Standing Committee on Health Care

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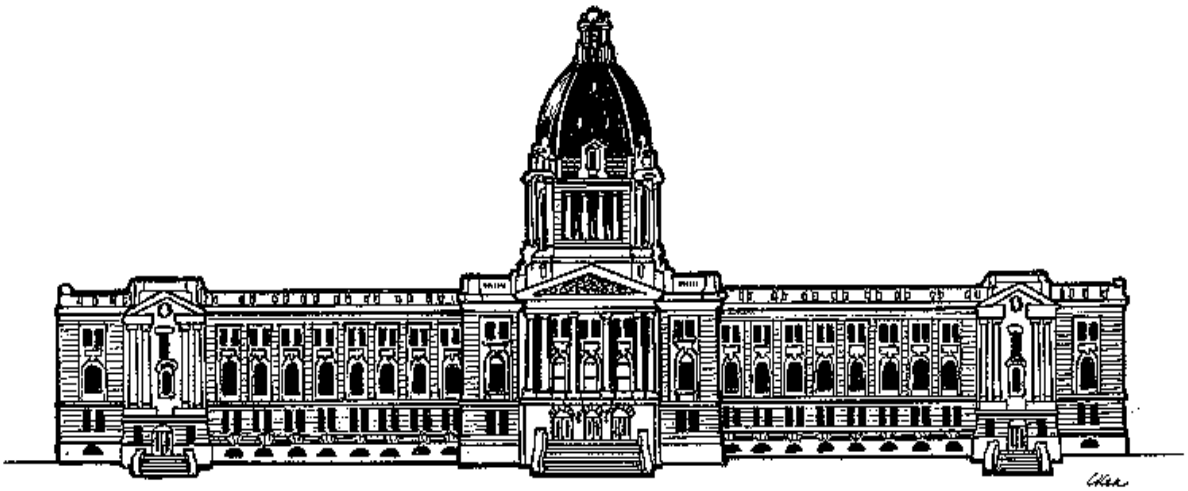

Legislative Assembly of Saskatchewan

Twenty-fourth Legislature

STANDING COMMITTEE ON HEALTH CARE
2001

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Andrew Thomson
Regina South

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

The committee met at 10:04.

The Chair: — Good morning. We'll start. We have a few members that will still be coming in. This morning you're in front of the Standing Committee on Health Care. It's a legislative committee of the Assembly. Its first order of business has been to receive and report on what we've heard, comments on the Fyke report, the Fyke Commission.

I'm Judy Junor, Chair of the committee. Dr. Melenchuk is the Vice-Chair. He'll be here shortly. Other members of the all-party committee are: Andrew Thomson, Warren McCall; sitting in for Buckley Belanger this morning will be Pat Lorjé; Brenda Bakken, Bill Boyd, and Rod Gantefoer. We have given each set of presenters half an hour and in that half an hour we hope to have some time for questions.

If you can just introduce yourself and who you represent, then begin your presentation. Thank you.

Ms. Longmoore: — Thank you, Judy. I'm Rosalee Longmoore. I'm the president of the Saskatchewan Union of Nurses.

Mr. LeMoal: — My name is Larry LeMoal. I'm SUN's (Saskatchewan Union of Nurses) employment relations officer with responsibility for communications.

Ms. Longmoore: — I'd like to thank you for the opportunity to present some very important issues to the Standing Committee on Health. Saskatchewan citizens urgently need a primary health care system which provides access to primary health care services and support in their own communities. The Saskatchewan Union of Nurses represents approximately 8,000 registered nurses and registered psychiatric nurses employed in long-term care, home care, acute care, public health and community health, as well as primary care centres. Nurses will be the single largest group of health professionals providing primary health care, and along with family physicians, key members of primary health multidisciplinary teams focusing on health promotion as well as prevention and management of chronic disease.

SUN endorses the World Health Organization's definition of primary health care as the essential nucleus of the health care system. It is the first level of contact of individuals, the family, and the community with the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

Primary health care addresses the main health problems in the community, providing promotive, preventative, curative, supportive, and rehabilitative services accordingly. Primary health reform must not be a smokescreen for cutting existing acute, long-term care or rehabilitative services or having reducing costs as its primary goal. Our existing acute, emergency, long-term care, and rehabilitative services must be enhanced, not downgraded.

While SUN supports province-wide reform of primary health services, rural Saskatchewan citizens must not face and will not tolerate another round of rural hospital or integrated facility closures or conversions under the guise of health reform, leaving communities with an empty shell of an agency which provides only eight hours of minimal services.

Mr. Fyke recognized the damage done by this strategy in 1993. He said:

> . . . it is not possible to reduce health expenditures prior to a major change in culture without throwing the system into more turmoil, further eroding public confidence and damaging workforce morale. This lesson was learned the hard way in the 1990s.

SUN supports development of a primary health care network which provides quality health services to citizens of Saskatchewan no matter where they live in the province. But there must be extensive consultation with communities and citizens as well as health providers to ensure the services that are delivered are the services most urgently required.

Saskatchewan citizens, nurses, and other health providers went through wrenching changes from 1993 to 1999 with few positive outcomes to show for it. Citizen and health provider trust in the government's ability to manage health reform has been shattered. That loss of trust can only be restored if government and the health districts produce evidence that they can dramatically expand community-based health programs while strengthening emergency and acute services in order to meet community needs before a single hospital or integrated facility is converted.

It is reassuring that the public solidly rejected the concept of a two-tier health care system and expressed support for maintaining the principles of medicare. Sixty-seven per cent of respondents indicated that while changes are needed in the way the health system is organized, the principles of medicare should be preserved. Only 9.7 per cent of respondents indicated that it was time to move toward a private health care system which allows people to buy the services they need and want when the public system cannot meet those needs or wants.

Now that the public has expressed support for publicly funded and delivered health services and necessary change to the system, it is time to act. SUN has important views on several issues arising from the recommendations from the Commission on Medicare, including the issues of how to address everyday health needs, provision of specialized care, addressing issues like poverty and unemployment that erode good health, and the funding of health services.

However, we wish to focus on one issue that threatens to dramatically curtail the current health services provided, as well as derailing future attempts to implement many of the recommendations of the Commission on Medicare. That issue is the accelerated migration of both new graduates and experienced nurses from Saskatchewan. This, along with primary health care reform, is the focus of our presentation today.

Health service delivery is threatened by the nursing shortage. The pediatric, palliative, and medical unit of the North

Battleford union hospital normally has 25 beds and 12.75 RNs (registered nurse). The hospital has been forced to close 15 beds because the unit is short 6 full-time nurses. Often there is only one RN caring for very sick children who require constant monitoring. RNs report that while working alone, they must take an extremely ill child in a stroller, sometimes with an IV (intravenous), while they attend to other palliative care or medical patients.

Safe patient care, positive clinical outcomes, and quality services to the public depend on healthy work environments for nurses and other health providers. Forced overtime, short staffing, overreliance on casual hours, consistent overload, and toxic stress must be reversed. In fact, Saskatchewan's health employers must create stable and rewarding opportunities for nurses to practise nursing — and quickly.

Commissioner Fyke indicated that there is ample need for all health care workers currently in the system and every effort to retrain or relocate should be made, rather than losing the people currently employed. Yet we have new evidence that Saskatchewan has not made every effort to retain and recruit nurses.

Bed closures are currently in effect because of the nursing shortage. The Regina Health District recently advised SUN that 45 beds in family medicine, surgery, cardio-sciences, and critical care have been closed because registered nurses are not available.

Nurses are facing overwhelming overtime demands. There are estimates that converting predictable overtime hours in the province to full-time hours would create more than 200 permanent, full-time positions.

Nurses are leaving and the destructive cycle will accelerate. Bed closures will intensify and the full attention and resources of health districts and the public will be absorbed by the struggle to maintain existing services rather than reforming and expanding community-based health services.

Here are the clear and frightening short-term and long-term indicators of the flight of nurses from Saskatchewan. Monthly SRNA (Saskatchewan Registered Nurses' Association) registration statistics indicate that out-migration of nurses is up dramatically. This year Alberta is again receiving the lion's share of the 241 registered nurses that have registered outside Saskatchewan — 47 per cent — followed by the United States with 19 per cent and British Columbia with 15 per cent. In the last seven months, 115 registered nurses from Saskatchewan have had their registrations accepted by Alberta, exceeding out-migration to Alberta for all of 1999, which was 111.

This year Saskatchewan is currently suffering a net monthly loss of about 45 registered nurses and registered psychiatric nurses when migration losses and retirements are included. Even moderate projections produce a net loss of 558 nurses for the year 2001 alone. These figures do not include nurses who simply leave the profession each year before they reach retirement age.

Actual and projected annual loss due to retirement of the 5,900 RNs and RPNs (registered psychiatric nurse) covered by the SAHO (Saskatchewan Association of Health Organizations) pension plan from 1999 to 2005 totals 956 nurses or 16 per cent of the current nursing workforce.

In the last six months, 23 psychiatric nurses have applied for registration outside Saskatchewan, 20 of those in Alberta. In the last two years, Saskatchewan suffered a net loss of 33 registered psychiatric nurses. The total number of practising or active registered psychiatric nurses has declined from 1,137 in 1997 to 1,072 in 2001.

The total number of all practising registered nurses in Saskatchewan has declined from 9,612 in 1991 to 8,987 in the year 2000, a decline of 625.

Data from the Canadian Institute for Health Information on the supply of nurses does not accurately reflect the shortage of nurses in Saskatchewan's health districts since it relies on crude indicators; that is the total number of practising registered nurses reported the previous year by the SRNA divided by Saskatchewan's population. The decline in annual registrations reported by the SRNA almost certainly underestimates the flight of full-time nurses from the province since registration numbers include all practising registered nurses. Of the total of 8,987, there are only 3,310 full-time registered nurses employed in the health districts.

One full-time position vacated by an out-migrating nurse may be filled by three or four casual nurses who are already employed, thereby masking the real decline of nurses in the province willing and available to work full-time.

For example, the 200 new nursing positions created in 1998 did not produce 200 increased registration numbers because most positions were filled by part-time or casual nurses who were already employed.

While it is true that the shortage of nurses is being experienced in many countries, solving the nursing shortage is primarily a provincial responsibility. Clearly we have not met that responsibility. Why are our retention and recruitment initiatives failing?

The province has set no goal for retention and recruitment and there is no one in the province who is monitoring and evaluating the effectiveness of retention and recruitment efforts. No one is monitoring and interpreting available data on the net loss of nurses each month, taking into account migration, resignations, and retirement. With no goal and no evaluation efforts, no progress is possible.

Saskatchewan health districts continue a pattern of creating part-time and casual positions instead of full-time positions. According to the most recent Saskatchewan health employer survey report, only 36.7 per cent of registered nurses are employed full-time by health employers; and 34.7 employed part-time and 28.6 employed as casual.

On June 28 and 29 of this year the Regina Health District posted 22 new registered nurse and registered psychiatric positions. Of the 22, only 3 were permanent full-time; 2 were temporary full-time; 17 were part-time positions.

There were 74 unfilled vacancies for RNs and RPNs in the Regina Health District hospital sector in May 2001. Of these, only 26 are permanent full-time positions. The remainder were 16 temporary full-time, 13 temporary part-time, and 19 regular part-time.

As of July 6, there were 106 nursing vacancies in the Saskatoon Health District, only 29 of which were permanent full-time positions.

Twenty point five per cent of Saskatchewan nurses must work for more than one employer in order to earn sufficient income. This is the second-highest rate in Canada of multiple employment.

Neither the government nor SAHO is tracking the increased number of nursing vacancies in the province. Experienced nurses continue to leave because of excessive overtime and unmanageable workloads, and the chronic stress suffered because they are unable to provide the quality of care Saskatchewan citizens deserve.

Nurses who stay in Saskatchewan face extremely stressful working conditions. There are currently 168 registered nurses and registered psychiatric nurses off work on long-term disability — more than the entire graduating class of student nurses.

New graduates and experienced nurses are leaving the province because they have given up hope that chronic patterns of excessive overtime, increasingly unmanageable workloads, and declining quality of patient care will be reversed.

Nurses are leaving because Saskatchewan is not offering competitive salaries, benefits, or permanent full-time positions.

According to the Student Nurses' Association at the university of Saskatoon, students are leaving Saskatchewan for higher salaries, paid training and upgrade courses, full-time positions, as opposed to temporary, full-time, part-time, and casual work, and better benefits.

The students' association estimates that 95 per cent of nursing students are working in jobs outside nursing to help reduce student debt load.

Even more disturbing is that some students who are working in health care institutions report that demoralized and exhausted nurses are advising the students to leave Saskatchewan because the government and employers do not value nurses.

Experienced nurses are watching more and more of their colleagues leave each month and are telling students that the nursing shortage will worsen, making nursing in Saskatchewan increasingly unbearable. This is creating a downward spiral with no relief in sight.

While Saskatchewan does little to retain graduating nurses, the Registered Nurses Association of British Columbia has approved changes to their regulations which will permit nursing students from other provinces, including Saskatchewan, to do clinical placements in British Columbia and to work as nurses during and between semesters.

The British Columbia Nurses' Union and the Health Employers Association of BC have developed a new classification for working students who will be supernumerary and will be paid about $20 an hour. The nursing schools will help define the limits of the student's ability to perform nursing duties.

The Calgary Regional Health Authority held a job fair in Saskatoon and Regina last month attracting more than 120 interested RNs, RPNs, and LPNs, (licensed practical nurse). Recruiters told SUN that in two days 32 nurses completed applications to work in Calgary.

The Saskatoon fair was visited by the entire class of student nurses who came there immediately after writing their nursing exams. The Calgary Regional Health Authority is offering relocation allowances of up to $4,000 and permanent full-time employment.

No records are being kept to track the number of nursing graduates who leave the province. Of the more than 200 students who will graduate as registered nurses annually, no one knows whether we retain 25, 100, or 150. As a result, we can't evaluate retention efforts, nor do we offer much to keep the students in Saskatchewan other than temporary employment.

Often such graduates are replacing registered nurses and licensed practical nurses instead of being in addition to normal staffing. This practice of utilizing graduates results in a decline of care and increased frustration for nurses who must handle greater patient loads while attempting to mentor and supervise graduate nurses.

Meanwhile, US (United States) recruiters are offering to reimburse tuition fees for third- and fourth-year students who commit to coming to the United States upon graduation. In effect, they are renting our College of Nursing classrooms and educators and reaping the harvest of students while we wave goodbye.

Saskatchewan is almost certainly losing more of its graduates than ever before because of these aggressive recruiting efforts from other provinces and the United States. Historically Saskatchewan has only retained about two-thirds of nurses who were educated here. According to the Canadian Institute for Health Information, fewer graduates from Saskatchewan and Prince Edward Island nursing programs have stayed in those provinces to work than in other provinces and territories.

Of the 10,331 Saskatchewan graduates employed in Canada, only 67 per cent are employed in Saskatchewan, while 15.7 per cent are employed in Alberta, 10 per cent in British Columbia, and 3.2 per cent in Ontario. In contrast, 91.8 per cent of British Columbia graduates have remained in that province.

Continued uncertainty about the future of health services in rural and urban Saskatchewan is an important factor in the decision of many nurses to leave the province. It is urgent that the government decides how the health system reform will unfold and act quickly. Mr. Fyke recognized the destructive nature of that continued uncertainty when he said in his report:

> ***Within three months*** of receiving this report, and based on these public consultations, the Government of

> Saskatchewan should release its formal response to this report clearly indicating how it intends to proceed.

Unfortunately, it appears the government will not meet this goal.

What accounts for Alberta's success in recruiting Saskatchewan nurses? A Calgary nursing recruiter told SUN that although Saskatchewan nurses were attracted by the higher salaries, that both experienced nurses and students were reporting that they saw no future for nurses in Saskatchewan, were facing continued uncertainty about stable employment, no opportunities to nurse in a clinical area of their choice, and that Saskatchewan had no plan to improve the situation.

The recruiter told SUN that the Calgary Health Region Authority surveyed their nurses and found very high levels of dissatisfaction and frustration. When they also considered the cost of increasing use of overtime to provide normal staffing and the fact that they were beginning to close beds due to the nursing shortage, the authority decided to act. The Calgary Health Region Authority is seeking to hire 5,000 more nurses over the next five years, to staff a new children's hospital and to care for a Calgary population which is growing by 40 to 60,000 annually.

In addition to recruiting outside the province, the district employs first- and second-year nursing students as personal care aides and unit clerks, hoping to retain them when they graduate.

Faced with exactly the same indicators — namely, high levels of dissatisfaction, excessive overtime, and beds closed due to the nursing shortage — Saskatchewan is not only failing to adopt aggressive retention and recruitment strategies; no agency is keeping track of the net loss of nurses. This lack of leadership exacerbates the uncertainty facing nurses.

Health providers and the public understand that the nursing shortage in Saskatchewan must be solved. When the commission asks the public how waiting lists could be reduced, most respondents favoured spending more money to recruit specialist physicians and nurses. Yet the province seems frozen in the headlights while nurse after nurse leaves the province.

Mr. Fyke noted that the province has been relatively successful at retaining family physicians. He notes that in 1996 only 44 per cent of family medicine residents stayed in the province while in 2000 that figure has risen to 80 per cent.

Undoubtedly this is the result of several recent initiatives undertaken to retain graduates and provide support for new graduates and practising physicians, including generous funding for rural relief services, resident weekend relief rosters, reimbursement for continuing medical education, the rural extended leave program, the summer extern program, the rural residency training program, the medical resident bursary program, the re-entry training program, the undergraduate medical student bursary program, the northern medical services program, the rural practice enhancement training program, the rural practice establishment grant program; a physician resource coordinator to coordinate recruitment efforts. These efforts are laudable but where are the corresponding programs to retain and recruit nurses?

The government must make a policy statement now, namely that Saskatchewan cannot afford to lose one more nurse. The government, SAHO, and the health districts, in co-operation with the SRNA, RPNAS (Registered Psychiatric Nurses Association of Saskatchewan), and SUN must act urgently to stop the flight of nurses from Saskatchewan.

The second area that I want to talk about this morning is implementing primary health care reform. Neither citizens, health providers, nor health districts are the obstacles to reform of primary health services. The public health providers and health districts, through their representatives, have signalled their willingness to proceed with primary health services reform. Only the government can initiate the funding, planning, and initial implementation of reform. What are we waiting for?

SUN supports and urges implementation of a reformed primary health care system, but a province-wide network of emergency services, community health centres, and community services must be fully functioning before existing hospitals and integrated facilities alter existing services.

The health needs of the people of the community must determine the nature of the services provided, not arbitrary decisions made by distant planners motivated by cost cutting.

However there is some evidence that government has already decided that many facilities may be converted before the communities affected have been consulted and the needs determined. SUN has been asked by Saskatchewan Health representatives to attend a meeting this month to discuss the implications of the following proposal: implementing the Fyke Commission recommendations would mean converting some 24-hour hospitals to 8-hour or 12-hour health centres, or to convalescent and respite centres.

This signals that a decision has already been made to downgrade services in some communities. Extensive consultation with and endorsement by the affected communities and health providers must precede implementation of new services in the community or changes to existing services.

Public opinion about primary care reform reflects a distrust of government and health district promises that conversions of existing facilities will provide better services to the communities. That is almost certainly why 63.4 per cent of rural residents said, we should keep hospitals open in as many communities as we can.

Even the public's response to the commission's survey regarding the concept of primary health services teams reflects rural skepticism about the real agenda of primary care reform being the eventual closure of health agencies in rural communities.

In response to the question about whether delivering care through primary health services teams would be positive or negative for the quality of health services provided, only 44.9 per cent of rural residents approved of this concept compared to 55 per cent of urban residents. This split of opinion may be because urban residents would see primary health teams

providing service in addition to the services they already have, while rural residents see a potential loss of services.

Clearly though, the public has told the Commission on Medicare that they support prevention and health promotion, an important benefit of effective primary health care services — 59.78 per cent of respondents responded favourably to the commission's question: "Is it the job of the health system to do more than treat disease, illness, and injury, and also promote health through things like improved parenting skills, better nutrition, and helping people quit smoking?"

Citizens also clearly favoured having the health system make a special effort to reach out to senior citizens and poor families because they often face higher health risks and may not always get the health care they need; 52.54 per cent of respondents agreed with this. Less than one-third, 31.73 per cent, thought we should have the health system focus only on helping individuals when they seek health care services.

Reform of primary health services and a shift from sickness care to health prevention and promotion promise enormous economic savings, along with relieving Saskatchewan citizens of the terrible human cost of preventable long-term illness and premature death. But these will be long-term savings, and primary care reform will require initial funding over and above existing services.

As Mr. Fyke noted in his report:

> I am recommending that additional funds be added to promote the transformation to a new system.

Improving quality and efficiency in the long run requires spending money in the short run. Put another way, only if the system spends more than current levels now will it be possible to moderate the increases in future expenditures in the future and achieve a sustainable system.

With respect to the other very important issues raised by the Fyke Commission, SUN remains available to the government for further consultation if that is required. We also refer you to the extensive brief concerning our views about medicare that we submitted to the commission.

We wish to conclude our presentation with an urgent appeal that the government take immediate action to demonstrate to registered nurses and registered psychiatric nurses that they have a future in Saskatchewan.

The Saskatchewan Union of Nurses appreciates this opportunity to put our views before the Standing Committee on Health Care. We pledge the support of our organization for initiatives which result in improved health services for the people of Saskatchewan.

The Chair: — Thank you, and thank you for your written submission. We also have distributed to the committee before we started sitting your brief to the Fyke Commission so we all have that also. Questions now.

Mr. Thomson: — Thank you, Madam Chair, and thank you, Ms. Longmoore, for your presentation.

I want to start by saying that I think a lot of what you've said today is both fair and accurate criticism of much of what we've seen happen over the last 10 years. Much of the advice, I think, that we've received in the early '90s — this government, and governments across this nation — simply didn't turn out to be the best advice we could have received.

I look at things in terms of how nursing numbers have decreased, which people said was a natural course, something that we should be welcoming as we looked at fewer admissions to hospitals and the rest of it. Clearly as we look at this now, as we try and correct some of the things that had happened in that first set of health care reforms, much of what you've said today I think will provide some guidance in that. And so in that regard, I want to say thank you for being both upfront and honest in your criticism.

I do want to say that in terms of the decisions being made, I want to assure you that the political leadership of the government have not made decisions yet as to what to do with Mr. Fyke's report. It has not made decisions about what to do with hospital conversions. And indeed I suspect that the government, the ministers — both the Minister of Health, the Premier, and other members of the cabinet — are going to wait to see what this committee says before moving in that direction. In that regard, I think your presentation today is very timely.

I have a couple of questions I want to ask, one of which deals with the primary care, primary health care teams. Ordinary people tell me that one of the concerns they have with moving to a primary health care team is that they won't see, they won't get the same quality of care because it won't be seeing the doctors. I suspect a lot of this is that they simply don't understand the advanced level of care that nurses can provide.

Are there things that we can do, are there measures that we can take to improve the image of nurses within the community as care providers so people better understand the type of training nurses have?

And are there things within the profession that we can do to make sure that nurses are using their abilities more fully? Whether that's a case of the RNs doing more of the upper-end things and abandoning some of the things that perhaps LPNs could be doing.

Ms. Longmoore: — Well I think the mistake has been not government but a number of people talking about all of these things as a replacement model as opposed to a team. So by talking in terms of nurses replacing physicians or licensed practical nurses replacing registered nurses, obviously people interpret that as something less. We need to talk about a team of health care providers that can better meet the need. Certainly citizens need to be able to access physicians and we can't be advocating that they're not going to have access to a physician.

Mr. Thomson: — I appreciate that. The second question I wanted to ask was concerning your comments about the provincial . . . the need for provincial recruitment and retention strategy for nurses.

There is a relationship obviously between SAHO as the employer of most of the nurses and the Department of Health as

the funding agency. Where would you see us building a recruitment strategy out of? Should it be housed in . . . at the district level? Should it be housed at the provincial level? Should it be run by SAHO? Should it be provincially directed by the provincial government through Sask Health?

Ms. Longmoore: — Well I think that decision has to be made once all the government's stuff out of Fyke is decided.

At this point I believe that SAHO would have, you know, at least some of the data and would have it from districts. So at a certain level it makes sense perhaps for it to be housed there, given the current structure.

Mr. Thomson: — Thank you. My final question concerns the uncertainty issues. I think much of the problem that we have in health care today is based around uncertainty — whether it's changing governance models, whether it's changing roles for health care providers.

One of the kind of things that nurses can do to, I guess, assuage some of those fears to help rebuild confidence within a publicly funded system . . . I take from your presentation that SUN still supports a publicly funded medicare system.

Ms. Longmoore: — Yes.

Mr. Thomson: — Are there measures that nurses can take within the community to rebuild some of that confidence within the system in terms of us, either in the workplace or in the community at large?

Ms. Longmoore: — I believe that nurses could play a key role in that, but first they have to have confidence that they're going to be in Saskatchewan and that's where the difficulty is today.

Mr. Thomson: — Finally then, from your presentation you believe that there's a number of different things that we need to initiate to ensure that the retention happens. It's not simply a case of us going through the next round of bargaining and increasing the grid necessarily. There are a series of targeted programs that you believe we should be looking at?

Ms. Longmoore: — There are a large number of issues. Collective bargaining will be a key part of that, but there are other issues as well that need to be part of the strategy . . . (inaudible) . . . a healthy work environment in every aspect.

The Chair: — Thank you.

Mr. Gantefoer: — Thank you very much, Madam Chair. And thank you very much for coming, Ms. Longmoore, and making this very insightful presentation.

I'll try to be a little less political than Mr. Thomson was in terms of trying to describe in the most negative light the last 10 years of experience in health care in Saskatchewan. But Mr. Thomson indicated that the government proceeded in the early '90s on the basis of advice by the medical system, I think was implied.

Was there any discussion . . . I know in the doctors in regard to registered . . . or family physicians that indeed a decision was made across this country to reduce the number of training seats. And that decision was followed on. However, that was not the only opinion that was given. It was the opinion that was chosen.

In the nursing profession, was there opinion given and was it the only opinion that resulted in the dramatic decrease in the number of training positions in . . . and employment positions for registered nurses and registered psychiatric nurses in the province?

Ms. Longmoore: — I think that the recommendation to reduce nursing seats was based on a pattern of laying nurses off across the country. And so a recommendation to reduce seats would have been based on that, because valuable resources were being spent to train nurses to lay them off and have them move out of the province.

Mr. Gantefoer: — On what basis was the . . . Was the basis for the reduction of employed positions of registered nurses based on health care delivery and quality health care delivery, or strictly a fiscal model?

Ms. Longmoore: — It was strictly cost cutting.

Mr. Gantefoer: — And so there was a degration, if you like, of the quality of health care as a result of that.

Ms. Longmoore: — Yes. The levels of . . . the level of care in every aspect of the health care sector has increased since health care reform.

Certainly we support, like many other people, that it's better to care for people as long as possible in their home. Therefore home care has greater health care needs. The people that enter long-term care facilities are people that are desperate and can't manage at home any more. The people in our acute care facilities are people that are very, very, very sick people. And there has been no corresponding increase in staffing to account for those changes.

Mr. Gantefoer: — In terms of waking up to the realities of this downward spiral, I think as you describe it in your brief, is going to create incredible difficulties in the system almost daily in going forward. Have other jurisdictions responded more timely?

You indicate that Alberta and British Columbia have moved very aggressively to not only increase training but to retain and to have re-entry programs; to indeed court students right out of the colleges of nursing; and have different nurse practising arrangements for nurses.

Have they been a lot quicker out of the gate in terms of responding to this shortage than we have been?

Ms. Longmoore: — Yes. I believe that they have acted quicker and they also . . . both of those provinces have traditionally relied a great deal on attracting nursing graduates from Saskatchewan. So I think that speaks even louder. They normally rely on our students and yet they're recognizing that they need to act quickly in their own provinces.

Nova Scotia has also undertaken a fairly extensive program

where they announced $5 million for a number of nursing initiatives similar to the ones where Saskatchewan committed $700,000 to those initiatives this spring.

Mr. Gantefoer: — I believe it's two years ago that there was a great deal of difficulty negotiating a new contract for the people under your bargaining unit and there were, of course, some monetary things which are easier to measure. But in my mind, the very significant issue, which is a little more difficult to determine if it's been succeeded upon, is the workplace issues. In your opinion, have the workplace issues been addressed in any significant way at all?

Ms. Longmoore: — No. I think if you talk to any nurse practising in Saskatchewan, they will tell you that, if anything, working conditions have worsened because of the shortage of nurses and little ability to feel like they have any control over the kind of care that they want to give citizens and don't feel that they are providing.

Mr. Gantefoer: — I believe in your brief you indicated that a, I think it was a Calgary health district recruiter said that in his experience or her experience, that monetary issues were not the most significant issue that allowed them to be successful in recruiting Saskatchewan nurses. It's workplace issues. The sense of self-worth and respect for their future in this province were more significant issues.

Has there been anything in the last two years following the contract that has improved that situation so that we are likely to be more successful in retaining our own graduates?

Ms. Longmoore: — No. I'm sorry to say that there is nothing happening today that provides any hope for nurses in Saskatchewan that they're going to see something different in their work environments in the next months, years.

Mr. Gantefoer: — In terms of . . . this committee has only the responsibility of reporting what it heard, it has no ability to make recommendations. The minister has indicated that there were going to be parallel processes or committees at work. In your report you mention that the SUN has been invited by Saskatchewan Health to meet this month to discuss the converting of 24-hour hospitals to 8- and 12-hour health care centres. Is that one of these parallel processes that the minister was referring to?

Ms. Longmoore: — I expect it is. It's a committee that I understand is working on some of the recommendations out of Mr. Fyke's report.

Mr. Gantefoer: — And you indicate from your brief that that meeting has been called for this month. Has a date been set?

Ms. Longmoore: — Yes.

Mr. Gantefoer: — Can you share that date?

Ms. Longmoore: — It's within the next week. I can't . . . we've changed the date a couple of times.

Mr. Gantefoer: — Thank you very much. You also say in your brief, and I quote:

> This signals that a decision has already been made to downgrade services in some communities.

Has that been your understanding, that it's not a question of if this should be happening, but it should be a question as to how it would be implemented?

Ms. Longmoore: — I think it would be fair to say we haven't had any discussions about it. It's just based on the letter inviting us to the meeting that the discussions would be how.

Mr. Gantefoer: — Thank you very much.

Hon. Mr. Melenchuk: — Sure. Thank you very much for your presentation. Just a couple of questions. With regard to . . . obviously a lot of your presentation was dealing with recruitment and retention. When we're talking about the appropriate mix between full-time, casual, and part-time, where would you see that ratio? Would you see it as 70 per cent full-time, or do you have other jurisdictions to compare to in terms of what would be the appropriate mix for that ratio?

Ms. Longmoore: — We have not been able to find literature that points to, for example, what's an appropriate number of casual staff to have. I actually have been participating on a committee through nursing council and we did a literature search to try and find that. I think a great deal of it depends on the age of the workforce as well. Certainly people as individuals have preferences at different times of their lives about what they are either physically able to do or what their family needs have.

Having said that, the health care system has to make decisions based on what has the best patient outcomes. There is literature starting to be done and reproduced and research being done on this area and we need to pay attention to that, based on patient outcomes and what provides also job satisfaction. If I'm the casual nurse on a unit, I'm less likely to devote my energy to making better . . . changes for things better on that unit if I'm only going to be there two days a month. I'm not going to make changes on a unit when other people are there far more than I am. So I think there's a number of areas that we need to look at and determine what has the best outcomes for both patients and for workers.

Hon. Mr. Melenchuk: — Okay. The second question with regard to the recruitment and retention issue, have you been tracking the full-time/casual/part-time mix, say over the last 15 years? How does today's compare with, say, what it was 10 or 15 years ago? Were there more full-time positions 10 years ago than there is today?

Ms. Longmoore: — I can't answer for 10 years ago. We did research in 1995 in our union and it was roughly a third, a third, a third was the mix at that time.

Hon. Mr. Melenchuk: — The other question I have with regard to job satisfaction, have you done any research with regard to comparisons in nursing satisfaction between nurses who are working 8-hour shifts as opposed to 12-hour shifts? Is there any difference in terms of job satisfaction?

Ms. Longmoore: — Again, we haven't done any surveying recently. In 1995 we did some surveying. People that worked

12-hour shifts at that time preferred them because of balancing family and work needs. I think the situation bears further research today because nurses are now working overtime on top of those 12-hour shifts and I think it's important to look at the health of individuals in those circumstances as well.

Hon. Mr. Melenchuk: — The next question I have is with regard to the Barer Stoddart report and the projections in terms of an oversupply of health practitioners that was done in the late 1980s. Of course the Canadian Nurses Association at that time stated that we were looking at a decrease and a need for nurses by the year 2000. We're obviously now in an undersupply situation and that seems to be worldwide. I think Japan and maybe one other jurisdiction is considered to be oversupplied with nurses.

In terms of where you see possible sources for nurses, would you recommend that we should be looking primarily to graduating more nurses in this province and keeping them, or looking outside of the province?

Ms. Longmoore — Yes, I believe that it will be extremely important to create our own initiatives and our own workforce. We need to . . . Certainly there is opportunities for individuals that come from other jurisdictions, people that may want to, you know, come to Saskatchewan. But given the worldwide shortage, I believe that every jurisdiction has to find their own solutions. The solutions are not to compete with each other for a very valuable commodity these days.

Hon. Mr. Melenchuk: — On page, I think it was 17, you talked about some of the initiatives that the medical association had negotiated in terms of recruitment and retention. Do you see similar programs working for nurses in this province?

Ms. Longmoore: — Yes, I think there are a number of programs that we could look at. I think clearly rural Saskatchewan is having difficulty recruiting new graduates to their communities. I think that there are things that could be done through the College of Nursing to provide learning opportunities in rural Saskatchewan that would perhaps assist with retaining those graduates at a future date in those communities.

I think there are a number of initiatives that we could look at from that program that could be transferable.

Hon. Mr. Melenchuk: — The next question I have is with regard to recruitment initiatives within the province of Saskatchewan where nurses who are practising in rural districts are being recruited by larger urban districts, and I don't think that's healthy for Saskatchewan.

On page 11 of your presentation you talked about, I think, a more centralized approach to monitoring and perhaps in overall recruitment and retention initiatives. Would you say that perhaps there should be an initiative from the provincial government to actually look at the province as a whole in its recruitment and retention initiatives and perhaps centralize the monitoring of this aspect?

Ms. Longmoore: — I firmly believe there needs to be centralized monitoring of the situation. Again, just like we can't have provinces competing with each other, the solution is not going to be to have districts competing with each other because obviously there's a couple that would win the fight there.

I think that government plays certainly a key role and I guess I'm not real firm on who does it, but somebody centrally needs to be monitoring this. Government has a role in planning for future needs because it ties in with post-secondary education and the number of seats that would be needed. So I think that certainly government needs to either work very closely with SAHO, if SAHO were the organization monitoring and overall responsible for, or government needs to be.

Hon. Mr. Melenchuk: — And my next question is with regard to other jurisdictions in North America. It seems that we're hearing concerns about nurses and pressures in the workplace environment in just about every location, whether it's Nova Scotia, Ontario, Texas, British Columbia, Alberta — they all seem to have the similar concerns.

Are you aware of initiatives, perhaps . . . of course the Calgary Health Authority with their initiatives are showing some positive, but are you aware of other jurisdictions where initiatives have been helpful in reducing workplace stress and enhancing recruitment and retention of nurses?

Ms. Longmoore: — I know that there are certainly a number of initiatives underway just like the re-entry program that this government initiated a couple of years ago. They are not successful in either retaining large numbers or recruiting large numbers. They're all helpful, but there is no one single solution to any of these problems, and it requires careful planning with partners in order to come up with a strategy that will be effective and will involve the regulatory bodies, the unions, and government.

Hon. Mr. Melenchuk: — And my final question is with regard to the working groups that were announced by the Minister of Health as part of the process in looking to implement the Fyke report and what will be implemented from Fyke. And apparently there are eight working groups and the recent newsletter from the Medical Association indicated that they had been invited to participate, as well as the College of Physicians and Surgeons, in several of these working groups. And I understand that you have also received an invitation to participate in those discussions as well?

Ms. Longmoore: — We have not been invited to participate on any of those working groups. We have been invited to a meeting with one of those working groups.

Hon. Mr. Melenchuk: — Okay, so you haven't been given an agenda in terms of what the outcome or what the . . . (inaudible interjection) . . . Okay.

That's all the questions I have. Thank you.

The Chair: — Thank you. And our next group is here, so Ms. Lorjé, if you could wrap this up please.

Hon. Ms. Lorjé: — Thank you. I hopefully will be quite brief.

Ms. Longmoore, I want to turn your attention to page 17,

because that is where you do have a listing of various programs that have been undertaken to recruit and retain new physicians. And I note there that you have included the northern medical services program.

And I wonder if you could comment specifically on the recently announced northern nurses access program, whether or not you feel that that will be a helpful program for retaining and recruiting northern and Aboriginal nurses. And also I wonder if you could just generally comment, since the Fyke Commission did seem to be rather silent on the whole issue of Aboriginal and northern health care, and if you could comment on what role you see SUN playing in assisting in those two initiatives.

Ms. Longmoore: — Okay first of all, I do believe that the northern nursing initiative is a very important step and I believe that will be helpful in increasing Aboriginal workforce, but also in retaining a more permanent workforce for the North.

SUN sees that as a difficulty right now for the North. We were able to negotiate, subsequent to our last round of bargaining, an enhanced package for the North. We've had some difficulty getting it implemented but it's there.

What's happening right now in the North is a lot of the care is being provided by agency nurses or nurses that are recruited to fly in for very short-term stints. And that doesn't provide long-term care for the citizens up there. I think that it would be healthier for . . . and their services would be better met by resident nurses than having people that just fly in and out to the community to provide very basic services.

So when we're looking, certainly at reform and implementation of primary health care services, I think that will be a key thing in the human resource planning to implement primary health care services in the North. And we would welcome the opportunity to work to do that.

The Chair: — Thank you very much and on behalf of the committee thank you very much for appearing today and for your written submission and your attention to the questions.

The next presenters could come and take a seat at the table.

Good morning. This is the legislative Standing Committee on Health Care, a committee of the Legislative Assembly. The first order of business of this new committee is to receive, and report on what we've heard, responses to the Fyke Commission or the Commission on Medicare.

We've given each group half an hour and some groups actually an hour, some by design and some not. But we apologize for being late starting your presentation.

This is an all-party committee, as I said, of the Legislative Assembly. I'm Judy Junor, the Chair of the committee. Dr. Melenchuk is the Vice-Chair. Andrew Thomson, Warren McCall, Pat Lorjé, Brenda Bakken, Bill Boyd, and Rod Gantefoer are the other members today.

The committee is to report back to the Legislative Assembly by August 30, so we're hearing presentations from groups as yourself for the next couple of weeks.

And if you could just introduce yourself and who you represent, and then you can begin your presentation.

Ms. Blau: — Good morning, Madam Chair, Mr. Vice-Chair, and members of the committee.

My name is June Blau. I'm the president of the Saskatchewan Registered Nurses Association and with me, as co-presenter, is Donna Brunskill, our executive director.

The Saskatchewan Registered Nurses Association, established in 1917 by provincial legislation, is the professional self-regulatory body for the province's 9,000 nurses. The Registered Nurses Act, 1988 describes the SRNA's mandate in setting standards of education and practice for the profession and for registered nurses to ensure competent nursing care for the public.

A council of twelve governs the SRNA: nine elected registered nurses, two appointed public representatives, and the executive director. The SRNA council is accountable to the public and governs in accordance with the Act.

Our vision is registered nurses as partners in an informed healthy society. Our mission is competent, caring nursing for the people of Saskatchewan, competent ethical registered nurses and graduate nurses, professional self-regulation for registered nurses, practice environments conducive to quality care, registered nurses understand and demonstrate the practice of nursing, healthy public policy, and members feel supported.

The SRNA shares with the Government of Saskatchewan and the Commission on Medicare the commitment to a publicly funded, publicly administered health system. Indeed, it is the public that our health care system and its providers strive to serve.

With this foremost in our minds, we would like to frame our presentation this morning within what we're calling a citizen-centred approach to health. Simply put, a citizen-centred approach is health care for the people and by the people. It implies citizen involvement at all levels of decision making and acknowledges the existence of fundamental prerequisites for health: namely, peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice, and equity.

Within this citizen-centred framework, we will present in detail four key concepts integral to the restructuring of our health care system and to the success of the recommendations of the Commission on Medicare, and ultimately the system.

The four are primary health care, the process of change, health human resources management, and measuring the quality of comprehensive primary health care.

So I'll start with the primary health care piece. Primary health care and a citizen-centred approach to health are intimately intertwined. Primary health care is essential health care based on practical, scientifically sound, and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation, and at a cost that the community and country can afford to maintain.

The underlying spirit of self-reliance, and self-determination guides how primary care unfolds in that community. It is promotive, preventive, curative, rehabilitative, and supportive, and focuses on preventing illness and promoting health by examining those factors which influence health, the determinants of health.

It is working to improve the root causes of ill health. Primary health care embodies the principles of accessibility, public participation, health promotion, appropriate technology, and inter-sectoral collaboration. It is the key to a healthy society and a healthy community of citizens.

Primary health care, however, must be comprehensive and not selective. Comprehensive focuses on the process of community empowerment and increasing control over all those factors that impact health and addresses the root cause of the problem or disease.

Selective primary health care, on the other hand, operates by addressing the end result of the problem in isolation of the social context of the illness or issue and gives the perception that medical care alone creates health. Additionally, it ensures that control over the health of citizens is maintained solely by health care professionals.

Selective primary health care focuses on the eradication and prevention of disease. Health is viewed as the absence of disease in contrast to the more holistic World Health Organization definition of health as being a state of complete physical, mental, social well-being.

Selective primary health care ignores the need to address issues of equity and social justice, which are at the root of many health problems.

When medical interventions are established as the most important component of primary health care, selective primary health care ignores the importance of non-medical interventions. For example: education, housing, food — which may have a greater bearing on health than the health services themselves. In the short term, selective primary health care may appear to reduce the prevalence of specific disease; however in the long term, the influence or root causes prevail.

As an example, examining the outcomes of an immunization program demonstrated that administering the vaccine was successful in reducing the number of deaths from measles, but did not actually reduce the number of deaths overall because those children who did not succumb to measles died from some other root cause of ill health — in this case, poverty. The eradication of smallpox in the Third World is yet another example of people simply dying of other causes as the overall mortality and morbidity rates remain unchanged.

The single-disease focus of selective, primary health care is of limited, short-term value; whereas comprehensive primary health care benefits the long term and is likely to be more sustainable — an important criteria recommended in the commission's report for our publicly funded system.

