Saskatchewan, under an NDP (New Democratic Party) government.

For the record, let me read the paragraphs in question, and I quote:

> The Board was clearly and deliberately delaying a responsible decision regarding my application for clinical privileges as a surgical assistant. There has been a display of absolute contempt for due process and any sense of fairness in this matter. There is no mistake that a lay Board has unconscionably over ruled the expertise of the MAC and the College (of Physicians and Surgeons) — this, in the face of a demonstrable need for surgical assistants in Regina!
>
> This contempt was displayed in the fact that certain elected Board members were expelled from at least one meeting and threatened prior to the next meeting by government appointed members. The matter of my clinical privileges was on the agenda for both of these meetings. This fact was reported in the media by one of the elected Board members. The media report indicated that the RHDB chairman, Mr. Garfield Stevenson, stated the elected members were not threatened, only asked to make voluntary decisions in their own interests. The Board then proceeded to hold meetings regarding the matter of my privileges in the absence of a number of elected Board members. I have no evidence whether the Board had a quorum, which included either the Chairman or the Vice-Chairman as required by statute at these meetings.

Ladies and gentlemen, it's not my intention to fight a battle that was fought three years ago . . . or two years ago, which I won, by the way, but just to point out the falsity of this statement, that there's no difference between board members . . . elected board members and appointed board members. In this case, the appointed board members threw out the elected members and threatened them with legal action.

This case is, right now, before the courts, so I'm limited in what I can say here.

Assertion no. 4; some members of the public . . . Ken Fyke:

> Some members of the public told the commission that the system is over-managed. In fact, within the current structure, there are too few managers, not too many. The existing managers in the system are spread too thinly.

Well ladies and gentlemen, with this statement Mr. Fyke disregards totally the fine men and women in the field that are trying to make this health care system work. Presumably some of the people who presented to this commission were board members from the district health boards. He discounts them completely. And this is typical of an arrogance that has permeated this government as regards health care in this province.

Not only that, Ken Fyke and his commission are showing some absolute contempt for the people who took the time and the trouble to appear before the Fyke Commission. They say — these people in the field — it's over managed. I have a master's degree; I can tell it's over managed. Mr. Fyke wants more managers. And the question is going to boil down to, do you want your health personnel at the bedside, where I think they should be, or do you want them sitting in the executive suite?

Two hundred years ago Thomas Paine wrote in his classic work *Rights of Man*, and I quote:

> Government with insolence is despotism, but when contempt is added it becomes worse. And to pay for contempt is the excess of slavery.

Well ladies and gentlemen, the Fyke Commission cost the taxpayers of this province over $2 million. So these taxpayers, as Thomas Paine said, have paid for the contempt they have received in the Fyke report.

Now I'd like to move on to the assumptions — the second A —

and these assumptions relate to economics and economic gloom and doom, which is interesting because I've been trying to track down some of the curriculum vitaes of the members on that commission. And as far as I can tell, and the economists I spoke to, none of these people are economists. And they're making grand economic statements here, most of them gloom and doom. And they're economic assumptions.

Assumption number one, page 3, quote:

> The fiscal challenge facing the health sector should not be underestimated . . . if major changes are not made quickly, the Commission projects Government expenditures on health will . . . (lead) to a gap of over $300 million at the end of four years.

A projection.

Assumption number two, also on page 3, quote:

> . . . the Commission does not recommend increasing health care funding to prop up the status quo . . .

Assumption number three, page 75, quote:

> Simply to maintain health services as they are . . . the health budget will have to grow about 6.5% per year merely to cover inflation, collective agreements, and other cost pressures.

Assumption number four, quote:

> . . . a failure to fund the system at the projected growth rate for the next few years will destabilize the system and indiscriminately reduce both needed and unnecessary utilization.

While these are all very interesting statements, they're definitely doom and gloom. And they're interesting statements made considering there's no economist sitting on the board or sitting on the commission. I think they are unnecessarily doom and gloom. This presumes that the Saskatchewan economy will not grow or will not grow as fast as Mr. Fyke and his commissioners think it will.

I'm a little bit more optimistic. And I think you have to kind of take it or leave it at that. There is something much more at risk here I think. This is what I would call a pseudo-economic presentation. The basis of the Fyke report is pseudo-economic. And that's fine.

But, you know, for one thing, Fyke is recommending, maybe in a backhanded way, is that physicians become the economic agents of government. They cannot do that. They simply cannot do that.

And, ladies and gentlemen, I've passed out an article here from 1975 from *The New England Journal of Medicine* by Charles Freid, who's a lawyer. This is one of the classic debates that took place in *The New England Journal of Medicine* in 1975. He was engaging Dr. Howard H. Hyatt, who's a bioethicist at Harvard there, and they were discussing basically the same kinds of questions that the Fyke Commission was trying to answer — what can we afford; what are the economics of this?

And what Mr. Freid is saying here is that people have rights in health care. And this I think applies particularly in the rural situation.

If I can direct you to page 242, I just want to read a few snippets of this, and I hope you will take the time to read the article. I've read it about six or seven times, and each time I read it I see something that I didn't get before.

Four lines down on the top of page 242, and he's talking about this economic agency. And I quote:

> For the traditional conception of the physician as one owing an obligation of personal care to his individual patient would be substituted a conception of the physician as agent of an efficient health care delivery system, acting very much like a maintenance mechanic working on a stock of capital goods.
>
> A manual of procedures tells him what repairs to make, what repairs are too expensive to make, when it is more efficient to allow a machine to wear out rather than to replace its parts, and when machinery should be retired from service altogether as having reached the end of its useful life.

Well what Mr. Freid is arguing about here and what Mr. Fyke did not carry on . . . he stopped in the middle of his economic argument with this Fyke report. What Mr. Freid is talking about is the marginal value of a life.

And since we're throwing economics around here, and figures, and figures of $300 million, this committee had better darn well figure out what is the marginal value in dollars and cents of a life of a Saskatchewan citizen. And this brings up a lot of other interesting questions since Mr. Fyke neglected to mention it.

Is the marginal value of life of a citizen of a city the same as the marginal value of life in a person from the rural district? I'll let you argue that one. Apparently not. The city dweller has more value because, you know, you're closing down the hospitals out there. At least there's a recommendation to close some of the rural hospitals.

And just to carry on with what Mr. Freid says, just picking up right before from where I left off, less brutally put, every physician would properly conceive his role in a way that physicians in severe battlefield situations are now expected to conceive their roles. The practice of triage would be generalized to all health care. First treat the gravely ill but salvageable, then the less gravely ill, and then the unsalvageable.

Well this is, as I say, the position as economic agent. And this swims against 3,200 years of the history of medicine. And Mr. Fried comes to that, if I can direct you to the bottom on page 242, last sentence on the page. He says:

> The intuition is that our right to personal integrity exists quite apart from questions of both efficiency and of just distribution of income.

Put quite simply, a doctor must use his utmost effort, his utmost talent, and more or less damn the expense to render the treatment that he feels is best for his patient.

Now Dr. Melenchuk and I both graduated from the same medical school and I think he will agree with me that our professors didn't teach us up there to spend money like water. They were more interested in precision, in how do we exact the correct diagnosis. Give me the test now, they would say, that will resolve this dilemma.

So I don't think I can agree with Mr. Fyke's inference that physicians are horrible, profligate individuals, spending money as if it was water. I just can't agree with that.

And if I can send you to page 243, again, the last sentence on the page, the last paragraph:

> The physician who withholds care that is in his power to give because he judges it is wasteful to provide it to a particular person breaks face with his patient.

Ladies and gentleman, a physician that would act as an economic agent of government at the bedside should be removed from the bedside and should probably never visit the bedside of an ill patient again. It's just not on. You can't do it.

Now we'll start with the apologies. Apology no. 1, page 81, and I quote:

> Quality is not a problem of individuals; it is a problem of system design . . .

Apology no. 2, page 82, Ken Fyke:

> There are no villains in . . . (this) piece; it has been a collective loosening of our grip on the terms and conditions of a sustainable system.

Apology no. 3, page 6, Ken Fyke:

> The quality problems are almost never the results of misdeeds solely attributable to individuals.

Ladies and gentleman, I mean somebody's got be at fault here. It can't all be the system. And I think this represents a failure to take responsibility in this health care system. And it's kind of typical of the way this government and the government that preceded it have dealt with the health care sector.

When there has been a failure, when there has been a needless or an unexplained death, we get into this tremendous discussion of system management and where is the system failing.

I don't think you can just leave it blank like this. There are people who are responsible who are manning positions of power at that time — they're the ones that were responsible.

And I'm coming close to the end here. I think the presentation of Mr. Fyke somewhat echoes the way myself and many colleagues of the medical profession of Saskatchewan feel that they've been handled. We've been handled rather despotically, we feel. We haven't received the necessary input.

And again, Thomas Paine said of this, and I would refer this . . . And you tell me if this doesn't sound a lot like what is suggested in the Fyke report. And this is the year 1790, by the way, that he's writing this:

> Against the species of despotism, proceeding on through an endless labyrinth of office till the source of it is scarcely perceptible, there is no mode of redress. It strengthens itself by assuming the appearance of duty and tyrannizes under the pretence of obeying.

This coalition government has no mandate from the people of the province to begin implementation of the Fyke report. This process was begun by Premier Romanow and he is now long gone from the Premier's office.

If this government wishes to implement the recommendations of the Fyke Commission, morally speaking, it must dissolve the legislature and seek a new mandate from the people of Saskatchewan. It must seek re-election on the basis of the Fyke report — yes or no. This is the issue of that campaign. To do anything else reeks of demagoguery.

I would like to close my presentation, ladies and gentlemen, and I'd like to quote from Sir Francis Bacon in his essay on cunning. Sir Francis noted:

> Nothing doth more hurt in a state than that cunning men pass for wise.

I'd like to thank you very much for the opportunity to present and for your attention. I'd be prepared to answer any questions that you might have.

The Chair: — Thank you, Dr. Wiser. Before we move to questions of the committee, I just want to clarify that this committee's purpose is not to make recommendations to the government. It's to receive responses to the Fyke Commission and report on what we've heard to the Legislative Assembly. I'll now entertain questions from the committee.

Hon. Mr. Belanger: — Thank you for your presentation. What I wanted to ask you is in terms of the necessary work that's being undertaken . . . was undertaken by Mr. Fyke. I think the general assumption that this is not really the issue of us going away from funding health care; this is really an issue of us ensuring that the rationalization of what spending we have out there is done in the most efficient manner possible so we're able to maximize benefits to Saskatchewan people.

And I guess there's two questions I have. First of all, what in your opinion is an adequate level of funding, given the fact that we're now at 40 per cent of government spending for health care? What would you envision being the necessary amount given your background? Is it 42 per cent? Is it 45 per cent? Is it 50 per cent?

And the second question I have is when you drive throughout rural Saskatchewan, when you see a green H — or northern Saskatchewan — what do you envision the green H can mean in terms of services? And if you envision that particular service can you . . . do you know that it's there?

So I guess my point being is that as members of this commission, not to be argumentative, but this is exactly the reason why we're participating in this process is to ensure that every life — no matter if it's in Camsell, Portage, or Weyakwin, or P.A. (Prince Albert), or Balcarres — but every life in the province of Saskatchewan is and should be valued the same. So there's the two questions I have.

Dr. Wiser: — Thank you, Mr. Belanger. Those are good questions. Let me see if I can deal with them.

You mention what is the adequate level of funding, where would I put the level of funding? I sound like I'm copping out. I don't know what the adequate level is. I don't think you can go percentage-wise.

I think government must look . . . It's not written anywhere that government must pay for all health care services. It simply can't. Government has other responsibilities and I don't think I need to go into them, but I will — roads, schools — I mean we can go down the list.

Now 40 per cent of a provincial budget is a pretty fair hunk, I'll tell you that. When I was in Manitoba as a senior policy adviser, we were running around with 33 per cent, and I thought that was a little high. So I think the question is that if government cannot pay for all of health care, then who shall? Do we move into the private sector, at least on some services? Do we de-insure other services?