Primary health care must not only be comprehensive but integrated. It needs to focus on meeting the community's needs; matching service capacity to the community's needs; has information systems to link consumers, providers, and payers across the continuum of care. It provides information on costs, quality outcomes, and consumer satisfaction to multi-stakeholders. It uses financial incentives and organizational structure to align governance, management, physicians, and other providers to achieve objectives. And it's able to continuously improve the care it provides, and it's willing and able to work with others to ensure that objectives are met.

A shortfall of our current health care system is that services offered are linear: one provider at one time and one problem at a time and on demand. Research however shows that the most successful strategies include co-operative and cross-sectoral linking physical health care to social services, mental health, and other services. It's comprehensive and holistic rather than disease-by-disease, treating the whole person or the family in context. It's proactive, reaching out to those who are unlikely to be able to find the help they need on their own.

Emphasis on sustaining a quality system is throughout The Commission on Medicare's report. The International Council of Nurses cautions that as we create conditions that allow populations to meet the needs of the present, we guard against compromising the ability of future generations to meet their needs. We need community development that is sustainable, provides a framework whereby groups, communities, and individuals have access to resources and opportunities, and exercise their rights, using them to create infrastructures that promote healthy communities into the future.

The purchase of the latest and greatest technology does not necessarily benefit health in the long term and indeed may sap resources from other areas of the health care system. Through the lens of comprehensive primary health care, the lack of equity or inequality amongst groups makes some groups of people more vulnerable.

A combination of biological characteristics, personal resources, and/or environmental supports contributes to this vulnerability. Ten years of research has shown that in national health insurance systems, measures to reduce these inequalities pay for themselves within a year and that health care costs can be reduced by simply helping people to get the services they require.

The most expensive services we now provide are those that are not tailored to meet people's needs or vulnerabilities. For example, providing support to seniors living alone and suffering from loneliness and isolation showed that the group receiving support consumed less than a third of the health care resources when compared to the unsupported group.

In another study comparing two groups of people suffering with chronic illness, poor adjustment, and poor problem-solving ability, the group that did not receive counselling and support, those that were left to struggle with poor coping skills, were half as well adjusted and cost the health system 10 times more than the other group — $40,000 versus $4,000 per person per year.

In some of these studies cost savings were not always found in

the health care budget, but were found in social services or even the tax system as people became well enough to return to work.

Intersectoral collaboration is integral for not only planning and implementation of primary health care projects but accurate outcome measures. A trial currently underway funded by the Canadian Health Services Research Foundation is testing the value of home care versus nurse clinicians in shopping malls, as it is hypothesized that similar clients who attend shopping malls will demonstrate improved health status but at one-quarter the cost of home care.

Nursing is in an ideal position to facilitate the implementation of primary health care. Though settings change, technologies change, and the role that nurses play may change, the reason for nursing's existence will not. Nursing is grounded in the belief that its practitioners add a unique benefit to society, which is derived from the broad education, skills, and judgment its practitioners possess, and the diverse roles and activities that they play, the profession's ongoing commitment to those it serves, and its obligation to act in the public's interest.

Whether in clinical practice, research, education, or administration, nurses are client advocates, assisting individuals in communities in maximizing their health potential across the continuum. Nurses are independent decision makers working in collaborative relationships with their clients and other health care professionals in providing holistic care.

Nursing has its own body of knowledge from which it draws and as this knowledge expands, so does its application to practice. In the public's eye, it is nursing that they trust above all other professions. It is nursing that they favour when surveyed as to who might provide more cost-effective, basic services — for example, general checkups and common ailments. The public trusts and accepts the care provided by registered nurses, whose services presently form the core of the health care delivery system.

The expansion of nursing practice and the recent legislation addressing advanced practice is therefore natural, timely, and positive for both our system and its health care providers. Nurses acquiring additional competencies through a combination of experience and education, enables nursing to contribute to the health care system in new ways. As entry points into the system, nurses in advanced practice enhance client access to effective, appropriate, and quality health care. Working collaboratively as integral members of the primary care team, they can facilitate access to care 24/7, close to home, including 24-hour telephone advice.

The formation of primary care teams not only benefits clients, but the team members as well, for as the quality of their work life and environment improves, so will their retention as valuable human resources. We believe that the quality . . . that the primary care teams are the fundamental building blocks to the sustainability of a publicly funded health system.

The health of systems is predicated on their ability to access appropriate health care services and providers in a timely manner. Let us remember that clients are seeking assistance from the system because of a self-identified issue they perceive needs addressing. In essence they become dependent on us for help. It is therefore the obligation of that system to remain with the client throughout the continuum until independence is regained. Use of the word discharged, for example, from hospital is a misnomer in an appropriately functioning primary health care system. They would be transferred, not discharged. The key to increasing access is in decreasing existing barriers to the system.

At the foundation of timely access is the system's level of emergency responsiveness. Belief in the availability of timely emergency response is mandatory for citizens to feel safe and secure, especially those living in rural Saskatchewan.

Government must implement as soon as possible a centralized, province-wide emergency medical service and medical transportation as well as a provincial 24-hour telephone advice service staffed by nurses with expertise and education in advanced practice. These recommendations must be implemented prior to any other extensive changes to the system, for example hospital closures or conversions. Citizens and health care professionals must know that a concrete foundation of health services is strongly in place so that their needs and the needs of their community will still be met and, ideally, perceived to be better than before. This is integral to the success of changes to our health care system.

It is said that primary health care has the most potential to be revolutionary in its impact on the health of the world's population. We believe this to be true and that, at this precise moment, Saskatchewan has an opportunity to truly embrace primary health care and become a global centre of excellence for rural and Aboriginal health services. The hard facts are, infant mortality rate for the Aboriginal community is double the national rate. Suicide rates are two to seven times the Canadian average. Diabetes and heart disease are prevalent and increasing.

Two citizen-centred, multi-district, primary health care demonstration projects that are fully functioning by spring 2002 is the materialized evidence that the public and all health stakeholders need to believe in this government's commitment to action. A decisive implementation of integrated primary health care services via a process that is inclusive and transparent, with nurses and citizens at the core of planning, implementation, and evaluation, will demonstrate our collective leadership.

Ms. Brunskill: — I'll now go on and talk a bit about the process of change. There is one quote that I would like to read you. I recognize it's in your text.

> If we were building a health care system today from scratch, it would be structured much differently from the one we now have and might be less expensive. The system would rely less on hospitals and doctors and would provide a broader range of community-based services, delivered by multidisciplinary teams with a much stronger emphasis on prevention . . . However, because we are not starting with a blank slate, we must be careful about the pace of change so that both the public and the health care providers maintain their confidence in the system — a difficult balancing act.

And that came out of the National Forum on Health.

So the process of change is what we believe is critical. We are very concerned that the last time that change — when hospitals were closed — it was imposed; it was sudden, and it was quick.

What we are promoting is that the necessary community infrastructure must be in place first. And so we are calling on change to be inclusive, for change to be transparent, for it to be respectful, and that there's careful planning implementation, and most importantly, effective communication.

Communities need to be aware that we're looking to improve health in those areas and that it's not about reducing or economic efficiency. The language of the business model is not the model that a primary health care framework would language.

Public and professional consensus around dissatisfaction may well be the driving force in acceptance of that change. When people are involved in the planning of change, then the people can go forward together and dialogue with the community about how best to implement what is needed.

We believe we need a strong citizen-centred approach. Many of our committees have lacked citizen presence at the planning tables. We believe that planning committees should be at least 50 per cent citizen composed.

We believe that the quality health council is essential as one of the first steps in implementing change in our health system. What's equally critical is that that quality council needs to be made up of at least 50 per cent expert citizens and 50 per cent health professionals and policy-makers; that there needs to be a solid balance.

Secondly, when we look at the advisory committees to health districts or to government, we're concerned that there has not been an equitable approach to the advisement that boards frequently receive.

Point in case is that, historically, health district structures have seen medical advisory committees that have significant power and influence upon the health district board. We are proposing that the ideal vision would be that there would be a professional advisory council that would be multidisciplinary. To get there, one may need to use incremental change and you may have physio or a nurse advisory committee or whatever, but that ultimately the goal should be multidisciplinary.

We must avoid purely economic-based decision making, which is in conflict with the principles of primary health care. Managed care systems are not the kind of model that deals with social change and social justice.

We must remember that we're looking at not what . . . that we don't view citizens as individuals, but that rather within a primary health care framework, we look at them in their lives, their relationships, their working conditions. And thus a system would begin to focus on their place of work, it would focus on their leisure time, and it would look at all of the areas that are the determinants of health.

Overall the process of change needs to be inclusive. It needs to be incremental because we cannot afford to alienate as we have in the past, and it must be well sequenced. This includes prerequisite core programming, what we talked about, emergency EMS (emergency medical services), 24/7 nurse call centres. If the rural and Aboriginal populations and the urban populations had access, and knew they had timely, solid access to resources like that, that's what helps to build trust and public confidence.

Secondly, we need two demonstration programs set up immediately. We don't have the health resources reconfigured to do a province-wide implementation at this time. Significant implementation to comprehensive health care, in the primary health context, is going to require significant resources to continuing education, to refocusing, and looking at how the system works. Community development does not happen overnight.

So we're promoting two multi-district demonstration projects — one that would involve several health districts in the rural area, one that will involve an urban community. And then let's be able to put it under the microscope, have the quality council working with that, and then be able to demonstrate the very positive benefit that can come from a primary health care model.

So those are our comments on the change process.

Ms. Blau: — You have heard this morning from Saskatchewan Union of Nurses on the nursing resources. And so I'm going to trust that the committee will read what's written here, and I'm going to try and hit the high spots so that we will have time for some questions at the end.

I want to start, though, by quoting the Hon. Allan Rock, federal Minister of Health from an address to the Canadian Nurses Association three years ago. And he said:

> Let me begin by acknowledging some hard facts. I think it is best to be blunt. No professional group has borne the brunt of health care restructuring more than have Canada's nurses.

And a number of things have come together. I'm going to trust you to read what has happened, because I think it's instructive for the future and what we need to do, and I'm going to turn to page 10 to the recommendations. This is what we're recommending as concrete solutions to the nursing shortage.

In addition to the nursing shortage, we need health human resources planning that covers all health providers. We need to implement a comprehensive, coordinated, provide-wide approach to health human resource planning that will examine all the human resources needed, all practitioners of health.

It is disturbing that in 1996, a health human resource plan for Saskatchewan was developed and has been put on the shelf. Now we are starting over but with an even greater deficit of health care professionals in the system.

There is a stark absence of appropriate representatives on the Health Human Resources Council. There is no citizen participation, no dean of nursing, no SRNA nor SAHO employer presence. Instead of being inclusive, the council

appears exclusive. That's a concern.

We need to provide appropriate government financial support to ensure that there are full-time nursing positions available in Saskatchewan so that nurses can have not only financial stability, but work life/family balance so that they remain in our province. Funding must also ensure reasonable workloads for nurses.

And just as an example, I spoke to a nurse in the grocery store last week. Her husband works for a company that has been recruiting nurses for Alberta in Saskatchewan. They have talked to nurses. They have looked in the newspapers for ads. Nobody in Saskatchewan is advertising for nurses. And Alberta has ads all over the place, and they have a recruiter in here going around and recruiting our people out from under our noses. We need to do something about that. Not that we can stop Alberta, but we've got to do something to keep people here.

We need to fund programs to create quality practice environments, provide incentives to maintain them, and develop indicators to monitor them. The release last month of the work of Linda Lee O'Brien-Pallas, funded by the Canadian Health Research Foundation, sums up the issues regarding the nursing shortage and the benefits of a healthy workplace for nurses, for their patients, and for the system.

Concrete recommendations are suggested for government, professional associations and councils, employers and educators and researchers. A co-operative endeavour is mandatory for any of these recommendations to come to fruition.

The SRNA is already a leader in this regard, having launched a critical program in quality workplace with the phase 1 in the Moose Jaw-Thunder Creek Health District. This is a program that we're hoping to go much beyond Moose Jaw-Thunder Creek. It's based on consultation; it's based on partnering and consensus building; it's based on community development, involvement of participants; and based on sustainability. It's an opportunity for employers and employees to create workplaces that support excellent nursing practice in quality health care.

The Provincial Nursing Council and key stakeholders comprise the SRNA's quality workplace program steering and advisory committees. This creative program is in urgent need of further funding. The public is indirectly being hurt by the quality of the health care environment. Conversely, happy, healthy nurses make for happy, healthy patients.

We need an immediate increase in the funded nursing education seats in the nursing education program at the University of Saskatchewan partnered with SIAST (Saskatchewan Institute of Applied Science and Technology).

We need to consider having students enrolled in professional health programs at the University of Saskatchewan — nursing, medicine, physical and occupational therapy, and social work — attend the same core curriculum classes focusing on comprehensive primary health care.

This will facilitate the development of the health care team that they can carry with them into their professional practice. Right now we're educating people in silos and they don't develop a team concept very easily. Similarly, have those attending health assist programs at SIAST — licensed practical nurses, occupational and physical therapy assistants, etc. — do the same.

Educational programs must ensure a match between curriculum and the skills required in the workplace by teaching leadership skills, conflict resolution skills, health care policy, and workplace health issues.

The University of Saskatchewan Health Sciences needs to become a centre of excellence for primary health care education, focusing particularly on rural and Aboriginal health. Our Aboriginal health status is comparable in many respects to that of third world countries.

We need to fund research for the development of databases, workload measurement, and human resources forecasting tools, not simple supply and demand models. We need to include research on indicators and models to monitor the health of nurses. Healthy nurses stay longer in the system and are associated with higher quality care and healthier patient outcomes. Sick nurses are associated with decayed morale, poor outcomes for patients, and an economic burden for the health system and all Canadians.

And finally, we support Mr. Fyke's recommendations for a strong commitment to health research.

Ms. Brunskill: — The one comment that I did want to take the ad lib opportunity to add and would want to draw your attention to is on the bottom of page 9 regarding what I think is a story little known:

> The Nursing Education Program of Saskatchewan (NEPS) is a model curriculum program worthy of international attention that graduates nurses who are qualified to function within the primary health care model.

What's really important is that in addition the Native Access Program to Nursing, known as NAPN, has the largest Aboriginal student population in Canada, and it has demonstrated incredible success. Two Aboriginal NAPN counsellors provide support to over 60 Aboriginal students.

And according to Dean Beth Horsburgh, NAPN offers the ability to develop Canadian capacity in the area of graduate nursing studies. This must be fostered. If we are to have strong Aboriginal nursing presence, we need Aboriginal nurses educated at the graduate level.

Dean Horsburgh further emphasized there must be ongoing support for Aboriginal nurses to pursue academic and research careers. The facts are obvious. Students want to enter the nursing profession; there's just no place for them in our province's nursing education program.

With that, I'm going to move on to the whole issue of quality of comprehensive primary health care.

We really do support the need for immediate priority implementation of the quality health council. Quality is a real concern expressed by registered nurses, as you know the largest

health professional group. When RNs leave their roles, they leave because they can't practise quality nursing. It's their positions and their jobs that are frustrating them, not the ideal practice of nursing. They tell us that although they still love nursing, they can no longer cope with their jobs.

Quality is one of the most essential building blocks within our changing health system. When one hears that it is 10,000 times safer to fly in a commercial airline than to enter a hospital, that is worthy of attention. When you extrapolate the Institute of Medicine's data that shows that over 98,000 Americans die every year, more than from breast cancer and other health . . . many health diseases combined. Extrapolated that means that in Saskatchewan one person dies every day from a medical error.

How can we spend over $2 billion a year and not be focused on quality and accountability?

So when one hears that our Saskatchewan hospital visit rate is 41 per cent higher than the rest of Canada, you have to question the community infrastructure. Why are those people needing to go to the hospital? Why is there not support services in the community?

We know that quality resources are lacking, particularly for marginalized groups. This morning, you heard about the female population, the rural, the Aboriginal populations. The Fyke Commission does not address the need for gender and ethnicity as critical areas to be considered when one is doing policy analysis.

The quality health council is essential. It must be established immediately and be ready to evaluate the implementation of the primary health care demonstration programs as previously recommended by the SRNA. It is recommended that the quality health council establish, at its outset, clear outcome goals for itself for which it must be held accountable.

The quality assessment framework must be established based on a social model of health and not on a medical disease model. Ongoing broad consultation with citizens of the demonstration region — our two demonstration projects that we are promoting — and ultimately the province is essential. The quality assessment framework will become the broad evaluation framework for the quality council.

And then I go on and lay out a plan on page 13 that shows what the quality framework would really look like. Many people hear the words primary health care and really don't know what that would look like. And we're saying, here are the outcomes you should be able to see, one through eight, where you have a community where there is social responsibility for health. We have healthy public policy. We have increased investments in health development. We have consolidation and expansion of partnerships for health. We have increased in community capacity. We have individuals, family, and community empowerment. We know that autonomy is essential if health is to be achieved at those levels.

Secure infrastructures for health promotion and illness prevention are needed. A major key to this is refocusing the interdisciplinary education at the University of Saskatchewan, Health Sciences division. Until we do that, we are going to continue to perpetuate silos.

We need a secure infrastructure for curative services. When we talk about primary health care, we're not talking about community-based care. It includes curative care. There must be a seamless continuum. So it's critical within the acute care sector. They need significant resources. What we need to be looking at is the seamless continuum of care.

When you ask about casualization, it's clear that the client is seeing a different provider every shift or every half shift. That's what it means to client care. Imagine the quality of student learning if there was a different teacher in the classroom every half day.

We're talking about error rates that need to be managed. There is not a national database for error management in our system. Errors happen in Saskatchewan — there is no national reporting system — and they will be repeated again in BC (British Columbia) and in Ontario. We need secure infrastructures for community and institutional rehabilitation, and most importantly, with our palliative care services.

So I won't go through a lot of the cost drivers and everything there, but that's where we must pay particular attention to. We need to look at the most vulnerable in our community and we need to look at those areas of populations where we're seeing real cost drivers. So you're taking both extremes of the population and paying particular attention there from a quality perspective.

So a quality council has much work to do. But what's critical is that the quality council needs to be made up of the public, expert public, and health professionals and policy makers. And that the health economists and the researchers should be resources to the council. They should not be the drivers.

So when we look at the value of the quality health council, it must include a commitment to comprehensive primary health care knowledge generation, excellence in quality improvement, openness, transparency, and public accountability. And as I've said in the report, if they're not able to demonstrate that they're making progress towards that, their funding would be curtailed and one would revisit their whole merits.

So what I've said is increased funding to the quality health council up to the maximum of $20 million, as recommended by Fyke, should be contingent upon its demonstration of providing sufficient evidence of both organizational goal attainment and the council's impact on influencing health policy within demonstration regions and ultimately the whole province when we're ready to do a full provincial implementation.

Ms. Blau: — In conclusion, there is no doubt in anyone's mind — government, the citizens of the province, and health care providers — that Saskatchewan's health care system is in need of major change now. We are all feeling the urgency around this grave issue.

Therefore the SRNA encourages the government not to procrastinate any longer and immediately clearly articulate a public policy for comprehensive, integrated primary health care. We believe that the absence of a policy decision is indeed a

policy decision and remains so until otherwise stated.

The SRNA advocates a strong, comprehensive primary health care system as the cornerstone of an overall health strategy for Saskatchewan.

While specific recommendations are contained throughout this report, there are two that are overarching and within which all the others are contained. Number one, that Saskatchewan become a global centre of excellence for primary health care with the establishment of two primary health care demonstration projects, one rural and one urban, by the spring of 2002. Particular attention to rural . . . or to Aboriginal and women's health as vulnerable groups should be a priority. The Health Sciences faculty at the University of Saskatchewan become a centre of excellence for primary health care in education and research, with the focus on rural and Aboriginal health.

We are confident that the Government of Saskatchewan will continue to demonstrate the required leadership for rejuvenating our provincial health care system, putting foremost in its mind the needs of the citizens of this province. The SRNA remains committed to working with the government to advance the quality of health and the health leadership Saskatchewan has shown.

The SRNA, on behalf of its 9,000 nurses representing 75 per cent of Saskatchewan's health care workforce, thanks the committee for the opportunity given us today to present our views. We look forward to further dialogue regarding the commission and we would take questions.

The Chair: — Thank you very much.

Mr. Gantefoer: — Thank you very much, Madam Chair, and thank you very much for being here this morning and presenting us with a very comprehensive brief that I don't think we're going to be able to touch on all the aspects of it.

A couple of areas that I want to talk about, though, or ask you about, is first of all in your recommendations you talk about the urgent need to increase the training seats at SIAST and the University of Saskatchewan from the current level of 260, I believe, to 400.

Earlier the Saskatchewan Union of Nurses in their presentation expressed a great deal of concern about our ability to retain these graduates and that indeed in some aspects we are functioning as a training ground for other jurisdictions. A significant number of the students coming out of the college are indeed taking their first job and maybe only job in other jurisdictions. The Union of Nurses also indicated some concrete measures that strongly need to be done in order to deal with the retention and recruitment of our people. Would you concur? Are there any concrete examples that you would add on to those comments?

Ms. Blau: — It's really key that this not focus on one strategy. I mean you absolutely must improve the workplace in which nurses function. Otherwise no amount of active recruiting — offshore or anywhere else — is going to keep nurses in the system. It's like filling a bucket continuously that has a hole in the bottom. We have to do something with the workplace to make nurses able to stay and continue practising.

At the same time we need to be educating enough nurses for our own market considering that we're going to lose some. We don't have mountains. We don't have oceans. But we do have a lot of things, and I think we need to focus on those.

So the retention strategy is absolutely key combined with recruitment, but also educating our own homegrown people who already have ties in this province. And right now there are people turned away from the program this year who wanted to be in nursing and who could not get into the nursing program. That's terrible. They're going somewhere else. Where are they likely to stay and work — somewhere else.

Ms. Brunskill: — I was just going to say in addition to what June has said, to add that in Regina this year we saw a decrease of 40 first-year seats for registered nurses. And those seats were transferred to Saskatoon. And so now you've lost the nursing faculty in the southern part of the province and you can't easily regain that. And so I'm concerned about the approach of the tap being turned on and off; that it needs sustainable planning.

Mr. Gantefoer: — Thank you. The number of 400, on what research or what information did you base your need to have 400 as the training seats?

Ms. Brunskill: — The decision was made based on the fact that historically we used to take in around 500 in this province and then would frequently graduate on a yearly basis around somewhat over 300. I think we've provided a sheet in your number.

The decision was actually based on a discussion amongst a group of senior nursing leaders in terms of what was a reasonable target that we felt we could move towards, whereby we could build in the necessary faculty, resources, and as well I think people are aware of the dire needs at the college as well for physical structure space. So it was based on a number of factors. So it was a discussion, collaboration, round table with a number of senior nursing leaders that we felt that 400 was a realistic, achievable target.

Mr. Gantefoer: — Thank you. On June 8 of this year in questions in the health care estimates of the province of Saskatchewan, that question was put to the Minister of Health — basically of what we need. And he quoted a study by Doug Elliott of Saskatchewan *Trends Monitor*, and it's in *Hansard* on page 1679.

And what he says, that this information was basically projected from '98-2008 and it would be going to another seven years (I'm quoting from here) so that the worst-case scenario — that is based on exactly the figures that we're talking about now — would be about 331 RNs, registered nurses, and RPNs, registered practical nurses, each year to meet the supply. Sort of a status quo number would be 235. And sort of the least required of that, I mean basically if everyone could stay in the province, is about 105.

Would you agree with the minister's assessment of what the need really is?

Ms. Brunskill: — With all due respect to Mr. Elliott, when that report was released, the SRNA had significant concerns. That report was done without accessing Saskatchewan Registered Nurses' Association year-end data, and was based on mid-year numbers and does not accurately reflect. I would encourage any of you to look what they've stated the statistics were during a given year and the SRNA would immediately be able to point out to you how inaccurate they are.

Mr. Gantefoer: — Thank you. The next question that I have is that it's been indicated, and in the previous presentation, one specific parallel committee, if you like for lack of a better word, on the reaction to the Fyke recommendations have been structured.

Have you been asked to, and are you participating in, any of these parallel committees on the discussion about the Fyke report?

Ms. Brunskill: — They have working groups. The Department of Health has created working groups. And I myself have been invited to participate on two working groups, namely the quality council, and then I am on a deputy minister's reference group.

Mr. Gantefoer: — Thank you. SUN indicated that they were asked to make a presentation to a working group, discussing the conversion or closure of facilities. Have you any representation on that particular group?

Ms. Brunskill: — No.

Mr. Thomson: — Madam Chair, I'll be somewhat less political than Mr. Gantefoer. I won't ask you to comment on his question period statements. But I do want to ask a couple of questions and I'll be brief.

The question concerning nursing programs and the work that's done at the university, you recommend on page 11, and you've highlighted it in your presentation today, that we need to make sure the same core curriculum classes are available for social work, physical therapy, nursing, medicine. This matter as I understand it, is largely within the purview of the university. Has work been done with the university senate and the Academic Council at the U of S (University of Saskatchewan) to move in that direction?

Ms. Brunskill: — I can't comment specifically. What I am aware though, from our dialogue with the dean of nursing, she indicates that certainly there has been discussion within the university deans about talking about the need for this; and that the merit that there could be . . . And it's not only core classes, but actually having students from different disciplines actually in the same class. So discussion has occurred.

Mr. Thomson: — It seems to make a great deal of sense. And I know that the SRNA and other organizations were very successful in getting the university senate to move over to the full baccalaureate program. And so whatever obviously you can do in that regard in working within the university, I think should be encouraged.

The second question, I guess the tangential question to that, or the corollary, would be the transfer of seats from Regina. One of the concerns that obviously I have, as a member representing Regina, is this idea of creating a single, integrated, education facility at the University of Saskatchewan and what that would mean for nursing education throughout the province. Obviously we do some nursing education here in Regina, and there's some done in Prince Albert.

I want to understand clearly, the SRNA in talking about the need for a more integrated education program is not advocating the centralization of it are they?

Ms. Brunskill: — No, in fact, quite the opposite. One of the retention strategies that we frequently talked about is the promotion of co-operative learning; that you could actually have co-operative learning programs where students could exit at, say, year three, and go up to northern Saskatchewan, or various areas, and work for periods of time — or in the summers when they're off school. And I think that when you look at the Faculty of Medicine, the Faculty of Social Work, all of those programs very much rely on experiences throughout the whole province.

Mr. Thomson: — Thank you. Earlier this morning we heard a presentation from the union of nurses, and they had talked about the experience in British Columbia, where student nurses are employed during their summers, to perform some nursing duties.

Is there an ability for us to move rapidly to implement such a program here in Saskatchewan, or are there — obviously as a registrar, but essentially the registrar of nurses, the regulator — are there issues that you would need to deal with?

Ms. Brunskill: — The one thing that we do hope to be able to do is to quickly bring our legislation back to the Assembly again. It would just be the whole issue of creating a student roster, much like the College of Medicine and nursing professions in the province of British Columbia actually have.

And one of the things that I've said, if anyone is interested in nursing even before they go on the program, it makes sense that rather than working at McDonald's, that they be working in a cafeteria of a health system, that the more you can socialize someone into the health system, the greater their chances of retention.

Mr. Thomson: — Thank you very much.

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

You've indicated this morning that the workplace and the problems there are probably the biggest problem that nurses in Saskatchewan face. And it's my understanding, from talking to nurses that work in the system, that that is the whole problem or one of the major problems in creating waiting lists and so on in our province. And yet you've also indicated that you believe that we need a massive change in our whole delivery system.

I guess I'd like you to explain to me why you think we need this massive change in the whole structure when I see it and a lot of citizens see it as the problem is the workplace and not enough

nurses to supply the demand.

Ms. Blau: — When we were doing this presentation or putting this presentation together, we talked about medicare 1 and medicare 2.

Medicare 1 was to pay for people's sickness. Okay?

Medicare, the next generation, is to look at health as a holistic kind of thing of which a part of it is the institutional workplaces. But it's not the whole piece and it's not the most important piece. And if we don't change the rest of the system, we're never going to be able to manage that piece, because if we don't move off here and start preventing some things from happening, we're never going to be able to keep up with what's happening coming through the doors of institutions.

It's a matter of thinking a bigger picture and looking at healthy people in healthy communities needing less acute care services because their needs have been met before they get to the situation of needing acute care services.

Ms. Bakken: — So do you as an organization support the closure of hospitals in rural Saskatchewan?

Ms. Blau: — I don't know. I don't know the answer to that, because I don't know what those communities need.

Those communities need to be involved in determining what their needs are in those communities. And as an association we really don't have a position on whether hospitals should be closed or not.

We have a position that says communities need to be involved, and it needs to be a community development model, not a top-down decision as to what happens there.

Ms. Bakken: — So you're not asking then that this primary care model, that can . . . that it should replace what we have today, but it should be in addition?

Ms. Blau: — It may be in place. It depends on what happens. But in this piece, the one thing that must be there is the emergency response, and people must be comfortable that if an emergency occurs, they know how to access the system and that the system will be there to respond to them. That's the foundational piece to take care of acute care. Whether or not primary health care ends up closing hospitals or not, I don't know the answer to that because it will depend on what that community's needs are.

Ms. Bakken: — So then I take it from that that you believe then that the communities should be consulted first and foremost before any of these implications that Mr. Fyke is recommending are put forward, and that they should be listened to and their needs addressed?

Ms. Blau: — Well yes, yes. They should be involved in the whole process because implementing change from the top down only makes people cranky. It really doesn't solve problems. It takes them out of the loop. They feel disenfranchised, if you will, in a democracy.

Ms. Bakken: — You indicated that you . . . you made a statement: there is a stark absence of appropriate representation . . . representatives on the Health Human Resources Council. Who is on the Health Human Resources Council?

Ms. Brunskill: — I can't speak to who all is on the Health Human Resources Council. I'm aware that there are different people who represent different . . . or who constituate, I don't know, different agencies but who are not there representing as such their agency. For example, one person happens to be there who happens to be a physician who happens to be on a regulatory body, you know, and so people are wearing several hats when they're there. But there is no organizational representation on that structure.

Ms. Bakken: — And what exactly does this council do?

Ms. Brunskill: — The council has a mandate in terms of health human resource planning, looking at scope of practice and looking at improving the quality of the workplace environment.

Ms. Bakken: — They report directly to the minister, or who do they report to?

Ms. Brunskill: — My understanding is that they would report to the deputy, but I can't answer that.

Ms. Bakken: — One last question. On the working groups — and I understand that you said that you're on two of them — what is your mandate? Are you . . . and are you making recommendations from this group or are you given recommendations to review and to advise on, or exactly what are you doing on this working group?

Ms. Brunskill: — What we are doing is reviewing the recommendations of the Fyke Commission in particular areas and then giving overall feedback that is then taken forward to the deputy minister's reference group.

Ms. Bakken: — You actually are making recommendations on the recommendations; you are not just making a report? Or are you itemizing what you think is good and bad or exactly . . .

Ms. Brunskill: — Not making formal recommendations as such, but saying here's what we see as some of the strengths, the limitations, and some overall suggestions. But it's not structured in the form of solid recommendation.

Ms. Bakken: — Do you have a time frame when you . . .

Ms. Brunskill: — I'm not aware. I would think that over the early summer seems to be the time frame.

Can I add one comment if I could with regard to Ms. Bakken's questions? When you asked about the question in terms of, are we supportive of the need to redesign and shift versus why can't we just carry on with more of the same, part of the concern is that there is a real inequity in access at this time; that we don't have any social justice within our system.

And when I look at particularly in Quebec where they have for one example, even with Infosanté, it's a nurse telephone line is one example, that alone has decreased the demand on

emergency departments by 54 per cent.

And you look at people being able to access the right resource at the right time at the right place, which is from their home, and the goal in acute care is always to be able to return people to their home and to their community as quickly as possible with the necessary supports.

What we're talking about is we want to see community infrastructures in place like enhanced home care services; community concepts like we talked about, having nurses, physicians, social workers, whatever the primary care team is, more visible in and throughout the community. We need not to be thinking of bricks and mortar.

Ms. Bakken: — Well I guess just further to that then, there is a real feeling by the people that have presented to us so far and that have called our offices, that they are going to lose what they have now; that there is not going to be an enhancement. If we lose our acute care in rural Saskatchewan and our hospitals, the doctors are going to follow. I'd like your opinion on how you think we are going to retain doctors in rural Saskatchewan when they do not have acute care facilities to practise in.

Ms. Brunskill: — There are a couple of issues there. Number one, what we call the building on the corner of what used to be Dewdney and Pasqua, a hospital, that that's a very different type of a facility than what you would see in Rocanville or another area that . . . We've had one definition of a hospital. And I think what we're looking at is that hospitals can play many roles and that probably there needs to be about 8 or 10 definitions. And so the word itself, it may be called a hospital or it may be called a community health centre, I think you have to look at what are the needs of the community, as our president has said earlier, and what needs can best be met where.

The system has changed and given the high technology, the need to be able to access timely resources, that what we're looking at is redesigning the system. And what we do know is that where you add advanced practice nurses, for example, to the primary care team, that really increases physician retention. Young physicians that are graduating do not want to be a in a solo community on call 24/7 and so they're really appreciating group practice and practising with a wide cadre of health professionals.

The Chair: — Thank you. Dr. Melenchuk, if you could wrap this up for us.

Hon. Mr. Melenchuk: — Sure. Just a couple of quick questions, and thank you for your comprehensive and extensive response to Fyke.

The two questions I have, number one is with your reference to the quality council. Now you would see the quality council as being an important ingredient, that its composition would be such that you would want approximately 50 per cent public representation, that this quality council would be independent, preferably reporting directly to the Legislative Assembly, and providing a report card on the system on an annual basis. Do you see that as absolutely crucial to overall reform from the Fyke report?

Ms. Brunskill: — I think that what is really essential is — we've talked about basic values or principles that must drive policy — and if you're looking at transparency and timeliness, accountability, openness, various principles like that, it's very important that there is a very open, transparent, ongoing monitoring of improvements to the health system.

Hon. Mr. Melenchuk: — And the second question I have is with regard to the complexity of the health care system and the perception that people have of our health care system and the language that needs to be developed and the understanding of where the health care system is moving to, and that leads into your recommendation for two demonstration projects, do you see that as important in dealing with some of the perceptions and misperceptions about what health care reform is all about?

Ms. Blau: — Yes, very definitely.

Hon. Mr. Melenchuk: — That's all the questions that I have. Thank you.

The Chair: — Seeing no other questions then, I'd like to, on behalf of the committee, thank you very much for your presentation. And we will read the parts that you didn't get to read, and I think it's fairly comprehensive. We appreciate your presentation and your response to the questions this morning.

The committee is recessed until 1 o'clock.

The committee recessed for a period of time.

The Chair: — Good afternoon. This is the standing committee of the Legislative Assembly, the Standing Committee on Health Care. The first order of business for the standing committee is to receive and report on responses to the Commission on Medicare — the Fyke Commission.

The committee has set aside half an hour presentation blocks for organizations and individuals, and in that half an hour we hope that there's some time for questions from the committee members.

I'm Judy Junior, Chair of the committee. Dr. Jim Melenchuk is the Vice-Chair. Other members of the all-party committee are Andrew Thomson, Warren McCall, Pat Lorjé, Brenda Bakken, Bill Boyd, and Rod Gantefoer.

If you want to just introduce yourself and who you represent and then you can begin your presentation.

Ms. Mahoney: — Thank you for the opportunity to be here this afternoon. I'm Jean Mahoney. I chair the board for the Saskatchewan Catholic Health Corporation.

Mr. Olsen: — Hi. I'm Dale Olsen, director of . . .

The Chair: — Just one second. Jean, you have to come a little closer to the mike. We didn't hear it quite as loud as we need to. If you can start all over. Thanks.

Mr. Mahoney: — I'm Jean Mahoney, Chair of the board for the Saskatchewan Catholic Health Corporation. Thank you.

Mr. Olsen: — Hi, I'm Dale Olsen, director of pastoral care, Luther Care Communities, Saskatoon.

Mr. Thibault: — Michel Thibault. I'm the committee chairperson for this presentation.

Mr. Fox: — Harvey Fox, the Chair of the Catholic Health Association of Saskatchewan.

The Chair: — Thank you. And you can begin.

Ms. Mahoney: — The Saskatchewan Catholic Health Corporation is an ownership, sponsorship group which, on behalf of the Catholic community of the province and under the leadership of the bishops of Saskatchewan, furthers the healing mission of Jesus Christ. The bishops of Saskatchewan believe that Catholics and Catholic health facilities must remain active players in health care in Saskatchewan to ensure that values, ethical principles, and pastoral care continue to play a strong part.

Today the call to continue that ministry is clear. As ways of responding to human needs for health care and healing change, the bishops are committed to the values that must guide our new ways in health care; the values which include respect and dignity for the person, stewardship, compassion, ethical reflection, social justice, and hope. The importance of integrating health and values in our health care system is critical.

The Saskatchewan Catholic Health Corporation currently owns eight institutions in the province, which include acute care, integrated facilities, and long-term care. These include: St. Joseph's, Ile-a-la-Crosse, acute care and long-term care; St. Peter's, Melville, acute care; Radville-Marian Health Centre, Radville, long-term care and health centre; St. Joseph's Hospital, Estevan, acute care; St. Paul's Hospital, Saskatoon, acute care; St. Elizabeth's Hospital, Humboldt, acute care; St. Joseph's Hospital/Foyer d'Youville, Gravelbourg, acute care and long-term care; St. Anthony's Hospital, Esterhazy, acute care; and Foyer St. Joseph Home, Ponteix, which will be transferred to us on July 29 this year, being long-term care.

Collectively, our facilities have been active in providing health care services in their communities and districts for over 500 years. Ours is a tradition of excellence, dedicated service, and unselfish caring, along with a strong sense of mission that is grounded in the inherent dignity of each person. Central to who we are is our mission to continue the healing ministry with a profound respect for the faith tradition of each individual.

In the last month I've had the opportunity to visit many of the institutions named and attended their annual general meetings. There was discussion at every meeting regarding the final report of the Commission on Medicare. I felt compelled to come before the Standing Committee on Health Care to share and to reinforce the comments and the concerns verbalized by members of the board, the community, medical staff, health care professionals, support staff, and residents, and clients.

The majority of the Saskatchewan Catholic Health Corporation's institutions are in rural areas. There's a strong community involvement and support for their local facilities. This was exemplified by the volunteer support of the community to care for those in need during the recent strike action. They are their neighbours, loved ones, family, and friends. And when there is a need they are truly there and willing to assist.

To summarize some of the concerns, consideration must be given to the promotion of involvement at the community level to participate in planning and process for implementation of changes in the delivery of services.

Community board members are progressive, and continue to work with the district to integrate services and assess the needs of the people within the demographic areas they serve. Programs are being implemented in community health and outreach services with emphasis on health promotion and education. Collaboration and responsible stewardship is being practised by all members of the health care team in the rural community.

The general public are requesting that there be clarification of the terms of reference related to community care centres, primary health centres, and the scope of practice that primary health service teams will offer.

Currently the integrated facilities and health centres in the towns are providing comprehensive health services in emergency care, sub-acute medical care, chronic care, follow-up, respite care, and palliative care. Long-term facilities within the district also access the services offered by the health care team in these same centres.

When one considers factors such as economics, we think of the cost related to ambulance coverage. Rural citizens are picking up the cost of referrals to larger centres. The utilization of community resources for non-urgent and routine exams done locally are more efficient.

Dignity and respect to individuals. This causes disruption and hardship for the elderly. Also there's a mobilization of chronic, frail, and long-term care clients to a regional centre. To whose benefit — they are asking.

Recruitment and retention of the health team in the rural community. Consideration should be given to have provision for basic health care needs locally provided, and laboratory and radiology services and treatment are essential.

Accessibility. The definition of primary health defined by the World Health Organization includes reference to essential health care that is universally accessible to individuals and families in their communities through their full participation and an affordable cost to the community and the country.

Accessibility to health care is also part of the Canada Health Act. Transportation issues and ambulance services in rural areas are major concerns because the cost will be passed on to the individual. The accessibility for the rural population in need of urgent health care service in regional and tertiary centres is questionable. Waiting lists are increasing and centres may and do go on bypass during the peak times. Will these services be there when I need them?

Rural health care delivery is a specialty and rural family physicians require additional education and skills. This should be recommended to the government and the College of Medicine and the concept should be implemented.

Equitable distribution of resources seems not to be evident throughout the province. This is a particular concern for Ile-a-la-Crosse. The lack of adequate equipment which is often obsolete and non-functioning on many an occasion and personnel to provide basic health service is not present. We recommend that a framework based on social justice be developed to address the needs of our First Nations and Métis peoples, as well as the needs of seniors and poor families.

Spiritual care. During our visit, it was gratifying to witness the dedication of the workers carrying on the mission and values of the foundresses and incorporating their values into the delivery of care. The spiritual dimension of care with a presence of sisters and pastoral care workers is a component of care that we value greatly.

It was indeed comforting to observe special care given to a dying person and family. The caring of the staff, the outreach to family and community was evident. They are indeed a much-valued part of community care.

We recommend that consideration be given to investment in the spiritual dimension of care and that this be made in all health districts. It is essential to provide spiritual care programs, which provide sensitivity to individual, religious, cultural, and social beliefs in the care of individuals and their families.

A fundamental value underlying ethics in health care and social services is respect for the dignity of each human person. This value aspires to protect the individual interest from physical to psychological to spiritual to cultural integrity. This is acknowledged in the United Nations' Universal Declaration of Human Rights. We recommend too that a provincial ethics network be established to assist in the process of ethical reflection and informed choice in decision making and stewardship related to health care.

The Catholic Health Association of Saskatchewan has completed some preliminary work in this area. The Saskatchewan Catholic Health Corporation and the Catholic Health Association of Saskatchewan would like to further explore this in the future.

In conclusion, we appreciate that resources are limited and we recognize the challenge before those in health care to practise responsible stewardship. Our religious founders and foundresses, offered health care as a form of Christian discipleship. We must continue to uphold the values of compassion, a sense of collective responsibility, a sense of equality and fairness, and concern for those in need. We also need to give priority to providing better care despite a shared concern for saving public dollars.

Thank you.

Mr. Thibault: — Madam Chairperson, members of the committee, thank you for the opportunity to be here to join our voices to those who have already made presentations to this committee.

In our materials you will have received some basic information of the three organizations that worked together to bring forward this particular presentation — the Catholic Health Association of Saskatchewan, Circle Drive Special Care Home, Alliance in Saskatoon, and Lutheran Homes of Saskatchewan.

In addition, there are a copy of these remarks in those materials and a copy of the booklet for the committee members entitled *Spirituality and Health* which we recommend to you.

It is our hope that we can call the membership of this committee, the provincial government, and the citizens of our province to a renewed focus on the kind of care we want to be able in the future to call medicare in Saskatchewan.

And why this hope? Firstly because we believe it can be done. Secondly we believe that we can be leaders in renewing and sustaining a quality system — the kind of quality that focuses on people. Thirdly because the goal of good health is about responding to human need for wholeness and healing.

We are well aware that health and health care are important to every person in Saskatchewan. Decisions about our health and health care today will affect each of us and our children for many years to come. Fundamentally, when we speak about caring for medicare we are talking about better responding to the need to promote and restore wholeness in life.

We are well aware that it takes more than good doctors, hospitals, long-term care facilities, and medicines to have a healthy community, a healthy society. We now have, with this standing committee, an opportunity to present suggestions for renewing a system to make it effective for the people it serves and those who provide the service.

It is clear to us today that the goal of good health cannot be just about dollars and cents. It is about values like dignity, respect, fairness, compassion, justice, equity, effectiveness, and efficiency. It is also about trust in the system and confidence that the treatments provided really work. It is primarily about responding to human need for healing and wholeness. This focus begs the question — what values? And what kind of evidence will guide decisions about implementing the recommendations in the final report on the Commission on Medicare?

Mr. Fyke states that the achievement of a quality health care system in Saskatchewan requires nothing less than a cultural transformation. This is not new. If we are to truly renew the system, we must focus on the big picture of what makes a person or a community healthy. This requires reorienting public policy to an enlarged vision of health such as the one described in *A Saskatchewan Vision for Health*.

A Saskatchewan Vision for Health, published in 1992, speaks directly to this enlarged vision of health, and it states: Wellness refers to our spirit . . . our physical, mental, and spiritual well-being. It means getting healthy and staying healthy. Wellness means improving our quality of life.

As one reflects on this vision for health for Saskatchewan, it is

quite obvious that the focus of our health care system must first acknowledge and then understand the connectedness of our bodies, minds, and spirits. It's quite obvious that the focus of our health care system must be on people, both keeping people healthy and helping people who need care.

The 1992 vision tells us that there are all kinds of things that determine whether or not we are healthy — realities of life like whether or not we have a job, our income, our working conditions, our physical environment, our self-esteem, our genes, all make a difference. There are also personal choices — whether we eat healthy food, smoke, drive safely, wear seatbelts. Some things we can control by ourselves and some things we can't.

Today with an expanded awareness of the big picture, we are beginning to adopt a more holistic model of health care. This approach to care calls for a threefold response to the needs of body, mind, and spirit. Health care providers are increasingly acknowledging that spiritual care and healing are often forerunners to physical and emotional healing.

In light of these introductory comments, we take the position that a significant aspect of our health care system has been overlooked, ignored, and omitted in the report, *Caring for Medicare Sustaining a Quality System.* We propose that this significant piece can be identified as ensuring a holistic balance in our health care system. Flowing from this, two questions require serious reflection and adequate consideration, and that is: how can our health care system respect the true nature of the whole person — physical, social, emotional, cultural, and spiritual? And how can the system integrate the holistic balance identified in the 1992 document, *A Saskatchewan Vision for Health?*

For today's health consumer reducing sickness to physical symptoms alone represents a failure to understand the true nature of the human person. The result is that disease is treated while the human person, who is sick and in need of care, is neglected.

Fortunately, the medical system is beginning to more fully understand and acknowledge the vital connections between the various human systems of mind, body, and spirit and how they work together to form the body's healing system.

Jeffrey Levin, an associate professor of family and community medicine at Eastern Virginia Medical School, points to 250 published, empirical studies in the medical literature that reveal a statistical relationship between spirituality and positive health outcomes. Over 20 per cent of those studies involved heart disease — the leading cause of mortality in North America.

Health care providers do play essential roll in promoting people's wellness in mind, body, and spirit. Health care systems will face the challenges of developing an approach to health care that will couple modern medicine with an understanding of the connectedness of the human person.

What is being suggested is not that we abandon technology or pharmacology in the health system. But as medicine goes more and more in the direction of advanced technology for evaluation and diagnosis, we must also advance our understanding of the reality that people are crying out for someone who cares for them. Someone who will sit down and actually listen to them.

In our vision of health care, we must manage a high standard of physical care, while at the same time devoting time and energy to meeting the spiritual needs of those we serve.

At the present time, there is only superficial, sporadic, and sometimes non-existent recognition by the health system that the whole person — mind, body and spirit — needs to be the focus of our health care. We acknowledge that health care givers are under increasing stress due to increasing needs and demands without matching increases in funding and support. Workers' insecurity in this situation increases stress. Therefore, if the work of these providers is to meet the needs of the whole person, then the health system must also give special attention to the well-being of the most valuable resource in the system, the human resource.

Historically in Saskatchewan care providers who served out of a faith community initiated and brought spiritual dimension of care into the health system. Perhaps it would be fair to say that the health system derived out of a sense of spiritual care. They provided for its implementation in the various facilities and the outreach in the community. While this already exists, it's not enough.

We recommend the integration of holistic care become a priority in our health system. Many studies show the positive impact of spiritual care with respect to health and health care systems. Studies verifying this reality abound in the States for over the last 12 to 15 years.

We suggest that we be bold in Saskatchewan and dedicate resources to create our very own statistics. Leading the way and seeing spiritual care as an essential component of our health care system, and then flowing from our practical involvement, we will be able to create research opportunities for the 21st century. We must, in Saskatchewan, complete the job of building medicare.

Numerous suggestions have been given to the commission regarding the location and number of health districts, the responsibilities of districts and provincial government, to numerous other factors that contribute to remedying the challenges of our current system. This need not be repeated by us and we know you will take it under advisement.

But simply put, we present the challenge of re-establishing a Saskatchewan vision for health: ensuring a health system that focuses on the whole person, physical, social, emotional, cultural, and spiritual; and designating, designing appropriate processes that are open for effective consultation; to evolve a realistic change plan prior to implementing such a plan so that the people can understand what the change is to accomplish; being highly concerned about the disparities among various groups of the population, people of the rural and northern Saskatchewan.

We firmly believe that the health system must enhance and support the spirituality component of health. People will accept change as long it's accompanied by a plan that they understand, and they understand in realistic terms what the change is to

accomplish.

In closing, it's our opinion that these considerations are basic to addressing the challenges that lie before us and are an essential part of the kind of care that we want to be able in the future to call medicare in Saskatchewan. Thank you.

The Chair: — Thank you very much for both the presentations. We'll now have questions from the committee. Mr. Gantefoer.

Mr. Gantefoer: — Thank you very much, Madam Chair. And thank you for coming this afternoon and presenting this information to us.

I have a couple of questions. Currently your institutions work with district health boards under affiliate service agreements, or some wording of that nature. Can you tell me, from your perspective, are these agreements working effectively? Are they identifying the critical relationships that need to be identified in order to make the system work? Are you satisfied with the current arrangement?

Ms. Mahoney: — I think they're working well. We have both the affiliate agreements and the operating agreements. And it's something that's ongoing. I think we have to, both the districts and the affiliates, be monitoring how we can best collaborate together. But I think it is being effective.

In many of our districts we do have the administrator of our facilities who is assuming district-wide responsibilities. And this is a good, positive thing to see, but we're always trying to monitor to know how best to work together.

Mr. Gantefoer: — Thank you. And in Mr. Fyke's report he talked about, and you called for some definition, I believe of primary health teams and things of this nature. And Mr. Fyke talks about more integration of service delivery in terms of medical doctors, nurses, pharmacists, physiotherapists, etc. Do your service agreements provide for the provision of just facilities, or also for service teams, or participation in service teams?

Ms. Mahoney: — As I mentioned earlier, often the administrator, or the director of nursing, will be assuming district-wide responsibilities. And I think we're now seeing the benefits of that working in some districts. So I'm sure others will follow suit and want to be able to assume that kind of management.

Mr. Gantefoer: — In terms of your challenge to the system to develop a more holistic approach, that I think you're saying encompasses more of the spiritual dimension of health care or of the wholeness of human reality, as part of a health care system delivery, how do you see that working in a practical sense? Would it be a component of the primary health teams that there would be an individual focusing on this dimension? Would it be done in consultation with community pastoral groups or things of that nature, ministerial associations?

From a practical sense, how do you see the health system incorporating more of these dimensions into the health delivery system?

Mr. Thibault: — I can speak somewhat to it. I think there's been . . . the emphasis has been on the local pastors to do a lot of that. And the local pastors, being often overworked and maybe not being able to carry out that as well as they could.

There is in Canada a Canadian Association for Pastoral Practice and Education, a group that certifies chaplains. It is a very highly regarded training program for clergy and others in terms of providing them with the abilities to specialize in pastoral care and spiritual care. And I think that there are those particular specialized people and they're probably underused here in the province.

I come from Alberta and in comparison I think that the hospitals — and I know that there's probably more money there — but they certainly use the specialized spiritual care people much more in their facilities and have more of them and are integrated with the whole practice of care.

Mr. Gantefoer: — Okay. Thank you.

Mr. Thibault: — I'd like to, if I just might, make the point then, in the main this whole area of spirituality has been left, if you will, to the voluntary sector. And whether they're voluntary in the terms of day volunteers or professionals in the sense of clergy, but what we need is it not to be an add-on but to be actually an essential part of the tripod, if you will, of the stool.

Just as we spend resources in the other dimensions, the spiritual dimension needs to get its support as a part of the whole system that delivers. And I think examples, for example, St. Paul's in Saskatoon making some efforts with respect to the Aboriginal people and their special cultural considerations and spirituality. This is not to suggest any kind of promotion of a particular religious persuasion here; this is a fundamental understanding of human health and involving those three components.

Mr. Gantefoer: — Thank you.

Mr. Fox: — I think it's essential that we approach it on an integrated basis right from the care team level through to the organization as a whole so that spirituality is looked at as part of the mission and the operation right throughout the organization, throughout the affiliate, throughout the district itself, and not so much an individual's responsibility but a responsibility that is part of the whole operation.

The Chair: — Thank you.

Ms. Mahoney: — I think it's very important too, as was mentioned earlier, that spiritual care be considered as any other department in a hospital. My experience is in Regina as a spiritual care volunteer; and it's now being requested by the Regina Health District that there be a proper and adequate preparation for volunteers as well as for our chaplains who will do this work, and so that they're more a part of a team concept. And I think that's a very, very important thing to happen. And I think we would like to see it in many districts.

Hon. Ms. Lorjé: — Thank you very much. I have two sets of questions and I guess my first question would build on the conversation that's already occurred between you and Mr. Gantefoer.

I do want to thank you for presenting the very important spiritual dimension of health care. And I would like to concur with your observations. And also I would . . . I'd like to ask you a question.

As a past board member of City Hospital, we spent some considerable time working out a protocol and developing appropriate relationships with the pastoral care community in Saskatoon. And I have always assumed that that work was transferred into the Saskatoon District Health Board and that there is a continuing protocol for spiritual care and for the spiritual caregivers in the Saskatoon Health District.

I first of all would like to check out that assumption and also ask you, what is happening in the other health districts across Saskatchewan? Is there a similar recognition across the whole of Saskatchewan, of the importance of this holistic approach — mind, body, and spirit — to health care?

Mr. Fox: — That's the difficulty. There isn't an overall approach across the province. It really is dependent upon the district that you are involved with or that you are talking about. And in some districts the relationship and the involvement in the spiritual care side is very, very active and part of the day-to-day operation. In others, it's virtually non-existent, and it's left to the volunteer and very little in the way of support is provided to the volunteer to present and follow through on the spiritual care side.

I believe in the Saskatoon District Health that there is a good relationship on the spiritual side and I think there is a city-wide pastoral care or spiritual care group that is very active and involves the three facilities as well as the long-term care facilities, and representation from various denominations in the city as well.

Hon. Ms. Lorjé: — Well I certainly know from my own personal experience just how challenging this can be, and it seems to me it cannot be left simply as a laissez-faire, hopefully it will evolve kind of thing. It was one of the more challenging parts of . . . bits of work that the City Hospital board had to do and I think it was also an extremely important and relevant one. So I do want to thank you for bringing the committee's attention to that important dimension.

And I also take it from your comments that you don't see this as being necessarily a Christian-dominated thing, but rather you are approaching it as an holistic, spiritually oriented proposal. Yes. Thank you.

Now my second question, I guess I would direct to Ms. Mahoney. I note in your presentation you were talking about equitable distribution of resources throughout the whole of the province and particularly zeroing in on Ile-a-la-Crosse. And I'm sitting today for my colleague, Mr. Belanger, who is from Ile-a-la-Crosse; and I have also had an opportunity to tour the hospital or health care facility in Ile-a-la-Crosse.

And I guess I would say that I think that you are being charitable in your comments by saying the lack of adequate equipment, which is obsolete and non-functioning, and personnel to provide basic health care is not present.

What would you be foreseeing? Would you see a totally new health care facility being built in Ile-a-la-Crosse? And if so, what would you foresee happening with the current physical plant, which I agree is extremely obsolete and I think that the staff there do an incredible job of care for the acute and long-term care people who are in that facility.

Ms. Mahoney: — I think that the care that we're offering is certainly commendable compared to some places that we go to.

And as far as a new facility, it's my understanding there has been some initial discussion on that, and we ourselves have set some dollars aside to be able to help with that when it does happen.

I think what concerns me the most is the lack of personnel. Just to cite one instance would be the lab and X-ray prepared type of resource person. And we've been in the position several times where we almost had to close that hospital because we had no such professional available. And also sometimes with the lab personnel. And not just with personnel but with the equipment which was non-functioning and so therefore it's very difficult for the doctors as well to be able to do what they have to do without that kind of resource available.

There are many, many things that are just taken for granted in other hospitals that are not even heard of there. And really it's difficult to provide the quality of care that those people should have.

Hon. Ms. Lorjé: — Thank you very much for elaborating on that. I think that that's an important bit of information for the committee to hear.

Hon. Mr. Melenchuk: — Thank you very much for your presentation. Just a couple of quick questions. In terms of the concept in Fyke of primary care teams throughout Saskatchewan, do you see a role for the pastoral care or spiritual care within these primary care teams?

Mr. Thibault — I believe absolutely. And I think Mr. Fyke just didn't deal with this whole dimension at all. And frankly it's, I think, a glaring oversight. So it definitely has to be involved in that component.

And secondly the more complex proposal of a quality council with representation from various community representation groups to be on a quality council, the lack of any reference to participation by spiritual care professionals, if you will, I felt is quite significant.

And I would hope that the references that Mr. Fyke made in referring to, quote, "special interest groups" was not intended to refer to groups that felt that spiritual care is an important part of health care. And I would suggest that he ignored that whole component completely. Definitely needs to be present.

Hon. Mr. Melenchuk: — The follow-up to that question then is, when we're talking about multi-disciplinary teams, there is various aspects to that. Some of the team members would have direct contact with the public; others wouldn't, would be seen more as a referral or as a support team member. Would you see the pastoral care or spiritual team member as being more of a

support to the team and to particular patients upon request? Or would you see them more as a direct contact point to a multidisciplinary team at the primary care level? It is a bit of a difficult question because we're talking about a concept that isn't in existence at this time.

Mr. Thibault: — Fundamentally, spiritual care is to be provided to the person that needs care. But it's also very important, and I think critically important, that the whole concept that spiritual care is a reality to be supported in the caregiver, that the caregivers are helped to recognize and to acknowledge when there's a dimension here, just like any other aspect of good health, that there may be a need here for something that goes beyond the psychological, psychiatric, or medicinal component, and how that people can be trained to deal with that.

So in terms of, as you point out, this is something new. It shouldn't . . . it isn't really new, but it's something new that we're suggesting be included as part of the triangle, if you will. Education of our health care professionals and advice to them within that context, certainly they would need that resource and assistance. But as well, it's the people who need the care that the attention should be provided to.

Ms. Mahoney: — A very important part of the spiritual care is the care that we can offer to families. Particularly you see it in times of respite and palliative care. I'd like to mention one other focus too, is on the parish ministry of care. We all know how early patients are being discharged from hospital, and this is a way of bringing that quality of care with the spiritual component to those people in their homes. And I think it's a very important intervention right now to happen. It's something you may want to look at.

Hon. Mr. Melenchuk: — And the final question I have is with regard to the long-term care and acute care setting, in terms of the pastoral care team having access to patient records, the entire patient record.

Now this was a bit of a topic that created some controversy some years ago, but it's my understanding now that upon referral to the pastoral team, that they have access to the entire patient record. Is that correct? Would you know that?

Mr. Olsen: — Well I can speak to Luther Care Communities who have a special care home in which pastoral care does have access to their records. In fact, pastoral care also takes part in the care planning, and consults with the nurses, social work, physician, etc., with that plan.

Mr. Fox: — Excuse me. That isn't, generally speaking, the approach across the board though. I think I should mention that there are districts and areas of the province where that access is not available, and I think something needs to be done to ensure that it is appropriately available.

Hon. Mr. Melenchuk: — Thank you.

The Chair: — Thank you very much. Seeing no further questions, on behalf of the committee I would like to thank both organizations for your presentation this afternoon and for your response to the questions.

If the village of Lintlaw and the municipality of Hazelwood would like to come and have a chair at the table. You might want your own microphone. You might want to each take a microphone. It might be easier.

Good afternoon. This is the Standing Committee on Health Care. It's a legislative committee. Its first order of business is to hear responses to the Fyke Commission and report on what we've heard back to the Legislative Assembly.

I'm Judy Junor, Chair of the Committee. Dr. Jim Melenchuk is Vice-Chair. The all-party committee members are Andrew Thomson, Warren McCall, Pat Lorjé, Brenda Bakken, Bill Boyd, and Rod Gantefoer. The committee has set aside half-hour blocks for presenters. We hope that with your presentation we still have a few moments at the end of the presentation time for questions from the committee members.

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

Mr. Johnson: — My name is Leonard Johnson, and I'm the mayor for the village of Lintlaw.

Mr. Smith: — Lyle Smith, and I work with the seniors at Lintlaw.

Mr. Johnson: — Yes, we're here, both here . . . we're making a joint presentation here to the committee. First of all, I'd like to clear up any doubt about the fact that I am against the recommendations of the Fyke report. I would like to say that as I read through the report, there are some merits . . . there are some points that deserve some merits. By the same token, there are very, some very grave concerns.

One of the main concerns is the closing of 50 hospitals in this province.

The Fyke report recommended that it would be quite possible that any hospital would be around an hour to an hour and a half from anyone in the rural area of the province. Well I can tell you that's too far. If there is an emergency and say that person is suffering from a heart attack, there is a very good chance that this person will not make it en route to the hospital. Also, as the hospitals are closed, there is a possibility of the fact that the province could be losing doctors.

This scenario doesn't seem to be very indicative of providing good medical services to the people of Saskatchewan. The people in rural Saskatchewan would be the big losers. The medical service would be doing a real disservice to the people of rural Saskatchewan.

Now one point that seems to be outstanding in this report is utilizing of funds and trying to get the best value for their dollar. Now this Fyke report, I think it was money that was not well spent. I'm sure that some of the people in the legislature themselves could have probably have gotten together themselves without the employ of Kenneth Fyke. You may have come up with some of the same conclusions.

The problems that we are having with the medical system is a

small problem compared to the problems that the province is having itself. Our medical system seems to be trying to work with a diminishing population of people. In the last four months of this year, it's been said that there has been an exodus of 1,800 people to other provinces. In the past two years, it has also been said that we've seen an exodus of 8,400 people that left the province.

Housing starts seem to be down. Job creation seems to be weak. You know, the people that we lose from this province are tradespeople, professionals, and people with good work ethics just trying to find better opportunities. These are people we can ill afford to lose.

As you know we have a wide range of natural resources in this province. The different businesses that come here to develop these resources are usually faced with a wide range of taxation. This makes it very discouraging when businesses have to forfeit a large portion of their gross income in the form of royalties, sales tax, payroll tax, and a whole myriad of other taxes, so at the end of it all they're . . . the company is left with maybe 30 cents on the dollar. Then you wonder why there isn't more development in these resources.

As you are well aware of there is the four basic industries in this province: agriculture, mining, forestry, and the petroleum industry. If all of these industries had had a more tax-friendly climate to work in, it would be apparent that these businesses would have had . . . given over time, developed these resources to the same extent as some of our neighbouring provinces. Actually if that could have been one of the . . . actually we could have been one of the wealthiest provinces in the western world, or I mean in Western Canada. Then our medical system would be trying to figure out how to deal with a growing population instead of a diminishing one.

If there was a vibrant industry base here there would be more work here. That would encourage our young people to stay here and work in this province. They would be earning their money here. They would be spending some of their disposable income here, and that would be creating more business. And of course, the government would be collecting their taxes as well.

You know when the medical system was first founded in this province, it was founded under the same political banners then as today. It was a model for the rest of the country, and the rest of the countries in other parts of the world to admire. It seems ironic that medicare is being transformed into something that is less than its true self when it was started by the same political party in the same province.

Now if this government goes ahead and adopts the Fyke Commission report word for word, in its entirety, I'm quite sure you will not have the blessings of the people of this province. I've talked to a lot of different people both young and old and, when I say old, I'm talking about people of my age or younger. These people are considering on moving elsewhere if the full implication of this report is about to be implemented.

When the Fyke report was presented to the legislature, Kenneth Fyke, on different occasions, a couple of different occasions mentioned that no money would be saved if these recommendations were implemented . . . if these implications were implemented. So if that's true, then why is the government considering it?

We already had a round of hospital closures some years ago and it didn't seem to fix the problem with the medical system, so closing more hospitals doesn't seem to be the answer. Maybe it might help if different parts of the bodies of the health system might get together and share a little more of the information they have on some of their patients. Thus it might save some time, you know, and make the system a little bit more efficient.

Now if the recommendations were introduced in an urban setting, the idea might work. However, when putting it into a rural setting, it probably won't. There has to be hospitals strategically placed so that anyone is within reasonable distance from a hospital. And they have to have a full complement of staff that can deal with, in general, any emergencies or most types of common diseases.

In a lot of cases, people today are living longer than they were before. Now some of the methods or treatments that they receive are responsible for this. Mind you, this is a cost to the system, but looking after the old and infirm is a measure of efficiency of our medical system. After all, the old people are us. Someday we might be them.

Now warehousing these people, as the commission calls it, sometimes is . . . leaves us no other choice. We have strived to obtain longevity of life, and so we . . . and sometimes . . . and some of us are lucky to, you know, to grow old with grace; some are not so lucky to do so. And the system must deal with that.

Now there are real . . . there are no real easy answers in keeping a system such as ours running efficiently and still maintaining cost effectiveness. However, closing more hospitals would be the last thing on the list that you might consider, as mentioned earlier.

Striving to get the best value for the dollars spent making . . . you know, making easier access of information among the different caregiving bodies of the health system so as to speed up the diagnostic tests, as well as improving on long-term care such as giving that care and getting the best value for your dollar, are some of the things that you might consider.

You know, if Kenneth Fyke has to access the medical system himself, all he has to do is probably is to travel a few blocks or maybe travel across town to obtain the appropriate kind of service he needs. Anyone living in a city has those amenities. However, try for once and picture what it would be like in a rural setting. You say we might be an hour to an hour and a half from the nearest hospital. I wonder, if there was a real urgency to the hospital, would any of you living in the city would care to be in the predicament . . . in that predicament that our government is considering on putting the rural people in.

Sometimes it helps to imagine by placing yourself into the situation to get a clearer perspective as to what we in the rural area are talking about.

Now if this government seriously is considering adopting the full recommendations of this Fyke report, I am sure it will not

be well received by the people of Saskatchewan. And therefore I would ask the government to give it a very serious consideration. Thank you.

The Chair: — Thank you, Mayor Johnson. Did you want to speak Mr. Smith? No. Then questions from the committee?

Mr. Gantefoer: — Thank you, Madam Chair, and thank you, Mayor Johnson, for your comments.

Can you outline where Lintlaw receives its health care facilities or services now? I would imagine Kelvington is the primary acute care centre, but long-term care. And do you get public health or home care services and where are they based out of?

Mr. Johnson: — They're basically centred around Kelvington, is where they really are.

Mr. Gantefoer: — So the citizens of Lintlaw and the RM (rural municipality) of Hazelwood would go to Kelvington for acute care and also for the long-term care home as well?

Mr. Johnson: — That's correct.

Mr. Gantefoer: — References beyond that, do you then move to Humboldt for example, or Tisdale-Melfort, or do you have any sense of how the patterns for further care move from that, from Kelvington?

Mr. Johnson: — Well the next possible care, if they turn around and close Kelvington — and I get the sense of the fact that they probably might be closing Preeceville, which would be the next closest one — I'm not exactly sure where we might go other than the fact that we would . . . might wind up maybe going to Canora, if those facilities stay in place, or probably Yorkton.

Mr. Gantefoer: — And can you outline what kind of distance and travelling time that would be from your community?

Mr. Johnson: — Well from Canora it's about, about an hour away. And to Yorkton it is probably about an hour and a half. And I also understand that there is — I'm not sure, but I heard that there is the possibility they might even close the facilities maybe in Yorkton. So then that would be moving on down to Melville.

Mr. Gantefoer: — Thank you.

Hon. Mr. Melenchuk: — Just one question. When you started your remarks you mentioned that there were some things in Fyke that you thought were pretty good. And during the course of your remarks, you talked about enhanced information transfer in terms of caregivers accessing patient information.

Were there other areas within Fyke that you thought the recommendations made sense or were appropriate?

Mr. Johnson: — Well actually as I said, like basically as far as what was recommended which I thought could be improved some too is, like I say you know, when you are first admitted into a hospital, you know, they get certain data, you know, and then afterwards if you have to be transferred into a bigger centre then it seems like they have to do this all over again. And sometimes I think, you know, if they could, like I say, share some of the information initially when they first got it, you know, it might, you know, it might start to speed up things a little bit, you know.

After all, I think like the doctors in the rural area, I think they're just as qualified as some of the people in the city. And not only that. The thing is like in the rural setting too, I think the doctor deals with a lot more things, you know, than they do in the cities. Because the thing is like they get a whole myriad of different things, you know.

Hon. Mr. Melenchuk: — One question with regard to the Fyke recommendation on a quality council which would be independent, would review the health care system, and provide a report card on an annual basis to the public of Saskatchewan, would you support that concept?

Mr. Johnson: — I believe I would.

Hon. Mr. Melenchuk: — That's good.

Ms. Bakken: — Thank you. Mayor Johnson, do you have acute care in Kelvington? Do you have doctors in Kelvington?

Mr. Johnson: — No. Well we have long-term care. We have like your primary care to start with, but that's what we have.

Ms. Bakken: — Do you have doctors in Kelvington?

Mr. Johnson: — Yes.

Ms. Bakken: — Do you have any occasion to speak to them about the Fyke report and how they feel about it and how it would impact their decision to stay in your community?

Mr. Johnson: — We have had some meetings here before. Anyways we held meetings like this. It was put on by the advocacy group there and anyways, they have mentioned some of the things, you know, that might be . . . you know, like as far as that goes.

The Chair: — Seeing no further questions, then on behalf of the committee, Mayor Johnson and Mr. Smith, thank you very much for coming today.

Mr. Johnson: — Thank you.

The Chair: — The representatives from Indian Head want to come up to the table?

Good afternoon. This is the Standing Committee on Health Care. It's a legislative committee of the Assembly. And the all-party members: myself, Judy Junor, I'm the Chair of the Committee; Dr. Melenchuk is the Vice-Chair; the other members are Andrew Thomson, Warren McCall, Pat Lorjé, Brenda Bakken, Bill Boyd, and Rod Gantefoer.

The first order of business of the Standing Committee on Health Care has been to receive and report on responses to the Fyke Commission, or the Commission on Medicare. So we have hearings scheduled, as you know, public hearings. And we're

allotting 30 minutes per presentation.

If you want to begin your presentation, after you introduce yourself and where you're from, we'd like a little time at the end of the presentation for questions from the committee. So if you just want to introduce yourself, you can begin.

Mr. McCall: — Good afternoon. My name is David McCall. I'm the mayor of Indian Head.

Mr. Johnson: — Good afternoon. My name is Thor Johnson. I'm an alderman from Indian Head.

Mr. Pearce: — My name is Bill Pearce. I'm an alderman with Indian Head also.

Mr. McCall: — Well good afternoon, Madam Chair, and committee members. As I already said, I'm Dave McCall, the mayor of the town of Indian Head. A little bit of background — I've served 17 years on the Indian Head town council, the last seven as mayor, and I was the Chairman of the Pipestone District Health Board for six years, from 1993 to 1999.

Thank you for the opportunity of letting us make a presentation like this today. The presentation that we are making is on behalf of the town of Indian Head.

Now there are many valid goals within the Fyke Commission report. One cannot quarrel with the desire for improved health services or the effective or efficient use of health care resources. Indian Head is not a community which is traditionally opposed to change. In fact change is the only thing that is consistent in our society over a period of time. But we do feel that when and if further change in health care occurs, it should take place in order to result in better service.

Now the recommendations in the Fyke report are considered and commented on in our report in this light. As many proposals are suggested in the Fyke report, we will respond to those that are of the greatest concern to us as a community.

There has been much discussion in health literature of the possibility of developing multifunctional, community-based health centres to provide a range of primary health services. It would be our contention that change has already taken place in and toward the development of such centres in Saskatchewan. This is not a novel, new idea.

In many communities, what were once just hospitals have now taken on much of the multifunctional role mentioned earlier. For example, the building known as the Indian Head Hospital now houses lab services, the office of community home care, the public health nurse's office, office and consultation space for mental health and addictions counselling, space for visiting dietary and physiotherapy service, as well as the administration for emergency services for the health district. Various community health clinics and education sessions are presented within this facility.

All of these services are being provided and the facility continues to provide 24-hour emergency and acute service and palliative care and recuperative care as deemed necessary by the local physicians.

In the report of the Health Providers Human Resource Committee in March of 1996, it seems highly significant that in the conclusions reached in the section speaking about community health centres, the committee recommended, and I quote:

> That such centres include acute care services where such services are in sufficient demand to justify their provision as part of a range of service.

It is not important what buildings are called, but what health services can be provided to the people within such a setting is important. A hospital health centre such as the one now developed at Indian Head provides acute care as needed daily to from five to 15 patients.

This is normally accomplished by two shifts of two care providers on 12-hour shifts — one registered nurse and one licensed practical nurse per shift. Excellent care is delivered to patients for whom the tertiary or regional hospitals would not have room.

This is done very efficiently and with the aforementioned minimal staffing levels and with no increase in overhead physical plant costs. The building would still be open, cleaned, and used regularly with or without acute care. There would be very minimal savings, in our opinion, to remove the acute care capability of this facility and there would be numerous other increased costs.

There are numerous costs and risks to communities if their hospital health centres lose their acute care component. The most obvious is that it's unlikely that physicians will continue to want to work there. Most physicians see the need to be able to hospitalize patients for treatment as essential to their practice. If the physicians leave, it is unlikely that pharmacy services would be maintained in the community.

In addition to the loss of these professional services, there's a very real likelihood that many people who are retired or about to retire will migrate out of the community. Certainly any that are already health challenged in any way would be reluctant to locate where physician services and hospital services are not available.

Of great concern should be that many people indicate that if these services are not going to be available they will not only move, but unfortunately they're looking to move out of province. When professionals and retired people leave the province, not only do they take their physical presence but they take their taxable incomes with them too.

When town officials meet with groups proposing economic development projects we are often asked, do you have a hospital? What physician services have you?

It is evident that the location of such services is a factor in the choice of location for economic development in rural Saskatchewan. There is much lip service paid to the need to revitalize rural Saskatchewan. Why would imposing closure of acute care facilities be carried out when it has such a profound negative impact on rural communities and their chance for economic development? It is revitalization not de-vitalization

that must be done. Maintaining hospital service is needed to retain the vitality and viability of our communities.

Another reason why the closure of hospitals should not be done is that the alternative care provision for communities that might be substituted is not available. It's our understanding that the primary health care model speaks to the provision of front line assessment, diagnostic service by nurse practitioners working in conjunction with co-operating physicians.

The Beechy model, known to many of you I'm sure, is often discussed as a practical alternative in areas of lower population and physician shortage. This model may work where there are very . . . but there are two very large problems associated with implementing such an alternative on a large scale across the province.

First there would need to be a supply of well-trained nurse practitioners with the competence and confidence level to take on such positions. And this situation may be achievable in time but that's not the biggest problem.

The second consideration is there would need to be physicians willing to co-operate in such an arrangement. We have seen very little evidence that physicians are wanting to abandon the present fee-for-service practices to commit to this type of arrangement. How then is it going to be an alternative for what is now in place?

I want to ask this question of the standing committee and, if I could, of Mr. Fyke. Given that on any day the daily census of the four remaining hospitals — there once were seven in 1992 — in the Pipestone Health District, there's somewhere between 40 and 55 patients. Given that an average of 10 people are probably under treatment at each of the other small hospitals of Saskatchewan, where are these 500 or more Saskatchewan people to get treatment if the acute care capacity of the small hospitals is removed?

It's quite evident that the tertiary hospitals in Saskatoon, Regina, and Prince Albert and the larger regional hospitals are already functioning at or near full-bed capacity. There is no possibility that home care can take care of this additional number of patients. They simply require a higher level of care than can be provided by home care nurses or other health provider staff.

One of the reasons that the daily census in smaller hospitals is reduced from former years is that physicians are assigning to home care those cases that can appropriately be taken care of by home care staff.

Since home care cannot provide for the needs of all these people, and the other large centre hospitals cannot either, what is to be their fate? If there would need to be large capital cost expansions in the larger centres to increase bed capacity, and people would have to travel much farther for treatment, is there any real advantage to making this adjustment? We think not.

It has been suggested that the round of hospital closures in Saskatchewan in 1993 did not bring about dire results to the health outcomes of the people in those communities. There was a definite, negative effect on the economies and the social morale of those communities that people in these communities will still tell you is impacting them.

Surely one of the reasons that the health outcomes were not more negatively impacted than has been the case is that there still were other acute care facilities where people could seek treatment that were located within a 25- to 50-kilometre radius of the community dealing with the hospital closure. The further away a patient has to go for treatment, the more costly it is for the patient and for the families and friends that would want to visit the patient.

There are a number of factors known to affect recovery and healing, among them is the social support of family and friends. Why would it be a better health system if this type of change was forced on people in rural Saskatchewan?

Although the hospital health centre at Indian Head is referred to as a small hospital, it's necessary to understand that it does serve a substantial geographic area and population. Indian Head Hospital and the Indian Head physicians provide care as needed to the nearly 2,000 people of the town of Indian Head, as well as to the people in the neighbouring towns of Qu'Appelle, Sintaluta, and Montmartre; the villages of Kendal and McLean; the rural municipalities of Indian Head, South Qu'Appelle, and Montmartre; and the resort village of Katepwa South, and the Carry the Kettle First Nation.

The total population in the area is about 6,000. It's about equal to the population of some of our smaller cities and the population is somewhat higher in the summer due to the resort area and tourism.

When people in this area need assessment and treatment, they can access service at Indian Head. Should Indian Head not have these services, it is most likely that the people from this area would seek service in Regina due to proximity to that city. Does Regina, with its already stressed emergency and other facilities, have the capability to handle all the extra cases that would present themselves?

Now hospital beds per thousand population ratio in the Indian Head area. Given its population and the size of the hospital, there's about 2.7 beds per thousand people. That's well within national guidelines and certainly not showing surplus capacity of hospital beds for that area and that population.

There are other problems that would be caused by the loss of acute care hospital capability in Indian Head. Unique to Indian Head is that it is home to the provincially used Pine Lodge alcohol addiction treatment centre. This facility has close ties to the service provided by Indian Head Hospital and the Indian Head physicians. It's our understanding that this much acclaimed addiction treatment centre could not operate as it now does without the service provided by Indian Head Hospital.

Of most critical and immediate concern to the province should be the lack of trained health care professionals. There's a growing frustration among managers with the lack of adequate numbers of staff to meet daily staffing requirements. In many rural hospitals and integrated care centres, facility managers are coming back to take the place of other staff in order to just keep

the doors open. This is a situation that cannot be maintained indefinitely.

There needs to be an enhanced program of training for nurses and licensed practical nurses. A program of financial assistance to such students refunded through service in Saskatchewan following training might be of significant benefit. Increasing the number of spaces in the training programs is also needed.

The need for these and other health care professionals is, of course, more than a provincial problem. It's a national problem and we recognize that. Saskatchewan needs to do what it can though to work on this situation and it needs to be done now. It is more likely that professionals trained in Saskatchewan will stay here and become part of the health care team than it is that people from other provinces and other countries will seek employment here.

It has now been about eight years since the larger health districts were structured. There has been a struggle to gain recognition and credibility carried on by all the district boards. Slowly but surely some stability has been established. Most communities have developed liaisons with their district boards. To reduce the number of boards and increase the geographic size of the districts will once again destabilize the delivery of health care. Like many communities, we fear an increased loss of autonomy in an even larger health district composition.

And what are the benefits of such restructuring? Can such restructuring bring about significant cost savings? It's unlikely to do so except in the area of board governance costs. It is probable that there would be significant increased costs for travel for staff, and even overnight accommodation costs for staff which are not common now. Mr. Fyke comments that the present health district structure does not have excessive management. Therefore it is unlikely that by making the districts even larger that any real administrative savings will be achieved on the management side of operations.

Most of the improved coordination of health services that needed to be done has already been done within the existing health districts. I speak to the issue of things like home care, acute care, long-term care, and community health services within communities, already being under the same management. That's what wasn't there 10 years ago, folks, and that's what is there today. And that's been a significant improvement. This in fact has been one of the successes of restructuring that has taken place.

There are many other issues addressed in the Fyke report; we have chosen to limit our opinions in this presentation to those issues which cause us the greatest concern and for which we have the greatest interest. Thank you for your attention to this presentation.

The Chair: — Thank you. Either of the other alderman want to speak at all, or just take questions? Questions. Questions then from the committee?

Mr. Gantefoer: — Thank you, Madam Chair; and thank you, Mr. Mayor, and aldermen for coming today.

Could you share with us, please, the number of physicians that you have working in your community?

Mr. McCall: — At the moment we have two physicians working at Indian Head. At times in the past we have had as many as four. The physicians we have are what I would describe as young and vigorous at the moment, and seem to be willing to carry the load that they're carrying. I don't know how long they'll be able to do that. But certainly I believe the health district and community would help them with recruitment should they want to.

But at the present time they indicate they're happy with the state of affairs and they're working very, very hard. But that is their choice.

Mr. Gantefoer: — Thank you. And can you tell me are they Canadian trained or off-shore trained and how long have they been in the community.

Mr. McCall: — We have one doctor that is Canadian trained, Dr. Bruce Zimmerman, a graduate of the University of Saskatchewan. And the other doctor, Dr. Nick Cloete, is from South Africa. Dr. Zimmerman has been with us for many years. Do you know, fellows, how many years? Quite a long time.

Mr. Pearce: — Twelve.

Mr. McCall: — Twelve years, I believe. And Dr. Cloete has been with us about three years, four perhaps.

Mr. Gantefoer: — Do they have any practice arrangements with doctors in neighbouring communities that you're aware of?

Mr. McCall: — My knowledge of that would go back to 1999 when I was still a member of the district health board, and I would hate to speculate on what might be the present arrangement. I believe they did at some times have some backup provisions in case of emergency when both of them were unavailable, that another physician would work with them, yes. But as I say, that's two years out of date and I don't presume to talk for the Pipestone Health Board as it's now structured. I don't really know in the last two years. I believe that is still the case but I'm not positive.

Mr. Gantefoer: — Thank you very much.

Hon. Mr. Melenchuk: — Sure, and thank you very much for your presentation. A lot of the focus was the reality that those acute care beds that you have in Indian Head are essential to maintaining the other structures within your community such as physicians, such as some of the other staff, and also that the role of the Indian Head hospital has changed significantly in the past 10 years to the point where it really is the hub in the distribution of other services as well. So there is recognition on your part and I think from other presenters that we've seen is that maintaining even a core of acute care beds is essential to maintaining other services in that community. Is that correct?

Mr. McCall: — Yes. That would definitely be our opinion, yes. And that comes in part from conversations I've held with the physicians too. I mean it's not just my own candid opinion, so to speak. I have had some discussions with the physicians and

they make that abundantly clear.

Hon. Mr. Melenchuk: — And I'd also like to thank you for highlighting how these beds are staffed in terms of the shifts and the amount of human resource requirements for them. It's a good point to make.

The second point I have which you didn't comment too much on was the Fyke recommendation with regard to a quality council and his recommendation . . . or some of the comments we've received from other presenters is that they would like to see this quality council independent. The SRNA recommended this morning that 50 per cent of its membership should be from the public, that it should be reporting directly to the Legislative Assembly, and should file an annual report card on the health system in Saskatchewan. Would you agree with that sort of process?

Mr. McCall: — Well this would be a very personal opinion, and not necessarily the opinion of my council, but I would have some . . . I guess I'll be the contrarian here. I would have some reservations about the need for such a council. To me, to say that you need a council like that means there's something wrong with the system as it's functioning at the moment.

I'm not convinced that there is that much wrong with the system as it's functioning at the moment. I think what we fear is further change in the rural structure which lessens service. That's what we're really afraid of. Setting up another bureaucratic review may or may not be of any benefit. Until such a thing was structured, until one knew how it was going to function and what it was going to report on and what useful function it would have, I personally would be reluctant to recommend it.

I know it's like opposing motherhood because when you stand up and say, gee we need another quality control thing, you know, how many quality control boards do we really need to have in this province. Every district that I know of already has a person on administration assigned to the issue of quality care. All the districts that I know have continuous quality improvement councils structured with their staff, and with their management already. Do we need more watchdogs?

I suppose if it soothes the public, there might be a political reason for having one, but I'm not absolutely convinced it's needed in terms of improving the quality of care. That's just my personal opinion, you know, as I say. I'm really not speaking for my council on this because this is a question we did not know we were going to get asked for sure.

Hon. Mr. Melenchuk: — Well that's all the questions I have. Thank you.

The Chair: — Seeing no further questions then, thank you very much, Mayor McCall, and Mr. Thomson . . . or Mr. Johnson and Mr. Pearce. Thank you very much for presenting today.

If the Kipling District Health Foundation would like to take chairs at the table.

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

Our presentations have been 30 minutes, and hopefully within that time there's some time at the end of the presentation for some questions from the committee members.

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

Mr. McMillan: — Thank you. As you have mentioned, we represent the Kipling District Health Foundation that is comprised of three villages, one town, and four rural municipalities. That's Glenavon, Windthorst, Kennedy, Kipling, Hazelwood, Silverwood, Chester, and Kingsley. And we were formulated recently.

I guess we have some reservations because we're really not sure what we're . . .

The Chair: — Can you just introduce the rest of your members?

A Member: — I'm sorry.

Mr. Steele: — Roy Steele. I'm the reeve of Kingsley 124, of Kipling.

Mr. Blackstock: — Linus Blackstock, town of Kipling.

Mr. Schmidt: — Herb Schmidt, mayor of Glenavon.

The Chair: — Thank you.