There is a book out now called *Code Blue* where they're talking about medical savings account. Maybe the government should look seriously at just advancing people, I don't know, X number of dollars in their medical savings account — it could be a thousand, it could be 2,000 — so that you get some fiscal responsibility of the patient. And this money, the patient would not be able to access this money, only for health care services. There would be a machine or something in the doctor's office or in the hospital. That would be another mode.

I don't think this province can probably afford more than 40 per cent. As I say, when I was in Manitoba I thought 33 per cent was high.

Now your second part of your question, Mr. Belanger, what do I think of when I see the green H in rural Saskatchewan, this brings up a very interesting point — what are we going to do with the rural hospitals in Saskatchewan.

There's a recommendation in the Fyke report to close, I forget how many, is it — help me out here — 53, 50, I don't know; and I've talked about this with several economists. It is wrong to think that if you close those hospitals, expenses simply stop. The expenses continue.

You remove them from the government ledger. They're no longer appearing on the government ledger sheet, but the costs continue. The people in these rural hospitals, when they have their hospitals close, have to travel further. The cost is moved off into home care, public health, down the line again. Those costs continue. It's just an economic transfer off of the government ledger.

So my recommendation would be to keep those hospitals open. There is no economic point in closing them. They're doing something out there. I mean, why were they out there in the first place? They must have been out there for a reason.

Or . . . you know the only reason you have . . . the only way you could make it plausible to close these hospitals is to say that ever since they have been out there this has been a complete misallocation of resources by the CCF-NDP (Co-operative Commonwealth Federation - New Democratic Party), whatever government, and now we're going to correct it. And we're going to close those that don't. Well, I mean, I think Mr. Douglas would have a heck of a time with that.

So my recommendation to the committee would be to leave these hospitals alone in the smaller towns, leave them open, because I think this very well may backfire — that you may end up spending more closing them. Because you won't see it on the health balance sheet; it'll just be shifted into where you can't see it. But the costs will still occur.

The Chair: — Is that all, Mr. Belanger, are you done?

Hon. Mr. Belanger: — Yes.

Mr. Gantefoer: — Thank you, Dr. Wiser. Doctor, in your research that you've done — and I think that from your presentation you've done a fair bit of research in documents and literature and things of that nature not only from a medical practice but a health economy kind of point of view — have you seen any other models in other jurisdictions, in Europe or Asia or Australia, New Zealand, that could provide some real guidance in terms of what model may be more appropriate for a health care system in Saskatchewan than what the Fyke report is envisaging?

Dr. Wiser: — Right. That's a good question too. You know, well I think, I just say the reflex reaction was that there's always the Americans. And I say that in jest. They have their own set of problems, big problems too.

As I say, I mentioned the medical savings account.

I wonder if it might not be time better spent . . . I see a kind of a hybridization. I think you have to somehow bring the private sector into this.

I mean there's no reason, as I said before, that government . . . Government doesn't have the money to pay for all health care. And if they had it now, they won't have it in the future, particularly we get into this genetic research and milieu that's going on. The cost projections on that are astronomical. So I'm just wondering if there could not be some kind of hybrid.

We have Bill 11 or whatever they're calling it in Alberta. I think we want to watch that with great . . . we just want to keep a close eye on that. I'm not recommending that at this point in time.

But you know, if government cannot afford it — and it's appearing more and more like they can't — then the only other place you can turn for funds is the private sector. Now when we do that, I know there's a lot of problems there, particularly a

group of individuals I call the unhappy triad. The people, when you ask for either upfront costs to be paid, that is user fees, or you start sliding costs on to them, the people you always hurt first and worst are the poor, the elderly, and the chronically ill. And if you look at the American system, that's who gets it every time.

So if there's a way to somehow blend a private and a government-run . . . You don't want to take government out entirely, certainly not; I'm not advocating that. But if there's a way to blend the two systems with those three groups and many others, for example, the young . . . (inaudible) . . . two and a half years old and under, I think they pretty much stay put. The elderly, 65 and over, probably they pretty much stay put too as far as changes that you'd make.

The Chair: — Our next presenters are here, so if I could ask our next questioners to be fairly short.

Hon. Mr. Melenchuk: — Dr. Wiser, thank you for your presentation.

Just one comment. Obviously a good bulk of your presentation was airing concerns with regard to physicians maintaining their autonomy and independence in decision making for their patients. And certainly that has been a topic of debate for a long, long time, and in fact was the critical topic in 1962 when the government at the time were to create physicians as agents of the Medical Care Insurance Commission. That of course led to a 24-day strike. And that clause was pulled and replaced with three billing options including billing the patient directly, billing GMS (Group Medical Services), MSI (Medical Services Inc.), or billing the government plan.

Today when we talk about various alternatives . . . alternative methods of payments, as you know there has been discussions between the government and the medical association for the past decade if not longer, in terms of a primary care model. And the College of Family Physicians with its green paper out of Victoria several years ago, talked about setting up primary care teams and family physicians participating in those teams.

Do you see yourself an alternate method of payment that would fit within a primary care team setting, other than a fee for service, that would not usurp the autonomy of a physician to independently manage his patients?

Dr. Wiser: — That's a good question too. There are many physicians out there who are on salary. I think what I saw coming in the Fyke report, he uses the word mandate again. He's going to mandate. This will be mandated. And I looked up the meaning of the word mandate. A mandate is something that — one of the definitions — is the League of Nations used to do to conquered territories. So I mean that gave me a fairly foul taste in my mouth.

I don't think — if you're suggesting, and I'm not sure you are, Dr. Melenchuk — that the way to go here is physicians on salary. I think this is something that must come from the grassroots up. I don't think it can come top down as Fyke is suggesting.

And as far . . . I agree with you on your comments on physician autonomy. This is vital. And as far as physicians taking part as teams, I think they can be team leaders. I don't think they're one of a group of equals.

And there's a professor . . . I don't think he would mind me using his name; it's not in vain. He taught both of us. Dr. Marc Baltzan used to say, I don't want to see you become a medical social worker.

So I think, I think that gives the idea of what the physician's place is to be in these teams.

Mr. Thomson: — A couple of questions, Madam Chair. I'm interested in this last comment. I don't completely understand what you're saying. You're saying the place of the physician on the team is what?

Dr. Wiser: — He is the one that is taking the most responsibility. Therefore by definition, he has to be the leader. He will certainly be the one that gets sued if a team does not perform up to . . . or shall we say performs in a suboptimal manner.

Mr. Thomson: — So other participants then in the primary health service would be the chiropractors or the lesser than equals?

Dr. Wiser: — I didn't say that. I said the physician is the team leader.

Mr. Thomson: — Could you also explain to me your comment concerning . . . I was confused. You made reference to the system probably worked for those under, I think you used two and a half years of age and over 65. You're talking, I take it, about the payment level — that the government should continue to cover people under 30 months of age and over the age of 65, but the rest should have some kind of co-payment or be solely responsible for their own health care costs?

Dr. Wiser: — Disease and illness and utilization of physicians or the health care services are most likely to occur in the very young and the very elderly. Now the figure two and a half years I randomly chose. If you would like to make it two years, one and a half, it doesn't matter. But the point is I don't think we wish to . . . I think the system more or less works fairly well for people at the extremes of life.

Now what I'm suggesting is that if you get past the age of two and a half, you've probably got pretty good genes, a pretty good home, you're off and running. You're probably going to do all right in life. Now, I mean, you can certainly falter and get into any number of things, trauma, you know, substance abuse. But I think unless you believe, Mr. Thomson, that government can pay for everything . . . And I will say again, here come the genetic drugs, here come the genetic treatments. If you want to pay for that, I don't think you can.

But I think something else between — and again I just randomly chose them — two and a half and 65, we have to look at another means of funding. And I think that we need a large political debate on that because I think it's just a case of any government, not this one — not just this one, but all the provincial governments not being able to afford the costs of this

health care system. And if they can afford it today, I can almost guarantee you that they can't afford it in the future.

Mr. Thomson: — So do I take it from your comments that you're not a supporter of the single-payer system?

Dr. Wiser: — I think that that is an in-depth question. Single payment is one way.

I think you have to look at alternate sources of payment. These alternate sources could come under one umbrella, one detached form of government, a body of astute members of society. Government is really only responsible for taxpayers' money that they give to the system.

Mr. Thomson: — I have no further questions.

The Chair: — Seeing no more questions, then thank you very much, Dr. Wiser, for appearing today.

Dr. Wiser: — Thank you.

The Chair: — The Canadian Diabetes Association is our next presenters. If you could come and take your chairs at the front here. We're passing out your written material at the moment.

Good afternoon and welcome to the Standing Committee on Health Care. Our first order of business as a committee of the Legislative Assembly is to receive responses to the Fyke Commission and to present those responses back to the Legislative Assembly by the end of August.

We've given presenters 30 minutes, and in those 30 minutes of presentation we've included some time for questions from the committee members.

I'm Judy Junor, Chair of the committee. Our Vice-Chair is Dr. Melenchuk. Our other members — and it's an all-party committee — our other members are Andrew Thomson, Warren McCall, Buckley Belanger, Brenda Bakken, Glen Hart, and Rod Gantefoer.

If you want to introduce yourself and where you're from, then you can begin your presentation.

Mr. Herbert: — Okay. I'm Garth Herbert, president of the Saskatchewan division of the Canadian Diabetes Association. And with me I have Jan Johnson, our communications coordinator with the Saskatchewan division.

I'll go into the presentation and get any questions that you have later.

I'd like to thank the members of the Standing Committee on Health Care for providing organizations like ours with the opportunity to present our views on the recommendations contained in the final report of the Commission on Medicare.

The Canadian Diabetes Association was formed in 1953 to be Canada's response to diabetes. Our mission is to promote the health of Canadians through diabetes research, education, service, and advocacy.

Diabetes is a chronic disease that has been diagnosed in approximately 5 per cent of the Canadian population. While Type 1 diabetes affects about 10 per cent of the people with the disease, Type 2 diabetes which can cause the same serious complications as Type 1, affects 90 per cent of people with diabetes.

Type 2 is largely preventable. It has become a serious public health problem in Canada as our population ages and becomes less active and more obese. Diabetes is a major cause of coronary artery disease, which is the leading cause of death in Canada, and is also a leading cause of adult blindness, kidney disease, and neuropathy. Diabetes is costly to both the affected person and society.

In general, people with diabetes have poorer health, and spend more dollars on managing their health than people without the disease. It's estimated that Canadians spend between 5 and $10 billion annually in treating diabetes and its complications. Currently most of that money is spent on treating the damage caused by poorly managed diabetes.

One of the key points that we want to make today is that a lot of money could be saved if the health care system invested in two areas — preventing Type 2 diabetes, and giving people with diabetes the support they need to properly take care of diabetes.

An investment today in providing better coverage for diabetes supplies as well as better access to health professionals specifically trained in diabetes education and treatment will save our health care system substantial dollars by reducing the cost of treating complications, and significantly contribute to the overall health of our population.

Turning now to the Commission on Medicare's report, we believe that it's an excellent document and that many of its recommendations should be implemented. We strongly support several items.

An emphasis on establishing primary health service teams, which will improve access to primary health care services at the community level. The need for provincial health human resource strategy. The commission's recommendation that the province increase funding for health research to 1 per cent of the health care budget, and investing money now in making the changes to the health care system will ensure it's sustainable.

During the next few minutes I'll explain why our association supports these recommendations. I would also like to raise some issues that either weren't addressed in the report, or weren't resolved adequately.

Canadian Diabetes Association's clinical practice guidelines for the management of diabetes in Canada were published in the Canadian Medical Association Journal in October 1998. The central recommendation in the guidelines related to diabetes care is that it be organized around a core diabetes health care team made up of a person with diabetes, a primary care position, who may be a diabetes specialist, a diabetes educator, usually dietitians and diabetes nurse educators.

In addition, a person with diabetes may benefit from the support of other health professionals, such as medical specialists, social

workers, psychologists, pharmacists, podiatrists, and community agencies.

This interdisciplinary approach to diabetes care and treatment has proven the most effective way of helping the individual with diabetes manage the disease well. The diabetes health care team, core and supporting members, possess specialized experiences and expertise. This team provides direct service, consults and advises other members of the primary health service, and acts as a resource for the clients and families.

The diabetes health care team approach fits well with the Commission on Medicare's recommendation that health care services be reorganized to put more resources into primary health service teams.

The report itself recognizes that diabetes is a good example of a disease that could be prevented and managed better if more resources were put into primary health care. It's important to recognize, though, that not all health professionals currently have training in diabetes education and treatment that is necessary to properly support the person with diabetes. Every primary health service team needs access to health professionals specially trained in diabetes education, care, and treatment.

Physicians who are part of the primary health service team should be encouraged to pursue continuing medical education opportunities related to diabetes care and treatment and should be encouraged to follow the CDA (Canadian Diabetes Association) clinical practice guidelines for the treatment of diabetes mellitus. These issues should be considered as part of a provincial health human resources strategy.

The commission addresses the need for professionals to work at their full level of scope and expertise. The Saskatchewan Advisory Committee on Diabetes recommended an expanded role for diabetes nurse educators to augment diabetes care and treatment. A provincial template for transfer of medical function has been developed and is now ready for implementation in the health districts. Nurses, with this transfer of medical function, will be able to provide continuing care and treatment for people with diabetes who are using insulin.

Primary health service teams also need access to specialist services. On page 21 of *Caring for Medicare*, the report acknowledges the problem of providing specialist services to a large, sparsely populated geographic area. The report concludes that specialist service should continue to be concentrated in larger centres with a reduced number of health districts contracting for these specialist services. Page 25 of the report suggests that contracts for specialists could include providing outreach services, consulting with primary health teams, and other activities in support of the overall health system.

What the report doesn't say is that specialists will only be able to play this broader role in support of the overall health system if we change the method of paying specialists. Under a fee-for-service method of payment, a specialist will receive remuneration only if he sees a patient in the hospital or in his office.

If specialists are encouraged to take on a broader role, they must be remunerated in a way that recognizes all of the services they are providing. The endocrinologists, for example, are going to provide support to the primary health care teams located in different parts of the province. They may need additional support staff. In addition, they should be compensated for the time spent consulting with team members by phone or time spent travelling to different centres. One potential option would be to put specialists who play this type of expanded role on salary.

There are many reasons why Saskatchewan has difficulty attracting enough diabetes specialists. Some are cited on page 23 of the commission's report.

Endocrinologists, like other specialists, need to be located in centres where there's an adequate client base to sustain their practice. They need to have access to equipment, diagnostic tools, and the expertise of colleagues in other disciplines. In Saskatchewan, this means their specialist services tend to be concentrated in the big cities: Saskatoon, Regina, Prince Albert.

Another reason why it's been difficult to attract endocrinologists to this province, especially to performing in a teaching role at the College of Medicine in Saskatoon, is that Saskatchewan is not competitive with other markets in supporting health research. Many attempts to recruit endocrinologists to work in the division of endocrinology in the College of Medicine have failed because the college simply has been unable to provide access to the equipment needed to do research or adequate financial support to prospective researchers.

CDA strongly supports the commission's recommendation that the provincial government increase its support of health research to 1 per cent of the provincial health care budget. It is critically important that Saskatchewan be able to support a strong health research community within the province.

One suggestion for use of the increased health research funding is to examine the relationship, if any, between the use of new drug therapies and savings to the health care system from a reduction in other services accessed by people with chronic conditions.

People with diabetes live with the disease 24 hours a day, 7 days a week. Proper self-management is the key to avoiding complications such as blindness, kidney disease, and strokes. People with diabetes who take care of themselves save the health care system many thousands of dollars. Yet most of them receive almost no financial support from the provincial government for the cost of their diabetes supplies.

The commission's report eloquently describes the dilemma that faces governments as they contemplate expanding medicare to include the cost of prescription drugs. Yet by doing nothing and accepting a system that only provides financial support for prescription drugs to a small percentage of people, we are accepting a system that places huge financial burdens on people who live with chronic illnesses like diabetes.

People who have diabetes require insulin, test their blood sugar levels and inject themselves with insulin several times a day in order to stay alive. Yet some of the basic tools that people with diabetes need to take care of themselves, such as syringes and

blood glucose monitors, are not included in the Saskatchewan Drug *Formulary*. Though other things such as insulin, test strips, and diabetes medications are included in the *Formulary*, they are subject to the $850 deductible for prescription drugs every six months.

People with diabetes who live on social assistance or have very low incomes can get financial assistance. However, there are many people who aren't eligible for support, and as a result, struggle every day to find the money to take proper care of themselves.

The Canadian Diabetes Association believes that costs should not be a barrier to proper diabetes care. We believe that Saskatchewan prescription drug plan coverage for medications and supplies needed to manage chronic illnesses should be reviewed with a view to reducing the financial burden on the individual living with the disease.

The commission report would seem to support this approach when it says on page 50 of the report that there should be clear, defensible, and transparent criteria for determining which experimental drugs and populations warrant special status for coverage that would ordinarily be denied by standard policy.

As well, epidemiological data on diabetes released last year by Saskatchewan Health shows that Aboriginal people in Saskatchewan are three to five times more likely to have diabetes than non-Aboriginal people. Diabetes has reached epidemic proportions in the Aboriginal population, but appropriate services are not yet in place at the community level to help Aboriginal communities address this problem.

The Canadian Diabetes Association strongly supports the commission's call for a structured dialogue between the First Nations people, the federal government, and provincial governments to figure out how to improve and coordinate the delivery of services to Aboriginal people on and off the reserve.

On behalf of the members, volunteers, and staff of the Canadian Diabetes Association in Saskatchewan, I'd like to thank you for the opportunity to address you today. And Jan Johnson and I would be happy to answer any questions you might have.

The Chair: — Thank you very much. Committee members have questions?

Mr. Gantefoer: — Thank you very much, Madam Chair. And thank you for an excellent report. It's very well done. And it's difficult to ask many questions because it is so well done.

I want to talk about, though, the relative dramatic increase of Type 2 diabetes in the population. Not only I believe it's particularly noticeable in the Aboriginal population, but I think it's also very significant in the non-Aboriginal population as well.

Is that largely due to lifestyle factors that we have in our society that are controllable or that we can fix, or is this a trend that goes more fundamental than lifestyle?

Mr. Herbert: — No, lifestyle is definitely a large determinant. As our population ages and tends to become more sedentary and gain weight, one of the risk factors of diabetes . . . or one of the risk factors that aid in the development of diabetes is being met.

As well, I think as time goes on, we understand the disease more and we see more people in the health care field understanding it. So we start to get more people who are diagnosed as a result of the greater education that's going on.

Mr. Gantefoer: — So part of the statistics may well be just better diagnosis, not necessarily a greater incidence in the base levels of the actual disease.

Mr. Herbert: — I think that would be a small part, yes; but I think there is a greater incidence of the disease due to the aging of the population and the lifestyle that we tend to adopt. That's probably the larger factor.

Mr. Gantefoer: — Thank you. You also talked about the collaborative approach and the team approach and you very much support that. And you mention that it is necessary that there be people adequately trained in the various aspects of diabetes management and control in order for these primary health teams to work.

Are there family physicians that would require special training? Are there special add-on programs that would be necessary? Or how do you see that adequacy of training and understanding of the diabetes disease to be disseminated to these primary health care teams?

Mr. Herbert: — Well of course we always believe in greater education about diabetes and we want more education on the disease. But some of it would be, I suppose, through physician education, but some of it would be through hiring the specialized services such as diabetes nurse educators who go through training and the coursework to learn more about the disease. And they could definitely aid in the management of the disease.

Ms. Johnson: — I think the other thing that the association is working on are the guidelines for managing diabetes which were mentioned in the brief, which were developed and implemented in 1998, I think are still quite largely not used in general practice. So there's definitely an education process with implementing these guidelines with this new data that's been developed with family physicians in Canada as a whole, and across the province specifically.

Mr. Gantefoer: — Thank you very much.

Hon. Mr. Belanger: — I have a couple questions here. In terms of the Diabetes Association, you support the commission's call for a structured dialogue between the First Nations, federal and provincial governments. I guess my question for you is, is there any glaring examples of how collaboration is really having a negative effect on our awareness in the fight of diabetes amongst the Aboriginal community?

Mr. Herbert: — I don't know of any collaboration that has had a negative effect. I think collaboration always tends to have a positive effect on sharing the information and learning more.

Hon. Mr. Belanger: — I guess my question would be that there's sometimes . . . you know, you protect your own turf. And has there been examples of any of that type of activity?

Because what you're trying to do, as you've indicated and you've supported, is you're trying to make sure that from the perspective of the provincial government and the federal government and the First Nations government that the collaboration that we all should have and have adopted is that it's maximum benefits to those people that are suffering from diabetes.

And I guess my question was, was there any particular sector or any particular activity that we're not doing to its maximum benefit in terms of this fight against the diabetes epidemic?

Mr. Herbert: — I think due to our focus on . . . we tend to focus towards the person living with the disease and the person affected by diabetes. We don't get involved in the collaborative efforts of the governments so we wouldn't really . . . That would be beyond the scope of what we would know.

Hon. Mr. Belanger: — And the reason why I was asking the question is that I know that there's been a number . . . I've met with a few chiefs who had talked about some of the challenges with diabetes. And some of them believe that there could be alternate ways of dealing with diabetes as opposed to amputation.

They say that amputation is the only natural course after certain stages of the disease affect the person. So as a result of that they say that amputations are quite prevalent amongst the Aboriginal community, while some of the chiefs contend that amputation shouldn't be the only option, that there are alternative options.

And I was just wondering whether there is a glaring problem there or if it's not as bad as it appears to be.

Mr. Herbert: — Well I mean, alternative options, of course, fall within the medical profession and we wouldn't be able to comment on that. But the options we advocate are getting the healthier lifestyle and getting to the diabetes management before it gets to a stage of requiring amputations or alternative treatments.

Hon. Mr. Belanger: — Thank you.

Ms. Bakken: — I'll just follow up on what Mr. Belanger was talking about. Are there not alternative treatments that are available in other jurisdictions and have you looked at those?

Mr. Herbert: — Well as we don't provide direct health care, we don't advocate for any particular treatment of the complications of the disease. We leave that in the field of the people providing direct health care.

So though we might know things about different treatments, I'm not qualified to speak to them.

Ms. Bakken: — You mentioned that specialists should be on a salary to provide adequate care. That's your view. Do you know of other jurisdictions where this takes place, that specialists providing care are salaried, and how it works?

Mr. Herbert: — Well I personally . . . That was not our only view; that was just a potential option. For example, one of the ways this would work is a salary. I mean there's other ways that that could work too — compensate people for their time spent on travelling to and from these specialized health care teams.

But as to other jurisdictions, unless my cohort knows, I do not.

Ms. Johnson: — No, I don't know. I mean I could certainly find out.

Ms. Bakken: — Just one last question. To supply drugs and the accessories and so on that sufferers of diabetes require, do you have any idea what that would cost if it was paid for by the system?

Ms. Johnson: — I can give you a range of individual costs of a person who is insulin dependent with Type 1 diabetes, that the cost, depending on . . . Because there are many treatments. There are many different options for the person. And depending on the severity or the lifestyle that they want to maintain, the cost can range anywhere from $4,000 probably upwards to $8,000 per year.

That's not taking into account any kind of special dietary needs that they have. That's strictly what I would call supplies which would include insulin and/or other medication; testing strips, which are incredibly expensive; and syringes.

Ms. Bakken: — Are testing strips covered at all?

Ms. Johnson: — Well testing strips are covered under the . . . they're on the *Formulary* and they're covered under the $850 deductible.

But there has been an arbitrary decision made about what is a month's supply of equipment or strips. So once a person reaches their maximum at the end of that six months, they are capped on how much they can buy at a reduced rate.

Ms. Bakken: — Okay. Thank you.

Hon. Mr. Melenchuk: — Thank you very much for your presentation. A couple of questions.

First off, with regard to your recommendation on research funding, it is your belief that by moving to a 1 per cent or perhaps higher figure in terms of research support for the College of Medicine, that that would enhance the ability of the college to recruit endocrinologists in this province?

Mr. Herbert: — I think so. Part of what we hear from researchers is of course there's not enough money, and within our province anything we can augment the current funding with is definitely an attraction to the research community.

Hon. Mr. Melenchuk: — The second question is just a follow-up to what Ms. Bakken was saying with regard to payments of specialists.