Mr. McMillan: — We do appreciate the opportunity to make the presentation. I recognize from hearing the last three or four that you're going to have a lot of duplication. We were torn between kind of directions because obviously no matter how good you might think you are, it would be impossible to deal with even the greater portion of the Fyke report.

And so I guess we have chosen a couple of routes, kind of a primary one and a secondary one, that is that what, kind of, affects Kipling and communities our size. I think it's fair to say that at least Kipling — and I hope we're not alone at it; I'm convinced we're not — but we have felt under attack for a number of years. And when health care was being worked on, such as it is in the Fyke report, it is worrisome.

I think everyone sitting here that is part of the presenting is born and raised in Saskatchewan and has watched with interest and tried to work with interest in trying to turn those things about. There are some things I think that Fyke has kind of assumed that may or may not be healthy for the overall set-up.

Recently listening to Dr. John Bailey, which is an after dinner speaker that's a dental surgeon, he said whenever you're speaking, he said always be very aware that there's words and there's things that you shouldn't say. And so if we do one of those today, I hope you'll kind of blame the messenger and not

the message.

His example was the second surgery that he did he used the word, oops. He said there wasn't anything he could say or do from there on that would attract the confidence of his patient. And so we recognize today if we lose you once, we've probably lost you for the whole system.

I have to tell you a little story because I think it's interesting and it applies maybe to us and maybe to Mr. Fyke as well. We'd been involved in the car business for a number of years and recently there was an older gentleman that came in and he was driving a '61 Pontiac and he was about 85 years old. And he needed a door handle. Rather unique — they don't make them any more, couldn't find them at the garbage dump.

He stayed briefly for coffee after. Our parts manager is a bit of pack rat, had been able to supply him with that and he was tickled pink. He was so excited and he was a very quiet person. Right in the middle of coffee he said, well I've got to go now. And I said, gee sir, we've just got to know you and, you know, this is great. And he says, well you don't understand, sir. He said, I've already told you more than I know. And so if that's applicable, why you can take it from there.

We're also very concerned that Mr. Fyke may be doing a Mulroney to us. And if you remember Mr. Mulroney and GST (goods and services tax), he came in with about a 11 per cent suggestion and then he backed off to 7. And he said aren't we wonderful; you guys aren't really that bad off after all. And so we are just a little bit worried that the Fyke report may be up that alley as well.

I was hoping to catch up with Pat Atkinson's report. It would seem to me she would be the first one here when we talk about revitalizing Saskatchewan, that she would try to plug the hole. So if she hasn't been here, I hope somebody encourages her to come. I would like to hear it.

It would seem to us that Mr. Fyke is kind of a half cousin of Mr. Garcea, if anybody remembers him. Mr. Garcea, I think, really deep down, believed that further centralization in an effort to survive is the way to go. Rural Saskatchewan doesn't believe that. I don't think — and I hope not — that any of you here believe that. Although if you look at Mr. Fyke's report, you'd have to wonder, wouldn't you, if centralization of everything.

And Mr. Garcea would have had us phoning to Weyburn or Moose Jaw or whatever to see if we could fix our garbage truck. And I think in a much larger sense Mr. Fyke would have us doing some of the same thing.

I think Mr. Fyke is kind of starting with the assumption that we have declined, we are declining, and that will be a continuous thing. And therefore we need to do whatever we can to make sure that 30 years from today that we have circled the wagons properly and at least conserved as many things as we can.

We are of the contention that somewhere along the line, surely we can turn it around. And I recognize we're smaller than we were 70 years ago, and I know people get tired of hearing that sometimes, but try living in rural Saskatchewan and see how tired you get of it.

And so I think that for communities our size . . . And I am very sympathetic to communities that are not that size because they may have already lost or never had acute care and the support system that goes with that.

But if Mr. Fyke has his recommendations implemented, it will raise the bar significantly. And like I was saying to Ron Osika the other day, it may just be that Melville is where we are. Follow? Because either you grow a little or you shrink a little. You can't do both.

And so I believe, and we believe, that rural Saskatchewan, our size, can grow a little bit and hold our own and look to do better. But we can't do it with centralization continuously chewing away at us. And so I'd ask you to help us with that.

One of the things that scares us too about Mr. Fyke's report is that some of us have not been with the district board since they existed, but many of us were with it when we had the old Union Hospital. And what we talked about and were promised at that point in time if we would co-operate with it, very much looks like . . . Mr. Fyke's report looks like what some had envisioned at that time. We didn't like it then and we don't like it now.

And so sometimes we feel maybe like it's just a two-stage process. And it's interesting that his views, and you can follow them maybe for yourselves so that you're convinced or not convinced, why his vision would be precisely what was envisioned by many at that time. It may be just a coincidence.

We have our concern, that he hasn't thought about a number of things. And don't get me wrong. I think that he embraces a lot of good things. Any time you chase excellence, you chase quality, you chase better emergency services, and so on, that is positive. And so I am not here to suggest that he is naive or that he was incompetent or anything else. That's not what I'm saying. What I'm saying is the things that affect us, we would like you to be aware of. There will be many others who deal with the very positive things that may be involved with, with his report. And hopefully we support some as well.

We are concerned where the acute beds are going to go that are in rural centres now. Are they going to disappear? Is his talk about overhospitalization now, is that how he is going to fix that? Or are you going to rebuild them somewhere else? And if so, how and when?

Staffing for his centralized health care vision. Are you going to convince our farmers' wives that play a big role, and many others from rural Saskatchewan, to move to the centres and fill in? Are we going to train them? Are we going to talk them into coming from . . . I won't name the place because that's an owie word, like a oops word.

Eighty-five per cent of costs, they tell us, are directly related to personnel. So the only way we're going to save money is to drop personnel. And as many have said before, and presenters to you, Mr. Fyke really hasn't talked about saving money. I don't know whether that's good or bad.

We are concerned about the Cadillac idea of the EMS system. As an example, I live about a 120 miles from Regina, some good road, some not too good road.

Now if you're going to be working on an EMS system that has highly trained people available 24 hours a day, where are they going to be positioned? What are they going to do when they're not busy, or are they going to be overly busy? And if they're going to be overly busy, then how are you going to have backup for them so that they come for those that need them that are, I guess, outside of that 85 per cent that Mr. Fyke talks about as being within the hour of receiving care?

And I guess one of the things that . . . And maybe you wouldn't expect him to, but he doesn't deal with how far it goes or with ambulances averaging 120 miles an hour or whether you're on 48 Highway or No. 1 or, you know, whether, after you've reached the patient and then you get within 60 minutes of that.

All of those are unknowns to us and maybe they're not totally relevant until we have the total picture. But that's one of the disadvantages that we're working under. We don't have that picture. And I appreciate you don't either.

Senior citizens in rural Saskatchewan — he doesn't seem to talk about them much. He doesn't talk about long-term care. Intentional? I don't know. Maybe that wasn't his mandate. But we think he hasn't addressed that.

Retirees. And I've heard it mentioned at least a couple of times today. Visiting with a couple at a funeral two days ago that lived in Weyburn, said our calculation is that there won't be acute care in Weyburn and so we may have to move. They weren't trying to be smart and they weren't trying to be funny. I think that's some real issues about retiring and something that we need to address.

If you're looking at industry of any form in Saskatchewan . . . PIC came to our community and we were super-glad for that. One of the places that we took them was to the school and to the hospital and to talk to the doctor. If you were a PIC employee, would you think about coming to Canada and coming to Saskatchewan if they said you know what, we have a Cadillac EMS system and should something go wrong, we will get you there real fast as long as the snow isn't blowing and a number of things.

We don't think that he has addressed the disadvantaged and we think particularly the financially disadvantaged. I'm 57 years old and if I need to get to Regina, I probably can, and if I need to, I can find friends to stay with. I can probably rent a motel and so on.

But there are hundreds of senior citizens in rural Saskatchewan that are not going to be able to do that. Are you going to help them? Nothing about it in the report.

And so as they come for this, for acute care or to visit people, they're coming for acute care. What are we going to do with them? If they have loved ones here it's fairly simple. People drive them around; they get them there. We don't even have a bus from Kipling, and so they'll have to bum a ride all the way to wherever that happens to be.

I almost promised you to start with that we would try to get back on track and be done by 3 o'clock so we'll speed up.

Intentionally, otherwise as we've mentioned, Fyke has not mentioned long-term care; and one way or the other, I think you're going to have to address that because he didn't. It needs attention. We have government approved rooms that were built at Carlyle that haven't been funded for up to two years and forcing us into a deficit which makes us look a little foolish. And when I say we, I am not on the district board, okay. But these always come up at our meetings that, hey, we're having trouble getting coordination between the two.

So I said well when you take Ms. Atkinson by the face and put her face right in front of yours and you say to her, now you have approved those rooms and we have built them and we don't have funding for them, what does she say? Does she close her eyes, or does she walk away, or what does she do?

Waiting lists. Mr. Fyke hasn't addressed waiting lists. I don't think it's political but Saskatoon tell us that they're at an all-time high — all-time high. I doubt that Regina . . . And some of them are very far behind. Is that not heart and core of health care? It seems to me it has to be awful close. It's not addressed. It seems to me somebody will have to address it.

The loss and the lack of specialists is not addressed and sometimes emanating from somewhere closely here the political games are played and speeches are made about health care specialists leaving and so on.

But I would just like to tell you one little story about a specialist that I followed out of province. And he's not the type of person that kicks you out before your pants are more than half up. He visits with you a little after — a very strange guy.

And we talked a little bit about health care. And at the time we were talking about the Plains and we were talking about a number of things. And I said, why did you leave Saskatchewan?

He says it's a long story. I'll give the short one: I got tired of the hassle. And I said, I bet you left for money. And he said, I want you to know — and he shook his finger at me just like I'm shaking it at you — and he said, I can tell you that every operation that I perform here is performed 15 per cent less across the board. He said, don't mention money to me again. He said the politicians do that. That's in Winnipeg, Manitoba. Take it for what it's worth.

We haven't considered the possibility of co-operation and forming partnerships with larger places. If this centralization is truly the answer, then why are not Mr. Fyke — maybe it's not in his mandate, maybe you'll have to do it — why are we not looking with more formal co-operation with Winnipeg, Calgary, Edmonton, and so on where a fair number of our people already end up either by choice or by force? Why don't we do that?

Once we drop the health care number to six or eight, I would ask you why we have them. Seriously think about it. Why would we bother having six health care districts? For public input? I think that's kind of out the window. That's gone. It's highly unlikely that any in our district are going to even know their representative, neither mind be able to intelligently elect them or whatever. And so it's entirely possible that maybe one district is better than a tiny, tiny number.

I would encourage you to interview people who have served on district boards, maybe just at random. I have taken the opportunity of doing some of that. And some of the people that I very much respect tell me that they have about that much discretion that they can use — about that much. It may be worth checking into.

Mr. Fyke hasn't dealt with the obvious negative economic effects of moving health care jobs from the rural to the urban. The one that just predeceased — predeceased us; came before us — dealt with that, that there was a downslide in '92-93 and there will be a continued one. It can't help it. You move those jobs, the economics are following. Their families follow, the schools, and on you go — the children, and there we are.

One of our real big concerns is trying to get physicians to locate in rural Saskatchewan. You know our record on getting Saskatchewan-born ones that do, that we spend a pile of money educating. Now we're going to put it up, I think up to 60 they said the other day. It'd really be interesting to know how many are locating in Saskatchewan, and how many are locating in rural Saskatchewan.

One of the things that worries me just a little bit about health care is, when I got on the town council of Kipling about 1980, we ran short of water all the time. Everybody in town used about twice the amount of water that anybody in any other town used. Our lagoons were filling up. We had three modern lagoons, and they were all filling. Man, we were having trouble. But we got real smart, we turned the pressure down. People quit using water.

And I would suggest to you that Mr. Fyke's concept for rural Saskatchewan is going to turn the pressure down, and the people are going to quit using the water.

If you want that, then I'd say go ahead. If you don't think that's the answer, then I'd suggest you resist it. Maybe you need to do what we did. We finally sat down and had a brainstorming and tried to figure out what is wrong with the core of the system. Not on the other ends and the outer ends of it; what's wrong with the centre of it?

You know what was wrong with the centre of it? We had torn the rink down about 30 years before. There was a 2-inch line in which . . . they didn't have time to seal it properly so they bent it off. And as time went on, this opened up and we were putting the water right through from the dam right out into the lagoon. We got our centre problem fixed, and we didn't have any more water problems, we didn't have more lagoon problems. Sometimes it's not as difficult as it seems.

I've already dealt with the idea that populations in towns our size are really on the borderline. Like it or not, physicians determine health care. There's some disadvantages to that, but it's a reality. They also determine to a great extent how many dentists you have, whether they draw that traffic from long enough to do that.

And if you're familiar with rural economics, you as a consumer, whether it's health care or cars or groceries or whatever it is, there's a limited number of things that will draw from a significant distance. Health care will. Your dentist will. But it's also a proven fact that one operation in itself can't draw by itself. One car dealership will not draw the average amount of people for 60 miles, but if you get two things going for you, it will.

And so as we lose our physicians, or maybe the good ones, then our dentists, our therapists, our chiropractors, our optometrist services, and so on will be much lower. They won't disappear but they'll be a downwards spiral. It'll change where people retire.

Mr. Fyke spends a lot of time talking about prevention, education, promotion of healthy lifestyles, and so on. And that's a lot of idealism and it's good. It's not bad; it's the right direction to talk about. But I am not sure that it centres in the middle of reality, and on top of that it has nothing to do with amalgamation and centralizing of health care. Those things can be pursued totally independent of that. So to tie those together, I have no idea whether that was intentional or not. But I hope it's not for you.

We are, as we stated before, very concerned about acute care for rural residents, and especially the disadvantaged. Obtaining and retaining physicians is a major chore for us. And if you haven't worked on that, then I suggest you talk to some people who have.

Lab and X-ray services are right behind it. And if we don't have sufficient physicians to do that, our lab and X-rays are not going to be there. In fact Mr. Fyke doesn't talk about lab and X-rays, if I'm correct. It's fairly well up the ladder. In Kipling we'll be travelling considerable length to get lab and X-ray.

You try to keep a doctor . . . if you were a doctor, would you stay without lab and X-ray? I don't think you would.

Convalescence, respite, and palliative care — hours away from where their people reside. Acceptable? Not to you, I don't think, and not to me. So why is he interested in forcing that on rural Saskatchewan?

We ask you who the Fyke report is really for. Like, who is it really for? By his own definition, it isn't going to save any money.

And he speaks then again often about that quality. And we appreciate that. We wonder if moving acute care and health care jobs from rural to urban really has anything to do with quality — I really don't believe that it does — or is that another attack on rural Saskatchewan.

I would like to get into a little bit of detail on how the tables are already tipped in respect to highways. You know, do urban people suffer when the highways are terrible? They come out to see us silly suckers out in the country, they probably do. But when I haul my cattle to the vet and so on, I bounce over the rough roads; not my brother living in Regina, for example, in the ministry here. Doesn't affect him. He feels sorry for me.

You talk about education. My home district is supplying almost, within that much, of 100 per cent of finances, 100 per cent. Provincial average is 60. Somebody's getting a deal. And if you don't know where it is, I'd encourage you to find out because I

think rural people in Saskatchewan have found out where it is.

We talk about health care. We have funding agreements in place that we had hoped would get approval from Sask Health to build an integrated facility — which is the buzzword. You want integrated facilities because it's more efficient, and we believe that. We have funding agreements with all of the RMs and towns and villages in place. We haven't received any word.

Let me just give you a little . . . if you're familiar with it. Maybe you are; some aren't. But it's amazing how many aren't. Initially we will have to come up with a third of that. If we want some furniture and equipment and so on, we'll be coming up with 100 per cent of that. If you want — as some of the people mentioned today — if you want chapels or you want anything else added to it, or doctors' offices or whatever, you will come up with 100 per cent of it. By the time it's said and done it's very close to 50 per cent. And I would ask you how many urban residents have contributed in that respect.

And so we think, we think that there are already a number where the tables are grossly tipped and to add this to it, where we go from here I guess will be anybody's guess.

We do sincerely appreciate you looking at this and working with it. It's not an easy question, I know that. It's complicated. Tradition and how we've done things — whether it's in religious forms or education or health care or whatever — is very powerful things. And to change them is very, very difficult.

We leave it in your hands. We need your help.

The Chair: — Thank you. Any other member of your delegation want to speak? Then questions from the committee. I have Mr. Thomson first.

Mr. Thomson: — Thank you, Madam Chair. And I want to thank the presenters for their presentation today. It was very . . . I think in many ways it cut to the chase and got to the real central point.

And I want pick up where you left off. I think that if this were 1962 and we were starting over, we might very well just be able to implement everything Mr. Fyke said. But it's almost 2002. We've got a system already in place. We know that we're spending $2.2 billion a year on health care. That's $9,200 per family of four every year. We know that that's growing at a rate of about 10 per cent a year, which for ordinary taxpayers is hundreds of dollars. By the time we get it to the provincial budget it's hundreds of millions of dollars we need to add in every year just to maintain the system.

Now you've made some good, I think, very good comments of things that have been overlooked. The question of long-term care clearly needs to be addressed in the rural areas. The question of what happens with lab and X-ray facilities, how do you have sustainable practices without those facilities being available, particularly in rural areas.

The question I guess that I am interested in is how do you see us moving forward, with a budget which is growing at 10 per cent a year, with the fact that they tell us Saskatchewan people are as healthy as everybody else but we hospitalize them 41 per cent more, 25 per cent more than Manitobans, that we've got waiting lists because we don't have the right specialists in the right areas.

How do we go about making those changes while still protecting the interests of ordinary citizens like you and I?

Mr. McMillan: — I guess personally I can only relate to some of the things that we were up against as a union hospital. On any given day for example in emergency, we would handle 25 or 30. They would handle 25 or 30 individuals and I think, by anybody's conservative estimation, 15 . . . or 50 per cent of those could have readily gone to the doctor's office, gone tomorrow, or whatever. But because the system is there, they will go ahead and use it. And that's human nature.

And I think, certainly not information that you're privileged to necessarily, but I am not sure that you won't find that the ones frequently did that type of thing are also duplicate, you know, and others, they come again and again. And I don't think . . . and it's always hard to be the hard guy. And I guess I was anxious at the time for the board to take the position and be very aggressive about listings in the waiting room and ads in the paper and so on, don't abuse emergency.

I gather it's still happening today because when the strike was looming or was on, guess what we were saying. Please don't come to emergency unless it's a real emergency. After that, you can come to emergency. Okay? Is that what we're saying? Somewhere in those types of areas, we need to get over that.

And as I understood it, back when I was involved, the call to the hospital, total cost to the taxpayer, was around $90 and the call to the doctor's office about 18. And I don't know how to say it kindly, but the doctor is as much to blame as anybody. But we're all playing the game.

Mr. Thomson: — I want to just also say I appreciate your comments about us needing to take a look at a more regional model within the prairie provinces for specialized services.

Clearly here in Regina, obviously we are at a point now where we're going to have to start looking at sharing specialists with Saskatoon, looking at provincial centres of excellence. And I think that that's a very positive comment.

Of course the problem always is that people like to have their services here. Southern Saskatchewan people like to have their services based out of Regina; central out of Saskatoon. It's the same kind of problem. But I think that there's a lot of merit to what you say.

The final thing I want to comment on is I just want to let you know that the government hasn't made a decision as to what to do with Mr. Fyke's report yet. That's part of the process we're going through right now — is hearing from citizens from around the province and the stakeholder groups.

And very much what you've said today, I think is . . . really does cut to the chase of some of the concern, particularly in rural areas. So I want to thank you for that.

The Chair: — Thank you.

Mr. Gantefoer: — Thank you very much, Madam Chair, and thank you for coming.

I wonder if you would outline briefly the current component of your health care service delivery. How many doctors do you have in your community? Are they Canadian trained, off-shore? Is there home care; is there long-term care? Just outline what services are in the area that you represent.

Mr. McMillan: — In the immediate area we have a South African doctor, a lady doctor who is very well liked and a big asset to the community — as the other doctors are so don't misinterpret that. She's been there, Dr. Swiegers — what? — 10 years, 8 years? The second doctor from South Africa, as well, has been there for about 4 years. And we have a locum at the present time. They normally try to maintain three full-time doctors.

I guess that's one of the things that I've pursued with the district board and when I was on the local board is that, without insulting doctors or where their past has been or whatever, I'm of conviction that communities need to have more input and more — not that we try to boss them around or anything else — but more interest in obtaining doctors and where they come from and so on.

And you know we've had some turmoil in Saskatchewan . . . or in Kipling as you know that. And it's just circumstantial. It's not to do with anything else. But it's very difficult to be in recruiting of doctors and so on, when they like to do it themselves and see that as an insult when you would like to be part of that process.

Mr. Gantefoer: — Do you see as well . . . Fyke talks about primary health care teams that'll involve doctors and advanced clinical nurses, registered nurses, pharmacists, you know, that kind of an integrated kind of approach. Do you think that there's room in the communities that you represent for greater use of other health care professionals in the delivery of services?

Mr. McMillan: — I think we would definitely say yes. I think there is already some very competent nurses bordering on that. In other words, when the ambulance goes to Regina we already have some . . . people have favourites because they are very, very experienced. And I heard one say the other day, there's a particular nurse that's been there quite a while, push came to pull, I'd just as soon she rode with me as the doctor.

And going back to long-term . . . I'm sorry I didn't answer that. Kipling has a long-term care centre that was built in the middle '60s. And the doors are too narrow and all those other types of things, and no sprinkler systems and so on. And so they don't want us adding to it or whatever. So either we do it all over or we just stay where we're at.

We were one of those that were caught. We were probably fortunate to have it early in the system but now that everything's gone kind of on the downturn, so to speak, or in the consideration stage; we have no idea. But in our opinion, to bring it up to an average of what Saskatchewan is, we clearly need a long-term care system in the very near future.

Mr. Gantefoer: — One final question: do the doctors that work in your community, do they work in conjunction with any neighbouring communities to provide, you know, coverage for emergency or those sorts of things? Are there intercommunity relationships, if you like, that enhance services?

Mr. McMillan: — Some. For example, they travel to Glenavon for example on given days and so on.

Mr. Gantefoer: — Thank you very much.

The Chair: — Any further questions?

Ms. Bakken: — A very, very good report and I think a lot of the key issues, if not all, have been certainly addressed by your presentation today. And one statement that stuck out in my mind is who is the Fyke report for?

And as I've listened to especially the presentations from those in rural Saskatchewan and have had people phone my office about it as well, I think it's becoming clearer and clearer that the Fyke report is trying to fix what isn't broken and we're not addressing what is broken.

And certainly in rural Saskatchewan I've seen — and I visited Redvers last week and went through their whole health system with them — that they have done what they needed to do and gone the extra mile to make their system work and to do it efficiently and effectively. And I'm hearing the same thing from you today. And I would hope, as I'm sure you do, that the government will take the message from this and realize that we need to address what is broken, not what is already working.

So I thank you very much for your thoughtful presentation.

Mr. McMillan: — Thank you. And I sincerely hope that you pursue the money end of it. There is lots of areas at the core of it without flirting with the outside edges of it that really aren't going to change anything long term. But there is some in the centre that mean big bucks and could mean big changes to it.

The Chair: — Thank you. Seeing no more questions, thank you very much on behalf of the committee for presenting today.

We'll take a three-minute break while we change presenters.

Good afternoon. Like I said, three minutes means different things to different people.

This is the Standing Committee on Health Care. It's a legislative committee of this Assembly. Its first order of business was to receive responses to the Fyke Commission, or the Commission on Medicare, and report those back to the Legislative Assembly by the end of August.

I'm Judy Junor, Chair of the committee. Dr. Melenchuk is the Vice-Chair. Our all-party members are Andrew Thomson, Warren McCall, Pat Lorjé, Brenda Bakken, Bill Boyd, and Rod Gantefoer.

And we've given presenters half an hour for their presentations.

And within that half an hour we hope to have some time at the end of your presentation for questions from the committee.

So if you can begin by introducing your delegation and who you represent, and then you can begin your presentation.

Mr. Blanc: — Thank you. I'll start off with introducing myself. I'm Doug Blanc, the president of Saskatchewan Government and General Employees' Union. To my immediate right is Friedrich Bayer. He's our executive director of operations. To my left is Norinne Berge. She's a lab technologist from our health sector.

We thank the Chair and the committee for the opportunity to give this presentation. The Saskatchewan Government and General Employees' Union, or SGEU, we represent approximately 20,000 unionized workers in Saskatchewan. We're affiliated with our National Union of Provincial and General Employees representing 320,000 unionized members from coast to coast, in all walks of life.

Our members in SGEU currently are our public PS/GE (Public Service/Government Employees). You might have heard them most recently in some of the news over the last number of weeks, which is our line departments, Department of Justice, Highways, SERM (Saskatchewan Environment and Resource Management) employees, land titles and so forth. We represent Workers' Compensation, Saskatchewan Crop Insurance, Wascana Centre Authority, the people that look after this particular facility, and so forth; adult education which is our SIAST campuses, regional colleges throughout the province, Saskatchewan Liquor and Gaming Authority. We have a wide representation of members throughout this province, one of which is obviously some health workers.

The brief that we're presenting today, we have commissioned to some of our health workers. It is not done by the president or the executive director of operations, although we have assisted and certainly given our input, but primarily it is done by the health sector workers.

We have collaborated them together, our members, so that they can present this brief, because we feel that it is the health sector workers that can give the best input to this particular committee.

And with that I'm going to turn it over to Norinne Berge who is, as I said, a lab technologist in Melfort, North Central Health District, and she will be presenting our brief, and we will certainly entertain questions at the end of that. Thank you.

Ms. Berge: — I'd just like to say thank you for the opportunity to present our response to the Fyke Commission report.

The Saskatchewan Government and General Employees' Union represents 20,000 Saskatchewan men and women in the province. They're our stakeholders in the health care system, both as consumers and as providers. Some 1,000 of our members are employed in North Central, Keewatin Yatthé, and Mamaweta Churchill River health districts, and by the Saskatchewan agency.

They work in a variety of professions, for example as licensed practical nurses, home care workers, lab, X-ray technologists, therapy assistants. We also represent 800 community-based workers, many of whom carry out activities directly related to health care delivery, including early childhood intervention programs, rehab, and community integration programs, mental health programs, assistance for victims of violence and people in crisis, and nutrition programs.

SGEU health care members agree with the Commission on Medicare that our health care system requires reform to develop a sustainable system. It is our view that a publicly funded health system is still the best method of heath care delivery. It is essential that any plan for change be well researched and clearly thought out so as not to repeat past mistakes of formulating great ideas without much thought going into the implementation of those ideas.

In our view, it is crucial to stabilize the system. Stability is required not only for the people that use the system but for the people that work in that system. Health care providers have been involved in change since the early '90s. Workplaces need to be a priority. Reduced staff to resident and patient ratio has resulted in employee burnout and poor morale. If anything, workloads have increased since reform. Recruitment and retention will only become a greater problem in this current atmosphere.

The concept of primary health care teams is one that we support in principle. However, it raises numerous questions to us and we feel that they need to be addressed before implementation. Currently, we don't see that there is any foundation to support these teams.

SGEU is in support of health care providers working as a team and treating the individuals as a whole, not as a single illness. For this primary health care team concept to be successful, a very well thought out plan for the delivery of services must be in place prior to implementation. This would ensure a continuum of care with reduced disruption to service delivery in the rural areas.

In rural Saskatchewan, transportation is an issue, particularly for the older population. Although the commission recommends improving ambulance services, the majority of health related travel is not an emergency. In these cases, there appears to be no plan beyond expecting family members to live nearby and transport their own families.

The family base, which it is assumed that patients rely on for support, isn't necessarily there in all cases. Nor, with the economy being what it is, is it always possible for one member of the family to stay home to take care of someone. It would be our recommendation that a plan be developed to provide public transportation for health care delivery points.

Under what structure do the health care teams work? The commission recommends that community health deal with everyday health care.

Who administers this care? We realize this may be where the concept of the advanced practical nurse comes into play. Expanding care provider roles is beneficial, but if you can't recruit physicians, how do you ensure that there's going to be an adequate supply of advanced practical nurses for rural

Saskatchewan as well?

We would recommend that there must be a plan to retain those already employed in rural Saskatchewan and follow it up with sufficient funds for retraining of those individuals.

If travel throughout the districts for some of the team members is part of this proposal, as it seems to be, then the proposed size of district raises concerns. Presently service areas share some programs and a percentage of time by employees is spent in travel now. If the districts become larger than the present 10 service areas, it may not be cost efficient to pay people time and travel to get to their points to deliver services.

We would recommend that service delivery should not be geographically expanded beyond the existing service areas. The commission recognizes the need for improved medical . . . emergency medical services, and we agree. We want a system that provides timely access to emergency services delivered by qualified individuals.

The commission's report suggests making collective agreements flexible to allow for EMS workers to work in long-term care facilities. What about training people already to . . . already employed in long-term care facilities to work as EMS workers? I mean it could work both ways. So we would recommend that we train people employed in long-term care facilities to work as EMS workers as well.

The concept of self-managed care raises concerns for us too. This kind of care, unless it is closely monitored, can be a problem if individuals managing care on behalf of clients are more cost conscious than care conscious. We would recommend that the government set up a structure to monitor self-managed care initiatives in cases where individuals manage care on behalf of clients who cannot manage their own care. Mechanisms need to be put in place to ensure that the quality is placed above cost as the deciding factor.

An item that we noticed that was missing from the commission's report is any real plan for addressing fee-for-service charges by physicians. It would seem that the expectation for health reform is based on change in communities, in services, and in health care providers, with the exception of the involvement of the physicians. We would suggest that the successful reform requires the involvement and inclusion of all health care providers, including the physicians.

We can see the merit in centralizing specialized services. Providers do become more proficient at a service that they provide if they're required to provide that service more often. We agree that there are some services — neurology, cardiology, etc. — that would be better served in the tertiary centres.

However, if some of the other basic services and procedures were provided in outlying districts it may relieve some of the pressure that's being placed on the larger centres. Some districts already have in place services that they provide that could relieve some of the pressure on the larger centres.

We would recommend that we build upon the current practice of some districts and service areas that contract specialist services. This could potentially decrease waiting lists in the tertiary centres and alleviate travel difficulties.

Although we agree that proximity does not always equal quality, we have definite concerns about how the elderly rural population is to access services. Emergency services, as I referred to before, transportation is there for emergencies.

But what about other services — your diagnostic services, your X-ray and your lab services? If they're going to be centralized in regional hospitals and people are going to be expected to travel to them, how are they going to get there? How are the elderly people going to get there, unless they can depend on their family? And as I said before, the family base isn't necessarily there to transport people. I know now that they just don't access those services if they can't get them.

We would recommend that the government needs to assist a social structure that will support families caring for their own and provide for those that may not have family to transport them to specialized and diagnostic services.

We see it as necessary that the provincial government, health districts, and Aboriginal communities develop a network that better determines the specific health area needs of the Aboriginal communities. They have special cultural needs and these have to be addressed.

There is a need to develop partnerships that will work towards ensuring the delivery of health care services required by these communities and we would recommend the provincial government, health districts, and Aboriginal communities should develop a network to determine the needs and to ensure delivery of health care services required by Aboriginal communities.

We recognize that there are unique challenges in the North for health consumers and for providers. To a certain extent, primary health care delivery currently exists in the North with the use of the advanced practical nurses. Our northern members deliver community-centred health care in the face of enormous challenges ranging from unclean drinking water to the debilitating effects of poor nutrition. As a result, our members are acutely aware of the correlation between social and economic development and good health.

Recruiting, training, and retaining northern health care providers is a challenge, particularly when they feel their work is unsupported. A case in point is the province's only remaining child-based dental plan, which operates under a cloud of rumoured cuts. This situation places emotional stress on the workers who feel they must always be on the alert to ensure their health board is not about to reduce a valuable preventative program.

We would recommend that there is support for a northern health strategy that deals with but is not limited to recruitment, retention, cultural differences, language barriers, health education, specialized services such as the child-based dental plan, poverty, and travel and distance.

We are supportive of a centralized quality council to make a renewed health care vision work. It is imperative that the quality of care is maintained. If that standard of quality is not

maintained, rural Saskatchewan's worst fears will be realized — a health care system geared to provide quality of care for only those living in urban centres, or for those that are able to travel to access those services.

We do not wish yet another level of bureaucracy with no authority to implement recommendations, leaving the greater decisions to continue to be determined by the politics of the day. Our concern is that a quality council would become a bean counting exercise with no real authority to examine and make recommendations on the basic fabric of health care delivery.

We question whether the effectiveness of such a council is jeopardized by removing any authority for implementation from the council and by continuing to place implementation decisions in the hands of vote-hungry politicians.

The role of the quality council becomes increasingly important when dealing the quality-oriented incentives in funding. There definitely needs to be a separate body that sets these standards so quality of performance can be measured and rewarded. But will this concept promote the concept of producing more with less or does this approach actually promote quality?

While evidence-based decision making is an idea with much currency in recent times, it is not a holistic system. The Canadian Health Coalition cautions, often these initiatives rely on technocratic control derived from statistical probabilities about needs and results. Although such evidence can provide useful guidelines for what physicians and other providers should do, it can also lead to rigid roles that substitute for decision making based on an understanding of individuals in their particular social context.

We would recommend that a quality council must receive a mandate to engage in broad-minded, informed decision making rather than being charged to follow rigid statistical measures. The council must have the authority to implement its decisions.

Who makes the appointments to the quality council and on what basis? There needs to be a minimum qualification required and an ability to ensure individuals involved have a good grasp of the practical application of quality health care. This will also ensure the standards set are reasonable expectations. We are concerned that there will be a built-in bias because of the appointment of members.

So therefore we would recommend that there should be minimum qualifications required for appointment to the proposed quality council, an insurance that individuals chosen have a good grasp of the practical application of quality health care.

We do support the reduction in the number of health districts in the South, but we cannot support the maps in the commission's report. Neither of the two suggestions for 9 or 11 health districts takes into account existing relationships between the current health districts.

As an alternative, we recommend using the present 10 service areas. Currently these areas already share some services. It would be easier to expand these relationships rather than redrawing the map and realigning services. This would be a logical solution falling exactly between the 9 or 11 districts recommended by the commission.

There is also a measure of comfort working within these service areas. To realign districts according to the map that we've provided is a far less drastic change and would be more palatable to the public, particularly in rural Saskatchewan. Yet it would accomplish the same goal of reducing the number of health districts to 12 — to less than 12.

As well as being less disruptive, districts developed upon these lines appear to be more manageable areas for primary health care teams to cover. It may also be easier to develop and implement such health care teams in districts that already have the beginnings of working relationships and have some shared services already. Common goals and strategies currently shared by these service areas can be built upon rather than disrupted by a realignment. We would recommend that the health districts be amalgamated according to the existing 10 service areas.

One of the blackest marks against health care reform to date has been the manner in which health care providers have been denied the right to choose their union representation. The 1997 Dorsey regulations superseded The Trade Union Act and the authority of the Labour Relations Board. Essentially the government assumed the power to assign unions to health districts. Only in districts where there was more than one union was a vote allowed, but only among unions already representing 25 per cent of union members. Unions with less than 25 per cent were simply erased from the ballot.

Thus in 1997 some 3,000 SGEU members were told they now belong to other unions when in fact they had signed SGEU membership cards. To date these 3,000 employees remain members of SGEU as per the legislation and the constitution of SGEU regardless of the supplementary memberships thrust upon them by the Dorsey regulations.

If the health districts are realigned according to the report's recommendation, once again union members will stand in danger of having their union representation reassigned without having any say in the process. There will be continued upheaval in the workplace and an entrenchment of the feeling that one's voice and vote count for nothing in an issue as basic as union representation, a situation that goes against the grain of both The Trade Union Act and the Canadian Charter of Rights and Freedoms.

We would recommend in the event of health district re-amalgamation, the Dorsey regulations must be rescinded, recognizing that only the Labour Relations Board should have the discretion to determine bargaining agents.

Denying health care providers the right to sit on health care boards, as the commission recommends, would also be a mistake. Who better to plan services than people who actually deliver them? They provide a front row view and have a vested interest in ensuring quality care is being provided.

Any citizen has the right to run for an elected position, no matter what their job. We were very surprised to see a recommendation that would subvert such a basic human right. We understand that this idea arises from reports of physicians

sitting on boards and potentially manipulating decisions in their favour. If such situations occur, democracy should be allowed to run its course with its natural checks and balances.

Further, a move toward fully appointed boards would be a grave mistake. Citizens already feel disenfranchised from health care decisions, particularly in rural Saskatchewan. One cannot devolve responsibility to communities on one hand while the other hand takes away the opportunities for involvement in decision making.

Democracy may appear imperfect on the surface at times, but it has strong foundations in our society and should not be mistrusted. The combination of a quality council and an interested, involved electorate will help ensure that boards carry out their duties efficiently and honestly.

We would recommend that health care board members should be elected by their communities and that employees of health districts should have the same rights to stand for elected positions as anyone else.

We support the premise that workplaces where workers feel valued and recognized is critical to the improvement of morale and to the assurance that quality health services are being delivered. Staff also need a sense of security and involvement if their work is to be reorganized and redeployed.

Currently, health care providers feel under the constant threat of job change and job loss. Using staff to their fullest potential increases the challenges of daily job performance and leads to increased job satisfaction. Having said that, we do not support offloading of job duties that would merely increase workloads.

We would recommend a transparent strategy must be in place to assure individuals that, by increasing scope of practice, job security will not be an issue; that a defined plan must be in place to provide retraining, relocation for currently employed health providers; that coordinated human resource planning and management must be done on a provincial level, and training dollars must be part of that human resource strategy.

SGEU applauds the commission's conclusion that public financing through the tax system is the best way to provide for health care. At the same time, public spending on health care as a proportion of all health expenditures in Saskatchewan has dropped from 82.8 per cent in 1983 to 74.1 per cent in 1999. And we are operating in a climate where political parties rush to outdo one another in cutting taxes.

The commission calculates that basic health care reform requires an investment of 100 million over four years. This investment will eventually result in cost savings that will allow a more sustainable system and potentially help fund an expansion of insured services. SGEU is in favour of seeking ways to expand medicare on a number of fronts, including full public funding for home care, long-term care, midwifery, mental health, pharmacare, children's school-based dental programs, rehabilitation and occupational therapy, and ambulance services.

Unfortunately, there has been no indication that the provincial government has any intention or desire to make the initial investment that could provide us with a full, sustainable health care service. This year's increase to the provincial budget contained a modest increase of 5.2 per cent over actual expenses, much of which will be consumed by physicians' fees and drug costs. At a pre-budget briefing, the Minister of Health stated that further increases should not be expected next year.

One wonders then if there's any point in discussing health reform along the lines recommended by the commission.

We fear that the government will seize on cost-cutting components of the report, such as the conversion of hospitals, without providing replacement services. This is a well-founded fear given past experience and customary provincial budget restraints. It is a fear that gives rise to suggestions this committee has already heard, including the idea of introducing user fees as a way to keep local hospitals from being converted to primary health centres.

We agree fully with the commission's exhortation that new funding must buy change, not time. We also agree with the commission's finding that user fees are not a useful source of funding. We urge the government not to fall into this trap and to instead make the necessary investment out of tax-funded revenues.

We would recommend the province of Saskatchewan must provide the financial investment required to engage in meaningful health care reform. The result of underfunded reform will be unsatisfactory health services coupled with rising private sector demands to fill in the gaps.

A shortcoming of the commission's report is its failure to recognize and make suggestions for addressing outside pressures on Saskatchewan's public health care system, ranging from attempts to weaken the scope of the Canada Health Act to international trade agreements that seek to define health care delivery as a service subject to free trade provisions. Clearly our best-laid plans are subject to events and decisions outside of our provincial borders.

If medicare is fractured nationally, we may have no choice but to open up our provincial borders to private health care corporations. Our provincial government will then find itself accorded no greater status than that of a bidder competing with transnational corporations to deliver the bottom line.

We would recommend the Saskatchewan government must ensure that health care services are not incorporated into the Agreement on Interprovincial Trade, that the Saskatchewan government must call for a moratorium on the signing of further international trade agreements, such as the General Agreement on Trade in Services and the Free Trade Area of the Americas, until an in-depth impact analysis has been completed, and that the Saskatchewan government should actively speak out on the national stage against any further expansion of or official sanctioning of private, user-pay health care.

In conclusion, the Commission on Medicare has provided a vision of holistic, sustainable health care, a vision which our members can support with the reservations stated in this brief. Meaningful, beneficial health reform requires a foundation that includes adequate funding, a well-planned human resource

strategy, attention to the needs of rural and northern communities, a plan that builds on existing relationships and structures, continuity of care with minimal reorganizational disruption, quality of care as the highest priority, fair and democratic decision making, protection of the basic principles of medicare.

It is our hope that the Government of Saskatchewan has the courage and foresight to use this opportunity to protect and rebuild our most cherished social program.

And now I would like to thank the committee members for all taking part in this process. This is an issue that affects all of Saskatchewan. It's not defined by political parties, and we are just thankful that everyone has been involved in this and that it isn't . . . or hopefully isn't going to follow political lines.

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

Mr. Gantefoer: — Thank you very much, Madam Chair, and thank you very much for your very thoughtful presentation. It's very well done and I wouldn't attempt to try to discuss each of the recommendations with you; we don't have the time. An area, though, that I would like to talk about is the area of reorganization of districts or service areas along the model of service areas that are currently in place.

I'm reasonably familiar with the kinds of inter-district relationships that are happening in the Northeast, which is a defined service area. And I wonder if, from your experience, that other service areas are operating to the same degree of inter co-operation or inter-district co-operation that we see in the Northeast, and just an assessment of how it's working in other areas, because I think it's an excellent suggestion.

Ms. Berge: — Well to be honest, I mean we have looked at the tri-district area that we come from as a model for what we see as the kinds of services that can be shared within districts. I'm not aware, or well aware, of what might be happening elsewhere in the province. But I mean I think it's a very good model and I would hope that there's the same kind of relationships elsewhere in the province.

Mr. Gantefoer: — Thank you. A presentation last week certainly highlighted the tri-district co-operation as a model for other areas to pursue. And I think your suggestions of actually quantifying this under these service areas is a good example. Are these service areas that you outline here currently recognized service areas or are they suggestions that you're making?

Ms. Berge: — We believe that they're the current service areas.

Mr. Gantefoer: — Thank you very much.

Hon. Ms. Lorjé: — And again I would like to thank you for your presentation, and there's a lot in it. So I guess I would like to turn my attention specifically to your recommendation 15, which is on page 8 of your presentation, recommending that the provincial government, health districts, and Aboriginal communities develop a network to determine needs and ensure delivery of health care services required by Aboriginal communities.

And I wonder if you could expand a bit more on that and tell me exactly what you're anticipating and what you would see the involvement of, for instance, the FSIN (Federation of Saskatchewan Indian Nations) and tribal councils to be in developing this network.

Ms. Berge: — When we developed this recommendation, we were drawing from experience in North Central that we know that there are partnership agreements that have been developed and we know that there is communication within the communities. And what we were suggesting was something along the same line, that there would be that open communication between the Aboriginal communities and the health districts and that there be some movement on both sides to try and develop a health care service delivery that would accommodate what kinds of needs that they need taken care of.

I know that in our own facility, and I'm just speaking from personal experience, oftentimes there's an identification of what kind of cultural aspects of their care that we need to take care of. And I would hope that that would be what other health districts might start to look at is actually communicating with the Aboriginal communities to find out what kind of, what kind of cultural differences they can incorporate into their care delivery that they are receiving.

The Chair: — Further questions?

Hon. Mr. Melenchuk: — Thank you very much for your extensive presentation and your recommendations.

The recommendation with regard to the quality council is the question that I have. It seems that you would support the Fyke recommendation that this quality council be independent, be based on performance measures but in his own words, "to have a broad mandate" to basically to de-politicize decisions. So would you concur with the Fyke recommendation in general principles on what a quality council should do?

Ms. Berge: — In general principles we did agree with what the quality council should do. Our concern came more from the makeup of that quality council and ensuring that the individuals that were involved in it were qualified in determining standards.

For example, in the lab, if you're setting up standards of care, you need someone that actually knows what kind of standards you want to be set up. And I would hope that that would be what would be applied to health care in general, that it would be individuals that would have experience in health care that would be setting up the standards.

Hon. Mr. Melenchuk: — And just to follow that up. There was a recommendation from the Registered Nurses' Association this morning that 50 per cent of the quality council should be from the community or public representation. Would you agree with that sort of line of thinking as well?

Ms. Berge: — I wouldn't disagree with the public involvement in a quality council, but again I have to reiterate that it would be qualified individuals that are aware of what kinds of . . . exactly what's involved in setting up standards for health care.

Hon. Mr. Melenchuk: — My final question goes to a bit of a

contentious issue with regard to Dorsey. But obviously you feel that if there is reorganization along the lines of 10 service districts that there needs to be some recalibration in terms of how Dorsey was implemented.

Mr. Blanc: — Yes, we believe that the basic workers' rights to choose a union of their choice should be done, and secondarily, the Labour Relations Board should be making that determination not legislation.

Mr. McCall: — Thank you very much for a very thoughtful and wide-ranging presentation. It's very useful to have the recommendations laid out in the manner that you've put them forward, and you . . . this committee is about soliciting and passing along what we've heard, so you've given us some very good things to pass along.

My one question . . . or two questions for you I guess. On yourself as a . . . and coming from a lab background, in the work of this committee, we've heard an awful lot about the pivotal role that laboratory and diagnostic services play in the various . . . be it in an integrated health care facility, or in the hospitals, or what have you, and I'm interested to know your thoughts on in the Fyke report there's . . . it would seem to leave the impression that lab and diagnostic only belongs in a regional hospital setting. And that below that it should be removed from the primary health care centres, or the community health care centres, or perhaps that's an imprecision in Fyke that needs to be cleared up.

But my question for you is in terms of recruitment and retention and the present operation of the various labs throughout the province, how do you see it functioning right now, and what challenges do you see posed for the system by Fyke in . . . (inaudible) . . . from the viewpoint of lab and diagnostic?

Ms. Berge: — In terms of regionalizing lab and X-ray services, from the perspective of providing a quality service to rural Saskatchewan, I see some real big problems. Because if you regionalize — and it comes to transportation — if you regionalize lab and X-ray services for example in, oh, let's pick Yorkton, and it has to cover I don't know how many mile radius, a hundred mile radius, and you've got your lab and X-ray services centralized, unless you have some kind of support out there that's going to either have bleeding stations so that you can draw the samples at the point of origin and send them along to a regionalized lab, or you have some method of transportation for people to get to your regionalized lab, it creates big problems. It really does.

And if you do set up a support system of, for example, bleeding stations, you have to have qualified people out there too.

And you're right. Then you're coming into the problem of recruiting people for rural Saskatchewan. As it is, we're in a situation now where in the next five years we're looking at retirements of 24 people per year and training of only 13 people. So we're already looking at a real crisis when it comes to the number of techs that are being put out.

And if something's not done to correct that problem, you're going to be in the same situation as we are with the nurses. There's going to be more call for people to go to the urban centres or to the regional hospitals as there is to being in rural Saskatchewan. So it will definitely create a problem.

Mr. McCall: — Thank you for that. My second and final question has to do with EMS and the recommendation that you make, it is number, recommendation number four, trained people employed in long-term facilities to work on EMS teams. Now that makes all kinds of good sense and I compliment you on bringing that forward.

And I was wondering, within your membership as it stands right now, are you aware of any situations where you have certain of your members performing other functions within the system that are contracted to provide EMS services in the various districts?

Ms. Berge: — We don't have . . . that I'm aware of, we don't have anyone that . . . (inaudible interjection) . . . oh, okay.

Mr. Blanc: — I think we have a couple members in the North, because of working conditions and hours of work. They're only working part-time in some of the facilities, they're also working part-time in other health care jurisdictions, whether it's in EMS or, you know, they're going from a long-term care to a hospital and vice versa. So we do have members that are working two different occupations in the health system currently. But it's simply because of the hours of work, they're not receiving full-time in any one particular job classification.

Mr. McCall: — I see the suggestion is not only workable, but it's the way we want to go.

Ms. Berge: — Well I guess the report raised some red flags for us when the suggestion was made, that the trained EMS individuals go and work into the long-term care. And we were just wondering why there wasn't the same reciprocal idea there.

I mean we've got a lot of people on casual on work lists that aren't . . . they get a lot of work in the summertime, but during the wintertime they don't necessarily have enough hours to continue. So therefore you end up with people that are on casual lists at three or four different facilities, and then when it comes down to the crux that you really need somebody to work, they're not necessarily available. And so by increasing the ability for them to be employed in maybe in two different, two different manners might help us to retain individuals or recruit individuals out to rural Saskatchewan.

Mr. McCall: — Absolutely. It would go to job satisfaction and, you know, a challenging workplace. Anyway, thank you very much for your presentation.

The Chair: — Thank you. Mr. Thomson, you could wrap this up for us.

Mr. Thomson: — Thank you, Madam Chair. I have two questions. One relates to the comments in your presentation, which I want to thank you for. But concerning the quality council, I'm interested in terms of how you see the quality council being set up and why you would not want there to be an appeal mechanism either through the Minister of Health or through the legislature.

Why we would come to expect a quality council to come up with recommendations either much different than what Mr. Fyke already has, which seems to meet with some public support and some public opposition? Why would you simply want to turn over the management of the health care system to unelected people?

Ms. Berge: — Good point. We came at it from a different direction though. We felt that if a quality council was made up of qualified individuals to make recommendations on health care, why would we want it to come to the government or the Legislative Assembly and, because it wasn't politically correct, be squelched. Why would the . . . We have some concerns about the opinion of the day being what came forward in the quality council. And we came from it from that direction as opposed to giving them, you know, the ability to make decisions independent completely of anybody else.

And I appreciate your comments on the appeal mechanism.

Mr. Thomson: — I don't think there would be any argument from the government that if we could have all the groups — the communities across the province, the unions — all agree that if the quality council decides something's being shut down, that we'd all just nod and say that's very good and it's made with good reasons. I suspect it would make question period very quiet around here. But I don't think we're at that point.

The second question I had concerned the question, the section of Mr. Fyke's report called paying the bills. In appendix C of his report he says:

> As described earlier in this Report, the status quo requirements of the existing health system will exceed available resources by over $300 million by 2004 . . . an amount far surpassing current funding for provincial highways. Expressed another way, an additional $300 million for health care would require an increase from current revenue of 10 per cent in overall provincial taxes, or 25 per cent in personal income taxes.
>
> This means additional money for the health system, either by massive tax increases or severe budget restrictions, but only to maintain a system already regarded by some as being under-funded.

In your presentation, you spoke at length about the need for us to expand public services. And you talked about how we were already . . . that we were not putting sufficient funds into the system currently. I'm interested to know what level of funding would be sufficient in SGEU's mind, and where that funding would come from.

Ms. Berge: — In our report we spoke to social programs to support the Fyke report. We couldn't see the reform of health care as proposed on the Commission on Medicare as being a move forward unless there was some, some programs there to support it.

Now in terms of adequate funding, you've got me at a loss. I mean unless . . .

Mr. Blanc: — No. Well I mean it's hard to determine adequate funding but I guess our point is that we feel that sometimes public funding and programs that are cut to save money in other retrospect cost money.

I mean I look at the school-based dental program that was shut down a number of years ago. Our belief is — in any of our research that was done — that it's actually cost the health system more now by not having that program in place. So we're saying that yes, you have to have the money put into the health system; you have to have it put into the public funding of the health system; at the same time, ensuring quality control and whatnot and that the service can be provided.

I guess it's, it's a . . . we understand it's a juggling act.

Mr. Thomson: — I guess the difficulty we have, at least on the government side, is we're the ones who have to juggle it. And one of the problems is, is that . . . And we've heard this from communities that have appeared before and groups that have appeared before us, who believe that we are now at the point — having listened to people in the system talk about the underfunding, talk about underpaid, overworked employees in the publicly funded system — are now saying maybe what we need to do is move to either a two-tiered system or user fees or premiums.

Now I guess what I'm wondering is, how do you see us moving forward to maintain a publicly based system? I haven't heard any communities appear yet — and I could be wrong and the Chair can correct me — suggest that we should increase taxes. And I haven't heard — other than the suggestion of going to user fees — any other options.

So I'm interested in how you would see us maintaining a publicly funded system and finding the resources for it within the context of expanding services and diminishing revenues.

Mr. Bayer: — I think I'll field that question and give you a response that I think is conducive to where we're coming from.

We're not necessarily looking at an increase in the taxes at all to the residents of this province. But we are looking at an effective government that has the ability to go to Ottawa and determine how the block funding for this provincial government is determined and on what basis the allocation for funding takes place.

My experience is from the Northwest Territories where we cover two-thirds of this country's land mass, and the service delivery was a considerable element of our problem as a union and in conjunction with the Public Service Commission or the government of the day and so forth.

I think it's incumbent on this commission and on the government of the day to make arrangements with the federal government in whatever realm you can address to ensure that this province gets adequate funding to allow service delivery throughout the entire body of this province and to make sure that the residents get the service that they're entitled to.

I do not believe that a tax increase is the answer. However, I do think it's incumbent on the government and this Legislative Assembly to make sure that we get the best bang for our buck

from the block-funding arrangements through Ottawa.

Mr. Thomson: — Thank you, Madam Chair. I'll just say I appreciate that as fair comment. Obviously the debate we always get into here is people saying, well health care is such a high priority, why don't we scavenge from other programs? And of course, other programs are important also. And obviously SGEU would recognize that probably more than most.

But I appreciate your comments, and I certainly appreciate the thoroughness of your paper and your presentation. So thank you very much.

The Chair: — Any more questions? Seeing none, then I thank you very much for your presentation today and for your written submission. Thank you.

Mr. Blanc: — Madam Chair, could I explain what is in the box? There's been a couple of questions.

The Chair: — I'm curious.

Mr. Blanc: — According to . . . in one of our comments, we said that we maintain the 3,000 members that we lost in Dorsey as union members. These are the cards.

According to our constitution, it says the provincial council — which is our supreme governing body between conventions — may enrol as members of the union, employees for whom the employee union is not the certified bargaining agent.

We maintain — although we are not the . . . although we do not have the certification order — our provincial council has deemed those 3,000 members are still members in good standing of the Saskatchewan Government and General Employees' Union, and those are the cards to prove them. We still have them and we are going to hang on to them.

The Chair: — Okay, thanks.

Mr. Blanc: — Thank you very much.

The Chair: — Our next presenters are from the town of Kipling, if they could come forward and take their seats at the table.

Good afternoon. I think some of you have heard this already but this is the Standing Committee on Health Care, and it's a committee of the Legislative Assembly made up of all-party members. I'm Judy Junor, Chair of the committee. Dr. Melenchuk is the Vice-Chair. Other committee members: Andrew Thomson, Warren McCall, Pat Lorjé, Brenda Bakken, Bill Boyd, and Rod Gantefoer.

The first order of business of the Standing Committee on Health Care is to hear presentations on the response to the Fyke Commission or the Commission on Medicare. And the committee is receiving those responses and will report back what we've heard to the Legislative Assembly by August 30.

The presentations are 30 minutes. We're a little behind today and I apologize for that. Included in that 30 minutes we hope to have some time for questions at the end of your presentation.

If you could introduce yourself and where you're from and what you represent or who you represent and then you can begin your presentation.

Mr. Varjassy: — Thank you, Madam Chair, committee members. I'd like to thank you for the opportunity to speak today. My name is Ed Varjassy. I am the mayor of Kipling and we are here representing the town of Kipling.

Mr. Blackstock: — Linus Blackstock, alderman of the town of Kipling.

Mr. Hubbard: — Perry Hubbard, alderman of the town of Kipling.

Ms. Haanstra: — Gail Haanstra, councillor, town of Kipling.

Mr. Varjassy: — About an hour ago you heard from another group. We promise we won't duplicate. There will be some overlap obviously, but we have gotten together to try to avoid that and avoid wasting your time. We put together a submission; I'd like to read that to you.

We are here representing the town of Kipling. We are a town of 1,100 people situated 150 kilometres southeast of Regina along No. 48 Highway. Kipling is a fairly typical Saskatchewan community. The past decade has been difficult but we have managed to grow slightly in spite of it.

We currently have a hospital with lab and X-ray facilities, a very busy medical clinic operated by three excellent family physicians, a drug and alcohol rehabilitation facility, a public health office, and a pharmacy.

Health care is extremely important in our community and I'm not only talking about Kipling, but the neighbouring communities of Kennedy, Langbank, Windthorst, Glenavon, Peebles, Corning, and beyond. People from these communities rely heavily on health care services offered in Kipling.

When we first decided we should present today, I wanted to draw together as many people as possible and represent their views. In preparing this submission, I have taken input from the hospital staff, doctors, members of council, ambulance attendants, and other citizens. This diverse group all had similar suggestions and we are here to share their views with you.

We have a great deal of concern with the recommendations of the Fyke Commission. I want to stress the fact we are not here simply turf protecting and trying to save our hospital for some self-serving purpose. We believe and hope to make clear to you the recommendation proposed will not solve or even ease the burdens on health care but may, in fact, create even greater problems in the health care system and to the entire economy of Saskatchewan.

The report created by Mr. Fyke clearly illustrates his urban, big city bias and he has a definite lack of understanding of our unique rural environment. His theories and recommendations may work somewhere else, but will definitely not work here. University theories and what looks good on paper often does

not work in the real world.

I hope that this government has learned from the experiences of the past. The slash and burn method of reform of the early '90s had a devastating effect on rural communities which has, in turn, lead to greater problems in the city hospitals and have left us once again looking for answers.

The answers that Mr. Fyke suggests are very similar in nature to the answers implemented in the early '90s. These will, if implemented, lead us further down the same road that we are on. We cannot afford to repeat our mistakes.

We see the recommendations put forth as an attack on the residents of rural Saskatchewan and a threat to all health care in the province. He seems to think that the problems of health care are solvable primarily by centralizing and removing services from rural communities and creating quality through teamwork.

Let's take a closer look at the ideas of centralizing services. There's not a lot new here for the tertiary hospital system proposed for the cities. For the most part, this is what we currently have. He does not provide details in terms of changes that would be required in Regina, Saskatoon, and Prince Albert.

The next level consisting of regional hospitals are also similar in nature to what exists today, I believe. These are the hospitals of our smaller cities, which most surely would be selected as the 10 to 12 regional hospitals. There's not much new for these either.

The only significant change is to the third and fourth levels of service centres. He proposes 25 to 30 community care centres open 24 hours for convalescence, respite, and palliative care in conjunction with long-term beds.

The fourth level is the primary health centre, which would be open 8 to 12 hours a day as a location of primary health services visits and programs supplemented by 24-hour telephone advice service.

These are the only major changes he recommends and they would have major effects on rural Saskatchewan.

It is clear that in Mr. Fyke's opinion the problems we see in health care today are there almost entirely because of rural communities wanting some level of access to health service. His solution targets the services in rural Saskatchewan eroding them through the point where they will be so weak we will definitely have a two-tiered system — one for urban and another for rural.

Yet will these changes address the real challenges and changes in health care? Some of these issues or challenges are increasing costs, reduced quality of care, ever-increasing demands on the system, and shortages of staff. These are just a few that I picked out.

Mr. Fyke recognizes these concerns, but the solutions he proposes will not solve them but may even aggravate them. Our report will focus on these four issues and closely examine the impacts of Mr. Fyke's recommendations on each of them.

What will this do to costs? For some reason Mr. Fyke has almost ignored this issue and has not done any cost-benefit analysis to back up his recommendations. He only suggests that current costs cannot be maintained and even concedes that his plan will cost more initially.

By closing or converting rural hospitals into community care centres and primary health centres, there will be definite savings in the operating costs of these facilities. There will be some capital costs associated with renovations of these facilities to fit their new roles. But let's face it, these existing facilities are not empty, wasteful hospitals. The patients that they see will not go away unless they too decide to move to Alberta.

They will need to get their health care in either regional or tertiary hospitals. Here is the problem. These hospitals are not equipped to handle the current loads. I'm sure you have heard the stories of beds in the halls, backed up emergency rooms, and so on. Closure or change of rural hospitals require yet another major expansion to the city hospitals to support the increased load. This would be a great capital expense and guess what? The savings and operating expenses we celebrated earlier are not real. There will be no saving in operating expenses but a shift from rural to urban. There will need to be an increase in capital expenditure as we add facilities in the cities and remove them from the towns.

What about quality of care? Mr. Fyke suggests that quality is the great dollar-saving mechanism of his plan. Does anyone really believe this could be true? Will his theories actually result in greater quality? Is there not quality in today's system? Should we allow two levels of quality to exist — one for urban, another for rural?

Perhaps his idea of a quality council may have some benefit. But I'm not sure how a quality council demanding more complex reports and creating more administration can be hoped to save costs. In my opinion and experience, quality costs money but is often worthwhile. And we deserve a quality health care system.

What about quality in the rural areas where we will change from a hospital to a community care centre or a primary health centre? Once again the rural residents will need to sacrifice and need to settle for a second level of quality below that enjoyed by the urban sector. We do not need or want a hospital in every small town, but we must . . . we most certainly need some.

By converting to one of these centres, rural hospitals will lose all lab and X-ray facilities as well as all acute care beds. In my discussions with our local doctor, I learned that the most important tool she has available to her is a lab and X-ray facility. It is essential in assessing emergency situations and very important for convalescent care. It is also critical that in these situations the lab and X-ray facility is located right there, not at a distant regional facility that will surely become overloaded and backed up. I am sorry but I cannot understand how this will equate to quality care.

Conversion of hospitals to community care centres and primary health centres will have another effect on quality. The very skilled and dedicated physicians that we have now will most surely leave for greener pastures. Who will be left behind to

head up the recommended primary health teams? Once again it sounds great in theory, but it will be hard to put into practice if all the skilled people have left.

We might find that the only qualified people we can find are at the end of a telephone line. The idea of a 24-hour telephone line — hotline — may be okay, but is it really needed? If someone has a medical question, there are all sorts of ways to find answers — books, Internet, medical clinics, etc. If it is an emergency they should go to the hospital without wasting time on a call. And if they are unsure, they can call the hospital and get advice from them. It may simply be an extra service that we cannot afford, and surely cannot be considered a quality way of replacing the lost services in rural Saskatchewan.

Another major change may be to emergency response service. Again these changes would mostly impact rural residents. The greatest concern will be in distances and times required to get to a hospital.

In our area we would not be able to provide a quality emergency response if our local hospital were changed. Weather and road conditions affect time of response. We are more than one and a half hours from Regina. Because of this patients need to be stabilized first in Kipling. If they went direct to Regina, additional time would be lost before seeing a doctor. There are often three- to seven-hour waiting times for ambulances in Regina already, currently. Often there are several ambulances backed up with up to 10 ambulances waiting in turn. Recently one of our ambulances was rerouted to a different hospital, as the emergency room was so full it could not handle them.

This situation will be further stressed by the recommended changes unless there is another major expansion in Regina and Saskatoon. Even with expansion our emergency patients would suffer, as they would lose the golden hour explained to me by our hospital staff. This first hour following trauma or illness is the crucial for patient recovery. An EMT (emergency medical technician) cannot replace the skills of a doctor. Other changes to this service may result in increased costs that may be unaffordable in smaller communities.

Although these recommendations are an attempt at improving quality, they will again increase costs and be ineffective if coupled with the changes of rural hospitals. Our doctor feels that in order for the ambulance system to be effective we will need to have hospital facilities where they currently are. Increasing the distances between hospitals will not work.

Still on the issue of quality, let's examine another aspect of health care in rural Saskatchewan. We currently have a medical clinic that is owned and operated by three physicians. This clinic sees on average 1,300 patients per month. The clinic has over 1,900 families on file that it serves. This clinic is extremely busy and is very effective.

The proposed changes would probably see the closure of this facility which would be followed shortly thereafter by the closure of our pharmacy. In order to function properly a lab and X-ray facility is required. The changes would also drive away the doctors that run it.

Again the patients and their needs will not go away. They will need to be seen in Regina or Yorkton along with the patients from the other clinics that will suffer the same fate. How can an already overworked city system handle this extra load?

A key emphasis of Mr. Fyke is the upstream treatment of patients. It is at these clinics where a great deal of discussion and advice for prevention of illness takes place. By forcing the closure of such facilities, we will certainly be taking a step back in this regard.

Quality of care is an issue today, but it is not as Mr. Fyke sees it. The concerns over quality today are as a result of long waiting lists, overcrowded facilities, and shortages, mostly in the cities. Patients that receive care are getting quality care. Mr. Fyke's recommendations do not address these real quality issues adequately.

Perhaps the largest factor in the problems we see result from the ever-increasing demands on the system. Mr. Fyke downplays the impact of our aging population on the system. This is short-sighted and should be a major focus of the government.

As people age, they use more services. And we are getting more and more aging people, particularly in the rural centres. These elderly people are the same great people that sacrificed to build this province. We cannot afford to turn our backs on them now in their time of need. It may be an inconvenience for me, a young person, to travel for medical services, but it may be impossible for a senior to do so.

Many people choose to retire in the towns they're familiar with. They often choose towns that have a hospital nearby. The idea of a community care centre or a primary health centre will not be adequate and will see our seniors also moving to the cities. What will be the effects of this future trend on the city hospitals and senior housing in these cities?

We need to focus more on services for the elderly. Home care is a good start but there needs to be much more done in regards to seniors and low-income housing. This can be accomplished much, much more economically in rural centres where housing costs are a fraction of those in the city. We also have a growing need for long-term care.

To address this issue, we have been planning for the construction of a new integrated health care facility, as Mr. McMillan mentioned earlier. This facility would consist of a hospital coupled with a long-term care facility. These are the kinds of services we desperately need in rural Saskatchewan.

Working as a team, several local area governments have agreed on methods of financing its construction using local tax revenue. These are the kinds of efforts that we need. I hope that the government will move quickly to remove roadblocks and allow us to proceed with this much-needed facility for our seniors.

The other issue relating to demands on the system is convalescent care. With the trends in recent years to release patients quicker after surgery, birth, etc., we have seen an increase in the demands of our rural hospital for convalescence. We've also seen an increase in the number of patients who have

to return for treatments resulting from being released too early.

Mr. Fyke states that we need to further reduce lengths of stay in hospital. If we become a community care centre specializing in convalescent care, then the attending physician would definitely need a lab. Without a lab, most convalescent care will need to occur in the regional hospitals where lab access is available. This will put a lot of added demands on their systems.

The fourth problem I want to examine is staff shortages. If implemented the recommendations will once again aggravate this problem. The change in rural hospitals to community care centres or primary health centres will certainly result in doctors leaving rural Saskatchewan. Most likely if they are moving it will not be to another Saskatchewan location.

We have excellent, dedicated professional doctors in our rural hospitals. If we want to keep them, and we do, we must stop blaming them for the problems that exist. It is not their fault. They must be seen and used as part of the solution. We cannot continue to tie their hands with administration and bureaucracy.

By converting to a community care centre and primary health centres, we will also lose a lot of our dedicated nurses. Mr. Fyke believes — or hopes — that they will freely transfer to the regional and tertiary hospitals. Some may but many will not.

If they are moving, many will be attracted by offers resulting from the shortages across this country. Many will not be able to move as they have roots in the community. Perhaps their spouse is tied to a business or a farm. They may choose to retire or leave the profession altogether. These recommendations will surely add to the problems of staff shortage.

These changes will have impacts reaching far beyond health care system. This will be yet another devastating blow to the economy of rural Saskatchewan. If this government is serious about revitalizing the rural economy it must not allow these recommendations to proceed.

Kipling's hospital adds much more to our community than health services. It keeps our senior citizens in town. Many retire here because they feel safe in knowing that there is a hospital. Many young people consider whether or not there is a hospital in town before moving. I did and would not have chosen Kipling to move to if it had not had a hospital.

Many new businesses and value-added industry have emerged in Kipling with a hospital as a contributing factor in their decision. We need to continue to attract this kind of industry. People create a tax base to utilize for services and recreation, which in turn attracts more people. Schools become viable and businesses thrive and grow.

We do not build hospitals to build the economy, but they do have that effect, particularly in smaller rural communities. The loss of our hospital would have a devastating effect on the economy and morale of our town, and all the neighbouring towns. Please do not let this happen.

In conclusion I would like to say the following. We do not believe that the recommendations of the Fyke Commission will adequately address the challenges facing our health care system. We feel that we need, and are entitled to, a strong rural hospital system.

Don't be scared of the word hospital — we don't need a name change. We realize that these hospitals will be different from the hospitals in the cities. They have to be. They are not the problem. They do not need to be in every small town, but they are needed in several smaller centres. They need to have a basic set of services available in order to make them attractive enough for our doctors. This includes lab and X-ray facilities, and beds for patients that require them.

Again, don't get hung up on the name. It should not matter if the bed is for acute care, convalescent care, or anything else. They all support the sick people that need them.

Reduce the administration if needed, but have some faith and trust in the front-line doctors, and nurses. Today our existing small town hospitals are the glue that holds . . . that is holding together a very fragile and delicate health care system. If you remove the glue, the whole system may fall apart.

Please take our advice into consideration when making your decision regarding the recommendations of the Fyke Commission report.

I thank you for the opportunity to express our community's concerns. I have confidence you will make decisions that will be best for our province. Thank you.

The Chair: — Thank you. Is there anyone else from the delegation that wants to speak? You'll have to get close to . . . quite close to the microphone.

Ms. Haanstra: — Thank you for the opportunity. In 1973 I moved from Ontario to Saskatchewan. A job opportunity took me out of the province for six years. That same job opportunity gave me a choice to make: move either to Alberta, Ontario, or back to Saskatchewan. I chose Saskatchewan because it provided me with the rural setting I was looking for to raise my children.

Rural Saskatchewan gave me excellent health care, with attending physicians. Dental care, education, policing, shopping, libraries, all within 10 minutes of my home.

Now some years later I am no longer guaranteed that same luxury I had in 1973. Granted I am not raising my children any longer, but maybe I want to provide the same services for my grandchildren.

Some of us like living in small town Saskatchewan, and we still need doctors, policemen, dentists, teachers, storeowners, librarians, and more to keep our communities active and viable.

Did I make the wrong choice? Only I can answer that question. But with each report that is written and each commission that is done, it is getting harder to live in small town Saskatchewan, where I want to live.

I am writing this as a concerned citizen of our small community and trust you will consider the needs of rural, as well as urban people. Thank you.

The Chair: — Thank you. Anyone else? No? Then questions from the committee?

Mr. Thomson: — Thank you, Madam Chair. I want to thank the presenters today for their written presentation and their verbal presentation.

It was right at the tail end of your presentation that I heard something I really liked, and I liked most of it. But I really liked this part because I thought it encapsulated a lot of the issue that we're getting into with Fyke, and that is this comment that we do not need a name change.

You then go on to enumerate the different services that you think your community needs and I thought it was interesting that in many cases it matches up with what Mr. Fyke has suggested, but it still maintains the lab services and that ever-important word, hospital, that I think all of us in Saskatchewan have come to be used to, especially those of us who grew up in small towns. I want to say that I appreciate that.

I'm interested though — because I'm supposed to ask questions — I'm interested in knowing, in addition to the lab and X-ray, the clinic, some emergency room care, long-term care, convalescent care, Fyke goes on to talk about the need for us to also build into these areas better public health, mental health, and rehab services, along with palliative and respite. To what extent are those other services currently being provided in the Kipling area?

Mr. Varjassy: — Actually I believe, and maybe you guys can help me out a little bit with this, but I believe everything that you mentioned is currently being offered either out of the existing hospital facility or an extension of that, that hadn't been there in the past. It is now and I think that's been an improvement.

Yes, we do have a drug and alcohol rehab centre and some of those other things that you mentioned.

Mr. Thomson: — I understand that there are three doctors currently in practice in Kipling?

Mr. Varjassy: — No. Yes. Sort of. There were, not that long ago. Our third one recently transferred to Redvers, I believe — was it? And there is one there taking their place.

Mr. Thomson: — I'm interested in this question of the acute care beds. Now you made the comment again just at the end of your presentation. You said it should not matter if the bed is acute care, convalescent care, or anything else. They all support sick people that need them.

How many acute care beds do we currently have in Kipling?

Mr. Varjassy: — Fourteen, I believe.

Mr. Thomson: — Can you tell me, just because I'm not familiar with the specifics of the situation, what are the type of services — acute care services — that people would get in Kipling and what would they then move on the next largest community for, which in this case is probably directly into Regina.

Mr. Varjassy: — Boy, I'm not an expert in that field at all but I'll go from my experience. We do have the lab and X-ray facility, physiotherapy, etc., those sorts of things are offered there.

Your question is what is offered in the acute care. I think that's a very wide range of services. Recently I had, based on my children, they've been in our hospital and I believe would have utilized the acute care beds. This past weekend my daughter had a serious blow to the head and they suspected a concussion so they had her in hospital overnight for observation.

In the past just observation of elevated fevers, etc. I'm not, as I said, an expert in that field but those sorts of things. And I just can't see transferring somebody to a regional hospital as being an economical way of doing things.

An earlier presentation from Indian Head, the mayor of Indian Head spoke about the level of service and the level of staffing required to provide that service. And I didn't go into that in my report and I wish I had because it would be very similar and I suspect if you checked into the other smaller hospitals, they're very well run.

Mr. Thomson: — Thank you. I want to make certain and I'm not arguing that they're not well run. I really am just not familiar with what the configuration in every one of the communities is.

One of the things I am impressed with, particularly down in the Southeast is the increased degree of co-operation among the districts. And you're in is it Moose Mountain? No, Pipestone, sorry . . . (inaudible interjection) . . . Moose Mountain. And Moose Mountain, South East, South Central, and Pipestone I know all have differing degrees of service contracts among them.

I'm interested as to what your view is in terms of some district amalgamation. Is there an ability for us to achieve a saving there?

Mr. Varjassy: — I'm not sure if the savings would be significant in terms of dollars and cents, and it doesn't seem to be a large issue in our community. Perhaps some amalgamation would be good. I think the general feeling, if you get to district models that are too large, then, as Mr. McMillan indicated earlier, what's the point of having them? You may as well have one central.

Mr. Thomson: — I'm curious, given your comments on page 90 of your report where you say we cannot continue to tie the hands of the doctors with administration and bureaucracy, as to whether that was part of the administration and bureaucracy you were referring to.

Mr. Varjassy: — At times there is frustration on the doctors' part dealing with the district health board. I won't deny that.

Mr. Thomson: — A final comment, Madam Chair, is the same one that I make to most of the groups appearing, is that I just want to remind you that the government hasn't made a decision on what to do with Fyke yet. Obviously that's part of the exercise we're going through right now, is hearing opinions of

citizens from around the province and stakeholder groups. And so as such I want to really thank you very much for your thorough presentation today.

The Chair: — Any further questions from the committee?

Mr. Gantefoer: — Thank you very much for your thoughtful presentation, and also it followed very well from the Kipling and area foundation presentation.

The general comments that I would have, I've made in that regard. But I would like to thank you for very clearly and eloquently articulating the real concerns about the provision of health care services in your community, and by extrapolation in most small Saskatchewan rural communities. So thank you very much for taking the time to come today.

The Chair: — Seeing no more questions then, on behalf of the committee, thank you very much for your presentation and your written submission. We appreciate that.

Our next presenters are from the Regina Health District. Good afternoon, and we apologize for being a little late but it's been very interesting all day today.

I'd like to welcome you to the Standing Committee on Health Care, a committee of the Legislative Assembly. It's an all-party committee. I am Judy Junor, Chair of the committee. Andrew Thomson is a member of the committee; Dr. Melenchuk is the Vice-Chair; Warren McCall. Sitting in for Pat Lorjé is Mark Wartman today. Brenda Bakken, Bill Boyd, and Rod Gantefoer are the other members of the committee.

The first order of business of the Standing Committee on Health Care was to receive responses to the Fyke Commission, or the Commission on Medicare and report back to the Legislative Assembly what we heard. And that's what we're doing now with the presentations from groups and individuals. Our presentations are 30 minutes, give or take, as you see. And we hope at the end of your presentation that we have time for questions from the committee members.

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

Ms. Bergman: — My name is Anita Bergman. I'm Chair of the Regina Health District.

Mr. Saunders: — Yes, good afternoon. I'm Jim Saunders, interim CEO (chief executive officer) of the Regina Health District.

Ms. Bergman: — I'll begin.

The Regina Health District appreciates the opportunity to make this presentation to the Standing Committee on Health Care. The purpose of our brief is to summarize the observations, comments, and recommendations of the Regina Health District regarding the report by Mr. Ken Fyke.

The Regina District acknowledges and supports the need for constructive change in the organization, delivery, and funding of the health care system in Saskatchewan. We believe that fundamental change is essential in order to ensure the sustainability of our publicly funded, publicly administered, health care system.

Strong, proactive, and creative leadership is required at the federal, provincial, health district, physician, and union levels in order to redesign our health care system to function in a fully integrated, coordinated, effective, and efficient manner. We acknowledge that tough questions have to be asked and difficult decisions need to be made regarding the reorganization of the various parts of the health care system.

We encourage each of these groups to approach the challenge with an open mind and with a focus clearly designed to place the patients, residents, and clients in our health care system as a single most important group.

We are also prepared to serve in the capacity of leader or participant in the implementation of strategic directions and action plans related to the organization of the health care system in Saskatchewan.

With those introductory remarks, I'll turn the mic over to our president and chief executive officer to give a more detailed response of the district to Mr. Fyke's recommendations.

Mr. Saunders: — Thank you. And thank you for this opportunity today. I think what you'll hear in our presentation today very clearly is that the health care system in Canada, and specifically in Saskatchewan, must be reorganized in order to assure that the current health care system values, principles, and expectations that many of us have on that system can be sustained.

Strong leadership and competencies are essential at all levels of the health care system including policy-makers, managers, and providers. At the broadest level the ability to operate an integrated, coordinated federal and provincial health care system is dependent upon clear definition of roles, responsibilities, authorities, and accountabilities for all of the key stakeholders. That point was brought forward very strongly by Mr. Fyke and the commission. The concept of accountability is an opportunity for all of us in the health care system to learn and to grow with.

The national health care policies and principles are currently well documented in the Canada Health Act. The Act does not have to be reopened, but rather the definition and application of the principles must be openly debated. The principles for a publicly funded, publicly administered health care system must continue but must be defined in such a manner which will allow the health system managers and care providers to function in a more efficient and effective manner.

In the organization of the commission's report, they organized their comments in six areas. And for clarity, we're going to follow the similar policy and we'll address our comments, observations, and recommendations related to the thoughts brought out in the commission's report in that same order. So I'll begin with everyday services.

First and foremost, the principle of an integrated primary health care system which was so strongly supported in Mr. Fyke's

report is also supported by the Regina Health District. We think that fundamentally an expanded role for primary health care and a network of services to support that network will be absolutely essential.

We did note, however, in the report that the concentration of primary health care was focused in rural Saskatchewan and perhaps in regional centres throughout Saskatchewan. We believe that the opportunity for a similar concept, a much expanded network of primary health care, which in fact could serve as a provincial model at the urban level, should also be developed to a much more sophisticated level.

In Regina, specifically, we see large opportunities for introducing an alternate entry point to the health care system through a primary health care network of services. In Regina, without going into a lot of detail, we see the ability to open a 24-hour, 7-day per week alternate care facility where the introduction of health services would be available to the community and that the access to those services would be delivered by the most appropriate health care providers. The physician would be a part of the team, but the point of first contact really would be by the most appropriate staff category.

We have that developed . . . we have that model developed in much more specifics in terms of location of those primary care centres throughout the city of Regina and surrounding areas. We also see them as a connection point to regional and rural Saskatchewan, looking for opportunities where the interaction between those regional and rural centres could be far more effective than it is today as they interact back into the urban centre, where we have the advantages of many new technologies and a much broader range of both physicians as well as other health care professionals.

We support the concept of telephone advice. We believe that the concept is valid, that the public is demanding this access and that we believe we can deliver that very appropriately. We think, however, one central service on a provincial basis is too large. We believe that two phone advisory services — one out of Saskatoon and one out of Regina — each serving half the province, would be very appropriate and that it would have a tremendous impact on the sense of acceptability of the health care system as well as the ability to access quality advice on all health matters.

We are supporting and promoting a network of telemedicine and telehealth services. This again is the ability to reach out from urban centres and to share the expertise that we have in our urban centres, both medically as well as professionally in all of our health care disciplines. Considering the vastness of space and sparse population base and the known shortages that we continuously face in our physician specialties, we need new access points to expand the availability for those services to the people of Saskatchewan. We believe that an effective network, a coordinated vision so to speak, of telehealth and telemedicine would be a very positive addition to our health care system.

We see it functioning with two base stations, a very sophisticated base stations, one in Saskatoon and one in Regina, complemented by a series of 6 to 12 satellite stations in regional and rural centres throughout the province. The exact location and the exact type of equipment that would be installed, both in the urban as well as the satellite units are yet to be determined. But philosophically this will provide a network of quality services and the availability of specialists who otherwise would not be available, and it would prevent the need for continuous travel either by care providers or by our patients, clients, and others who need to access our health care system.

We support the concept of tertiary services and we liked the philosophy put forward in the report regarding having designated tertiary centres, which are well equipped, well staffed, and well financed. The infrastructure and the ability of this province to continue to provide high quality services make that component an essential ingredient to focus the health care services in the province.

We note that Regina, Saskatoon, and Prince Albert are noted as tertiary centres. Without drawing conclusions in terms of the final outcome of our comments, we believe that with the relatively small population in Saskatchewan of about a million people, that we would recommend that the inclusion of Prince Albert as a tertiary centre be reviewed in more detail before the designation is confirmed. We state this in a positive way, not to speak of the capabilities of Prince Albert, or any other health centre for that matter, but simply on the basis of the expectations for tertiary centre are very, very extreme.

The ability to provide the range of services that would normally be defined as tertiary level services are critical in their ability to make the right decisions by EMS and by our patient groups. And also our capability of providing the capital equipment and technology to support a tertiary centre makes this decision one that requires additional detail.

Also we would draw your attention to the cost of trying to redefine two different levels of tertiary centre, which would be obviously the case if we had three in Saskatchewan.

We have not noted it in the report but we would ask that you would note it in the margins of our report, is that we would support a coordinated provincial EMS system with two call centres. We believe the ability to assure access by qualified health professionals in a timely manner will be dependent on that EMS system. We think they are the lifeblood of connection between all parts of our province into qualified health care services. They also serve as a critical assessment and triage centre for individuals experiencing health problems.

We believe that the specialist physician compensation — and I would also add the compensation for family physicians — needs to be reviewed. The current incentives for our physicians is unacceptable. The ability to pay them only on the basis of the volume of patients that they see is long past time that it was changed.

We believe that the physicians themselves would support a review that would be constructively engineered and designed to include strong participation by the physician groups in the review of their compensation, but that we look for alternate payment plans which would functional . . . that would be functional, that would be valued by our physicians groups, and that would be a long-term solution, and that would also be cost effective.

We also support the concept that with health districts assuming the responsibility — and I hope that through this series of changes, increased the accountability for the financial aspects of it — it's also supported by the Regina Health District, that the transfer of funds for specialist from Saskatchewan Health to the health districts take place.

Quality council — an interesting concept. We support the philosophy of a much stronger and more thorough review of quality throughout our health care system. But we're concerned with the terms of reference of the quality council that is outlined in the report. The report provides the council with significant scope of responsibility, tremendous breadth of responsibility, but what we can see and read into the report, very little authority to enact the changes that would be required if their recommendations were implemented.

We see, we see the concept of quality review as essential, but we don't see the need to create a new infrastructure, which would mirror the capacity that we have in our Saskatchewan health groups now and in our health districts. So we would ask that the cost be reviewed as well as the role and authority of a group. And perhaps the group and the organization of such a quality review group could be redefined to a broader level.

Recruitment and retention. This perhaps is one of the greatest challenges that we face across Canada and, in particular, in Saskatchewan. Recruitment and retention of physicians, nurses, and health professionals at all levels including our technical groups and our health science groups including pharmacists and others. The ability to keep these individuals in our province is absolutely essential, and we are not doing an adequate job of assuring that we are doing everything that we can to show our value for those people and to provide a workplace that is, that is seen by them to be an effective and an appropriate health care system that they want to be a part of.

We need to be more aggressive. We need to increase our initiatives. And we need to increase our investment. The investment increase has to come at the provincial level in terms of setting aside some funds that would proactively look for ways to increase the awareness of the good parts of Saskatchewan that we know exist and to assure that the opportunities for the lifestyle that people in Saskatchewan can, can experience is well known. We also think that health districts themselves need to invest more money in this initiative.

We are calling for a provincial summit on physician and health professional manpower. Whether they have to be two summits or one, what we do know is that we need a provincial focus and a provincial plan that would look for new and more appropriate ways to expand our success in this area.

We believe in health promotion, disease and injury prevention. We believe that we're not investing enough money in it. But alternatively, we can share with you that the competition for money to spend today is far greater than the incentive to look down the road at the . . . where the outcome and the positive effect of health promotion and disease and injury prevention would be seen. These are long-term strategies. What we are suggesting is that Saskatchewan Health allocate a specific percentage of the Health budget and remove it from the day-to-day operations as an investment in the future, and that those monies be spent in a coordinated manner with the input of health districts about where the most effective and appropriate expenditure and investments in those areas would be.

Getting results. We are highly supportive of evidence-based decision making. We are highly supportive of health districts in Saskatchewan producing annual reports for measurable quality, access, statistical and financial benchmarks.