Currently in Saskatchewan, the only salaried positions are in the academic setting where services by internal medicine specialists, as well as surgical specialists, they are paid as

academics. They provide teaching, research, and of course clinical services. The clinical services that they provide is then funded partially through the medical care insurance branch because they bill the fee codes for the actual services. That then goes into a pool that then goes to help pay the salaries of all of the academic staff in the College of Medicine.

So there is . . . it's a blended model that exists here in the province. There are no straight salaried specialist services providing direct patient services. And I don't know if there is in Canada, but in other jurisdictions — in Europe, for example — they do have that.

But the question that I have is: is it a salary or is it other models? I mean there are, there has been discussions with specialist groups through the Medical Association and the Department of Health for a long time now in terms of alternate methods of payment. But you would see an advantage to an alternate method of payment in terms of providing those services that normally are not seen as fee codes — such as consultations with other care providers, such as direct information to patients, or perhaps providing seminars and these things — that this would be a benefit in the education and prevention side?

Mr. Herbert: — Definitely some alternate method would help. What we said is that the current methods does not encourage the extra time that would be spent on helping these specialized teams. It's only, it's mainly for patients and seeing patients. And as a result, if you're assisting colleagues, there's got to be something there that encourages that and recognizes that a substantial portion of an endocrinologist's time could be taken up in that area.

Hon. Mr. Melenchuk: — And the final question is with regard to drug plan coverage. Have you done an analysis of various plans in other provincial jurisdictions as being seen as a better model than the one we have here in terms of what you'd like to see with regard to diabetes?

Ms. Johnson: — I don't know that there's been an analysis done on whether there's a better model out there. There certainly . . . you know, we have data on other provinces and what other provinces have. And we don't fit all that well in terms of what we have for coverage.

Hon. Mr. Melenchuk: — It's my understanding at one point in time diabetic testing supplies were 100 per cent covered by the provincial plan here?

Ms. Johnson: — Prior to '92 I believe they were 100 per cent covered.

Hon. Mr. Melenchuk: — Thank you.

The Chair: — Seeing no more questions, thank you very much to the association for coming today and for your presentations. I'll ask our next presenter to come forward and have a chair at the table.

Good afternoon, and welcome to the Standing Committee on Health Care. We're a legislative committee, an all-party committee. I'm Judy Junor, Chair of the committee. Dr. Melenchuk is Vice-Chair. Andrew Thomson, Warren McCall, Buckley Belanger, Brenda Bakken, Glen Hart, and Rod Gantefoer are the other members of the committee.

Our mandate is to receive responses to the Fyke Commission and to report what we've heard back to the Legislative Assembly by the end of August. We've given presenters half an hour and in that half an hour we hope there's some time for questions from the committee members.

If you want to introduce yourself and then proceed with your presentation.

Ms. Martin: — Right, thank you. My name is Linda Martin and I'm the professional leader for the active living initiative, In Motion. I'm with Saskatoon District Health and In Motion is a health promotion strategy with a focus on physical activity. I'd like to begin my presentation with providing you with a brief background on this initiative.

As many of you are fully aware, Saskatchewan health districts have a legislated mandate to improve health as well as to deliver treatment. Saskatoon District Health looked at ways that it could improve the general population health of its residents and as a part of their three-year planning in 1999 determined one of three must-do priorities within the district would be the development of a comprehensive, community-wide, active living strategy, which we have called In Motion.

The other two must-do priorities for our district in 1999 were the Y2K (year 2000) initiative or a problem at that time, the issue of Y2K, as well as recruitment and retention. So just given the magnitude of the other two health district priorities, this one around health promotion and physical activity really became quite important for us.

Based on the overwhelming amount of research supporting the health benefits of physical activity in the promotion of health and prevention of illness and disease, this initiative which we have called In Motion has become certainly a priority for Saskatoon District Health. Some of the interesting statistics we have found through the research are that more people face increased health risks through physical inactivity than face health risks from smoking. So that to us is very significant.

Physical inactivity dramatically increases a person's risk of many major diseases and illness — things like premature death, health disease, obesity, high blood pressure, adult onset of diabetes, osteoporosis, stroke, depression, colon cancer, and many others.

We know that the benefits of physical activity improve health and appearance, improve fitness levels, better posture and balance, improve self-esteem, weight control, also continued independent living later on in life. People are more energetic, are relaxed. There's certainly a reduction of stress with increased physical activity, and stronger muscles and bones.

An interesting quote that we picked up from Dr. Robert Butler, who's the former director of the National Institute on Aging, stated that:

> If exercise could be packaged into a pill, it would be the

single most widely prescribed and beneficial medicine in the nation.

And yet we continue to ignore the incredible health benefits behind physical activity, knowing that we could make millions if we could in fact package physical activity into a prescribed drug.

We know there's a need for immediate action. Physical inactivity is one of our country's top public health concerns. Only one-third of Canadians are physically active on a regular basis and reducing the number of inactive Canadians by a mere 10 per cent could result in an annual health savings of $5 billion. And this is supported by the Canadian Fitness and Lifestyle Research Institute.

Our concerns also include, over 50 per cent of the population is obese and with an increase in obesity amongst children. Also some of our concerns are with the aging population — aging population of the baby boomers and maintaining health into the older years.

Locally we have seen this need for action but we also needed to determine what the activity levels of our population were within our own residents of Saskatoon Health District. We therefore conducted a baseline survey and found that 77 per cent of Saskatoon and area residents believe that they are physically active on a regular basis. So that was very good news.

But then what we found was only 33 per cent of those people were active enough to achieve the health benefits. Now the good news behind this is that people do see themselves as physically active and are in fact physically active, but we need to move them a little bit farther ahead in increasing that physical activity so in fact they can achieve those health benefits.

So the good news I think in Saskatoon, and probably within Saskatchewan, is that people really are physically active. We just need to increase their physical activities so that they're actually achieving the health benefits.

I talked about In Motion being a health promotion strategy. Our goal is to have all of the citizens of Saskatoon and district make regular physical activity a part of their daily lives.

And we see ourselves doing this in two ways. One is through a public awareness campaign on the importance of physical activity around health. But we want to do more than just do a public awareness campaign. We want to ingrain the understanding and behavioural changes of physical activity into the culture and fabric of our community. We want physical activity to be a normal part of everyone's regular daily activities.

So with a public awareness campaign and moving towards really changing people's behaviours, we're targeting a very strategic community-targeted action strategy.

Our vision for In Motion is that Saskatoon District Health will lead the collective action of community partners in making our health district the healthiest community in the country through physical activity. And we have a fairly lofty vision and we would certainly like to share that with the province.

We believe that through this health promotion strategy we can serve as a model for not only our province but for our nation and for other international initiatives. We are, from our understanding, the only health district or health region within the country promoting physical activity as a health benefit, as a key to health promotion.

So how will In Motion be achieved? Our key components are in building partnerships, building community awareness, targeting community strategies, and of course measuring our success.

Measurement and evaluation is a key component of what we're doing. Our founding partners include Saskatchewan District Health, the city of Saskatoon through the community services branch which is formally known as the leisure services department, the University of Saskatchewan and the College of Kinesiology, and ParticipACTION Canada.

Some of our community partners include Saskatoon and area school divisions, our business community, non-profit organizations, community associations, our ambassadors for In Motion, and the local media.

I've provided you with a structure for our In Motion program. And I just wanted to highlight there that the coordinating committee is made up of three of the founding partners which include the health district, the city, and the university.

From there we are directly responsible to the partnership which includes all four, and ultimately to our health district board.

The leadership for In Motion is really a key to moving this health promotion strategy forward. We have the support of our district board and the senior administration. Our partnership, our founding partners are accountable for the actions as well as moving that again forward through the health district to our board. And of course we could not do this without the support of our community leaders.

Just to highlight some of our ambassadors for this health promotion strategy: people like Peter MacKinnon, president of the University of Saskatchewan; both of our directors of education, both the Saskatoon Public School Division and the Catholic School Division; our own CEO (chief executive officer), Jim Fergusson; our mayor, Jim Maddin; our chief medical health officer, Dr. Cory Neudorf. We also have representatives from the business community; representatives from Justice, Mary Ellen Turpel-Lafond; and others.

And we also have many others who have requested become ambassadors because they not only support the health promotion strategy but personally support physical activity as a health benefit.

On building community awareness, we've been working on a communication and marketing strategy that includes branding In Motion and our logo, consistent messaging that includes the message: physical activity, do it for life. And we feel that that message has a couple of meanings. One is for your life and to live a healthy life, but also over the lifespan, and when we talk about the lifespan we're talking from children to old age.

Also building community awareness through hosting special events and through some of our media campaigns, regular public awareness campaigns, and support of other community initiatives that support health through some of their initiatives.

Advertising and promotion includes a number of different venues and we have an information line that anyone can call for more information on this health promotion strategy. We're also using different types of media advertising through bus boards, billboards, newsletters, posters, and many other types of promotion material.

We also have a Web site, and I would encourage you to please check out our Web site. It's very comprehensive. It's an interactive Web site. It includes a self-assessment; self-assessment tools for people to be able to assess their own current level of physical activity. So that people can actually assess their physical activity without having a lot of background information or testing done.

We have targeted our Web site, we've targeted all age groups — children, youth, older adults. We've targeted the workplace and physicians. We have options for physical activity — personalized walking program and many other features on that Web site.

Building awareness through our targeted community strategies, moving into sort of the second key area of what In Motion health promotion strategy is all about. Our targeted community strategies include schools — so children and youth through the schools — our workplace, a physician referral program. We've targeted inactive adults and that's specifically through our partner, the city of Saskatoon. We've targeted older adults, and then the primary prevention and early intervention of Aboriginal diabetes.

So I just want to highlight some of the targeted strategies. And I won't go into them in too much detail but I can certainly respond to any of your questions later on.

Our In Motion schools. One of the things that we've done with our schools is we've set a goal for 30 minutes of physical activity every day for every child. And this is outside of their regular physical education classes. And the reason we've done that is that physical education classes really work on skills and techniques. And although children are physically active during those classes, they're not necessarily physically active for the 30 minutes, or 30 to 40 or 50 minutes that they're in that class. So we're targeting physical activity for every child, every day outside of their phys ed classes.

In Saskatoon we have over 30 In Motion schools involving just over 9,000 children and youth including both the public and the private . . . sorry, public and the separate school systems. Schools like Vincent Massey, which is an In Motion school, are doing very unique types of programs around physical activity that include morning community walks and are involving the community and embracing the community as a part of their physical activity and their health promotion.

Some of the feedback that I just want to highlight from our In Motion schools include improved morale and school atmosphere, fewer discipline problems. Morning walks have improved punctuality and attendance. And in particular, for those schools who were experiencing attendance problems in the mornings, found that their early morning walk actually brought children to school on time versus coming even later following the morning walks. So children were really looking forward to their morning walks with the community.

What these schools also found was that there was an improved relationship between the community members and the schools. So older adults living in those communities who joined on the community walks were now getting to know the children and found it not only beneficial for their health — the walk certainly benefiting their health — but also improving relationships within the community.

So those are just some of the highlights of the school. Our focus for the workplace is really on walking as the physical activity option for the workplace. We've targeted walking because it's easy, it's low cost, and it's accessible.

In Saskatoon we just have, currently, over 63 In Motion workplaces involving over 19,000 employees. We have large and small businesses and both private and public organizations, including our health district as an In Motion work site promoter.

We've developed a number of resources around the workplace, and part of those resources are assisting workplace employees and management in getting started in how to promote health within the workplace through walking and through other physical activity. We're also promoting that physical activity can be done outside of the workplace and that it's not necessarily something that has to be managed within the eight- or nine-hour working day.

And I won't say anything more about the workplace. There's a lot of resources developed around there, and a number of successes.

Our physician referral program is called PACE. And PACE is a physician-based assessment and counselling program on exercise. It's both an assessment and a referral program for physicians. And we've introduced it to our family physicians, and have currently had a number of training sessions for family physicians around the PACE program.

Our College of Kinesiology, through the University of Saskatchewan, is conducting an evaluation, an 18-month pilot study which has been funded through the Sport Medicine Council of Sask Sport.

So our physician referral program is currently underway, and we are recruiting more physicians in Saskatoon to be trained in the fall for this assessment referral program.

Just to highlight a number of our other targeted strategies, inactive adults. We're targeting adults between the ages of 20 and 64. And the program that the city of Saskatoon, as one of our partners, is working on is a program called Smart Start, and it's a program just to get people started. For those who are not currently physically active and who are contemplating getting active, it's a whole program around getting people into that first step.

They've also been promoting a number of new initiatives including walking clubs within their community associations, and really working at the neighbourhood level at improving health of the communities through the neighbourhoods.

Two of our newer Action Committees which we're just pulling together for this fall are on older adults and then the primary prevention of Aboriginal diabetes. We're going to be targeting older adults through some pilot programs based out of seniors' housing complexes. The focus of these programs will be on resource development and peer leadership.

Primary prevention of Aboriginal diabetes. We're working in a partnership with the health district, the community, Saskatoon Tribal Council, and the city of Saskatoon. And again we'll be working on a pilot program based out of our city centre facility on 20th Street. And this program will include physical activity and nutrition, and we will begin by targeting youth between 12 and 19 and then moving on.

We were fortunate to receive a research grant in the sum of just over $1 million from the Community Alliance in Health Research. And with this research grant the focus will be on researching community capacity, older adults, children and youth, and the Aboriginal population. This is the largest physical activity grant that anyone has ever received in Canada so we're very excited that the College of Kinesiology will be leading us through this research on physical activity.

Outside of the research grant we will also be continuing with our ongoing evaluation and research around the schools, the work sites, our general population, and our baseline survey, as well as the programs through the city of Saskatoon.

Just a note on the provincial initiative. We are currently building support for the provincial initiative to really move In Motion forward provincially as a health promotion strategy with the focus on physical activity.

Our emphasis again is on partnerships tailored to each community area and also assisting with the provincial marketing and development of this health promotion program.

In closing I think the recommendation here or the thought here is what can you do or what can we do as a province, as a provincial health care system?

And I think what we would really like to see the province do is make health promotion and physical activity a priority area, knowing the health benefits around physical activity and the impact that we can make on illness and disease. We would also like to recommend a continued partnership to make Saskatchewan the healthiest province in the country.

So with that, our recommendation is really to keep health promotion and physical activity a priority and on the list for recommendations for the final report. Thank you.

The Chair: — Thank you very much. Any questions from the committee?

Hon. Mr. Melenchuk: — This is primarily an initiative from Saskatoon in terms of their health district. Do you know of other health districts that are moving along these lines as well?

Ms. Martin: — Currently we are not aware of any other health districts. We have done a number of presentations provincially, and what we have found is a lot of health districts and municipalities calling us to assist them in moving a health promotion strategy similar to this one forward in their districts and municipalities.

Hon. Mr. Melenchuk: — And the second question is, you now have 30 schools enrolled in your In Motion program. Do you see your involvement in the school system as being very important to your overall role?

Ms. Martin: — Absolutely. We see working with the schools, children and youth, just an absolute priority. It's one of our number one priorities.

We would like to see all schools within Saskatoon and district become In Motion schools, and that's our goal.

Hon. Mr. Melenchuk: — Okay. Thank you very much.

The Chair: — Seeing no more questions then, thank you very much for your presentation and for your information that you've left with us.

We'll take a three-minute break while we set up for the next presentation.

I think if we could all take our seats we'll begin our next presentation. We have the town of Tisdale with us, and welcome this afternoon to the Standing Committee on Health Care. I'm Judy Junor, the Chair of the committee. It's an all-party committee of the Legislative Assembly and our first order of business as a committee was to receive and report on responses to the Fyke Commission.

The other members of the committee are: Dr. Jim Melenchuk is the Vice-Chair; Andrew Thomson, Warren McCall, Buckley Belanger, Brenda Bakken, Glen Hart, and Rod Gantefoer.

We've given presenters 30 minutes and within that presentation time hopefully there's a few minutes left at the end for questions from the committee members.

So introduce yourself and where you're from and who you represent, and then begin your presentation.

Mr. Zimmer: — Thank you, Madam Chair. My name is Rolly Zimmer, the mayor of Tisdale, and my right ringer today is the former mayor, Maurice Taylor.

We want to thank you very much for the opportunity to be here today. I guess number one, being allowed to give the submission to the standing committee; and number two, you're having some rain here today and we're hoping to hook on and pull some of it back our way. It didn't start till about Southey, so hopefully we can pull some back up north.

Our presentation will be brief and to the point. It's going to deal strictly with the economics of closing a hospital in a vibrant community such as Tisdale.

Decision makers within the health care industry are quick to point out that their business is health, it is not economic development. The problem with the statement is that, number one, our economic health and our tax base form the foundation for health care and the level of services we can provide.

Hospital changes also have a profound impact on economic development and to ignore this is to ignore the root of the problem — that of expanding our tax base. The big question is not how do we cut costs to fit within our budget, but rather how do we increase our tax base so we have a larger budget.

So how would the implementation of the Fyke report impact economic development, we ask. The major drawback of the commission is that the attempts to cut costs can be detrimental to the goals of expanding our economy. Let's look at some specifics and how the Tisdale Union Hospital has in fact impacted our community.

Construction of a hospital was completed in 1993 at which time Tisdale had a population of under 3,200 people. Tisdale now has a population of over 3,500 people. The community has grown by more than 10 per cent since the hospital opened its doors just eight years ago. At present Tisdale is experiencing some of the most dramatic growth of its time and the hospital may very well have kick-started the whole drive.

Some of Saskatchewan's best success stories, such as Northern Steel and Walker Seeds, are thriving here and doing business all over the world. Global business is a key because it means that foreign markets are in effect paying for the salaries and taxes of workers in Saskatchewan.

I just make reference to an incident when I walked in at the Canadian grain exchange in Vancouver, Walker Seeds is very well-known. I had a meeting there two years ago, just on a social basis.

Tisdale has been a model for economic growth and international business in rural Saskatchewan. Over the past five years, Tisdale has become the regional centre of the grain industry in northeastern Saskatchewan with three inland terminals and two high throughput elevators. Grain is an important export but we also move speciality crops, processed agriculture products, and manufactured goods out of the country.

Of greater significance is that we are seeing spinoff industry development and we plan on playing an even bigger role in the Saskatchewan economy with the years to come.

So what would implementation of the Fyke Commission mean for Tisdale? Obviously moving from 70 hospitals down to 20 means that our hospital could be slated for closure. Losing our hospital services would mean recruitment of doctors would become very difficult. Recruitment of other professionals and services such as teachers would become just as difficult.

Reduced professional services would put serious limitations on population growth. Citizens, especially seniors, would migrate out of our community and fewer people would consider Tisdale as a viable community in which to live. New business development would become difficult as new businesses are much less likely to develop if we have no hospital. The net effect on Tisdale would be a major blow to the town's economic health.

If we want to expand our tax base and bolster health care, we need to support and build more Tisdale Alfalfa Dehyds, Northern Steels, Walkers Seeds, Nuform Packagings. The closure of our hospital would seriously hamper our ability to do so.

Our economic development department is working on a variety of value-added projects . . . or adding projects at this time, including a cow-calf initiative, a hog barn project, feedlot project, honey processing venture, and a fibre processing project, just to name a few.

In making any decisions regarding hospital closures, the opportunity cost needs to be examined. What opportunities could the province be losing by removing a hospital from our community?

Currently, Jack Stabler ranks our community as one of the six communities in rural Saskatchewan provides a full range of services. This is one of the factors that has contributed to a compounded population growth of over 2 per cent per year over the past decade.

This rate of population growth is eight times that of the Saskatchewan average. 1996 census figures show that $60 million has been invested in new construction in the town of Tisdale and the RM (rural municipality) of Tisdale. On a per capita basis, this is 10 times higher than Calgary and 20 times that of Saskatoon. How much of this development would be eroded if our hospital were to be closed?

These facts and figures that I just presented to you were in fact done by Dwight Percy, who has been involved in our community for some time in planning sessions.

Saskatchewan Economic and Co-operative Development states that successful communities like Tisdale, Maple Creek, and Shellbrook are building on local strengths for jobs and prosperity. These progressive communities and many others like them are leading the way in revitalizing rural Saskatchewan, and we can all learn from their success.

People in Tisdale also have a history of making things happen. In 1995, partners in the community sat down and developed a vision. This vision built a joint youth facility of which we are very proud. It's comprised of cultural, education, recreational, and community health facilities that is unique to North America.

Attitude and vision are valuable commodities and are as much a part of development as financing and marketing. When the vibrancy is taken out of the community, so too is the potential to start and grow successful enterprises. The closure of the hospital would break the spirit of the community and turn optimism — that can be so hard to build, takes many years — into pessimism.

I want to add that our people, up to this point, have worked very hard to provide new opportunities for our citizens, and also to maintain job retention. It's been our number one goal. And that

hospital has in fact been a very, very strong backbone in the community that helps us do that.

So with that — I'm sort of slowing down here — I'm going to turn it over to Mr. Taylor.

Mr. Taylor: — Well thank you, Madam Chair, and members of the committee, for allowing us to be here today. And I want to thank the mayor for allowing me to represent our community here today, a community which has meant a great deal to me over a good number of years and a project so important to us as the hospital is, to appear before this commission to point out some of the reasons we think our community just couldn't exist without a hospital.

Business developments and tax building are important health care issues, but so too is non-tax spending. Amalgamating hospitals may cut costs from the health care budget, but it will add expenses to the budget of the average citizen who will be forced to spend more on food, travel, accommodation, and other expenses associated with obtaining medical services.

Fyke does not take these figures into account in his analysis and is essentially cutting health care costs at the expense of individuals and families. An increase in taxes would have the same effect, although this would not bring about a better economic state.

It should be noted that the equipment and facilities of the Tisdale Union Hospital have been highly commended and their underutilization would be a tragedy. The diagnostic services of the hospital are in steady demand and there are lineups to use the facilities.

It should also be noted that the loss of a hospital would create excess travel for seniors. This is not only difficult to cope with but detrimental to their health. Subsequently it would result in an outflow of seniors from the community and would leave many of our senior facilities underutilized.

Since the hospital opened we have been experiencing an expanding senior population for which we have been building infrastructure. We just cut the ribbon in April for a 400,000 senior citizens' hall. We've built three senior housing complex and developed an extensive walking trail system. All of these facilities would become underutilized given an outflow of seniors.

As a significant point of interest, seniors are a vital point of the community because they participate in all the events and volunteer for many organizations and projects. If they were to leave, this would have a far more negative effect than underutilized facilities.

If we take into account the opportunity costs of reduced economic activity, additional out-of-pocket expenses borne by citizens, and underutilization and rebuilding of infrastructure, the concept of 20 regional hospitals does not sound so appealing. Centralizing hospitals may make some sense, but instead of 20, the economics may work well with, say, 50.

The northeast has already taken a regional approach to health care with Tisdale servicing a large area to the south and east and working collaboratively with Nipawin and Melfort. Melfort provides a surgeon who travels to both Tisdale and Hudson Bay. Tisdale and Melfort share a joint contract for a radiologist to serve both communities. A medical officer of health has been jointly funded by all three health districts with Saskatchewan Health. The dialysis treatment facility is Tisdale's contribution to servicing the whole of the northeast.

The dialysis treatment facility was established three years ago based on strong interdistrict support for Tisdale and its central location within the region. There was also strong support among districts to raise capital funds for the project. These units have been doing a wonderful job of servicing the entire northeast region. And the public continues to show their support through many fundraising initiatives.

In closing, we would like to acknowledge that there were many positive suggestions made in the Fyke report. We recognize that health care in Saskatchewan faces some serious challenges in providing service to citizens of the province. We do, however, remind policy makers that our tax base is the foundation for health care, and any decisions that are made should be made with our tax base in mind. If the future of progressive communities is shattered by removing hospitals, future health care budgets and future health services will be jeopardized.

And I just want to again emphasize the dialysis treatment facility, Madam Chair, that started in Tisdale two or three years ago. And it's one that is utilized to the very maximum. But it's the way it came into being that . . . We had some terrific support from our community in helping to fund the dialysis treatment facility and it's one that is used extensively and people are lining up to use. I think it helps our seniors particularly, but anyone who needs that service.