We recommend that we begin as soon as reasonably possible to develop exactly what those benchmarks would be. We believe that the success of it would be in the development of a buy-in from all of the stakeholders, including health districts, physicians, and others who would help us design a system where you can collect data in a consistent and orderly manner so that it can be reasonably compared, not only internally in this province, but externally to other provinces and professional groups as well.

We support the concept of incentive funding. We believe that there should both be incentives as well as penalties. From a good business model we accept the fact that we need to be efficient but there needs to be some rewards for being efficient. It has to exceed whether or not you balance your budget. It has to exceed how effective you are . . . how efficient you are in terms of the range of services that you provide, and it has to include innovation and the ability to offer services in ways which are meeting the needs of the client, the satisfaction of the client.

So it's more than a money issue. The incentives should be based on the quality of organization, the results that you achieve.

We support change. The number of health districts should be reduced, but only following open dialogue and consultation with existing health districts, physicians, unions, and publics. Through this consultation process the criteria should be developed and then applied for the reconfiguration of health districts.

Such criteria should not be limited to reconfiguration of health districts based on existing district boundaries. The specific number of health districts should not be pre-selected pending the outcome of this consultation process. And among the principles to be defined would be acceptance of normal trading, travel, and current health care delivery patterns, and destinations for those health services.

Health services for Aboriginal people are not meeting their needs today. A clear definition and clarification of policy and funding responsibility of the federal government related to new and revised network of health services for both on-reserve and off-reserve Aboriginal peoples must be developed.

On a national policy and leadership, there must be input from our health care system to accommodate the Aboriginal health initiatives through more creative client-centred programs and services. A national strategy needs to be designed recognizing the combined health and spiritual needs for Aboriginal peoples.

Pending the introduction of self-funded capital equipment strategies, Saskatchewan must invest in capital equipment for

its health care system. To do so we're recommending that a capital equipment fund equal to 4 per cent of an annual operating budget for tertiary centres be provided; 2 per cent of annual operating budget for regional health districts; and 1 per cent for rural health districts. Without adequate technology and without keeping up with the tremendous evolution and change in capital equipment we will not be able to sustain the quality of health care services in this province.

We support an increase in teaching and research but at half the level recommended in the commission's report. They recommended 1 per cent. We believe that half of 1 per cent would be an important starting point, perhaps not the end.

We should create an innovation fund. When we spend all of the dollars and we have nothing left to provide people with the incentive to think differently, to open up their mind to new pilot projects, we are destroying the incentive for our health care people at all levels. We're recommending that the creation of an innovation fund of $5 million per year be made available and administered in a way that rewards the creativity so that we can try new pilot projects on one-time funding basis and move forward constructively, hopefully in the improvement of our health care system.

We need to set high expectations for the coordination and integration of health services in Saskatchewan. This small paragraph speaks widely for the opportunities that we see in Saskatoon and Regina for improving significantly how we operate health services in this province. We believe that there are great opportunities to consider provincial programs, the ability for Saskatoon and Regina to co-operatively design programs which would be serviced in one location for the entire province.

We believe also that there should be serious consideration and interprovincial discussions with other health departments in other provinces about the ability and feasibility of introducing interprovincial programs where one province can't support the kind of technology and infrastructure and specialists that it would require for the highest quality of health services. There are many opportunities, we believe, in that area as well.

We would like to see Saskatoon and Regina charged with the responsibility to bring forward a list of potential provincial programs and then to work with Saskatchewan Health and the medical groups and others to finalize those plans.

The roles, responsibility, authority, and accountability of Saskatchewan Health must be redefined. We believe that government can provide strong leadership, good policies, and clearly defined standards and expectations. And then we believe that health districts should be fully accountable for maintaining those pre-established standards for quality, access, and financial performance to the extent that health districts must accept that board and management changes will be considered if accountability is not fulfilled.

We believe that a business model should be introduced where business principles in the funding and operation of health districts can be considered. And in that, I guess my previous comments around capital equipment and the ability to function differently and to allocate funds so that we can plan for the future for our capital equipment and other needs in a more businesslike way on a multi-year budget basis.

We believe the federal government should be providing to the provinces stability over a multi-year funding and we believe that the province should be providing to health districts the ability to plan on a multi-year basis. And then we should be held accountable for the results that we achieve.

A common national definition of what health services will remain insured and what health services may fall outside of the public responsibility must be undertaken on a national basis. The debate frightens most of us. But the ability to come to terms with what it means to assure that we have a sustainable long-term health system that will be here tomorrow is essential; that we look at the services that we're covering and what we're paying for those services. And if we don't confront the issue head-on, if we don't debate the issue openly, then we'll never get to the final ability to determine how best we can sustain this wonderful health care system that we have in Canada and in Saskatchewan.

That concludes my remarks. Thank you, Madam Chair.

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

Mr. Gantefoer: — Thank you very much for your submission. It's very comprehensive and very detailed and would result in us being here beyond what's reasonably allowed to discuss all the implications of it.

First of all, let me say that the focus that I detected in here is one primarily from the perspective of the Regina Health District. And I think that that's normal and expected, given the fact that other presenters have focused from their own perspectives. But I would like to try to wed some of the concerns that we've heard in these hearings, from your perspective as well, that isn't specifically covered in your brief.

A number of communities in southern Saskatchewan today and last week have made the point that if, as they fear is implied in Fyke's recommendation, that there is a diminishment of acute care services, lab services, those kind of facilities in rural Saskatchewan, it'll result in a snowball effect that will eliminate the desirability of rural physicians to practise in those communities and will simply push those kinds of demands into the centres that you represent, like into Regina.

Have you seen that trend happen over the last number of years, since the initiation of health care reform in '93, the urbanization if you like, the demand for increased services placed onto your health district? And if Fyke is recommended and the concerns of these rural communities are realized, does this imply greater pressure on the tertiary centres for increased services?

Mr. Saunders: — I think the point is a very sensitive one for the populations in rural and regional centres throughout Saskatchewan. It has also been a pointed debate in Regina, and I'm sure in Saskatoon, with regard to the potential workload if more things were funnelled in.

I think what Mr. Fyke was promoting and I think what we

would promote in that regard is the expanded responsibility for the coordination and integration of health services beyond our current walls. The change in responsibility and the change in organization doesn't have to take things away from the community.

In fact in many respects it may bring things to the community that aren't currently available because the responsibility and the breadth and scope of that responsibility expands. The opportunity to look for what those needs are in those communities and to look for better ways to meet those needs, with an increased base of resources, an increased base of people, health professionals, and physicians, Telehealth, and technology, is a tremendous opportunity that we would see not taking away from those communities but adding to it.

Mr. Gantefoer: — I think that the concern would be from these communities, anticipating their response to your comments, would be that they lose the autonomy and they lose the ability to articulate effectively and efficiently what the needs are and how those services will be delivered.

I think everybody would agree there should be better coordination between services on convalescence, on recuperative, on palliative services, even acute and trauma cases, between rural centres and the major tertiary centres, that there's a lot of work that can and is being done in order to improve that coordination.

But I don't know that rural people are real excited about the idea of just sort of abrogating that whole process over to Regina Health District in the instance of southern Saskatchewan and Saskatoon in the centre, North, without some kind of meaningful involvement.

And that leads me to my next question. You talked about there should be some reorganizing, re-rationalizing of health care delivery. From your comments in terms of the responsibilities of the Saskatoon and Regina tertiary centres, there almost is an implication that we really needed two districts in this province, one based out of Saskatoon and one out of Regina as the major tertiary centres.

Because in your report or in your presentation, you talk about that's how the EMS system should be organized, how the Telehealth system should be organized, how community coordination should be organized. I think that you might be suggesting that an efficient service delivery model might indeed mean two or maybe three health districts.

Mr. Saunders: — If I did, if that was the implication of my comments, then I'd like to clarify that no, we're not recommending two districts. I think we're looking to where it is economically and medically feasible to consolidate services that are required on a broad scale, that Regina and Saskatoon are well located and have the infrastructure to provide those services.

The criteria that would establish how many districts you need are quite varied. And I think when you look at the local needs, then you don't look at an extremely large infrastructure as the answer to a health care delivery system based only in two centres. I think there are a number of primary care initiatives that need to take place at the local community. There are a number of things that need to be planned for individual communities that they can best do themselves.

What we're suggesting on the broader scale in terms of provincial programs, as well as essential infrastructure support systems like Telehealth and Telemedicine, are that we can do that and service those other communities effectively without assuming any sense of control over their individual daily decision making in the health system.

Mr. Gantefoer: — Thank you. The other just small part of your brief that I want to touch on is the requirement for capital equipment allocation of resources. And you indicate, I think, a 4 per cent, 2 per cent, and 1 per cent sliding scale of . . . as a percentage of the operating budgets of those health districts.

Is the demands on the tertiary centres so much greater both in absolute and in comparative terms that you'd indicate a higher percentage level of, of course, a much higher budget than would be the budgets in other centres? Are the demands there that much greater that it would justify a sliding percentage scale in addition to the fact that just a single percentage scale would result in increased funding for the tertiary centres?

Mr. Saunders: — Actually there is a very significant difference. The technological requirements for Saskatoon and Regina to function effectively as tertiary centres is dramatically different than a regional and certainly than an urban . . . or than a rural hospital. Our ability just to maintain the technology that we have in diagnostic imaging and laboratory and in all of our medical service areas is critical to our ability to offer the high technology services.

You don't require MRIs (magnetic resonance imaging), you don't require special procedures rooms, and all of the other sophisticated testing and assessment equipment that tertiary centres require in centres other than those tertiary centres.

We believe . . . and basically we took our annual budget at about $400 million per year, 4 per cent is about $16 million. We have a list that our physicians and professionals have put together that exceeds $60 million, and a priority list that exceeds $40 million, and an absolutely can't-do-without list that exceeds $20 million.

We are behind the times. We have not invested in capital equipment and we are going to, if we don't invest in that capital equipment, face situations where the ability of our subspecialty physicians to assess accurately the health issues will not be available. Mistakes will be made. And frankly, our ability to attract physicians and technicians and other health professionals is also contingent on having the capital equipment that is suitable for the kind of responsibilities that we carry.

So I would say clearly there is a very distinct difference in our needs to the others.

Mr. Gantefoer: — Thank you. And one final area. In terms of access to diagnostic services, are there some things that could actually be regionalized more; for example, CT (computerized axial tomography) scan? And I know MRI is a more sophisticated level, but CT scan seems to be becoming much

more of a mainstream, routine diagnostic tool than it used to be just a very few years ago.

And are the realities that the only places really that we have CT scan equipment is in Saskatoon and Regina, with the mobile in Moose Jaw/Swift Current, I believe. But for example, could we make much better use of resources if for example CT scan capabilities were put into Yorkton for example. That is all these people would have to come to Regina now. Are there things like that? I use that by way of example.

But are there things that you are currently forced to do now in your district that actually could be providing some relief in terms of waiting times and accessibility if some of them were actually regionalized?

Mr. Saunders: — I wouldn't comment specifically on the CT scans but I would say that there are opportunities that should be more aggressively pursued in looking for ways that would prevent patients from having to travel into the urban centres and would enable us to return those patients to their home communities earlier.

A number of considerations would have to be taken into mind. First of all, the ability to staff. To put the technical and medical staff capability in those centres would be a prerequisite.

The cost to operate them and the type of volume in terms of the draw area would be considered, but I think I would accept that there are opportunities we haven't explored today that would involve decentralized equipment in some form or another that could be much more positively discussed with those other health districts and our health professions.

Mr. Thomson: — Thank you, Madam Chair. I wanted to ask questions particularly around the area of waiting lists, of managing the system, and funding.

I was recently in a meeting of the Standing Committee of Public Accounts where we were discussing with the Department of Health and the Provincial Auditor the funding mechanisms within the districts. And I was interested to learn that if I lived in a small urban area, that my district would receive funding for let's say gallbladder surgery that could be performed in Weyburn. But if I chose to come into Regina, that funding would not follow me in to get the surgeries done.

I was surprised at this inequity. So in fact what we have built into the system is a place where the urban people are competing with rural people for the services we're funded for here. Can you quantify for me what that level of funding inequity is?

Mr. Saunders: — The waiting list requires a lot of work because it's very misunderstood and the accuracy with which the data is collected is questionable.

The funding for health services that we provide for in Regina, for example, is based primarily on a global budget for our redistribution, and then some designated funds. It's also assumed that within that funding base, the services that we have been providing for out-of-district provinces is accommodated in our funding base.

For example, in Regina about 40 per cent of our clients, of our patients that we see in the Regina Health District don't live in the Regina Health District. But in reviewing our funding each year with Saskatchewan Health, it again is assumed that this has been a historical trend that has been maintained over time and therefore the funding to look after those people is built into our budget.

Mr. Thomson: — One of the items that concerns me with Fyke's recommendations, in terms of the implementation of it, is this idea that we would regionalize the services; that we would set up these regional health care centres where you would have expanded surgical opportunities.

I was talking to a woman a couple of days ago who was saying that she had wanted some surgery done. Had tried, her doctor had tried to get her into Saskatoon; there were no beds. Tried to get her into Regina; there were no beds. And recommended that she go to Calgary.

As it turns out, the surgery was able to be performed in Yorkton. The doctor was not keen on performing . . . on referring her there because of concerns over, I don't know what, and instead recommended an out-of-province referral.

How do we build up the confidence level of people to make use of the regional services where we're funding them to get their surgeries done? Or is this a flaw in Fyke's report and we should simply look at expanding capacity in Regina and Saskatoon which people seem to want to use?

Mr. Saunders: — I think what Mr. Fyke did was based many of his comments and observations on the concept of quality. He did not believe that there was an adequate volume of surgery done to warrant safe surgery continuing to be offered in small centres. He didn't believe that there was adequate backup and he didn't believe that the volume of individual surgeons in small centres was sufficient enough to maintain their skill levels.

So that, that resulted in that recommendation. I believe the data behind that was based on quality and that's saying you should not be doing things; they can be more safely done elsewhere.

Now having said that, the waiting list is confusing in many respects. First of all, if you were on a waiting list for an orthopaedic surgeon, surgeon A and surgeon B could have six-months difference in your waiting time depending on how busy they are and their access to services.

Our ability to use alternate types of surgical facilities to try to offload the surgical volume that we have in our hospitals are opportunities that we haven't explored yet, in terms of ambulatory surgical centres, taking things that don't require a hospital-based, fully-integrated operating theatre environment that could be done elsewhere. We don't have the capacity to make that choice at this point because we don't have facilities outside of our hospitals to do that.

So we could make better use of facilities like Yorkton, Swift Current, Moose Jaw in southern Saskatchewan, if we had a better coordination and ability to move the patients and the surgeons simultaneously. The trouble we run into is the

surgeons don't want to travel, and the patients are very uncomfortable, and the infrastructure support in the other centres doesn't mirror what they have available to them in the large urban centres.

Mr. Thomson: — One of the areas that concerns me as I read Fyke's report — and I'm looking at chapter two, "Specialized Care" — he talks about the number, the large number of surgeries that we are not doing on a day surgery basis. He talks about 2 per cent of gallbladder surgeries in the province done on a day surgery basis compared to a national average of 29 per cent, or 44 per cent in Manitoba.

He says the same for hernia repair. We're doing about 20 per cent on a day surgery as opposed to a national average of 53 per cent. He says the same for tonsillectomies; 3 per cent are done on a day surgery compared to a national average of 54 per cent, and 72 per cent in Ontario.

This would seem to me that we are not effectively utilizing our operating theatres. We see Regina as a major tertiary centre; a lot of these surgeries will be done here. What sort of management tools have you put in place to make sure we're more effectively using our operating theatres?

Mr. Saunders: — First I would comment that the data is quite old that was quoted in the report. We believe that we've made improvements since that, since a number of the statistical data reported was produced. But nevertheless, we would also agree that the ability to improve our utilization is probably one of the greatest opportunities that we have in our health care system to improve efficiency and effectiveness of the system.

We need benchmark information. Our support for evidence-based decision making would include the ability to look very seriously at the kind of medical practices that we have. There are individual choices made every day by surgeons and physicians about what resources are required, how long a patient should stay in hospital post-surgery, and a number of other aspects. Whether that patient could be done on a day surgery basis or an overnight basis are physician's decisions. And they do it in their best consciousness, based on their best past practice.

I think what we need is the educational tools and the understanding of what others are living with safely and appropriately. We never want to put the patient in danger, but we do need to know if other surgical groups in other centres are able to provide such a significantly different pattern of practice. Then we believe our physicians and surgeons are quite capable of reviewing that data objectively and changing practice where it's deemed to be safe and appropriately the experience of other health districts.

We don't have that database now. We are crying out for it. We are trying to move to appropriate benchmarks to measure ourselves against others. We have not done a very good job of that. And it is a large opportunity area for us which we are promoting in terms of our support for the provincial benchmarking initiative and our ability to provide reports that can be compared to something else accurately. That doesn't exist today.

Mr. Thomson: — My question concerns, again, a set of statistics which are somewhat old now. HSURC (Health Services Utilization and Research Commission) had reported that emergency rooms were being overused, that we had approximately 77 per cent of the people appearing in our emergency rooms were not emergency cases. At some time we had talked about setting up better ambulatory care centres to redirect these particular patients over to.

Listening to people in our own community here, and certainly listening to the comments from the opposition politicians, people are concerned about the waiting times, continue to be concerned about waiting times in emergency rooms. What measures have we taken within this district to make sure that Regina residents are making effective use of the emergency rooms?

Mr. Saunders: — We pursued a fairly aggressive public relations initiative on two occasions in the recent past trying to educate people about when to use the emergency department and when not to. It's a delicate balance. You don't want to turn them away if they really require those services; alternatively we would also agree there is inappropriate utilization of very highly technical lifesaving department in each of our emergency departments.

What we are proposing to change is our access points. We would like to see the primary care centre concept developed. As we indicated in the brief, we would support not less than one and probably not more than three centres; not less than one operating 24 hours a day, 7 days a week which would be a base and alternate system for access than the current system which really provides you access only through your family physician's office. And they're very busy to get timely access to them. Or your only other alternative is the walk-in clinics.

So people choose to come to the hospital. They have confidence in the hospital. They know eventually they're going to get good care. And they are triaged when they get to the hospital. The problem is that the less serious get triaged to the point where they end up waiting hours. And that's not meeting their expectations.

So we would see several alternatives. I think the telephone advice line will help. I think people would phone and get the preliminary advice of a health professional as to whether or not they should come to the hospital or not. I think, secondly, there may be alternates that might be available to them that would prevent their need to come to the hospital and then get diverted to somewhere else. And finally, I think, a different opportunity to work with family physicians in terms of how they operate their offices, how they operate their call systems, would also be appropriate initiatives to pursue.

Mr. Thomson: — Thank you for that. If I can offer one closing comment. One of the things Fyke didn't address, but I think that we need to seriously consider is how we communicate to residents throughout the province that the hospitals here, in Regina and in Saskatoon, are the province's hospitals. We've heard time and again that Regina has a Cadillac system, the cities have everything, that we're over-funding into the cities, that there's one quality of care here in Regina, there's another quality of care in the rural areas.

I know living here in Regina that I don't have that same sense of that. Now obviously I don't experience rural care, but I know the problems we have within our own district. I hope that one of the things we look at, regardless of whether we go with district reform, is that the Regina District will spend time with health care providers in particular, who are the patients' primary access point for information, to make sure they understand that these are provincial hospitals and help to break down some of that rural/urban bias which we have unfortunately heard a great deal that people believe exists.

So that is on your list of 800 other challenges, I think one more that you might just want to put on the bottom. Because I think you do an excellent job, considering the fact that funding doesn't always move from the districts that patients are funded in into our own facilities, as well as trying to provide to those of us who are funded in this district.

So with that, I'd simply say thank you for your presentation.

The Chair: — Thank you. Mindful that we have our next set of presenters patiently waiting, Mr. Wartman.

Mr. Wartman: — Thank you. I have a very brief question. I thank you for your report. It's regarding point 2.3 in your report on the quality council. You note there that you support the concept but you have some concerns regarding the fact that quality council would not have the authority to enforce their recommendations.

My reading of Fyke would indicate that his intent was not that a quality council would enforce its recommendations, but would report to the legislature. And that through that medium of reporting and providing information on quality of care, the legislature itself, the Health minister, and the department would then hopefully be able to provide the tools and the initiatives that would then help provide better quality care.

So can you say a little bit more about that just to help clarify, because I'm not sure I quite get the sense of where you want this to go.

You support it. Would you like to see the quality council have more authority to enforce recommendations? Can you say more, please.

Mr. Saunders: — We're concerned that the infrastructure required to put another layer of reviewer into the health care system would not be the best use for any available new money. We would support an overseer role that would evaluate quality.

But we're also supporting, in that same concept, the ability to put public reports out, where the boards of health districts assume primary responsibility for the services that they deliver, the quality of those services, the access to those services, and the financial cost and ability to live within the budget responsibility.

We see the Department of Health having a tremendous role and responsibility. Saskatchewan Health has a wonderful group of people and they have an infrastructure to support the measurement of quality. If they set appropriate expectations and benchmarks, then I would see the role as not being nearly as onerous as the role put forward in the report.

I think a citizens' council with a range of professionals on it that would look at the benchmarks, that would perhaps not review new technologies, new drugs, and new other things that are in the current terms of reference, but would perhaps look more critically at the reports that are produced by health districts, that would look at the standards that were being set and work with Saskatchewan Health in establishing an infrastructure and a review process that was outside of the political realm, outside of the medical realm, and outside of the realm of health districts, which everybody needs a check and a balance.

And I think that there is room for a new group to do that, but not one that requires staff of significance and that in fact takes away from the accountability of the health boards and the Department of Health.

The Chair: — Thank you. Dr. Melenchuk to finish this presentation.

Hon. Mr. Melenchuk: — Just a very short question, and thank you very much for your presentation.

I'm intrigued by your concept with regard to urban primary care. Having read Fyke and having had a chance to discuss some of his issues in primary care in rural Saskatchewan, I think it's his opinion that he would like to see a primary care model become the exclusive model in rural Saskatchewan.

Now I'm looking at your proposal for urban Saskatchewan. And what it suggests to me is that one, maximum of three, primary health centres would mean that there would be 120 or 130 fee-for-service physicians still practising in the community and competing for primary care patients.

So the concept to me is interesting in terms of your point of view of decreasing the amount of visits to your emergency rooms in providing them a lower cost option and probably a more appropriate option for quality. But how do you jibe that with a fee-for-service system where physicians are competing for patients, and also they're provided, in most circumstances, their own resources to provide those facilities?

Mr. Saunders: — We see a shift in the role that the physician is playing in the health care system having a dramatic impact on the access to services. We see physician groups who are very conscious about the type of services that they're able to provide to their patient, and they're also concerned with the hours with which it takes to do that adequately.

And they're looking to the system, whether that be through the new, specialized on-call service which was just approved by the Saskatchewan government or through other mechanisms. But they're looking back to the health district to assume some of those responsibilities.

Frankly, I think the fee-for-service mode of payment to family physicians as well as the specialists is outmoded. It has the wrong incentives in it and doesn't provide us with the ability to offer alternate types of care that may be more time consuming in some cases and may in fact be unnecessary in others. So that

we would need to develop a formula that does work.

The sensitivity that we outlined in the report is, we can't do this in spite of the physicians; we have to do this in partnership with the physicians. They are ready for those discussions. And I think constructively we could come up with a model that would work much better and provide different incentives that the current one.

You're right. We would see our primary care centres as being a primary hub that would allow people a different form of access, sometimes to a non-physician, and that it would be a new opportunity for them. We wouldn't want to see it in competition to the family physician offices.

Hon. Mr. Melenchuk: — That's the only question I had. Thank you very much.

The Chair: — Thank you very much, on behalf of the committee. Obviously a high degree of interest. Thank you for your written presentation and your presentation here today personally.

Thank you very much for your patience. This is the Standing Committee on Health Care. You probably heard my presentation already. Our first order of business is to receive responses to the Fyke Commission; and our presentations have been about half an hour, and obviously we're running late, so some of them are longer than others.

The committee is a committee of the Legislative Assembly and it's an all-party committee. I'm Judy Junor, the Chair of the committee; Dr. Melenchuk is the Vice-Chair. The other members of the committee are Andrew Thomson, Warren McCall, Mark Wartman, Brenda Bakken, Bill Boyd, and Rod Gantefoer.

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

Mr. Deg: — Thank you, Madam Chair. We are appreciative of you setting this time aside for us today. I'm Bruce Deg, I'm the chairman of the Rolling Hills Health District. Our CEO, Wayne Button, is here with me to answer some of the technical questions that you may have for us.

It's quite ironic that Rolling Hills follows Regina in the podium today. We are probably the smallest health district in the health system, but we also are quite efficient. And so I think in recognition of time — our full document was previously submitted — therefore I will keep my comments to a few highlights that the board had made in their response to the Fyke report.

We used a SWOT (strengths, weaknesses, opportunities, threats) analysis method and that's how our document was developed. The Rolling Hills Health District sees many positives in the recommendations of this committee . . . or the commission, particularly the focus on quality care and health services. The report is well written and timely.

However what is not in the report is of far more interest to the board than what is contained. The report opens issues but does not clearly state what is intended or how it would work. Therefore one is left with a great deal of interpretation.

A clear example of this is the lack of clarity around primary health care, and the functions of community care centres and existing integrated health care centres.

The district also believes that for success, plan implementation is essential. Many of the issues within the report clearly needs to be considered on a national level.

And I think some of the questions that you have asked some of the other health districts, there's I think the need to look at how the doctors are being paid, may have some answers to some of these questions. I think salaried doctors on a national level would be an answer. I'm not sure. There's lots of questions around that.

But if we're going to implement a primary health care system in rural Saskatchewan and in Regina, how . . . some of the questions rose from that . . . and I think salaried physicians would answer some of the competitive nature that this system might bring to the health system.

The district has demonstrated their awareness for the concept of integrated facilities and a focus on primary health care. Our district for example, since reform, four of our seven facilities within the district have integrated long-term care and health care services. Another two health care centres, Vanguard and Hodgeville, will be delivering primary health care come September.

And we're quite proud of that fact that we've got to that step. It took a lot of work and talking and co-operation with our physician to come to this point in our evolving progression as a health district. The remaining facility in the district is the district's only hospital in Herbert.

Truly as demonstrated by the success within our district and to gain our awareness and ensure success provincially, committed individuals in the local community can accomplish it. And that's how we were able to come around to our primary health care system, is we need that local autonomy to be able to understand what the community will want and need; and so in recognition of that, we believe that the districts should have full provincial implementation of all of the recommendations.

The number of the districts and the governance should be the last issue tackled. The board is not opposed to change. However it feels that it is important for change to be managed and based on evidence and not for the sake of change.

Another point that I'd like to touch on, is that the board is also supportive of Mr. Fyke's observation that administration to oversee and guide the delivery of health services is essential and that in recent years this has been reduced to a crisis level.

The board is also concerned with issues such as recruitment and retention that has been magnified by the level of uncertainty currently exuding in the system. Many quality individuals have left for a more secure future as this system seems to be perpetually reviewing and changing. And it is also our opinion that a larger district would not address this issue.

The lack of addressing intersectoral issues, the role of the Department of Health, and the responsibility of the issues are also a weakness in this report. He didn't talk about those issues at all.

Emergency medical services will need to be enhanced and expanded into areas where currently individuals cannot receive services within 30 minutes, as was recommended by that emergency report. It is essential that this occurs before any kind of conversion or closures of any of the other facilities that are in rural Saskatchewan are done. Currently many areas in our district still do not have that response time. Mankota for instance does not have that 30-minute time frame.

The Rolling Hills Health District fully would like to reinforce and support the positions and responses of the SAHO commission. All of the health districts sat and helped develop that position and we were unanimously in support of that. And I'd like to reiterate that again today. I understand that they will be making a presentation on the 27th of this month.

In closing, quality focus is the most important issue. And what a quality system is built on is practices and good policies. And in our case, I feel that our, our health district is evolving naturally. We're developing more shared services with some of our neighbouring health districts. So in light of that, I think that the last issue should be the one of politics, the governance, and district numbers, etc. The current delivery system is now maturing into a system that can make the needed changes.

Thank you for your opportunity. And if there's any questions, I'll try to attempt to answer some of the questions. The more technical ones, I'll slough off to Wayne.

The Chair: — Thank you. That was very succinct. Questions from the committee?

Mr. Gantefoer: — Thank you. I will try to be equally brief. One of the presenters earlier talked about the co-operation between districts and service areas to provide services on an area basis rather than an individual, district basis.

Can you tell me . . . As I understand from the definition of the services area, Rolling Hills, Swift Current, and Southwest would be in a service delivery area. Can you tell me, do you have any programs of service area nature that, that indicates co-operation between the districts in the southwest?

Mr. Button: — Yes. And I think we're continually developing some of them. Certainly the ones that were in place probably at the time of reform and that are still practising, would be in the public health side, specifically in public health inspection and some of those programs. However in the past year we've actually developed some new partnerships, specifically in the IT (information technology) sector where we will be sharing some information technology with them.

And we are currently looking at amalgamating some of our mental health. We had a mental health worker within our district and we certainly see where there's opportunities for us to expand that out and actually provide a higher quality service to the residents we serve.

So the districts are doing these things and I think, you know, these things are evolving and I think some of these opportunities will only continue to grow.

Mr. Gantefoer: — Thank you.

Hon. Mr. Melenchuk: — Just have one question with regard to your particular location and the fact that you are the smallest in terms of population of districts and likely, under Mr. Fyke's recommendations, a district that would be consolidated.

Under a possible scenario where there would be a larger district created, there has been a suggestion from an earlier presenter with regard to Swift Current and the old boundaries of Health Region #1.

Would you see that type of incorporation in terms of primary, secondary, and perhaps Swift Current being one of these regional centres as meeting the needs of citizens in that area of Saskatchewan?

Mr. Deg: — Well I think if amalgamation was felt necessary by the government of the day, that that could be one of the boundaries or the profile that we could use.

The two models that were suggested by Mr. Fyke in the report are I feel too cumbersome, too large. And in fact we've sat with the other four boards that have been indicated in these models and have discussed this, and to a person we feel that that is not the way to go.

Health Region #1 was certainly an innovative and pioneering way of delivering health services in southwest Saskatchewan, or in Saskatchewan in particular, and that could possibly be a boundary to use, a system to use considering the service area.

Hon. Mr. Melenchuk: — There was a suggestion from earlier presenters as well that the boundaries or the map that's listed in Fyke's report was not suitable because it didn't recognize, for example, current service agreements, current trade patterns, etc., and that before there was any kind of restructuring, that clear criteria amongst stakeholders and the public at large in terms of how this would occur would be necessary. Would you concur with that sort of a concept?

Mr. Deg: — I feel that definitely consultation with the public would be very, very important.

One of the things though that we feel that has to be maybe taken into consideration is the current boundaries that the health districts have and already the current service agreements that have already been derived when considering if there is going to be any type of consolidation of the health districts, that that should be considered quite strongly. So that you're not in the process of splitting up a health district when you've already developed a teamwork approach through the health district and other aspects would be greatly hindered. And I think for the sake of the people themselves, that it won't be as disruptive.

One of the points in my opening comment that I made about Regina and us, and it was ironic that we were following each other, is I also was . . . it was amazing that we have the same similar opinions about the Fyke Commission and we're . . . I

think that's quite ironic too. But, yes, I think that's all I have to say about that.

Hon. Mr. Melenchuk: — My final question is we've had a number of presentations and we've kind of been all over the map, I think, but there was a recommendation from one our presenters that we should go back to the old system where there were roughly 500, you know, boards, extremely decentralized system.

And then there was recommendation earlier as well that we should just have one board for all of Saskatchewan, so completely centralized. So we've got a completely decentralized and a completely centralized, and then of course the regional concept. And the question is do you support the regional concept or a variation of the current district structure that we have?

Mr. Deg: — I think one of the pitfalls of the earlier system was, is there is always little different pockets of different health groups going on. And as evident of that was the home care system when there about 10,000 different home care systems — I don't know what the number is — but none of them had any type of structure that was similar to say a neighbouring one, so one person would be doing one type of thing and one other type of person would be doing another type of thing. One of the things that we found with the latest reform is that we can get a handle on that and try to straighten some of that stuff out.

I think that being one big health district would have a lot of disadvantages too. And I think that 12 or 13 health districts is a small number to work with as well.

The Chair: — Any other questions? Seeing none then, thank you very much for your patience and thank you for coming today and presenting. On behalf of the committee I thank you very much.

The committee stands recessed until 7 o'clock.

The committee recessed for a period of time.

The Chair: — Good evening, and welcome to the Standing Committee on Health Care. Our task is to receive submissions of response to the Fyke Commission or the Commission on Medicare. The committee is a standing committee of the Legislative Assembly and we have to report back to the Legislative Assembly on August 30.

So we have half-hour presentations. And I'm Judy Junor. The committee is an all-party committee. I'm the Chair. Vice-Chair is Dr. Jim Melenchuk. Other members are Andrew Thomson, Warren McCall, Bill Boyd, and Rod Gantefoer.

And if you want to introduce yourself and where you're from and who you represent and then begin your presentation, we . . . it's about 30 minutes then we have some questions . . . hopefully, time for questions at the end of the presentation.

Ms. Barclay: — Good evening, members of the legislature, and the Health department officials. I am Myrna Barclay. I'm the president of the Community Health Co-operative Federation. And on my right is Mary Flynn, who is the executive director of the Regina Community Clinic, which is one of the federation's members. On my left is Jill Forrester, who is on the board of directors of the Regina Community Clinic; and on the far left, Patrick Lapointe, who's the manager of the Saskatoon Community Clinic.

So Jill and I are elected officials. We are volunteers in the system and, of course, our other two colleagues are managers of the clinics . . . of two of the larger clinics. So we have clinics in addition to Saskatoon and Regina. Our clinics are in Lloydminster, Prince Albert, and Wynyard. So there's five clinics in all.

Okay, our report tonight . . . our brief covers three areas. We want to talk about our agreement on the areas of top priority with the Fyke Commission. We have some further recommendations based on the community clinic experience, based on our experience, and then we have some ideas on how community clinics can help with health reform.

So we were very pleased to see Commissioner Fyke's strong advocacy for the continued support of the core operating principles of health care in Canada, that medicare should continue to be publicly funded, a single-payer system designed to ensure that everyone is treated equally.

We agree with Mr. Fyke's conclusion that we can have an affordable, sustainable system while operating within the bounds of these principles if we take positive action to ensure the system is efficient and effective and of high quality.

We support his recommendations concerning the ongoing development of performance indicators, the creation of a quality council, the development of reports to Saskatchewan citizens, and finally developing a quality oriented accountable and performance driven system.

We share with the commission a belief that effective primary health care reform is the most important step to ensuring effective, efficient, and affordable health care in Saskatchewan.

Mr. Fyke eloquently advocates for the development of interdisciplinary team-based primary health care services. He points to Saskatchewan's community clinics as models for the kind of primary health care we should develop across Saskatchewan, noting that we have been providing this kind of care for over 35 years. And actually it was 39 years this month.

We are delighted to see that Mr. Fyke argues for a community health centre approach to the primary health care, saying that it leads to stronger emphasis on health promotion and disease prevention, better management of chronic diseases, better attendance to health risk factors and groups at high health risk, more efficient and effective use of the skills of all health professionals, better diagnosis, treatment and care coordination, tailoring of services to meet the unique needs of communities and groups, and also more cost-effective care management. We must move our province toward this model of primary care, and we of course have felt like that for many years now.

We also agree with the Fyke report's recommendation that initial primary care development should be focused on those rural areas where primary health care needs are at risk of not

being met.

We strongly agree with Mr. Fyke's observation and recommendations concerning our need to focus more of our resources on health promotion, on disease prevention, and addressing the determinants of health. The primary health care service networks and teams can be very effective at preventing risk groups from getting chronic diseases like diabetes and heart disease. Canada's existing community health centres have been providing team-based care in these areas for many years.

A key component of the effective management of people with high-risk factors and those with chronic disease is the establishment of an adherence to common care protocols for team care. Health centres here in Saskatchewan and the rest of Canada have been developing protocols such as these, and we'll be pleased to share our experiences and expertise with provincial primary health care working groups.

We agree health districts and the provincial government must play strong roles as leaders and collaborators in bringing key community and provincial stakeholders together to develop and carry out strategies to address important health and social issues such as child poverty and the need for safe and healthy housing for all.

We very much agree with Mr. Fyke's recommendations on coordinating human resource planning on a provincial basis and renewing our health science education programs. In recent years we, like the health districts, are finding it more difficult to recruit health professionals we need to care for our clients. The province must play a strong leadership role in ensuring we have professionals to provide the quality care to our residents.

We agree very strongly with Mr. Fyke's conclusion that 40 per cent of the provincial budget should be sufficient if we manage these resources well. We share his concern that if a greater portion of the budget is expended on health care, it will compromise support needed for other social programs that also address the determinants of health — such areas as income and employment, educational opportunities, affordable and safe housing, social and recreational resources, environmental protection, and safe and secure communities. These determinants are pieces of the larger health care puzzle that we must not leave out.

We also agree that there are incremental development investments needed if we are to have the positive, upstream impacts we need to sustain our health system. What we mean is that we know that it costs more money to start with the development in some of these areas now, but that there will be payback in the future for health care reform and primary health care reform; for enhanced programs of health promotion and disease prevention; for rationalizing a system of specialized services; quality performance measures; and targeted investments in health research, information technology, and human resource development.

The provincial government must ensure that these are its developmental priorities. Diverting available resources to other areas will compromise the future effectiveness and sustainability of our health system.

We are very pleased to see citizen participation emphasized in the report. Community clinics strongly advocate that citizen participation in the development and operation of health centres is established as a core, essential element in the development of these centres in Saskatchewan.

Users of primary health care must be active members of primary health centres if our goals for effective primary health are to be realized. They need to be members of the team. Our members, clients, and health providers have a long history of working together to identify primary health needs of the populations we serve and develop, deliver, and evaluate services to meet those needs.

Community health centres like ours also have a long history in identifying health and social development needs of their communities. For example, citizen participants in our centres address important health and social issues such as advocacy for protection of the core principles of medicare; ensuring safe and healthy housing; food security for the poor; and providing support and fostering self-help groups for at-risk population, such as seniors or teen moms with their children.

Our experience has been that fostering strong partnerships between users and providers and encouraging citizen participation leads to better self-care as well as to collaborative action to address community, health, and social issues.

We had some recommendations based on our experience. Mr. Fyke recommends that health districts be given responsibility for organizing and managing primary health care services, teams, and networks, and for creating primary health care centres. He does not prescribe the specific organization structure that primary health care centres should be operated within. Based on our experience, we recommend some . . . we have some recommendations for you on the implementation of primary health care reform.

The first one is alternative payment schemes are needed for physicians, such as contractual or salary relationships. And this should be a priority. It's interesting to note that some of our clinics are experienced increasing interest in alternative payment arrangements and team-based practices from physicians seeking employment. And if you have questions later, Mary can speak to that.

The second recommendation is added funding for group physician practices is not effective. We counsel you to avoid simply funding group physician practices by adding on other health providers like expanded role nurses. The experience in Ontario with this kind of model is that group practices continued to be doctor-dominated. This means they're not team-based; that they do not make effective use of the other primary care members; and they do not have the focus needed on health promotion, disease prevention and self care.

The third recommendation is a no for full-profit primary health care centres. Government must ensure that there's no avenue by which full-profit health care companies can operate primary health centres in our province. One only has to look at the United States to see the harm full-profit providers like HMOs (health maintenance organization) can cause to quality, primary health care. We believe strongly that this is not the way to go.

Four. Conversion to primary health care centres must be thorough. Converting small community hospitals to effective primary health care centres is a very demanding and comprehensive exercise. You not only have to reorient citizens but also the health professionals to progressive, primary health care demands. And it demands a strong public education and community development skills — retraining, reorientation, and usually renovation and re-equipment of existing facilities. So it's very . . . it's going to take some time and it's going to take a lot of work to make that change.

We also think that expanded role of the nurses is key. The key to effective primary health care reform will be expanding the role of nurses in primary care. They need to be the first point of contact and empowered with the capacity to diagnose and treat illness, prescribe medication, and refer to other members of the primary health care network.

The government needs to make it a priority to upgrade the skills of existing nurses so they can take on this expanded role, and must ensure our education institutions are recruiting and training sufficient primary care nurses to meet our future needs. Finally, we strongly encourage the government to provide existing health centres the resources we need to include expanded-role nurses in our primary health care teams.

Six. Rural residents require 24-hour access and emergency response. Mr. Fyke advocates the conversion of a large number of Saskatchewan's remaining small rural community hospitals to primary health care centres. We believe the government will only have success in doing this if it also ensures that health care centres have the capacity to provide people with the 24-hour access to health care they need and rural emergency response systems are upgraded to a point where rural residents are confident their health crises and emergencies can be addressed promptly and effectively.

Number seven, the use of the co-operative model. We advocate that the provincial government encourage and support citizens and primary health care providers to form partnerships to develop, own, and operate primary health centres in their communities. We advise the government to encourage and support the development of centres in the co-operative model. The co-operative model places high emphasis on the empowerment of collective ownership and the benefits of people working together to address their own needs and their communities' needs.

After all it's people want to have some control over the decisions that affect them, not just in health care but in most areas of their life. And the co-operative model has been there, been used many ways by both urban and rural Saskatchewan citizens to help them solve problems they have faced over the years.

Number eight, community clinics need to be informed and involved. Mr. Fyke did not address the issue of the place of Saskatchewan's co-op health centres in primary health care reforms. He does advocate that health districts be responsible for organizing and managing interdisciplinary teams based . . . team-based primary health services, including contracting with and otherwise paying family physicians and other health professionals.

Community clinics and their members are deeply committed to the interdisciplinary and participatory nature of the clinics. It is very important therefore that the clinics be consulted and involved in any discussions of the transfer of primary health care responsibilities to the districts that will have implications for our five centres.

Our members value highly the commitment made by the government that consent would be required if responsibility for our clinics was transferred to district health boards. We ask for renewal of this commitment. We also request that we will be at the decision-making table in the discussion of primary health care reform that will affect our centres.

It concerns us greatly that Saskatchewan Health has initiated a working group of primary health care stakeholders to plan its response to the Fyke Commission on primary health care reform and we have not been consulted or invited to participate in that working group. We would like to be part of it.

It is essential that the government actively involve community clinics in decisions that affect us, and decision making around primary health care should be transparent.

How can community clinics help? We encourage the government to make use of the experience of . . . and the government and all MLAs (Member of the Legislative Assembly) to make use of the experience of the community clinics to assist with the change process.

Areas we are able to provide assistance include, one, developing and implementing goals and performance indicators. Some community clinics have already been very involved in developing performance indicators for primary health care, and Patrick Lapointe can answer any questions you might have on this matter.

Number two, developing goals and expectations for primary health care centres. These goals and outcomes that are established by the provincial government need to be clearly defined. And the clinics would be pleased to work with the government and other primary care stakeholders to develop expectations and measurements of health care achievements.