I think we couldn't help but emphasize again, Madam Chair, the location of Tisdale. Tisdale is in the hub of the northeast. And while it may not be the biggest centre in the northeast, it certainly is the centre of the wheel and is the closest by far of any of the large centres in the northeast.

Again, I want to thank, Madam Chair, you and the committee members for hearing our presentation. And we'd be happy to answer any questions that you may have.

The Chair: — Thank you very much.

Mr. Gantefoer: — Thank you very much, Madam Chair, and welcome, Mayor Zimmer and Mr. Taylor.

There's two or three areas that I want to ask you questions on, and more for getting on the public record than for not understanding a fair bit about the community.

And the first one is to pick up on the last point that Mr. Taylor made about the dialysis project in Tisdale. And that to me was one of the greatest examples of three health districts and three major communities in those health districts working together in a very collaborative way.

As they got together and visioned this, they recognized that Tisdale had the facilities and more centrally located. I believe the CEO of the North Central Health District took a leadership

role in terms of making the presentation to Sask Health. Service clubs from the whole northeast worked on raising the funds to provide the facility. And I think it's a perfect example.

And certainly there have been other projects as well and you've made some of them. But there are a great deal of projects that are what is called tri-district projects. And they involve programs on public health, nursing programs, training programs, financial accounting programs, computer programs, and things of that nature.

And I'd like you to comment on how that's working. And I think in effect we have a regional service delivery model that involves the three health districts and the three major communities in the district, and the important role that all of them play in this.

Mr. Zimmer: — Okay, on the regional health, if Maurice can maybe just comment on that.

Mr. Taylor: — Well yes, Madam Chair, and Mr. Gantefoer. I think the relationship that the three health districts have has been just a boon for the whole northeast. And I think certainly the travelling surgeon, if you want to call it that, has worked very well and has provided a service that up till then we certainly didn't have. People would have to go to Prince Albert or Saskatoon. In that respect, that is working exceptionally well. And I guess this is what we're so apprehensive of. We fear losing that. Because it's working so well, why, why should we want to change that.

But I think the communities, other than health, certainly have had a good working relationship, Rolly, and you might want to comment on that.

Mr. Zimmer: — Yes, definitely. I asked Maurice to comment on health because he's our health critic.

But certainly the northeast is strong. Regionally we work together on every issue. We, in fact, as mayors get together in the northeast and meet quarterly. We just finished having a meeting three weeks ago. I think it's very, very important. The agenda was lengthy and we met for two and a half hours, and it flew by so quickly it was unbelievable.

But we do have a good working relationship in that regard, and especially in economic development. We do sit down with our EDC officers and the mayors and we work together. And that's why we're strong up there.

When I speak, not just for Tisdale of course — my main goal here today is to speak on behalf of Tisdale — but the northeast also helps Tisdale survive, not just Tisdale. So it's a very strong region and we work good together. We leave the hockey on the hockey ice.

Mr. Taylor: — Madam Chair, I would be remiss if I didn't add just one other thing, that I guess another hat I wear is on the Pasquia Health Board, and I just seem to be notified that I've got another year to serve on that, but that's so be it.

Pasquia Health District though, I think is worth noting that we have always operated within our budget and we've always operated in the black. And I think that's a statement that not many can stand up and say. But we have done that while providing good services.

And, Madam Chair, I want to say that we've had some tough decisions to make. We had to close a hospital, and that's not easy in any community. So we've lived through some hard decisions, but we have been the winner because it's turned out that we have an excellent, efficient health district.

Mr. Gantefoer: — Thank you. The other area that I think . . . and I really do appreciate and recognize the inter-community co-operation that has and is occurring and actually improving. I think the other thing that has changed in the last while is there's much more inter-district co-operation between physicians.

And you outlined some of the specialty programs that are occurring. But certainly there's more and more co-operation between the family physicians, I think, in the three communities in terms of working together to make sure that support services are available in the northeast.

Would you outline please again, for the record, the basic family physician component that you have in Tisdale, and the itinerant visiting specialist programs that are based in the Tisdale Health Centre?

Mr. Taylor: — Well in Tisdale we have five physicians. And I think for the record I should say, Madam Chair, that one of our physicians, Dr. John Shewchuk, can be recognized for many other things, but he was selected to be in charge of the dialysis treatment centre, and we're very proud to think that we have someone like Dr. Shewchuk who could take care of that.

They work well together, the group that we have, but they do have other specialists coming in and I can't, Madam Chair, name them by name, but we certainly have them coming in. I think there are the . . . I think for specialists for bones I think you can go to Melfort. You come to Tisdale for some other specialized services, and you go to Nipawin for some. And that's the arrangement they have worked out, Madam Chair, and it's worked exceptionally well. And I think that was brought about by the professionals in the three health districts.

Mr. Gantefoer: — Thank you very much.

Hon. Mr. Melenchuk: — Thank you very much for your presentation. Obviously I think you've really itemized the role of the hospital in terms of the economic impact for your community and how important that role is.

The question that I had specifically . . . a number of the questions actually were asked by Mr. Gantefoer. But in terms of the actual number of beds in Tisdale, do you know what the number of beds in the hospital is at this point in time?

Mr. Zimmer: — Well Maurice, he can probably comment on that because he's on the health board, but I believe it's 12. Am I not correct?

Mr. Taylor: — I believe it isn't. I think it's more than 12, Rolly, and I want to say 30 but I'm not absolutely sure.

We have a wing, Madam Chair, which can be opened up if need be and that might be confusing me. And it's something I should have known and I should have had that documentation in front of me but I don't have it, I'm sorry.

Mr. Zimmer: — I think it was 12 beds that were cut, the one wing. So I reverse that. We lost 12.

Hon. Mr. Melenchuk: — The second question that I have is with regard to the physicians that are there. You have a fairly stable physician group that's been there for some time. Have there been any changes recently in the past year or two?

Mr. Zimmer: — No, we've had none. Certainly with the Fyke report there was some, you know, instability in the community and even in the physician end of it. They were wondering what was happening. It took us a couple of weeks to kind of quell . . . just reassuring them that Tisdale's not going anywhere. We're going to fight like heck to keep our hospital, and at the same time, our community, going.

We do have some physicians that have been there for some time and there's two I would say that within the next five years, or one for sure, will be moving on because of the seniority. Otherwise it's stable.

Hon. Mr. Melenchuk: — The last question with regard to itinerant specialist services. Now I understand that you do have an arrangement with a radiologist that works between Melfort and Tisdale. Are the itinerant surgical services provided primarily out of Saskatoon?

Mr. Taylor: — No, in Melfort and some in Tisdale, and I would suspect some in Nipawin. But I think for the large part, perhaps in Saskatoon.

Hon. Mr. Melenchuk: — The question is then, there are Saskatoon specialists coming to Tisdale, Melfort, and Nipawin and are there specialists located in Melfort? I think there's an orthopedic surgeon there. Does he do visits in Tisdale and Nipawin as well?

Mr. Taylor: — Right, there is a surgeon in Melfort that travels.

Mr. Thomson: — Madam Chair, I want to thank the two individuals from Tisdale as well. What I am particularly interested in this afternoon is this discussion about inter-community co-operation. Because I think in many ways the northeast is really leading the province in terms of building, not simply around this idea of having a regional hospital, but rather having regional health services.

Do I understand then that the people from Nipawin would avail themselves of the services in Tisdale; people from Tisdale may use services in Melfort; people in Melfort may use services in Nipawin. Is that basically how the three districts work together?

Mr. Taylor: — That's right.

Mr. Thomson: — Is this spelled out in terms of any agreements among the boards or is it simply driven by where the doctors happen to be or where the patients prefer to go?

Mr. Taylor: — Well I think . . . I don't think there's anything hard and fast. But I think this is an arrangement that's been kind of devised by the physicians themselves and certainly have been acceptable with the boards involved.

Mr. Zimmer: — I know of no agreement in place, other than I know Dr. Eric Bodenstab, to name the physician there or the doctor that headed that. When I was still in the chamber of commerce for example, he brought this proposal to us. And he was the guy that got the regional aspect going, of the co-operation between the physicians and bringing in some specialized service, and really is nothing in place other than they know that they can go to Tisdale to have their eye, ear, and nose checked.

Mr. Thomson: — As we look at the Fyke report and look at this question of setting up primary health care teams, is there an ability there for Tisdale to take advantage of enhanced services through better use of nursing personnel or to work more closely with doctors or perhaps have other service professionals recruited?

Mr. Taylor: — Well I just don't know how to answer that, but I think we have fairly well worked as efficiently as we can, and I think we've made the necessary cuts that we can. So we're wondering just how much more efficiently we can work. But, however, it's kind of an awkward question. I think we've done what we think we can do in that regard.

Mr. Thomson: — My final question concerns board structure. Mr. Fyke's report recommends that we look at amalgamating districts, trying to find larger service areas. The co-operation level that has been established within the three districts that you've talked of this afternoon, would it lend itself then to us looking at establishing a larger single district in that area? Would there be a cost saving? Do you currently have three full-time CEOs working?

Mr. Taylor: — We do have three CEOs, that's true. In some ways the way we've been talking here, it would be advantageous to be one northeast health district. I think that's a comment that . . . As a health district, Pasquia was out meeting some of our people and it's a comment that we've received. In fact we received it from none other but the mayor, Rolly. So it's been there.

And just as a private individual it makes some sense to me. However I'm not in the management of the health districts.

But certainly the northeast has got along very well, not just in health, but in everything — whether that be the sports, Rolly, or town, the municipal arrangements — we have done well together.

So I think that's about all I can say there, but certainly I suppose there will be some other things. What the savings are, of course that's opening up another discussion.

Mr. Thomson: — Let me just conclude by saying that I very much appreciate the presentation this afternoon in terms of both the frankness and candour of how you've worked together as communities, some of the difficulties you've overcome that way.

But I want to say, very much in terms of the report, to me the compelling issue around the Tisdale hospital is the fact it's being effectively used and the fact that you have found a way to effectively use it both as a centre for specialized service with a dialysis unit, but also in terms of working with other communities. To me that is a very compelling argument, as opposed to the economic development one, for maintaining the level of health services in the area.

But I appreciate very much the discussion and the information you've brought us this afternoon. Thank you.

Mr. Taylor: — I just want to add one other thing and I think along the line that you're saying, Mr. Thomson, was the fact that Tisdale — and I suppose the whole northeast, but I can only speak for Tisdale — Tisdale has been the inventor of many things.

And I think we learned many years ago that you don't just build something because you need one thing. You build it to incorporate as many things as you can. And if you came to our community, you would see that we have perhaps a state-of-the-art complex which you think would be, this is a sports complex. No, it isn't. It's a sports complex associated with school. We have a full range of education facilities. We have Department of Health in it. We have a library equal to none in the province and we have an arena, a curling club, a shooting range.

And we did that because, as a community, that was kind of an idea born with the community and we needed it, we built it. And I think that was the first in the province. Education people tell us the first perhaps, you know, in Canada.

So we are innovators. We've learned that to get anything done, you do it. Thank you.

Mr. Thomson: — One last thing. I'll say that, having grown up in the Prince Albert area, I have always had a healthy respect for what happens in Tisdale, both in terms of the type of athletes you guys turn out there and just the sense of community spirit.

I think in northeast Saskatchewan and north central Saskatchewan, we have really seen communities come together and have very clear visions of how they want to move forward in terms of economic development, in terms of social policy. And you really are to be congratulated on that.

Mr. Gantefoer: — Thank you. I just wanted to comment on the last statement Mr. Taylor made and to show another idea of how Tisdale has got this foresight.

When they built their new hospital that was opened in the early '90s, they built it in attachment to the major senior citizens home so that's all connected.

There's a further project that's at the beginning stages of drawing, of a second senior citizens home that needs replacement in the reasonable future. And that project is being designed to be coupled onto the existing seniors' home and the existing acute care facility.

So the town has to be complimented not just on their recreational and health and educational foresight in terms of their complex, but they've also planned for that in their health care facilities as well. And I just wanted to make sure that that was recognized.

The Chair: — Seeing no more questions, on behalf of the committee I'd like to thank Mayor Zimmer and Mr. Taylor for coming today and raising the profile and the provincial awareness of what a wonderful community Tisdale is. Thank you very much.

I believe the town of Balcarres is next. If you want to come and have a seat at the table here. We're just passing around your written submission.

I'd like to welcome you this afternoon to the Standing Committee on Health Care. It's an all-party committee of the Legislative Assembly and its first order of business is to receive and report on responses to the Fyke Commission. We've given presenters half an hour and in your presentation; in that half hour, we hope there's a few minutes at the end for questions from the committee.

I'm Judy Junor and I'm Chair of the committee. The other members are: Dr. Melenchuk is the Vice-Chair, Andrew Thomson, Warren McCall, Buckley Belanger, Glen Hart, and Rod Gantefoer. Ms. Bakken has also been here during the day.

If you want to introduce yourself and where you're from and who you represent, and then you may proceed with your presentation.

Mr. Stephens: — I'm Keith Stephens, the reeve for the RM of Abernethy which also contains the town of Balcarres.

Mr. Baber: — I'm Ervin Baber, mayor of the town of Balcarres. And Keith and I will present a joint submission.

Mr. Stephens: — I would like to start off our submission. Thank you for taking the time to listen to us and providing this opportunity.

On reviewing this well-written report — and I would like to actually have access to those writers because it was put together very well — I see many opportunities that could be . . . that should be acted upon that will lead to a better health system for us here in Saskatchewan.

The first that came to mind was the establishment of the quality council with a mandate to improve the quality of health services in this province. And I think that's an excellent idea. The responsibilities listed for the QC (quality council) in chapter 4, page 51 of the Fyke report are very common sense items that I do not feel are being done very well currently.

Our health care system appears to be unaccountable to anyone and without any direction. If the quality council could have input into the Saskatchewan Health funding, we may see a more coordinated approach to health care.

Information management is the key to success in today's world. A key element as to why we are failing in the health care

industry is our lack of easily accessible, standardized information and how we look at it.

I understand that the Saskatchewan Health Information Network, or SHIN, is working on this problem along with other provinces. I would hope that a standardized, centralized, and meaningful database could be used by all the stakeholders to make better decisions.

I would like to know as a potential patient, how many operations a surgeon does and the repeat or failure rates for the different surgeons or different procedures. It may also give me contact people who have gone through an identical situation and by talking with them, I would become better informed of what may lay ahead for me.

A centralized database would mean that a set of tests that were done at one location would be readily available to another physician at another location without duplication of tests. It may also mean that trends could be spotted easier and more proactive steps could be looked at. Variations from the different clinical labs may also show up any weak areas within the current system.

The report mentioned a 24-hour medical telephone service. I think that this is an exciting idea with potential. A careful study of existing systems in use should help determine how to proceed with this project.

Try not to reinvent the wheel — rather to improve upon it. One must also remember that it takes a great deal of time and investment to educate people to use a different approach to deal with a medical problem and you would have to have some patience in doing something like that.

Chapter 3, which is titled "Making Things Fair," talks about trying to prevent some of our health problems. This is generally recognized as the best approach to the problem. I see great strides that are being made with our education system to intervene early so society does not have to deal with failures. Anything that we can do in this area will pay dividends in the future.

Mr. Baber: — I'd like to speak on some of the repercussions and uncertainties that I found in the Fyke report and possible repercussions that we might have.

It seems that the primary centres appear to be taxed to the limit now with long waiting lists. Will the money saved in rural Saskatchewan be given to the cities to address the problem? It has already been proven that throwing money to the problem will not fix it. Or will this money be used to build a new facility in the city of Regina?

We suggest starting reform from the top down, thereby getting the primary centres working smoothly before touching the small acute care. We see nothing but bedlam and chaos if 53 acute care centres are closed indiscriminately in short order.

We were very fortunate in the Balcarres area to have had the approval of a new integrated health centre which opened two years ago. So this is mainly long-term care but we have six acute care and respite, palliative, and convalescent.

There is a substantial local investment in this, as the rules now state that you have to raise a third; so the local investment in that was $3.2 million. This was raised, you know, with a tremendous effort by not that many, not that many people. A lot of this money was raised on the basis of there being some acute care there.

Some services that it seems haven't been addressed by the Fyke report are long-term care convalescence.

I really find it hard to fathom how we could function without doing the convalescence that we do in Balcarres. So even though there is good home care in some cases, and in some cases it's First Nation people, which we have four reserves to the east of Balcarres, sometimes the home care isn't working out there. We've had a person having to convalesce in Balcarres for two weeks after bypass surgery because the home care nurses on the reserve had quit.

How would we manage this? How would this person manage if we didn't have the acute care? Like, it seems as though we're certainly providing a service to the larger centres by being able to do this.

Palliative. There's another important item. I think we would all choose to spend the last days of our life in our home territory with staff that we've known for years and with our friends and family nearby. We can perform a valuable service there.

Respite is self-explanatory. That's very important. Very often when you get the respite people, there's just nowhere else for them to go.

Diagnostic hasn't been mentioned in the Fyke report, when our people have to go to larger centres to get every little blood test done.

Physicians would not remain. We have two physicians and have had a relatively stable physician tenure. They would not remain there without acute care.

So therefore, you know, if people had to go to larger centres more than they are now, the cost of health care for our rural people would increase dramatically.

You know we are presently coming to Regina for many, many specialist appointments. And if any of you have ever brought a 95-year-old family member who is in a wheelchair to Regina for an appointment, you'll know exactly what I'm talking about. It's a hardship. My father said why don't you just let me die. And this would be done more often, as I see it, if we can't perform diagnostic services and other services in the local area.

We feel that bigger isn't always better. And businesses have gone the bigger route and then come back to the smaller more workable units. And we believe that we did a very good service, cost-efficient service under the old union hospital districts and we believe the Touchwood Qu'Appelle Health District is operating very efficiently, also without large deficits, even though it's small.

So we don't really see the need to become bigger. It has not been proven that large health districts are more cost-efficient.

The loss of employment and economic activity would be devastating to rural Saskatchewan, without any evidence of cost saving. You know, just imagine how many second incomes for farmers come out of our facility.

Ambulance service. I'm not sure that the personnel is there for the increased ambulance service that one would have to have if every trip was going to be an hour away. And I understand there's a big migration of ambulance attendants to other provinces. Can we stop that?

There must be a definition of services available to all Saskatchewan residents. Primary health care services must be in place prior to restructuring. Rural Saskatchewan's suffering now. The indiscriminate closure of most of the acute care centres would be a serious blow.

We realize, at the same time, that the current system is unsustainable without adjustments. We would suggest a special support plan modelled after income-based drug plan, dental, and optometric plan. The drug plan system of payment works very well, and it's very, very fair, and subsidizes the people who have a lower income and a high drug cost.

User fees are not an option in the Fyke report, but I personally wonder whether it shouldn't be. In fact, it seems to me the late premier of this province, the late Tommy Douglas, used Sweden as a model of social programs for Saskatchewan. And I read in the media where Sweden has instituted user fees.

I think that there are many, many good aspects in the Fyke Commission. I personally know Ken Fyke. I'm also a pharmacist. And I knew him before he became important. And some things certainly must be addressed.

We must remember though, it's only one man's opinion. Should we get, should we get more opinions? And I think we should, we should try to find other options of raising money. As I suggested, user fees and some of the methods that the drug plan uses or other health agencies use.

Thank you, Madam Chair, and committee members, for your attention. We'd be happy to answer questions.

The Chair: — Thank you.

Mr. Thomson: — That was a very good presentation, I appreciate the overview of what's going on in the Balcarres-Abernethy area.

This new integrated care centre that is pictured on the front of the presentation looks most impressive and obviously must be a real benefit to the community in terms of providing good health care.

I'm interested in the co-operation, the level of co-operation between, say Balcarres and Fort Qu'Appelle in terms of sharing doctors and health care resources. You're relatively close to Fort Qu'Appelle. Is there a relationship there in terms of sharing professionals?

Mr. Baber: — Of course we are in the same health district, and yes we share many tertiary services, as we do with other health districts. And we share some of their facilities. Some of their . . . some of the services they provide in their facility, a radiologist. And there isn't really any sharing of physicians.

Mr. Thomson: — Now as . . . looking at how patients would look at the system, obviously if there's an emergency issue they would go to the facility here in Balcarres. If they needed another level of service, would they go to Fort Qu'Appelle or would they go to . . . I see you shaking your head. Where would they go next?

Mr. Baber: — It's Balcarres, Regina.

Mr. Thomson: — Balcarres, Regina. I'm thinking . . . I'm sorry . . .

Mr. Baber: — In case of an accident, possibly both ambulances would be used so that's shared service. We would help them as we would help Melville. We have. Just two weeks ago during that terrible accident at Melville, there was also one north of Balcarres, and there was some shared work done there.

So if there was an accident, they would use both facilities, both ambulances. But generally it's stabilize in Balcarres and then on to Regina.

Mr. Thomson: — Given that then, can I ask a question about the health districts? You had said you weren't necessarily sure there was going to be a saving by amalgamating districts. Mr. Fyke has recommended creating fewer districts, ostensibly I guess to provide for greater sharing of resources but also to cut down some of the administration costs. He has, if I'm not mistaken, got the Touchwood Qu'Appelle district in with Melville, I think, into a kind of an east central approach.

Would it make more sense to put it into an enlarged, enhanced Regina district?

Mr. Stephens: — Can I respond to that one? Well there's a paragraph I skipped out here and it touches on things like that.

One of the greatest challenges for the quality council would be to define and measure population, health, goals. That is not an easy task — and he stated that — or it would have been done by now.

Once you have measurable goals in place, you have a yardstick to judge the performance of our health districts and health centres. Currently we don't have that. Only then will we have the information needed to make informed, rational decisions.

If we spend as much energy analyzing data and developing our measuring sticks for quality of care as we will spend defending ad hoc closures of hospitals, we would be so much further ahead.

Mr. Thomson: — In many ways, as I read the Fyke report and I listen to what citizens from around the province are saying, I think that the issue is one of how do we efficiently use our health care services and make sure that the right kind of services are provided in the right communities.

You had mentioned in the presentation the question of

sustainable costs and whether we should be considering user fees. It's an option. Certainly the question always arises as to what's the appropriate fee. And I won't ask you what you think we should be adding on. I'll simply say that with the amount of money that the province looks at spending, if we were to put a basic hundred dollar user fee on, or a premium fee, we would only raise $30 million. That would be about a fifth of what we put in for new money this year alone.

So the question is not so much one of how do we find more money. Governments have an ability, I always think, to do that. We can simply raise taxes. We can get away with that once or twice but it's not the most popular approach. The other is how do we more efficiently use the services. And I think that that's one of the things I'm interested in hearing in this particular area.

Is there a way for us to have Balcarres and Fort Qu'Appelle and Regina co-operate more to make sure that there's better quality of service in Balcarres and area and still make sure that we have a well-rounded system? I'd be interested in your comment on that.

Mr. Baber: — Well I think we're co-operating to some extent now and I think we're filling our need. We're helping, and they're helping us in Fort Qu'Appelle, and we're aiding the situation in Regina with convalescence.

I think Balcarres is giving very cost-efficient, effective service.

The Chair: — Any further questions?

Mr. McCall: — Mr. Baber, as a pharmacist, I was wondering what your take was on what the present status is. As the pharmacist in Balcarres, what kind of co-operation you engage in with the region in terms of Melville and Fort Qu'Appelle? But what's your take on the primary health care teams? And do you see that as going beyond what's already in place in your neck of the woods, or do you see that as a positive?

But anyway, you as a pharmacist, how are things working right time in teams, of teamwork in the region? And do you see Fyke's proposals around primary health care teams as being a positive or a potential good?

Mr. Baber: — Well I think things are working very well now. And health reform has brought some very, some very good things to rural Saskatchewan. Home care is doing a tremendous job, and it's helping us as a pharmacist, and it's helping the facilities. And so I think things are working very, very, very well.

Mr. McCall: — So it wouldn't be so much a matter of adding to what's already in practice? There's already a fair level of coordination between yourself and the various services?

Mr. Baber: — There's good co-operation going on out there now.

Mr. McCall: — There's a de facto primary health care team right now.

Mr. Baber: — I beg your pardon.

Mr. McCall: — You've got a team approach in practice. All right. Anyway, thank you.