Number three, building public understanding and support for primary care reform. We appreciate that gaining acceptance and support for public and health professionals . . . from the public and health professionals for major reform is the most critical challenge that the government faces. Community clinics can assist by helping to inform the public and health professionals about the benefits of this model, and by demonstrating how it can both better meet clients' needs, promote healthier communities, and enhance professional satisfaction of health providers.

We can arrange visits of politicians, citizens, and health professionals to tour our centres to witness the benefits of our unique way of providing services. We can have our board members, health professionals, and clients travel to health districts to meet with citizen groups and health professionals to give testament to the benefits of our model. And we can have our physicians talk about their satisfaction with the remuneration they receive through contractual or salaried

arrangements with health centres, and their experience of the benefits of working in an interdisciplinary team environment. Lastly, we can assist interested communities and districts in establishing community health centres.

So in conclusion, do we have the political and social will to make the changes needed to ensure quality, sustainable health care for future generations? We think we do. Saskatchewan has demonstrated a long, innovative history of taking steps necessary to ensure the health and security of our citizens.

Taking these steps will demand courage and strong leadership on the part of the provincial government and I believe the opposition as well to get a strong, collaborative working relationship between the government, the health districts, and the health professionals, and an understanding from the public about where we're heading.

We ask that you act on Mr. Fyke's recommendations. We at the Federation of Saskatchewan community clinics are willing to work with the government to help facilitate the changes that we feel must be made.

We know from our experience that public understanding and acceptance of primary health care reform is attainable. Citizen participation and partnership will be key to the successful primary health care reform. And again it just means involving people in decisions that affect them.

So we'd like to thank you for your opportunity to provide our perspectives to you. We wish you well in your very challenging task ahead and look forward to working further with you.

And hopefully we have some time for questions.

The Chair: — Did anybody else in the delegation want to speak before we go to questions? No. Okay, questions then.

Mr. Boyd: — Thank you, Madam Chair. Thank you very much for your very thoughtful presentation. I have questions in two areas that I'd like to explore with you.

First of all, when we discuss the area of alternative payment methods for physicians, and you're looking at contractual or salaried relationships, you're saying should be made a priority. What kind of time frame would you like to see something like that come into place?

Mr. Lapointe: — We believe that the key piece to the kind of changes in the health care system that Mr. Fyke speaks to is the primary health care reform. And our hope is that over the next year or two that you would establish and implement a structure of supporting physicians to move to alternative payment.

Mr. Boyd: — I understand your opposition to for-profit health care centres in Saskatchewan and you're saying that you would like to even see legislation or limiting regulations. To some degree we already have them. We have eye care providers, laser treatment, chelation providers, chiropractic services, and arguably doctors' offices who are for-profit.

Would you like to see restrictions placed or the removal of those services?

Mr. Lapointe: — I think in the legislation that was established on the incorporation of physician businesses, the stipulation was that the physicians needed to be the sole owners of the business or sole shareholders. And we accepted that reality in terms of the restrictions of the legislation.

What we want to avoid is to have corporations, which may include other stakeholders than doctors, involved in delivering primary health care in Saskatchewan. And that's the kind of restriction that we would like to see continue to be put on primary health care.

Mr. Boyd: — You would then welcome eye care providers, as an example, or you would not?

Mr. Lapointe: — It's a very slippery slope, isn't it. Like I think that we've managed to ensure that we don't have that kind of for-profit provision of physician services, and I hope that we continue to maintain those bounds.

I mean I think that you can talk about pharmaceuticals as being for-profit or physical therapy as being for-profit. I think that a profit becomes a mode of, you lose what should be the primary motive and that is providing quality care to the people of Saskatchewan.

Ms. Barclay: — If I can just add to that. What we would think in terms of eye care is like at the Saskatoon clinic there's — and at the Regina clinic — we have optometrists as part of our health care team. And so we . . . they're part of the interdisciplinary team.

Mr. Boyd: — One final question. I currently have two friends who are seeking services outside of the province of Saskatchewan for cancer treatment. Would you afford them the opportunity to do that if they wish? Or do you feel that they shouldn't be allowed to do that?

Mr. Lapointe: — I don't, I don't feel that I would certainly have the expertise to comment on that, Mr. Boyd. I don't understand that issue.

Mr. Boyd: — It's a philosophical question. It's a philosophical question. It's not a question of . . . a professional question. The question is do you support people who make a decision for health care services if they want to seek those services outside of the province of Saskatchewan?

Mr. Lapointe: — I believe that all medical services in Canada should be provided in keeping with the five principles of medicare in the sense that they should be comprehensive and accessible.

If we're having difficult with getting people access to the services they need in Saskatchewan because we don't have the professionals to . . . we can't recruit the professionals in our province, or that these services are so specialized that they're better delivered in larger centres than those available in Saskatchewan, then it makes sense that those people would have the opportunity to be able to travel to those centres.

But that should be all covered underneath a publicly funded system.

Hon. Mr. Melenchuk: — Thank you for your presentation. Just a couple of questions.

You currently have your five co-operative health centres. They're in larger communities. Wynyard I guess would be the smallest. But in terms of the model that Fyke is proposing, he's talking primarily about rural Saskatchewan and the smallest of communities. How do you see your particular model that has evolved over the past 30 years applying to those smaller rural communities?

Ms. Barclay: — Well I think one thing we talk about is citizen participation and having people involved in decisions that affect them. And I think that people aren't necessarily feeling that way these days. And so the co-operative model I think will help with that. And giving people some, not only some say, but also some information on their own health care and the needs of their community and how the system works.

And we just find that if you look to the broader co-op system, that there are often layers like there would be in health care. There's the local credit union but there's also the system provincially and nationally, and that objectives and standards flow throughout the system. It's certainly something that the co-op model is very used to in terms of the tiers and not having all the say in everything, but in the things that are most affecting the rural area, as to you know, if you've only got so much money, what do you spend it on. What is the particular need of that community?

I think the co-op model is very good for that. And people take an ownership and take an interest in the affairs of the health centre.

Hon. Mr. Melenchuk: — The involvement of the community I think you're obviously believe that's extremely important. I think most people would agree.

The question that I'm trying to get at is in the smaller rural communities. What would you see as the core in terms of the multidisciplinary, interdisciplinary team? A physician? A nurse practitioner? A pharmacist? What is that core? Obviously in Saskatoon you've got optometrists, you've got pharmacists, you've got mental health workers. I mean you have a wide range all sharing the same charts I would understand.

So what would you see as the core, the base core, to be a primary care team?

Ms. Barclay: — I'll let Patrick answer some as well but it can change from community to community. You know, it doesn't have to . . . you don't have to have physicians at a community health centre. There are many in Ontario that didn't have physicians. It depended on the community and what they decided were their needs. And then they often evolve. But I'll let Patrick speak to it as well.

Mr. Lapointe: — Yes, we know that the communities are varying sizes. Like you might have a place like Canwood which is 2 or 300 people. And then you can have communities that are a couple of thousand. A lot of the configuration of those services will depend on the size of the community it's intended to serve.

But the model that we're speaking to had, at its core, an expanded-role nurse, what in other provinces is called nurse practitioner. And they're in close involvement with physicians who may work with . . . who may be serving a number of communities with different nurse practitioners in them.

They need to be linked up, as Fyke talks about in his report, with primary health care networks because it could well be that you'll need to have a visiting community mental health nurse. You may need to have a physical therapist visit, a social worker, those are the kind of people that you can have come into those communities and serve identified people who need the benefit of their specialized kind of services.

Also it could well be that a person in those communities may not be able to have all their primary health care needs met in that community and may have to go to one of the larger centres for more specialized kind of services.

I think the challenge is one of creating a flexible, integrated, coordinated system where you have really strong assessment at the beginning and you identify a person's needs, and the community health centre staff take responsibility for linking people up with that network of services that they need to support their health.

Hon. Mr. Melenchuk: — And the final question I have in terms of governance management, I think you have . . . you're not for profit; you have boards that are elected. And in terms of funding, how does the funding . . . I think you're accessing some fee-for-service pools on the physicians' side, but are you getting grants, do you charge membership fees? Like, how is your organization funded?

Ms. Flynn: — Our organizations have global funding from Sask Health. But we also have members, so we have member dues as well as we do some fundraising for equipment and other capital assets.

Hon. Mr. Melenchuk: — And your physicians would bill MCIC (Medical Care Insurance Commission) as well, would they?

Ms. Flynn: — What they do is sort of dummy billing if you will.

Hon. Mr. Melenchuk: — So it would be a check off then. There's not an actual bill submitted but the records are kept by Sask Health then. Okay.

That's all the questions I have. Thanks.

Hon. Ms. Lorjé: — Thank you. I'll try to be brief and quick. I want to first of all apologize for not hearing the full presentation. I was off in Moose Jaw experiencing at first-hand the effects of health care system in this province.

So I apologize that I didn't hear your full presentation but I've been leafing through it and it seems to me that you're coming out solidly in favour of Fyke and if anything you want Fyke-plus. Is that a summary of what you're saying . . . (inaudible interjection) . . . Then I'd like to ask you about a specific possible potential paradox that I see in your

presentation.

On page 4, you say that you agree with Fyke's conclusion that 40 per cent of the provincial budget should be sufficient and I note that Fyke has said that we will probably require a $100 million extra per year for the next four years to implement his recommendations.

I then turn to page 7 of your presentation where you're talking about conversion to primary health care centres and cautioning us that it may take a full generation before we bear the full fruit of this change. So I would like to both know how you arrived at this estimate of a full generation before small community hospitals would be converted to progressive primary health care centres and how you see this transition for a full generation being funded.

Ms. Barclay: — Well I'll attempt that first and then Patrick can maybe . . . The first thing is that we did say that we needed more money now to get the health reforms started. So you need to have increased funding, and then as time goes on those reforms should then level down and you would get future payback in terms of efficiency and effectiveness.

But this is not something that can happen overnight. You can't take the mindset of folks right now, where they're at, whether it's some of the health care professionals or some of the people out in the communities, and change them. They have to experience it.

One would be with . . . an example would be with nurse practitioners. People often will be opposed to the idea until they experience it, and then they will be, they'll say, hey, well that was okay, I got what I needed. I'm happy. But it might be a while before we have health practitioners out fully deployed in all corners of the province. That's going to take a while.

And it's going to take a while for attitudes to change like that; say, I don't need to go see a doctor; I don't need to have a prescription for antibiotics when I don't have an infection. It takes a while to get people's ideas on those things changed.

And I think that's what . . . and that's what those words mean to me. And maybe, Patrick, if you have anything else to add, or Jill, or Mary.

Mr. Lapointe: — Ms. Lorjé, I'm thinking of you from another life when we were involved in home care program development. And I remember when the provincial government introduced the home care program — a magnificent social and health program — and how we started up districts and it only took us about three years to get all the districts started up.

But my experience was that it took 10 or 15 years before the whole notion of home care was fully embraced and acted upon in communities where people saw it as a real alternative to support people with independence in their home. I think the same kind of community development reality is going to be experienced in the development of community health centres in Saskatchewan.

Hon. Ms. Lorjé: — Thank you.

Mr. McCall: — Actually it's a related question. I was glad that you did underline the challenge that constructing primary health care teams imposes in terms of reorienting people's mindsets. And, you know, just within the disciplines themselves, it's going to be no small feat to get all those shoulders pushing the wheel in the same direction.

But I was just wondering if you had any further advice from your point of view in terms of incentives that could be provided to facilitate this teamwork? Or if you had any further ideas on how we might successfully go about constructing these primary health care teams?

Mr. Lapointe: — When you talk to people in Ontario who have developed over probably the last 15 years 150 health centres in Ontario, their arguing is, in an ideal world, you should start with nurse practitioners first; that if you start with a doctor-dominated system, it's very hard to move away from that and have the first point of contact be the nurse practitioner.

So if you were moving to a community health centre model, I'd certainly like to advocate for a really strong focus on the empowerment of the nurse to be involved in assessment, diagnosis, and treatment. I think that's critical.

Having said all that, and of course you have to have a strong partnership between physicians and nurses to make this go well.

Mr. McCall: — Okay. Anything additional?

Ms. Barclay: — When I lived in Ontario, I lived in Ontario for six years, and I was on the board of a CHC, a community health centre in Ottawa, in the inner city of Ottawa. And you know, many of the CHCs, as Patrick mentioned, in Ontario started without physicians.

But it is a . . . they have done . . . the one that I was on the board of was particularly very good in all primary health care providers working together. And there also was a very big emphasis on the determinants of health, and advocacy for people who . . . So an example would be — being not a professional I always have to come back to examples, people examples — of a woman who is going to lose her job. She came to the doctor, she was stressed out, and she didn't have a health problem that way.

What was causing — you know, like drug-wise — what was causing her stress was she was losing work, days of work, because her son was always ill. The reason — she was an immigrant, a recent immigrant — and the reason her son was ill was because there was drafty windows in their apartment that they were living in.

So one of our workers, our advocacy workers, went with her to the landlord, got the windows fixed, and then the health care problem for her son improved and she didn't lose work and she didn't lose her job.

And that is you know, looking at the determinants of health, in my view, going beyond, you know, nurse practitioners as well and being very advocating for the determinants of health in the community. And that goes a long way to solving problems rather than just dealing with problems.

Mr. McCall: — Thank you.

Mr. Lapointe: — If I could add just one more example, and it has to do with the whole notion of citizen participation and community development. At the core of the definition of what community health centres is all about is that whole notion of being involved with the dialogue of the citizens of your community about what are their health needs, and how you work collectively with them and collaboratively with them to address the health needs in their community.

And I think some of the district health boards have done a good job around this. I think one of the examples had to do with them dialoguing with the community about . . . they were concerned about some of the destructive behaviour of their teenagers in the evening. And secondly, they were concerned about teenage smoking and the impact that that was having on their health. And the focus of the community is how do we work together with health professionals in our community to address the issues.

I think that that's the key to making community health centres work in Saskatchewan is by cultivating at the outset that kind of dialogue with the members of your community about how can we collaboratively work together to address our common concerns.

The Chair: — Thank you. Any further questions? Seeing none then, I thank you very much for your presentation and your offer to continue to participate in us as we do any planning. Thank you.

Our next presentation is from the College of Medicine from the U of S. Welcome, good evening. Welcome to the Standing Committee on Health Care. It's an all-party committee of the Legislative Assembly and I'm Judy Junor, the Chair. Dr. Melenchuk is the Vice-Chair. Andrew Thomson, Warren McCall, Pat Lorjé, Glen Hart, Bill Boyd, and Rod Gantefoer are here with us tonight.

We have 30 minutes for your presentation and hopefully some time in that 30 minutes for some questions from the committee. If you want to introduce yourself and who you represent, then you could begin your presentation.

Dr. McLennan: — Thank you, Madam Chair. My name is Dr. Barry McLennan. I'm the dean of research in the College of Medicine at the University of Saskatchewan, and it's in that capacity that I'm here this evening. I also am Chair, on a volunteer basis, of a national coalition, the Coalition for Biomedical and Health Research. Some of you know me in that context as well, so I thought I should make that clear with you.

Thank you for giving me an opportunity to speak to you tonight and to speak to your committee about the Fyke report. I will submit a written submission within the time period. I think it's the 27th. I'll be pleased to do that. I apologize that I didn't have it ready for you tonight.

Let me start off by saying that, in general, I believe the Fyke report is a very good assessment of the state of our health care system in Saskatchewan. The people of Saskatchewan, indeed all Canadians, deserve a quality health system. I don't think there would be any debate about that.

Ken Fyke emphasizes that we do not need to spend more money on health care in Saskatchewan, and I agree with him on that point. We currently spend 2.2 billion, or approximately 43 per cent of our provincial revenue on health care. Spending more dollars, even if Saskatchewan could afford to do so — and it cannot — does not mean better health. We do need to emphasize quality and not quantity.

Fyke has made a number of recommendations pertaining to everyday services and specialized care. He has laid out a road map or a plan for getting results, and he has made key recommendations in support of change. Ken Fyke points out that, number one, that health services are underfunded. He believes that the skills of the cadre of health providers is not utilized effectively in our province. The full use of their skills could result in better patient outcomes and savings to the health care system. We need to figure out how to do that.

Fyke observes that one of the cornerstones of health reform is the translation of health research results from the bench to the bedside to the community. There's a lot of talk about evidence-based medicine not only in Saskatchewan, but across Canada. But we're not very good at implementing evidence-based medicine. And we need to do that.

Fyke recommends the renewal of health science education programs including increased funding for health research. He emphasizes several times that improvements to the health care system depend on the availability of research-based information — in other words, the evidence — evidence-based information. To put it very simply, we need to do research in order to obtain the necessary information to improve the health care and to sustain a quality system that Fyke advocates.

Recently we have seen in Canada an enormous growth in health and health-related research. However, unfortunately Saskatchewan has not kept pace and we are missing significant opportunities in this province. Health research has exploded across the rest of Canada during the past five years. The governments of Ontario, Quebec, Alberta, and British Columbia have invested substantive amounts of money into health research.

At the national level, the federal government has launched an innovation strategy to move Canada from 15th up to 5th in terms of R&D (research and development) expenditures in the world. They have created the CFI, the Canada Foundation for Innovation. They've created the CIHR, the Canadian Institute for Health Research. And I had the pleasure and the privilege of working with the interim governing council that put the CIHR together.

The federal government has created the Canada Research Chairs Program, which will put in place 2,000 world-class researchers in university positions across this country. I dare say the competition is keen and it's fierce. We must participate in that.

And more recently, the federal government has created the geneo in Canada. And I submit to you, some of the greatest changes that will happen in the educational programs for our

medical students and health workers generally will happen in the area of genomics and protonomics. It's absolutely amazing what's happening there. We'll soon be able to make decisions about the prevention of disease, rather than the treatment of disease or just the treatment of disease.

The total public sector investment in health research provided by the federal government will double in the next five years. The federal government wisely plans to spend 1 per cent of the national health care budget on health research. The Health minister, Allan Rock, and the federal government are to be commended for their leadership and courage in increasing support for research in Canada. This is great news for our country. It also presents a tremendous opportunity for every province including Saskatchewan.

It also provides us with some challenges, and let me talk about those a little bit. I believe the challenges can be met. We simply have to resolve to address the challenges and get on with it. And I think we can do that.

Among the challenges, we are faced with the following, as Fyke points out, Saskatchewan is increasingly less competitive in health research. Saskatchewan researchers now attract less than 0.5 per cent of the total CIHR budget. On a population basis, you could well suggest that we should get 3 per cent of the national total; a million people out of 30, we should get roughly 3 per cent.

In the last competition, we had 3 successful applications out of 17 submitted. That's a success rate of 6 per cent. The national success rate in that competition was 31 per cent.

Let me emphasize, through no fault of their own — through no fault of their own — our Saskatchewan researchers are not competitive in national research competitions and the reason is very simple. The reason for this is the prolonged underfunding to the University of Saskatchewan and the lack of support for health research in this province.

To put it simply, Madam Chair, and members of the committee, Saskatchewan has to pay to play in the health research arena. If we choose not to do so, we will continue to lose quality faculty and clinicians to our neighbouring provinces and to the United States. And worse than that, we'll be unable to recruit the quality of people that we want to practice medicine in this province to treat our people and to teach our students.

Secondly, Saskatchewan researchers tend to be spread very thinly over large numbers of areas partly due to the lack of resources and partly due to the retention problem.

As you know, research knows no boundaries. Research is a global activity. Health researchers now collaborate on an international basis. And because we do not have a critical mass of expertise and proven excellence in most areas of health research in Saskatchewan, we're at a severe disadvantage in both grant competitions and in the recruitment and retention of personnel.

Now on a positive side, we have some good news too. We do have research strengths in this province which we must build on and which we must nurture. There are also areas of research in Saskatchewan where we can create a niche for ourselves and where we can perform at an internationally competitive level.

The current support for health research in the province is at a crisis level. As a percentage of health care spending, it's about 0.25 per cent — about a quarter of 1 per cent. And I've already set out for you that the target of many jurisdictions is to aim at 1 per cent. And that number hasn't changed very much in the last 6 to 10 years.

The gap between Saskatchewan and its neighbours will grow unless there's a policy backed by funding to reverse the decline. As Fyke says, and I quote:

> There's a real danger that Saskatchewan will have no future in health research as scarce talent leaves and new recruits choose not to come to Saskatchewan.

You might well be asking, does it matter? Why should we do health research in Saskatchewan? Let somebody else do it. I submit to you we must do health research in this province for the following reasons.

Firstly, as the mission statements of our hospitals and the College of Medicine proudly proclaim, quality health care and excellent teaching depends on research. Science education programs are ultimately unsustainable without the continuous input of knowledge from research.

But both the transmission of knowledge, evidence-based medicine, and program accreditation, increasingly demand a strong research presence. Program reputations are largely built on research, and those with declining reputations tend to spiral downward.

At the moment, Saskatchewan educational programs continue to produce high-quality graduates. And you might say, so what's the problem? Well the current situation is not sustainable. And the sad truth of course is that when we lose researchers and graduates from this province, they have no difficulty finding a job. They are well trained; they're good practitioners. Unfortunately when they go somewhere else, they then become our competition.

Secondly, research is the foundation of an evidence-based health system. As I mentioned earlier, we need research-based information to solve the problems identified in the Fyke report. A diverse and well-respected research community creates role models for tomorrow's practitioners and clinical scientists, and most of all — most importantly — it champions the cause of evidence-based decision making. This adds a powerful voice to improved quality and accountability.

Part of our dilemma, I think — and it's not just true in Saskatchewan — is that governments tend to separate health care responsibilities from health research responsibilities. They presume to do this because they don't want the problems of the urgent and the sick to drive out the long-term and economic problems. The net result is that the burden of disease, which represents about 22 per cent of our gross domestic product — the burden of illness is real and costly — the net result is that about 22 per cent of our GDP (gross domestic product) plays no real role in driving the research agenda. And research is not

effectively translated into clinical practice. So we need to change that.

Five years ago the Department of Health set up a health research strategy task force. I had the pleasure of working with a group of people in preparing that report. We identified areas of research strength in Saskatchewan. These included the neurosciences, cardiovascular and stroke research, and infectious diseases, among others.

We also identified areas of research of particular concern to Saskatchewan people and areas where we could create a niche for ourselves and where Saskatchewan could make a difference. Our regional health, rural health, the social determinants of health have obvious and profound relevance to Saskatchewan. While we have some research activity in these areas, we're well below the critical mass of researchers needed to make a difference and to achieve world-class levels of activity and accomplishments.

Unfortunately that report, which was published in '96, was never implemented. And it won't surprise you when I tell you that in that report we recommended that this province start adopting a strategy of spending 1 per cent of health care on research. If we'd started six years ago we'd be in much better shape than we are now. We must ensure — and I plead with you — let's not make . . . let's not give the Fyke recommendations a similar treatment.

Fyke also points out that research should be a major driver of ongoing reform and adaptation in the health system. He emphasizes that Saskatchewan has been a leader in structural reform and organization. But Saskatchewan has not excelled in developing quality and performance measures in reducing variations in practice or in transferring clinical and basic science knowledge to the front lines.

Researchers and health science education programs should be incubators of change and leaders in the move towards quality and accountability. Without the presence of a vibrant research community, health system debate becomes political, focused on incomplete information, and needlessly acrimonious.

We can do it right in Saskatchewan. We have some good examples. I refer you to the most vibrant agriculture biotechnology research park in the world in Saskatoon. That park was established by government investment, initially seed money, a number of years ago. Who could have imagined it would so be successful? Who could imagine that there would be such a beehive of activity as we see there today. Truly a world-class enterprise.

I submit to you that with an appropriate investment in health research we can make a difference as well.

Madam Chair and committee members, Saskatchewan has no choice but to make a strong commitment to research by investing one to one and one-half per cent of total health care spending in health research. Without such a commitment the health care system will never achieve the quality to which it should aspire, and evidence-based decision making will remain a dream.

The education programs will decline in quality and prominence even to the point of non-viability. Our best and brightest will continue to leave and the prospects for recruiting excellent people from other jurisdictions will be poor.

The benefits of investing in health research in Saskatchewan are obvious. Firstly, investment in health research provides jobs — 80 per cent of a research grant goes to jobs, immediately. It generates economic activity. Provides a return on the investment, 10 to 15 per cent. Those are not my calculations, other people have shown those.

It's not an expenditure, it's an investment. Investing in health research in Saskatchewan will turn brain drain into brain gain in this province.

Finally the biggest payoff of all is that we will underscore the improvements in health care for all residents of Saskatchewan. We will reduce the economic burden of illness. I've already mentioned that that's about 22 per cent of the GDP. The health sector in Canada is the largest job-creating sector in the economy, much better than aerospace or anything else.

More jobs in Saskatchewan will improve our tax base and provide opportunity for our sons and daughters so that they don't have to move to Alberta to establish their careers. Wouldn't that be nice? Wouldn't it be nice if we could offer opportunities in this province for our sons and daughters to establish the careers for which they've been trained and to make their homes here?

In conclusion, Saskatchewan has to make a choice. We can choose to invest in health research with all of its inherent benefits; or we can choose, as we have in the past, to be disadvantaged.

I urge the members of the standing committee to recommend in the strongest possible terms the absolute necessity to invest in health research. The strategy should be, as I've said, to invest from one to one and a half per cent. Time is of the essence.

Thank you, Madam Chair, for the opportunity to speak to you tonight. And if I can help in any way with your further deliberations, I'd be glad to do so. And as I said, I will get you a written report within a week. Thank you.

The Chair: — Thank you very much, Dr. McLennan. Thank you for your presentation. Just one point of clarification. The committee is to receive responses to Fyke, and we don't . . . we won't be doing recommendations. We will be reporting to the Legislative Assembly what we heard.

So we're gathering responses to the Fyke Commission. We won't be making recommendations to the Legislative Assembly, but we will be reporting what we heard, and we heard you.

Further questions?

Hon. Mr. Melenchuk: — Thank you, Madam Chairman. Thank you, Dr. McLennan for your presentation. The topic of the 1 per cent in terms of research has been out there for some time. And I think one of the first references might have been

with the Kerr White report, but I know we've had this discussion many times with regard to the 1 per cent.

Now in terms of, just for clarification, when we're talking 1 per cent of the health care budget, which I guess roughly would be about $20 million, do you see that 1 per cent as being grant dollars for primary research or do you see it in other ways supporting salaries? How do you see that 1 per cent?

Dr. McLennan: — I see the 1 per cent as across the board, all aspects of health research.

As you know, the situations change rapidly with respect to the way research is conducted, health research is conducted in Canada. If you're familiar with the basic tenets of CIHR, the Canadian Institute for Health Research, they are saying we must support basic biomedical research, clinical research, health services research, population and health research.

And it's no longer sufficient that individuals prepare a grant in one area and hope to get funded. The challenge of CIHR, the legislation indeed mandates it, that research must address all four pillars. Indeed the individual research institutes in CIHR have that mandate. The directors must insist that all four pillars of research are supported.

That doesn't mean that every grant will do everything, but the thrust is clear. Therefore the answer to the question is, I see the 1 per cent covering the broad spectrum. And I would think that when we look at the ways to implement that recommendation — if that should come and I hope it will — that we need to look at . . . define what's important in Saskatchewan.

There's some mechanical things that we need to do first. We need to hire more personnel, we need to provide them with adequate space and the tools to do their job. But having done that then I would suggest that we need to define what's our top priority, what's our most important thing.

Should we focus, for example, on upstream activities rather than downstream? Should we put more effort, research, into getting people to change their lifestyles? Smoking, exercise, obesity in children is becoming a national problem; it's also true in Saskatchewan.

So I think the answer to your question is that it covers the entire spectrum. We'll need to define in this province what we want to work on, what we need to push. We can't do everything, we're too small. But we do have strengths and we do have talents and we can make a difference to the health of the people in this province.

Hon. Mr. Melenchuk: — My second question — and thank you for a comprehensive answer — was with regard to the provincial dollars that go into research. What proportion would those dollars draw sort of on average in terms of federal or private money? For every dollar, provincial dollars, would it roughly be doubled in terms of new dollars that it attracts?

Dr. McLennan: — I think it's higher than that. In other words, you're really asking, what's the leverage. If we put a dollar on the table from the province what can we expect to lever? I think the answer's anywhere from 3 to $5. It depends on the circumstance.

But just take one example. The Government of Saskatchewan funded an initiative which was started by the Rick Hansen Institute a few years ago, three years ago — the Saskatchewan neurotrauma initiative. That program has come to a close now; it's the end of its three-year stint. And in the neuroscience research alone — that program supported more than just neuroscience research — but the neuroscience piece alone, the research invested there returned $5 for every 1 invested by the province. So it was a good return.

It'll vary a little bit depending on the area, but there's no question, and the programs that I mentioned, CFI, CIHR, Canada Research Chairs — and excuse me if I'm using acronyms but we live in an alphabetical . . . acronyms these days — but these federal programs are very enticing. I mean they offer us cheap dollars. You know whether it's 40 cents, 60 cents, or 20 cents, they're cheap dollars and we need to respond to that. And to be competitive we must do that. So the leveraging is there, no question.

And it's not just the federal/provincial, if I may add to that. There's also opportunities for funding from the private sector, from provincial associations, and so on.

And a good example which the province put together a plan a few years ago, was the partnership program with MRC (Medical Research Council of Canada), where the province matched dollar for dollar that program. Now that has been an excellent program. But I hasten to add that that is a program to sustain and rebuild research; it's not to replace, you know, the regular funding programs.

But the leveraging is very real and useful.

Hon. Mr. Melenchuk: — And my third and final question with regard to Fyke and his recommendation for a quality council. There has been some suggestions by earlier presenters that perhaps HSURC and its role could be rolled into this quality council. And I'd like your opinion on that.

Dr. McLennan: — Yes, I read that section with a great deal of interest. He suggests that the health service work of HSURC, activities of HSURC, be rolled into quality council. And that on the other hand, that HSURC become a more well-funded research commission for the province. And I applaud that. I think the vehicle . . . that would be a very attractive way to allocate the 1 per cent number that we're talking about. You used the figure 21 million, which is about right.

HSURC could be charged with the responsibility of conducting the peer review programs and deciding, with input from stakeholders in Saskatchewan, what areas of research we should be working at and so on.

No, I think that's an excellent idea.

Hon. Mr. Melenchuk: — That's all I have. Thank you.

Mr. Gantefoer: — Good evening and thanks for coming. A couple of areas that I'd like to talk about is, firstly, the research component and its importance to the College of Medicine and

its ability to attract and retain practitioners and instructors. The college probably sees a threefold mission for its people — research, clinical work, and pure instruction.

How difficult is it for the college to recruit and retain the professional body for the college in light of the fact that we are underfunding research by at least a fourfold shortfall?

Dr. McLennan: — We have had an extremely difficult time and we are . . . it's very tough. I question how much longer we can continue unless there's some changes.

The reason is simple. In the basic science departments the researchers have very high teaching loads compared to their peers across the country. Ergo, when they make applications in national competitions, there's not as much productivity there as their competitors.

On the clinical side of the house, when I talk to the clinicians and the particular clinical department heads and say, why can't you protect the research time for that clinician — he's got a national award, you need to protect his time . . . his or her time so they can do research? He says, well I can't do it because of the service work.

It really comes down to personnel, lack of personnel. We probably need a 40 per cent increase in personnel across the board.

Now so is it difficult to compete . . . or to recruit? Yes, it's terribly difficult because people come and they look at the environment. And by the environment I mean, do you have space to do research, do you have the equipment, do you have the resources, the infrastructure, and how's the salary? Now any one of these items in themselves is not, is not going to make the day one way or the other, but when you put the package together that's our competition.

Department heads are continually frustrated by the fact they bring people in, they want to hire them, and they say . . . they look around and say well you know, I can get a better offer somewhere else.

We're losing, on the biomedical and clinical research side, we are losing a researcher at least one a month. And when they come in and tell me they're leaving, I can't even enter into a dialogue with them and try and match the offer they've got from elsewhere. It's just so much better it would be silly to have a discussion. So I shake their hand and wish them well. That's not what I'd like to do.

So we're in a very serious situation and recruitment's a problem.

Mr. Gantefoer: — Recently Dr. Roger Pierson has been quoted in on-campus newspaper periodicals and also in the general media of expressing a great deal of concern about the future of the College of Medicine in light of some of the issues that you've outlined. And indeed I think he's quoted as saying that there may indeed be an emerging problem that is very soon upon us in terms of accreditation in light of how many people we're losing. Is that a real concern or is it undue alarm?

Dr. McLennan: — My concern is . . . And I'm familiar with Roger's views on this, and he's right. I mean if we want to have a viable, sustainable College of Medicine, we have to fund it. Full stop. Now if we don't do that, what happens? If we do nothing, what will happen? Well we'll continue to slide down the slippery slope and my fear is that we'll reach a point where we can't recover.

Research isn't something you turn on and off like the hot water on your sink. Research takes . . . it takes time to build up research programs. It takes time for researchers to reach their level of . . . their true level of production and so on.

And just one simple example. When we lose people, we can hire somebody else, usually. The problem is, if we lose someone at the peak of their career — when they're very productive, maximum output — we lose them and their team and their ideas and their patents and their brain power to some other jurisdiction.

We hire a new person. The new person may look — that's if we can get them to come — may look very good on paper, but we won't know for 5 years or 10 years whether we've made the right decision.

So, you know, to an accountant it's a zero-sum game: you lost one, you gain one; what's your problem? Well my problem is we didn't gain what we lost. And that's why we become uncompetitive.

Mr. Gantefoer: — Finally, you talked about a paper that you worked on in terms of research initiatives in Saskatchewan three or four . . . in '96, I believe you mentioned. And you identified, as I listened to you, some niche opportunities in terms of Aboriginal health, rural health.

Included in that, was there any discussion about the issue of diabetes in the population, which seems to be increasing fairly significantly and it has some impact, particularly in the Aboriginal community, as one of those niche areas of research?

And then finally, while I'm just on the question of niche areas, do we potentially or are we potentially losing a tremendous advantage in terms of the Canadian Light Source and its impact on medical research and especially pharmaceutical and molecular research? Is that a market that is there now and won't be there forever?

When the president of the university was here a week or two ago, he said that it's critical we make some important decisions now in terms of where we're going with the remaining light beams and who was going to operate them so we don't end up in a situation where we have teams of technicians coming in for three weeks, doing their research, and leaving to do the more detailed research in other jurisdictions.

I'd like you to touch on those areas.

Dr. McLennan: — To your second question first. Yes. The synchrotron presents a tremendous opportunity not only for Saskatoon but for Saskatchewan but for Canada. It's the only one in Canada. It's a tremendous opportunity. And as it ramps up with the full array of beamlines, there will be an absolutely

limitless opportunity for first class research around the world, really.

I agree with President McKinnon completely. We would be totally embarrassed in this province and certainly at the university, if when the switch is thrown and the synchrotron is turned on, if we don't have an array of our own researchers and scientists participating in that and all of it's being done by visitors, that would be absolutely embarrassing and totally unacceptable.

We've got again a narrow time period to ramp up to do that. Part of it is an educational thing. That's a new area of research for many people. And please understand that the synchrotron is a device, an instrument. You need to have the research laboratories around the country, around the province, in western Canada, elsewhere in Canada. But we're talking about Saskatoon now or Saskatchewan. We need to have the research laboratories there, doing the work, that presents the data that needs to be analyzed by the synchrotron.

So you're absolutely right. We need to recruit people who can use the synchrotron in their research programs and we need to make sure that the researchers we have, have the tools and the skills to use the synchrotron. Absolutely.

Now back to your first question. When we did the health research strategy, we identified some areas very briefly. We didn't delve into the Aboriginal health issue. But I would agree with you that in the five years that's passed, that is very large now on the radar screen — not only in Saskatchewan but across Canada. And so it should be. Every health industry that I can think of in the Aboriginal community is way out of line with the non-Aboriginal industry.

In our report, we did identify an issue we could work on, there's been some work done on, that is in population health. And you may be aware that we have formally created the Saskatchewan Population Health Evaluation Research Unit; SPHERU for short, S-P-H-E-R-U.

That by the way is one of the first, I think at least in the health research area, first examples of a research enterprise that is a provincial enterprise and spans both the U of S and the U of R (University of Regina). I'm on the board of directors of that, and happy to tell you that I think it's off to a good start. It's taken a little longer than we thought, but I think they're making good progress and the researchers are making some successes in national grants competitions.

So we have high hopes for SPHERU, and that's just one of those initiaries that we talked about.

Mr. Gantefoer: — One final area — and you talked to and identified a couple of areas that need immediate attention — the issue of a commitment to research dollars, a commitment to appropriate funding to allow the College of Medicine to attract and retain the people that they need.

My impression of being around the campus on a couple of occasions is that we also need a commitment to some physical resources in terms of research laboratories; and the university has on the table a proposal for an integrated health sciences facility that I understand is focusing not only bringing the various colleges together in an integrated environment, but also has the potential of creating some badly needed research spaces within that.

And I wonder if you'd like to comment on the physical requirements other than ATCO trailers, if we're going to indeed put the other two components in place that you've identified, that we need some physical commitment as well.

Dr. McLennan: — Well you're absolutely right. I mean to do research you need people and you need space, and they need equipment and tools and research assistants — the whole puzzle. So yes, and we're desperately short of space. And so is the district.

The notion of an academic health sciences centre is not new. It may be new in Saskatchewan, but it's certainly not new across Canada. It has a lot of merit. And I think there's a lot of good things could come out of that discussion.

Let me just say a little bit, a word about the acrimony that seems to go on between the district and the university. You know, if you have two children and you've got one bag of food and you give it to one and not the other, or you give them a half a bag each, what are they going to do? They're going to fight. And that's exactly what's happening. It's not a desire enough to get along — they're both so pressed for resources they start fighting with each other. That may be an oversimplistic analogy but I think you understand my point

We need to do health research, as I said in answering Dr. Melenchuk's question, across the board. The health care system has as many questions that require research as do the basic researchers in . . . that you referred to. And yes, we need to give them the facilities to do the job, whether it's a health research building, a change in structure.

We have to find ways quickly to make our health researchers competitive on a national level. That's the simple truth of it. We can no longer sustain our researchers getting . . . having a 6 per cent success rate in national competitions when the norm is 31 per cent. And we've got to change that.

And as I said earlier and I'll repeat it if I may, we have quality researchers. We're small, but they're good. And as I said the sad truth of that is when they leave and go somewhere else, they get funded. So it's . . . there's a solution there if we put our mind to it.

The Chair: — Thank you. Mindful that our next presenter is waiting in the wings, Mr. Thomson.

Mr. Thomson: — Thank you, Madam Chair. I have a few questions tonight that I want to pursue because I'm not completely sure I understand all of the pieces that we're talking about.

Now the request that you say that we should be aiming for is 1 per cent of our health care budget being spent on research. So that's approximately $20 million. We need to continue to fund the College of Medicine, which is I don't know how much money. We need to build an integrated health care service

centre, which I don't know how much money. We need to continue to find more money for recruitment. We need to keep open rural hospitals. We have a long list of programs the government employees' union wants. I suspect CUPE (Canadian Union of Public Employees) is going to come in not offering to take pay cuts tonight. And all of this has to be done within this magical 40 per cent that people say we can live in.

I guess the question I have is one of priority setting. And that is how do we deal with the requests that you're making tonight, which sound logical and advantageous to the province? How do we work that into what we're trying to do in terms of this 40 per cent, which everyone says is enough for the system to live on?

Dr. McLennan: — Well there's no simple answer to your question. And I have lots of empathy for your problem, but I hope you won't try to do it alone. I think we need to put our heads together and solve this problem.

Let me flip it around for you a little bit. I think you'd probably all agree that what . . . the system we have now is not sustainable. We can't continue as a province or as a nation to keep increasing the percentage of our total provincial revenue on health care. I heard Mr. Fyke speaking in Calgary on the 24th of June. He said the numbers across the country are similar and they're ramping up from 40 to 50 per cent.

And if you project the costs — as he says in the report — if you project the costs over the next few years, we'll quickly spend the entire provincial budget on health care. Well that's not sustainable. We can't do that.

So it seems to me we have to take a very close look at the things . . . set some priorities and fund those first. It isn't going to happen overnight but we have to do that. We have to look at implementing evidence-based medicine. We have to reduce health care costs where we can. We have to make the system more effective. As Fyke says, we have to emphasize the quality piece and not the quantity piece. And I think we can do that.

There's no simple answer to your question, I don't think. But surely to goodness with the resources we have in this province we can do a better job than we've been doing.

And the research, the research piece is always a devil. Because the accountant will ask you, well, okay, if I spend this much money, give you this much money for research for the next year, where are the results, where am I going to save the money? It's not quite that simple.

You have to think of research — and health research is an excellent example, as I tried to say, because it returns the investment to you — think of health research as priming the pump to the health system. It leads to the creation of jobs and companies and spin-off companies and so on, which in turn generate revenue, the revenue you're looking for to solve your problems, for example.

Now not every research project is going to do that. So we have to capitalize and make sure that we take action on those ones that will and return that revenue to the province instead of farming it out to somebody else. So that's part of it. We need to look at the system very carefully and see where we can economize, see where we can make efficiencies, make it more effective.

Now I've given you a long answer. But there's no simple answer to your question. But I suggest to you again, we simply can't continue the way we're going.

Mr. Thomson: — I appreciate that. And at this point we'll take whatever sympathy we can find.

Dr. McLennan: — I'm sorry.

Mr. Thomson: — At this point we'll take whatever sympathy we can find because nobody seems to want to come in and point to what programs we should be eliminating.

One of the questions that I guess I'm interested in in terms of the priority-setting exercise, within the university context to what extent is medical research given a priority within those research budgets?

Dr. McLennan: — There's two answers to that. In responding to national initiatives such as CIHR, CFI, and so on, the Research Chairs Program, part of that process, the university had to sit down and develop a strategic research plan for the university. And it's just as tough as the question you just asked, to look across the broad spectrum of research in the university and say, okay, what are our important topics? What are the ones we really want to push and which ones are we going to set aside?

So the university's defined five or six key areas across the entire research spectrum which they're going to push. And that's what they've said. Now I don't think we've . . . some would say we haven't gone far enough yet. When Dr. Alan Bernstein, the president and CEO of CIHR, was out, he said we have to focus even more. He said health researchers in Saskatchewan should define one or two areas and pursue those.

And indeed he went one step further. He said, if you define those two areas and come to us with a plan, we will help you. A regional plan. And maybe we'll involve Manitoba as well. Because as I said a while ago, health research knows no boundaries. And I really believe we should be working with our other provinces in all these aspects.

He said, if you develop a plan, we'll help you fund it. In other words, he was hinting they may very well continue with the regional partnership notion. Now if it was difficult to define six areas, I can tell you it'll be much more difficult to find the two. But that's the challenge for us.