The Chair: — Thank you. Seeing no more questions, thank you very much, Mayor Baber, and the reeve . . . sorry, Sinclair?

Mr. Baber: — Thank you, Madam Chair, and committee members, for your time.

The Chair: — Thank you for coming. Our last presentation for the day is from Saskatchewan Parks and Recreation Association. If you want to take a seat at the table.

Welcome to the Standing Committee on Health Care. This is a legislative committee and it's an all-party committee of the Legislative Assembly. We have been mandated as our first order of business to receive responses to the Fyke Commission and report on what we've heard. That report goes into the Legislative Assembly from this committee at the end of August.

So our presentations have been limited to 30 minutes per presenter, and hopefully, at the . . . included in that 30 minutes we have time for questions from the committee members. And the committee members are: I'm the Chair, Judy Junor; the Vice-Chair is Dr. Melenchuk; Andrew Thomson, Warren McCall, Buckley Belanger, Brenda Bakken, Glen Hart, and Rod Gantefoer are the members of the committee here today.

And if you want to introduce yourself and who you represent, and then begin your presentation.

Mr. Campbell: — Thank you very much. My name is Norm Campbell. I'm the chief executive officer of the Saskatchewan Parks and Recreation Association. And I'd like to thank you for inviting me to have this opportunity to discuss the Fyke report with you and the manner in which it may impact on SPRA (Saskatchewan Parks and Recreation Association).

Prior to making my comments on the report, I would like to provide you with a brief overview of SPRA and its operations. This will assist in establishing an understanding of the role of SPRA, what it currently plays, and the future they can play with regard to improving the quality of life for the people of Saskatchewan.

Saskatchewan Parks and Recreation Association is a not-for-profit, volunteer-based provincial organization that is the recognized voice for parks and recreation in the province. SPRA is the umbrella organization for its member agencies, some of which include municipalities, regional associations, provincial recreation associations, Indian bands, and rural municipalities.

An elected board of directors governs SPRA. The ongoing operation of the association is administered by paid staff based out of Regina. SPRA is the voice of parks and recreation in the province and represents over 630,000 Saskatchewan residents in its membership . . . city membership alone.

Our vision is recreation for all. And I've listed there some of the ends that we follow, and for the sake of brevity I'll maybe just go through the bold ones and won't subject you to all the rest.

One of our ends is that communities have coordinated leadership in parks and recreation. Also communities have assistance and support. We hope to have a recognized voice for parks and recreation in the province, and designated land for recreation purposes.

It's the one that I've listed last that we'd really like to kind of focus on today — that communities have a strong recreational component. And when we're defining that we're looking at promoting an active living lifestyle. And we're defining active living as a way of life that values all forms of physical activity for the contribution to individual and social development, well-being, and quality of life. Active living encourages people of all ages to make physical activity an integral part of their daily routines and leisure pursuits.

And it's this last end — it's our commitment to promoting active living lifestyles — that provides us with our strongest link, the Fyke report, and provides the basis for our presentation today.

We strongly believe that a coordinated province-wide program that promotes increased physical activity and extols the virtue of more active lifestyle can play an integral role in addressing some of the issues outlined in chapter 3 of the report, "Making Things Fair", and also, in chapter 6, "Paying the Bills".

While the report addresses the issue of investing upstream to prevent the need for costly treatment downstream, it does not specifically address the role active living and an increase in physical activity can play in reducing health care cost and improving the quality of life within Saskatchewan.

Our association is committed to promoting active living. And in our February submission to the commission, we'd indicated that promoting active living through participation and recreation, sport, and cultural activities should be one of the cornerstones of health planning.

Our association believes that in many instances we share the view of health care service providers and that we can work together to offer programs and develop initiatives that would be beneficial for all. We believe we have some of these shared views and, again for the sake of being brief, we've listed some of the benefits of recreation and active living: prolong life up to two years; active living prolongs independent living for seniors; increasing physical activity significantly reduces coronary heart disease. And it goes on for a number of points, but I don't know that I have to read them all. I'm sure everyone can read them . . . (inaudible) . . . as they get through it.

Needless to say, we're committed to the idea that active living and promoting physical activity is something that can benefit Saskatchewan in general and specifically the health services field.

On page 4, chapter 6 of the Fyke report, "Paying the Bills", includes as one of its recommendations enhancing the overall health of the province. The importance of this recommendation is illustrated below in the small chart you have.

I would like you to note that under cost, where it lists diabetes 2, the cost being 572,000 and the savings being 877,000, that should be 572 million. So if you can add three zeros on to the cost list on the diabetes 2 and the colon cancer, it gets a little more accurate for you.

The manner in which the recommendation to enhance the overall health of the province is implemented could have a profound impact on SPRA and its programs. We believe that prevention of illness programs offered through organizations that are not traditionally seen as being within the jurisdictions of health services can play a major role in helping prevent illness and reduce health care cost. As a result, partnerships between health care providers — government departments, non-government agencies, volunteer agencies — are all imperative if the benefits in this area are to be realized.

In appendix C of the report, a service delivery model shows health promotion and injury prevention as a local function. While the actual delivery and the prevention of . . . preventive services and programs should be a local function, little mention is made of creating partnerships or developing a global provincial strategy that would provide program continuity and consistency.

The strategy should be provincial in scope, increase the level of physical activity across the province, and be relevant to both urban and rural Saskatchewan.

The province-wide program that is needed is based on the following principles: building partnerships. We strongly believe that any kind of initiative, if we're trying to go the active living route, any initiative has to be based on numerous partnerships. The size of it transcends any one local agency, department, or group.

In order for strategies to be successful, stakeholders must seek each other out and involve as many players as possible. Non-health service partners that could include SPRA and other not-for-profit organizations would be instrumental in maximizing the effectiveness. In a lot of cases, there is already a delivery system in place in these other organizations that could augment or complement the existing health services delivery system.

Building awareness obviously is another one. People have to be aware of the benefits and we have to kind of keep going at them that there is a benefit and what it is. Cost for promotion, not only of the benefits but of the programs that are out there, are necessary.

But awareness isn't enough. Everybody's aware that smoking is bad for us, but some of us continue to do it. So it's not just the fact that you have to be aware of it. What you have to be aware of is that there are specific strategies that you can do in your community that may help you, and these strategies have to be entertaining, fun, and something that somebody wants to participate in.

So targeting these community strategies becomes a very important part of our principles. Specific target areas within communities must be identified and programs developed accordingly. It must be recognized that needs will vary between communities and there must be enough flexibility to ensure that the need to have an overall provincial strategy doesn't impinge

upon a community's right to meet the other individual needs.

And finally, there must be a way to measure our successes. It's not much value to be able to say, yes, we're going to do this, without knowing where we're starting. If we don't know where we've started, we don't know where we've gone. So it's important that we measure our successes so that we know the value of the program.

I guess in closing I'd just like to say that there are a number of organizations in Saskatchewan that are developing strategies and programs that will result in an increase in physical activity levels across the province. It is the hope of SPRA that the Fyke report can act as a catalyst and hopefully more, that will bring together the various stakeholders that can move the initiative forward to a better and more healthy Saskatchewan. Thank you.

The Chair: — Thank you very much. Questions from the committee.

Mr. Thomson: — Thank you, Madam Chair. Thank you, Mr. Campbell, for the presentation.

In 1993 when we started out on the first round of health care reform, we had . . . (inaudible) . . . under this banner of wellness. And it was supposed to help refocus the health care system away from being an illness-based, acute care system to a more holistic approach where we took into account people's general health levels.

Somewhere along the way, a lot of that fell by the wayside. To be honest about it, I guess it fell by the wayside in part because we were under tremendous pressure to build back in, acute care capacity.

We have a chance to do this again, I think, to take a look at making a larger system. And I'm very interested when you talk about building partnerships on page 5 of your presentation.

Within the primary care teams that Fyke talks about, how do you see us possibly expanding beyond simply the health care professionals into, as you call them, the non-health service partners and non-profit organizations to help create that awareness, to help build those opportunities?

Mr. Campbell: — Well there's a number of ways of doing it. Across the province there are what's called regional recreational associations. They're charged with the responsibility of offering programs. One of the things that SPRA does is we try and get the active living concept out to the regional associations, who in turn then try and get it out to the communities and organizations within, within their jurisdiction.

One of the things that we'll be working towards — and are working on — is trying to get a closer working relationship, I guess, between the health care providers in each of the areas, health districts, you know wherever it is; that we start to say okay, we have recreation programs. Rather than just seeing this as a recreation program and then seeing this as a health program, there's some, you know, efficiencies of scale here. Just contact each other; talk; and say okay, now we've got this program, can we jointly look at it?

In a lot of cases SPRA, for example, has certified fitness leaders. I'm not sure that we could ask health care providers to be certified fitness leaders. They can certainly know about fitness. They can certainly know about nutrition. But would they be able to provide all the certification required for fitness leaders? Well if fitness is part of a health care services program, doesn't it make sense to approach your regional association or your municipality, get access to these leaders, and combine the programs?

So that's the kind of partnerships we're talking about on a local level.

Mr. Thomson: — In many ways I can see where this would fit in nicely with some of the ideas around these primary health care teams, at least as an ancillary aspect of it.

As I look at the larger cities, I wonder about how we work towards those goals here? I don't see the Fyke report leading us towards having primary health care centres within the cities as much as we probably should have. How do we then approach this issue within say Saskatoon or Regina? Do you do it on a geographic basis that we try and build it within the neighbourhoods; do we do it on a constituency-oriented basis, i.e., the seniors; do we approach them or do we approach . . . How do you see that working?

Mr. Campbell: — It's tough to say because depending on which community you're in they may have a different delivery service for each of their . . . say specifically for parks and recreation services, for example; and I'll go that way because that's my base rather than health services.

Some cities are based on zones. Some cities aren't. Some are based on community associations being in given areas. It would be a matter of just identifying what system is being used and how it can integrate.

I know in Saskatoon . . . And I believe earlier this afternoon you had a presentation on the In Motion project. I mean there's a good example of where the health district started to take the initiative and went forward and now the other players see that happening and become part of that and then develop programs from that.

So I can't really answer that because I'm not sure which specific community we'd be talking about, and I'm not aware of them all. So that's kind of tough.

Mr. Thomson: — I just want to say thank you for the presentation. It was very good.

Hon. Mr. Belanger: — Yes I'd like to thank you for your presentation as well. And there's a couple of points I want to make very quickly here. It is getting on in the day here.

In terms of the diabetes and the increased cancer problems, we heard a presentation last night that talked about northern Saskatchewan and the fact that in that particular area there was some very, very concerning numbers that were coming out of the general health population.

That being said, I, from experience, know that many of the

recreation programmers and the directors in these northern Saskatchewan communities where the prevalence of diabetes and cancer is high, basically, if I can be blunt, they are glorified fundraisers; which they operate buildings, they've got to pay for the buildings, so they constantly run fundraising programs to pay for infrastructure. And this is where they would count on SPRA, and again, you know, kind of realizing that SPRA does have a limited budget.

I guess my question for you is, is there any particular benefits that are directed to northern Saskatchewan to help alleviate the financial needs of the northern Saskatchewan communities when it comes to programming for children, promoting healthy lifestyles, and so on and so forth, while helping the glorified fundraisers who are called the recreation directors in these small northern communities?

Mr. Campbell: — Specifically related to the health care issues and stuff, I'd have to say right now no, because we're still moving that whole idea forward. I know we've been in touch with Saskatoon and talked to them about their initiative they're looking for in the diabetes initiative that we're saying, hey, looks like a good program; how can we partner; how can we get together. And they've been just great.

As far as the other non . . . this . . . presentation related, I know that there has been developments in the North with the community school program and the NRCC (Northern Recreation Coordinating Committee) and all that, that have happened and have been evolving over time.

Whether there's anything in the works in the immediate future, I couldn't say because I know right now nothing's been on our plate as far as the budget-wise goes that way.

The Chair: — Seeing no more questions, I'd like to thank you very much on behalf of the committee for appearing today and presenting your view. Thank you very much.

We'll now entertain a motion to adjourn until July 17 at 10 a.m. Dr. Melenchuk so moves.

The committee continued in camera.

The committee adjourned at 16:14.