Now when you do that, if the researchers that you've . . . are in the areas you've selected, they're happy. But you can imagine how the ones feel whose research area is not in those six areas you've identified. But I don't think you have any choice. We can't do everything in this province.

And I think it's the same with your health care system. There are things that you cannot do; there are things that you cannot fund. And maybe that's part of the answer to your question.

Mr. Thomson: — Certainly in Mr. Fyke's report he talks about

the need for us to co-operate more, both within the province and between the major centres. And I would be interested to know, I guess, where the College of Medicine sees that going, both in terms of research and in terms of doctor selection.

I was recently meeting with rural physicians and they told me that it's a mistake for us to think of our — our — College of Medicine as being in Saskatoon. Saskatchewan's College of Medicine is really in South Africa, because that's where we're recruiting the physicians from.

Dr. McLennan: — I think I'll answer your question this way. It's not just the College of Medicine's position. If I may, Madam Chairman, I should tell you about another initiative that is currently underway. Indeed I was on a conference call with it today.

Western Diversification has been having meetings across the four provinces to develop, to get ideas, to develop an initiative which will stimulate economic activity in all four provinces through health research. And this plan will be available in the — that is the written document — will be available within a few weeks, I think.

There's no secrets here, but it addresses your question specifically. It says, are there things that we could do in the West to get a better bang for the buck? Are there things that we can do in the West to make Western Canada the global centre for health research — global centre for health research? Are there areas that we could define and articulate for them? We think there are.

It speaks directly to your point about co-operation. And this would be co-operation not only between governments and between health researchers, but also between the business community, the biotech companies, the investors, venture capitalists, and so on. I think it's a very exciting initiative. And I look forward to sharing that with the community as soon as we can. But it speaks specifically to your point.

To use another example, you know there's one veterinary college in Western Canada. And if we were starting over, back in 1905, maybe that's what we should have done. We should have put a medical school here and a law school there and a school of engineering there, instead of one in every province. We don't have that choice now, but it doesn't mean that we can't work together.

And the same with the health districts. When I talk to some of our colleagues in the health districts, they have similar concerns. I mean the questions that the Saskatoon Health District is asking about process are the same as the ones that they're are asking in the health authorities in Alberta and in Manitoba. We need to pool those resources and get people talking to each other and getting a more effective answer to that expenditure.

Mr. Thomson: — Thank you.

The Chair: — Thank you. Seeing no further questions, thank you very much, Dr. McLennan, for your presentation and we look forward to your written presentation.

Dr. McLennan: — Thanks very much. If I can help in any way, let me know.

The Chair: — Thank you very much.

Our next presentation is from the town of Wynyard. Good evening and welcome to the Standing Committee on Health Care. Our first order of business as a committee is to receive responses to the Fyke Commission or the Commission on Medicare. So that's what we're doing with these hearings. We're hearing responses to the Fyke Commission and we report back to the legislature on what we've heard. We don't make any recommendations, but we'll be responding to the legislature about what we've heard.

We have an all-party committee. I'm Judy Junor, the Chair. Dr. Melenchuk is the Vice-Chair. Andrew Thomson, Warren McCall, Pat Lorjé, Glen Hart, Bill Boyd, and Rod Gantefoer are with us tonight.

We've got 30 minutes for our presentation, give or take half an hour. Hopefully we will stay within the 30 minutes as we have the rest of our presenters still waiting back there. In the 30 minutes, we've allowed for some time for questions from the committee members, and hopefully we'll be able to keep to that today.

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

Ms. Armstrong: — Well my name is Sharon Armstrong and I'm the mayor of Wynyard. And my presentation ties into the town pin, so if I can just take a second and run around and give you one. This is in no way to be construed as a bribe. Well I only have nine, so thankfully two have left on that side. So otherwise my MLA over there was going to have to do without one.

Well I came in here more or less calm and ready, but that last discussion got me all riled. And before I start on my Wynyard presentation, I have to ask Mr. Thomson, what was your point about the South African college? We have . . .

The Chair: — Just one second, Sharon. We're not debating, Sharon. You'll just have to go straight into your presentation.

Ms. Armstrong: — Wynyard has used the services of South African doctors for many years. We're very happy with them. And I support the request for research dollars and I support the idea that Saskatchewan trains doctors. I'm happy that you've decided to increase the number to 60. I think that our Saskatchewan children deserve an opportunity to go to medical school and if they choose to leave, that's the right of any citizen to work where they choose. So just made a point.

Okay now I'll . . . what I really came to say. First of all, if you would . . . Now I guess I do have half an hour so I was going to give a quick little rundown of Wynyard just to introduce you to the town because I'm presuming most of you haven't been there. And it was originally a railroad town; has a solid infrastructure of paved roads; 11 wells — which is now 13 wells, sorry — a large reservoir and filtration plant; 3,000-foot

by 75-foot paved airport, radio-controlled with landing lights, low-lead fuel available.

Our largest industry is agriculture. We're in agriculture service as most rural communities are. We have the largest poultry farm in Saskatchewan, and that's within town limits. We have an elevator; two large implement dealerships, several government agencies; used to be Sunnyland, now it's Lilydale, has 520 employees and expanding. It has an eviscerating plant, a hatchery, a rendering plant, and operates a fleet of trucks.

In the spring of '97, then Sunnyland announced plans for a multi-million dollar expansion. This has happened and that's why Wynyard has . . . we had to spend 800,000 on our filtration plant and reservoir to accommodate that expansion, and build two more wells.

Big Quill Resources is there which produces a high quality potassium sulphate. This began as a community bond project and has expanded twice since 1991, and it has 56 employees.

A strong retail sector is enhanced by many trade and professional services. Recently Wynyard has entered into intergovernment and business arrangements with some of the neighbouring First Nations.

We have nine churches, two preschools, an elementary school, a composite high school, and a community college with SCN (Saskatchewan Communications Network) facilities. The busy library is a resource centre with Internet service and soon-to-be sub-office of the Ventures Community Futures Development Corporation.

The community-minded people support 12 service and fraternal organizations, 17 sport and recreation organizations, and 12 social organizations.

Our recreation facilities include a licensed, nine-hole, grass-green, fully irrigated golf course with clubhouse, canteen, and modern washroom facilities. Club cart rentals are available.

Families enjoy five well-equipped playgrounds and a paddling pool.

For sports enthusiasts there are two paved tennis courts with ball return board, a heated, 25-metre outdoor swimming pool with lifeguards, change, shower facilities, and modern washrooms. The pool includes 1-metre and 3-metre diving boards.

The newly upgraded sports ground has four ball diamonds, one soccer pitch, 14 horseshoe pits, canteen, meeting, and modern washroom facilities.

The town isn't afraid to spend money on these kind of things because we accept the idea of wellness and all of our recreation facilities are geared to that end.

The regional park has a pond stocked with trout, 22 electrified campsites, modern washrooms with showers, a playground, sewage disposal tank, and drinking water.

For winter activities, we have an artificial ice plant skating rink with canteen facility; room for 1,000 spectators, 200 spectators in the heated lobby. The arena is wheelchair accessible. We have modern washrooms and seven dressing rooms. Skate sharpening is available. There's a four-sheet, artificial ice plant curling rink with canteen facility and licensed lounge. Lockers are also available.

For fresh air buffs, there's an outdoor skating rink with lights, heated change room, and groomed ski trails.

Seniors' drop-in centre offers carpet bowling, card tables, darts, and billiards.

There's also a billiard parlour; two auditoriums and four halls accommodate our many indoor activities.

Located on the Yellowhead Highway between the famous Quill Lakes, Wynyard is ideally located to develop tourism.

One of 22 municipalities in the North American Waterfowl Management Plan, Wynyard was selected as the site for the dedication of the Quill Lakes to the Western Hemisphere Shorebird Reserve Network. Long sought out by hunters, it's now famous as a destination for birdwatchers.

Other popular attractions include a heritage site, a civic centre complex with a pioneer scene in cement relief, a peace park, works of local artists, and touring art shows. The stately court house is splendid amidst beautifully maintained shrubs and flower beds. The Royal Canadian Legion club rooms features a cenotaph and World War I cannon on their scenic grounds.

The wheelchair-accessible interpretive centre, displaying the Quill Lakes geography, economics, and cultures, and the Frank Cameron Museum are visited by many. Both double as a tourist information centre and have a modern washroom facility.

Tours can be arranged by appointment for the eviscerating plant; the elevators; Big Quill Resources, which also has a research and development centre; M & S Concrete Ornaments; Georgie's Greenhouse; Penny's Nature Tours. And nature lovers can enjoy the greenhouse as well as scenic bed and breakfasts, an emu farm, a petting zoo, and many first-class yards and gardens.

Wynyard is fortunate in having many volunteers who put their energy and talent into organizing events throughout the year.

Within easy driving distance the tourists can find the World War II RCAF (Royal Canadian Air Force) bombing and gunnery school, located north of Dafoe; Kildeer Park at Kandahar; musical street signs at Mozart; an Icelandic family in bronze at Elfros; St. Michael's Church heritage site located on Highway 35, just north of Wishart; the stone church southwest of Wishart; and the large cairn marking the Kutawa trail used by Middleton in the Northwest Rebellion. For more information you can talk to the town office or the Frank Cameron Museum.

Environment and protection services include a state-of-the-art disposal site; recycling centre; a SARCAN outlet; a Royal Canadian Mounted Police, and we have built them a new facility in the '80s; a dedicated volunteer fire department with Jaws of Life, and we built them a new facility in the '90s;

ambulance with paramedic service; a dentist; five medical doctors — four right now; many other health practitioners; a hospital; special care home, and our new one was just opened this year — that was, I think it was about an $8 million project; the town put 1.6 million and then on the volunteer part another 800,000 — seniors and low-rental housing; and the citizens on the patrol program.

Protective services enjoy broad community support through boards, auxiliaries, and private donations.

So that's my town.

Now if you'd like to look at that little pin I gave you. The top of the pin has the wheat sheaf and that is because Wynyard was first and foremost an agriculture community, agriculture service community, and that includes all services which the people in the area have come to expect.

Further down you'll notice the blue strip, and that stands for the Quill Lakes which the province has been interested in having the Quill Lakes as a destined area team up with Chaplin which is also a destination area; and we tie in with the northwest flyways in the United States.

Further down there are some little white birds which could be mistaken for pigeons. That stands for our eviscerating plant and our chicken industry with 520 employees, and there will be more when they expand.

That project serves to provide employment for about 22 other communities so we've been very fortunate. Those people from the other communities drive to Wynyard, work, drive home, and we haven't had to worry about a problem of housing and the related . . . but we're doing a lot to sustain that portion of the province by providing 520 jobs.

We have had provincial help in the past. I think in the '70s the plant was in serious danger and that SEDCO (Saskatchewan Economic Development Corporation) came through with a loan which has all been paid back, but it did save the plant in a dangerous time.

Further down you'll notice the prairie lily. Now that prairie lily is on there, it stands for Saskatchewan. And probably to just remind you tonight that Saskatchewan, with a million people, is one community. And what I see happening, and I think most rural people see happening, is a grave danger of a two-tiered system. And I don't mean rich and poor, I mean rural, urban.

So when I get into your report I'm going to be most anxious to know what kind of cut-offs you're using for your diagram for the delivery of services. I understand the Saskatchewan, Regina, Prince Albert, but as it goes on the 25, and the centres, and the teams, I'm not sure what your cut-off would be for providing that service.

Another important aspect of Wynyard is a population breakdown. And I just thought I would point out our total male and female population, from 65 to 95, we have 850 from 65 to 95. We actually have 150 people between 80 and 84, and 69 people from 85 to 89, so we're talking an aged population.

So Wynyard is not a typical rural town. We have the rural population, which is aging, and then we have the plant with the 520 young employees, and about 300 of those are families which live in Wynyard; their children go to school and so on. So we have a diverse population age-wise.

And I also brought a letter from the Lilydale. I was pretty lucky; the person who happens to be there this week is the corporate health and safety manager out of Edmonton, and she was kind enough to write a letter for me which I'll just read into the record:

> Attention: Mayor Armstrong.
>
> It has come to the attention of the management of Lilydale Foods that the Saskatchewan government is considering the closure of rural hospitals, which of course would include the Wynyard Hospital. As a large employer of residents in Wynyard and surrounding communities, Lilydale Foods opposes this closure for the following reasons.
>
> We recruit people from across the province. Part of the attraction of relocating to Wynyard is the fact that there is an active treatment hospital to support our employees and their families in the event of illness or injury. If there is no hospital, the local doctors will have no incentive to remain in the community. The town will have a very difficult time retaining medical staff. Our employees in Lilydale Foods will incur the expense created by lost time from work if our employees must drive long distances to seek medical attention.
>
> The Lilydale Foods organization hopes that you will reconsider these proposed hospital closures in rural communities. We support Mayor Armstrong in her attempt to keep the Wynyard Hospital in operation.

Now I'll get to the other point. I've brought with me your provincial partners in prosperity book which I received from the Premier, Lorne Calvert. And I was looking through it and actually I concur with most of the things in here. It's talking about a vision for a prosperous province and what are the things that Saskatchewan needs.

One of the things they mention is strong communities, and there's a big description of what a strong community encompasses. And of course we all know one of the things to make a strong community is the services that you offer.

In this book, which is part of the same package, there's a discussion of diversifying and strengthening agriculture, revitalizing rural Saskatchewan. All through this the plan is that rural Saskatchewan is going to help enhance the province's economy.

Because I know we've heard so much about rural Saskatchewan in decline and rural Saskatchewan on the rocks, I think the province is very optimistic and I congratulate them for putting this attitude forward. I think we don't get a fair break in the media. Saskatchewan is doing better than a person would think if they didn't live here.

But it is important to notice revitalizing rural Saskatchewan is

one of the big points, as a cornerstone, for the province's prosperity. Diversifying and strengthening agriculture is a key point in revitalizing rural Saskatchewan. And this is where Saskatchewan is at with our support for Lilydale.

We have 13 wells. A well costs about a quarter of a million dollars, to find the water, drill the water, and pipe the water. The plant for purifying and cleaning the water is an $800,000. So we're doing our share.

Transportation system, northern communities, strong urban communities. There's a comment:

> I would like to see more help for agriculture including better roads, more help to small communities, and more help for the maintenance of our health services.

So I could go on, but now to look at this report. Where do the things that I've just read fit in here? I'm not sure.

I have to confess I did not read the whole report cover to cover. But I did look at the portion of the terms of reference and the summary of recommendations. So on the terms of reference on page 86, the principles of the Canada Health Act — universality, portability, accessibility.

I think that the proposal for the closure of so many hospitals or at least maintaining 11 or 14 might beg the question of accessibility. Given our climate and our roads and the disperse nature of our population, accessibility is going to be a problem if you only have 14 hospitals in the whole province.

> Distributes costs in a way that is fair and equitable; (and)
>
> Ensures (success) . . . to service based on health need and not on the ability to pay.

Of course this is easier said than done and I sympathize with the province trying to ensure access to services. And the ability to pay in our province is sometimes difficult.

Now I would like to have heard a little more complaints about the way the federal government isn't funding you; but I don't know if you can go ahead with the recommendations because they look to me fairly expensive.

Starting over with the recommendations, on page 90, the health district organizing these interdisciplinary teams and contracting or otherwise paying family physicians, I have a little problem with the idea of health districts contracting and paying family physicians. I would hope if you were going to get physicians on salary, there'd be a provincial grid.

I'm a teacher by profession and we had school districts contracting and paying teachers. Back in '71 or '73, we went on a provincial grid. So I would think that would be a serious step backwards if you were to start with health districts paying doctors.

The services close to home, and then you have a system of 25 or 30 community care centres, well, how close to home is that going to be for most people in Saskatchewan if there's 25 or 30? That's going to be the respite, convalescent, and palliative care, and long-term care.

Now I believe that respite, convalescent, palliative, and long-term care should be close to home. But in 25 or 30 centres, it's not going to be close. There'll be a lot of people that it won't be close to.

The tertiary services in Saskatoon, Regina, P.A. (Prince Albert), and you know, I can accept that you have to have some exceptional hospitals to do the very expensive procedures. But the network of 10 to 14 regional hospitals to provide basic acute care and emergency, I would think that that would have to be moved down.

So flipping over to your chart, which is page 104, the specialized services, I don't think anyone would argue with that. But when I see regional and local, I guess I have a question. Are you allowed to answer my questions? Or can you tell me . . .

The Chair: — Actually, no, we're not dialoguing at all. We're just taking your responses.

Ms. Armstrong: — All right then . . . When I see regional and when I see local, like, I'm wondering how small is local. When you're talking about interdisciplinary teams and primary health centres, that's going to be local. And then primary health networks seem to be a combination of these teams — that becomes regional. And the specialized services isn't until you get to regional and that's your 10 to 14.

So I would think in a province dispersed as we were, this will not be acceptable. You won't have appropriate accessibility if you limit the services to 10 to 14. And of course, we all know that they would be cities.

So I guess what I'm protesting is the cut-off, the cut-off for these services which we now take for granted in Wynyard. The cut-off is now going to be . . . well, you'd have to be at least 5,000. Like your critical mass seems to be 5,000.

Well I consider 2,000 quite an appropriate group. I even would favour keeping the services you have in populations of a thousand. Now I'm not saying go and build hospitals in, you know, every hamlet, but certainly if there's a hospital in a community of a thousand, as now there's one in Watrous, one in Lanigan, I think that should be kept.

And I'm not suggesting you do brain surgery there. But certainly there should be a division of basic acute care which could be still continued at the local level in those hospitals that are presently in existence, and leave the more difficult and more expensive procedures for the cities.

Coming back to page 92, "Making Things Fair." I would like to see all of those items done by the province. Public health, health promotion, strategies to address the broader determinants — that should all be provincial. I hope there isn't a plan to put that in the health districts.

You know there's such a waste of money when you think of duplicating some of the services. For example, if there's one person in each of the 30 districts who's dedicating their time to

thinking how do we deal with obesity in children? How do we deal with smoking in children?

You know the most successful wellness campaign that this country ever saw was Participaction. And that was done at the national level.

So I consider that more appropriate. I think that anything that's going to be meaningful should be handled at the provincial level. It's a needless duplication, and no health district has enough resources to do a good job of it.

> Primary Health Service Teams working within broader . . . Health Service Networks to address the population health needs of the people they serve.

Prevention of injury and management of chronic conditions. This again is . . . it's a question mark to me. I don't know how you would expect a health team . . . I mean that's going to be very costly. And I'm not sure that it's going to be effective. It seems to me that what you have in the old hospitals now is a health team. So why you would try and come up with a new diagram for the delivery, I'm not sure.

Page 94:

> Co-ordinated human resources planning and management on a provincial basis.

I certainly agree with that.

> Persons having a salaried or contractual relationship with a health district prohibited from standing for election . . .

I certainly agree with that. And recommendations for paying the bills, enhancing overall health, research to support health, changing the . . . this should all be handled by the province.

Your description of the proposed health districts, surprisingly enough, this doesn't scare me as much as you would expect. I would have expected you may have even proposed five districts.

I think that Saskatoon and Regina should just include the city so the Regina Health District should be the city of Regina, Saskatoon Health District should be the city of Saskatoon.

And we did some restructuring in SUMA (Saskatchewan Urban Municipalities Association) and I know across the bottom of the province and the north of the province the population is more scarce. There's a strip in the middle, kind of a diagonal strip from Saskatoon through to Yorkton, that could possibly be three.

It's conceivable to me that if you gave the two major cities, whose population comes to approximately half of the province, if you gave each of those cities their own health district, and conceivably we could have maybe five for the rest.

And then with the money that you would save from having 30 you would put more resources on the ground. See, I don't see an advantage to having 30 sets of people at the top. I would rather see that on the ground, in nurses and medical services right at the local level.

And I believe I've mentioned the Appendix C; this is the scary part to me. I think all of the services that would be provided by the team are provided very adequately now in the old hospitals plus there's the potential for some basic acute care. So I reject your proposal for restructuring.

Now that's it. I'm sure you won't have any questions.

The Chair: — Thank you, Mayor Armstrong. Questions from the committee?

Hon. Ms. Lorjé: — Thank you very much, Your Worship. I don't have a question; I do have a comment. Yes, I agree with your assessment that Participaction is probably one of the most successful preventative programs that we've had but I think that you're doing Dr. Howard Nixon and his team in Saskatoon a disservice by saying that it was a national program. It was developed in Saskatoon.

Ms. Armstrong: — Well, thank you for correcting me. I didn't realize that it was Saskatchewan-inspired, but it was accepted nationally and it was promoted nationally. I mean it took the resources of the federal government to do it is what I mean. A single health district could not have accomplished what Participaction did. But thank you for correcting me.

Hon. Ms. Lorjé: — Thank you.

The Chair: — Seeing no further questions, thank you very much, Mayor Armstrong, for your presentation and your pin.

Ms. Armstrong: — Thank you. Oh, I will have it written and send it along if you require that.

The Chair: — Thank you. Good evening, and welcome to the Standing Committee on Health Care. Our first order of business as a standing committee is to receive responses from the public in groups or individuals, the responses to the Fyke Commission or the Commission on Medicare.

The standing committee is an all-party committee. I'm Judy Junor, the Chair. Dr. Melenchuk is the Vice-Chair. Andrew Thomson, Warren McCall, Pat Lorjé, Glen Hart, Bill Boyd, and Rod Gantefoer are with us tonight.

We've got 30 minutes and hopefully your presentation will allow for a few minutes of questioning at the end. And if you'd just introduce yourself and who you represent if anybody, and proceed with your presentation.

Ms. Roettger: — Thank you. Well you're all tired. This I can see. It's been a long evening for you. My name is Shirley Roettger, and for about 10 years I worked in pastoral care. I'm just a private citizen tonight, and I'm presenting on my own.

I read the Fyke report and I recognized that spiritual care has virtually been left out of that report, so I'm here to bring your attention to that, and to bring our attention to that.

Why do I think this is important? Well I thought it was important enough to give seven years of my life free, as a

volunteer in our health care system. I thought it was important enough to spend three years as a chaplain within that system, and I'm still a volunteer.

When I was with the spiritual director, he once asked me, what do you do with doubt? So I wrote a poem, and with your permission I'd like to recite that poem.

> Lord, you have not made this world an easy place to believe in your infinite goodness And with human eyes, I often wonder if you are paying attention.
> When I say I have faith, I say I believe,
> But at times it feels the same as to make believe.
> It is then that I take myself looking at the world and all that is in it,
> Not just the beauty, but also the ugly.
> And deep in myself I go searching to find where you're present in it.
> I will work to my full potential, take the abilities hidden in me, and use them to serve other people
> And in some rare moment of serving, I'll see you or sense you beside me.
> These gifts are the treasures I cherish.

And may I suggest that each of you is sitting here tonight because you too treasure something about the mystery of life, or you'd be off doing something else. Correct?

So when we look at the commission's report and we think about what's missing in Saskatchewan, may I suggest that Saskatchewan has a spiritual problem.

Now what do I mean by that? I mean that I think we've lost a sense of who we are.

And how do I see that? Well we have a rural crisis. That's a reality. We are jailing far too many of our youth. That's a spiritual crisis. Our school systems are under a bit of discomfort, let's say, at that at least. The health care system has been stretched to the limit.

Many ways in which this province, we, as a people, one of the things, our strength about us is that we've always been able to look at each other and to say that our neighbours count and they count enough that we are going to give something of who we are to them. Correct? I think that's what makes us different from others.

Now how does this play itself out in our health care system? And where does that money come from? Perhaps we need more money. I don't think so. I think we need to re-empower each other again.

I think that that has something to do with the fact that we have bought into the myth of the expert. To some degree, that just is a myth.

How we walk beside each other matters and what we bring to those relationships matter. I think there needs to be integrity. I think that that integrity needs to take the form of deep honesty, and honesty when we look at our structures and what needs changing within those structures.

So that's basically the message that I've come to bring to you tonight. I think that when you're talking about a caregiver, that there is certain areas that you want to look at. And I think of them as compassion, the ability to suffer with another. How many of us can truly do that? In my time in pastoral care, I have come to recognize how easy it is to dismiss another. It's that easy — all you have to do is divert your eyes and you can do that.

Now one of the things about health and about wellness in relationships is good communication. Correct? So if we are going to have people who are walking beside our most vulnerable people, we want them to be good communicators. And this is often not the case in health. So we want people to be compassionate.

There has to be a certain level of competence. Now you think I'm talking out of both sides of my mouth, right? The myth of the professional. I believe that competence doesn't necessarily come with a particular paper. It comes with that desire of the human being to learn and to grow, and I think that that's innate in all of us.

Confidence. You have to know enough about yourself and your own vulnerabilities to be able to share in another's. You have to be able to say I, too, will have an end; I, too, will die and to be able to face that squarely in order to walk in the health care system with integrity. There has to be a consciousness about what you're doing and why you're doing it. And there has to be commitment.

These are factors that we cannot let go. In my opinion they are the attributes of a caregiver.

St. Ignatius of Loyola said:

> I come from God, I belong to God, and I will return to God.

This is the waiting God, the already-there God, the I-am-with-you God. God uses the realities of our life experiences to invite us to new perspectives.

What do we need to look at in Saskatchewan to better our health of our population? We need to look at our brokenness. We need to look squarely into our pain. And then we need to make decisions on how we move from there.

I would believe that if we're looking at our health districts here that some more money needs to go into pastoral care. I think that we need to not be burning out our chaplains. Most of our chaplains are provided by the main denominations: the Roman Catholic, the Lutheran, the Anglican, and the United Church. All of these churches are under some financial strain.

So it becomes important if we believe that spiritual care is important, and in most of our mission statements we say that we do. We say that we are trying to provide health in body, mind, and spirit. So if that's true, then some money has to go to that area.

And I believe that when you're looking at an acute care setting, such as the General Hospital, for instance, you would probably want to put a chaplain in the cardiac care unit, in the

neuroscience unit, hemodialysis, in psychiatry, and in emergency, and that connected with the critical care units. So I don't think that you can get by with less than five chaplains and do an adequate job, if indeed our mandate is to supply care, spiritual care. And indeed, we say it is.

We also need in this province permanent educators in this area. Who these people should be, I don't know. The one recognized body in Canada and the US is called clinical pastoral education. Now for myself I took one unit. I didn't like it much. It wasn't for me. But that doesn't mean that it's not a good program; it is.

I also don't think it's the program for Saskatchewan — at least not if we're looking at the size of our province and how we need to empower people within those communities to walk with the people in those communities, hence not costing us more money but educating our volunteers and our clergy that are already there.

I don't think that they can take three months of their life and give it to a clinical pastoral education program and get one unit which doesn't really . . . isn't really all that well recognized.

Quite frankly people are saying that you need two units, three units, or four units, and from what I see — and this is only my perception — is that that's not necessarily what makes the best chaplain. In my opinion what makes the best chaplain are those attributes of care.

So if you have any questions, I'd be willing to answer them to the best of my ability.

The Chair: — Thank you very much. Just for your interest we had the Catholic Health Association of Saskatchewan and the Saskatchewan Catholic Health Corporation here earlier today talking about spiritual care and pastoral care included in the health system. So I thought you might like to know that you aren't the only voice that's saying that.

Any questions from the committee members?

Mr. Thomson: — Madam Chair, you've said exactly what I was going to say, which is this is the second time today we've been reminded of that oversight in Fyke and the need for us to make sure that there's a truly holistic approach to healing. So I thank you for coming tonight.

Ms. Roettger: — And if I can be of any help let me know. Thank you.

The Chair: — Thank you very much on behalf of the committee for appearing tonight.

Our next presenters are from CUPE, Canadian Union of Public Employees. Welcome to the Standing Committee on Health Care.

We are here tonight as a committee of the Legislative Assembly to hear responses to the Fyke Commission and to report on what we've heard back to the Legislative Assembly by the end of August. It's an all-party committee.

I'm Judy Junor, the Chair. Dr. Jim Melenchuk is the Vice-Chair. Andrew Thomson, Warren McCall, Pat Lorjé, Glen Hart, Bill Boyd, and Rod Gantefoer are the members here tonight.

If you would . . . we've given people 30 minutes. As you've seen we've strayed a little. Included in that 30 minutes we hope to have some time to have committee members ask questions of your presentation.

So if you want to introduce yourself and then proceed with your presentation. We have copies of your presentation tonight. We had also pre-distributed this in our package before the committee started, but we welcome it again. Thank you.

Mr. Foley: — Madam Chairman, I guess we were sitting back there wondering what we should do maybe to wake everybody up but what we'll do is get into the meat and potatoes of our report.

First and foremost my name is Stephen Foley and I'm the president of the CUPE Health Care Council. Presenting with me tonight is John Weldon sitting next to me, he's a CUPE national representative; and next to John is Cheryl Stadnichuk who is a CUPE research representative in the province.

Because our time is somewhat limited, and I guess given the lateness of the night, we are going to keep our comments brief — I imagine you'll appreciate that. And we're going to keep them in line with the submission that we handed out to you. Then, hopefully, after we've gone through the submission, we're prepared to try to answer any questions if time permits.

The Canadian Union of Public Employees is pleased to have this opportunity to present our views to the Standing Committee of the Saskatchewan legislature in response to the recommendations of the Saskatchewan Commission on Medicare.

Our union represents approximately 23,000 public sector workers in the province in a broad range of workplaces in both urban and rural settings. About one-half of our membership, around 14,000 to be exact, work in health care. We are the largest union in the province, as well as the largest health care union.

You may or you may not be aware or familiar with which classifications of health care workers that we represent. CUPE represents diverse front-line workers in 987 classifications including maintenance workers, nurse and home care aides, laboratory, radiology, and diagnostic technologists, therapy, dietary, housekeeping aides, cooks, and licensed practical nurses.

Our members work in 18 out of the 32 heath districts in this province and in one northern hospital in Uranium City. And you will find a full list of the health districts in which our members work in Appendix B in our submission.

As front-line workers, our members have seen inefficiencies in our health care system, and they strive hard on a daily basis to provide the best health care possible to their patients and residents. They know that there could be a better way of doing things and have an interest in seeing positive changes brought

to the system. We are hopeful that the report of the Saskatchewan Commission on Medicare, if implemented and expanded upon, will provide some of the needed changes to make our health care system better to serve our citizens and the workers in the system.

We'd like to present our union's response to the report and outline where we think the recommendations could be strengthened. Overall, CUPE supports most of the recommendations of the Commission on Medicare. In particular, we believe that the move towards a primary health care model is an extremely positive proposal.

In some instances, however, we believe that the commission did not go far enough to provide enough detail on how the recommendations could be implemented. We hope that through consultations of this Standing Committee, further recommendations to strengthen the commission's report will be developed.

Our submission tonight will not go through every single recommendation of the commission, but we will highlight what we consider to be the most important elements.

In Appendix A to our submission, we have provided a point-by-point response to the recommendations of the Commission on Medicare.

Ms. Stadnichuk: — So the first recommendation of the commission was the primary health care model. We find that this is one of the most positive elements of the commission's report. In our union submission to the commission we had posed such a model similar to the community clinics here in the province or the CLSCs (centre local de services communautaire) in the province of Quebec. We feel that the creation of interdisciplinary teams of health care providers is the best model for providing health care because it recognizes that there are a broad range of factors that affect health status.

Under this recommendation, the commission also calls for full utilization of the skills of all health care workers. This is a recommendation that we fully support and a proposal that our union has been making for some time. In particular, our union has promoted the full utilization of the skills of licensed practical nurses and has met with health boards and the provincial government on this matter in the past.

We also support the concept of a primary health network in which specialists would travel to rural communities. We believe that this could provide timely and needed services to residents in rural Saskatchewan, and would reduce travel time and out-of-pocket expenses of those who normally would have to travel to one of the major urban centres to see specialists.

Although we are supportive of this recommendation, we believe it could be strengthened in several areas. We feel for this primary health care model to work, it is essential that the government recognize which elements need to be in place first to have success.

With respect to provincially coordinated emergency services, we're pleased that the commission recommended the creation of a provincially coordinated emergency services system. Our union believes, however, that emergency services need to be publicly financed, publicly coordinated, and publicly managed. A private/public mix of emergency services leads to inefficiencies and complicates the goal of provincial coordination.

Compensation of physicians. The Commission on Medicare recommends that physicians participate in primary health care teams and suggests that specialists have a contractual relationship with the health districts. We feel that the commission should have gone further and recommended that the government eliminate the fee-for-service method of compensating physicians, and that physicians be paid a salary under contract with health districts. The primary health care model will have limited success unless physicians are integrated into teams and are accountable to the health districts. Fee-for-service encourages unnecessary tests and procedures and impedes the success of a new model.

Conversion to community health centres. This recommendation is no doubt one of the most controversial in the report. CUPE supports the creation of community health centres that provide . . . that would provide a broader range of health services than the current, limited acute services of rural hospitals. The number of hospitals that would be closed or converted, however, is a difficult point. It is important that the government develop a health services plan for these communities that outlines how services would be maintained in the event of hospital closures.

There are many factors that need to be considered before any such closures take place. First of all we believe that a labour adjustment strategy must be in place, similar to the program in British Columbia which minimizes job loss and ensures redeployment of workers in the system. Ideally there would be no job loss. Considering the high workload and stress levels that our members face, we do not want to see fewer workers expected to provide more services under this new health care model.

Secondly no closures or conversions should occur until a public, provincially coordinated emergency services system and the primary health care teams are in place and functioning well. Until the health districts and the government can assess the success of emergency services and health care teams in meeting the health care needs of rural Saskatchewan, it is unwise to close or convert hospitals. This is a lesson that we should have learned from the last experience with health reform.

The second recommendation, specialized care. We support the proposal to concentrate tertiary services in the three major urban centres of Saskatoon, Regina, and Prince Albert. The creation of centres of excellence in these cities may assist in attracting specialists to the province.

The proposal to develop a network of regional hospitals is another idea we support and one that we recommended to Mr. Fyke. However we believe that these regional hospitals need to be able to provide a full range of diagnostic and surgical services to reduce the heavy demands on Saskatoon and Regina health districts.

As we noted in our submission to the commission, 70 per cent

of all surgery is performed in these two health districts. The provincial government needs to provide appropriate funding for equipment and personnel to the regional hospitals to ensure their surgical capacity.

Mr. Weldon: — The third recommendation that we are dealing with is "Making Things Fair." In this section the Commission on Medicare makes several general recommendations with the respective detriments of health, health promotion, and prevention. The report also recommends that measurable and clearly defined health goals be adopted across the province.

While we are strongly in support of these ideas, we feel that the discussion on detriments of health and the possible solutions should have been dealt with in a much more comprehensive and in-depth manner. Tackling the social and economic detriments of health, we believe, should be one of the major thrusts of health care reform.

In our brief to the commission, we used an example of how the French government reduced the number of premature births by 30 per cent by paying women to attend prenatal sessions, providing them with food supplements during pregnancy, expanding maternity leave, and allowing pregnant women 30 minutes off at the beginning and the end of each day so that they wouldn't have to cope with heavy traffic.

The Saskatoon Health District recently released a report making the links between poverty, substandard housing, and poor health status. The report makes many recommendations for a broad range of multi-sectoral approaches to improve health status, including an increase in the minimum wage.

In our brief to the commission we pointed out that health care is the industry with the highest rate of injuries reported to the Workers' Compensation Board. And that was some time ago. We just received the recent Workers' Compensation Board report and we're still number one, which is not something I think we should be proud of.

Although the commission makes reference to the improvement of working conditions, we would like to see a more detailed plan for dealing with the high rate of stress, workload, and injuries in the health care sector.

To give you a slight example of that, the health care sector has the highest rate of injuries reported to the WCB (Workers' Compensation Board) board for violence of any other industry combined. That includes police, prisons, 7 Elevens.

We believe that it is essential that a new health care strategy recognize that a variety of social and economic factors and physical environments influence our health status. Clean air and water, healthy workplaces, family and social supports, and adequate living conditions make a tremendous impact on our health.

The only other point we have on this section is regarding the northern health strategy. We support this recommendation but feel that in the spirit of self-government, Aboriginal communities should have the autonomy in defining and implementing strategies that are best to meet their needs.

Getting results. The recommendations that fall under this section deal with the creation of quality health systems through the development of performance indicators and a quality council that sets standards. In general terms CUPE supports this recommendation but we have some concerns about how performance indicators would be developed and under what criteria.

We hope that front-line workers through their unions will have input into the development of performance indicators. For example, it may be fairly straightforward to develop best practices for drug prescribing, but how do we measure the more subjective aspects of quality of care.

Our members tell us how increased workloads have meant less personal time with residents or patients which has a negative impact on quality of care, while performance indicators attempt to measure these factors.

The commission has envisioned a quality council as an objective body composed of experts using evidence-based methodology to set standards and develop performance indicators. We agree that the quality council needs to have a level of expertise and an objectivity that provides it with some authority to set standards. However, we want to caution that there are some limitations to evidence-based methodologies.

Last year the Health Services Utilization and Research Commission, HSURC, released a study that claimed that seniors are more likely to die or lose independence if they received home care services than those who did not receive services.

This study raised some questions and ignored the more subjective quality of life benefits of home care services. The year before that, they did a study that said that if you never went to a hospital, you'd live forever, essentially.

CUPE would like to see the quality council include representatives from groups with a broad range of community experiences such as anti-poverty and women's groups, community development activists, and unions. If we acknowledge that social and economic factors influence health status and that the quality council will be the watchdog of our health system, then we need expertise from activists on the council.

The fifth area was support for change. CUPE supports reducing the number of health districts to ensure high quality, consistent services across the health districts.

And I want to qualify that a little bit. We don't simply support larger health districts for the sake of larger health districts. I think the report outlined a very good rationale behind why there should be larger health districts.

We are not tied to the 9 or the 11 health district model, but if necessary we choose the 11 districts over the 9. Ideally the creation of districts should follow natural flow patterns that currently exist, which we feel that the 11 does versus the 9.

Again, as we mentioned earlier, there should be no changes to the health district structure until a comprehensive employment

and training strategy is in place.

The commission's report recommends province-wide coordination of human resource planning and management but does not address the problem of the duplication of human resources structures in health districts and affiliates. CUPE recommends that affiliates fall under the jurisdiction of the health districts. And what we're saying is it should be legislated out of existence and amalgamated with the health districts, or at the very least that human resource management be centralized under the health districts.

We continue to support the concept of fully elected health boards instead of the current mix of elected and appointed board members. We are totally opposed to any ban on health district employees being able to run for health board positions. We believe that there are adequate conflict of interest guidelines in place that ensure fair participation of health district employees on boards.

While the commission's report makes reference to the need to clarify roles and responsibilities and to ensure accountability between the various structures in health care, we feel that the province must dramatically overhaul the governance structures for health care.

Ultimately the provincial government is responsible for setting the policy direction in delivering health services to residents of this province, and ultimately the provincial government wears whatever happens in health districts.

Then we have the Department of Health, committees of the Department of Health, the health districts, the affiliates, and the Saskatchewan Association of Health Organizations in the mix.

At present the various roles and unclear lines of responsibility create confusion and frustration. Although the government fully funds health care, it has delegated authority for bargaining to SAHO, an organization that seems intent on creating strife in health care labour relations. And that's a brief on its own.

The Commission on Medicare recommendation to create a quality council will add another layer to this hierarchy. We would like to see fewer layers and clearer lines of accountability.

One proposal we'd like to put before you today would be to create a structure or a body similar in nature to a Crown corporation. This body would have responsibility for developing policies and standards for health care and ensuring the implementation of health care strategies. It would provide direction to the health districts, and the health districts would be accountable to this body. SAHO would be dissolved and this new structure would have the responsibility for bargaining with a clear mandate from the provincial government.

The quality council composed by the commission would be an arm or a branch of the new structure. The new structure would have an advisory committee with representation from community organizations active in the area of the detriments of health.

We feel that such a structure would ensure more accountability and direction to our health care system and would ensure more effective delivery of services.

Ms. Stadnichuk: — Recommendation no. 6 around paying the bills. In this section of the commission's report the commission does not recommend any expansion of services to be covered under medicare but states that costs first need to be controlled through quality control measures.

We consider this section to be one of the weakest sections of the report. We strongly believe that our provincial health insurance plan needs to expand to include a broader range of services and that if alternative health services were covered we would see cost savings to health care and to our social programs.

For example, limited home care services can create burdens on informal caregivers whose own health may then suffer. There is a study of rural women in Saskatchewan that found that half the women interviewed saw their health deteriorate since they began to care for aged or disabled family members. Additional resources invested in home care would reduce health care costs of informal caregivers in the long run.

Funding midwifery could reduce the high costs of obstetrical care.

Reinstatement of the children's school-based dental plan would be a valuable investment in the long-term health of children.

Although all Saskatchewan residents are guaranteed access to a physician or a hospital regardless of income, the economically disadvantaged do not have equitable access to other services that are just as important if not more important to good health.

In 1999, for example, only 40 per cent of low-income Canadians saw their dentist compared to 80 per cent of high-income Canadians.

Mr. Foley: — In conclusion. In conclusion our union supports the main recommendations outlined in the Commission on Medicare report and we are especially pleased with the proposals to develop a primary health care model and restructure the current number of health districts. We feel this will create a more responsive and integrated health care system.

We do have some concerns with the generality of the recommendations because they leave the door open to interpretation in many cases. What is needed is a detailed implementation plan that outlines how arising problems and obstacles will be addressed.

We also feel the scope of the report could have been much broader to develop strategies and ideas for addressing socio-economic factors that affect health status. Although the report makes general references in support of population health approaches, it provides little analysis or no specific recommendations on this important area. Thank you.

The Chair: — Thank you very much. Does the committee have questions?

Mr. Thomson: — Thank you very much, Madam Chair. I want

to thank the presenters for both the initial brief and this submission tonight.

The question I have concerns long-term care, home care. And it was an issue that you highlighted in your initial brief to Fyke but not in the presentation tonight, and that concerns the personal care homes. I'd be interested in knowing how you see us moving forward as we need to expand the amount of long-term care in terms of attracting more people to work in the long-term care homes; what sort of relationship we can have with home care as we move in that direction, respite care. And I guess obviously, for the record, I might as well get your position on personal care homes.

Mr. Weldon: — Well I'll answer the last question first. Our position on personal care homes is that when the government lifted the moratorium, they created a scenario that they weren't prepared to. They were simply reacting to a budgetary concern back in the early '90s, and as a result of that set up a system that is now somewhat out of control and are trying to figure out how they can put into place regulatory standards for these personal care homes without having to fund them. So it's a little bit of a problem they've created.

We believe that personal care homes do play a role within the province of Saskatchewan. However we don't believe that they should be the industry that replaces what has been a publicly administered, publicly funded system of long-term care.

As far as the integration of home care and long-term care, home care provides a service beyond just long-term care, but long-term care is probably one of the largest industries that it does service.

And what we've tried to do now in three successive collective agreements is to try and integrate those systems fully so that we have members who are fully trained in all the areas and can cross the borders with little or no resistance, to create a single nurse-aid classification that would be able to work in acute care, long-term care, and home care, to create an LPN position likewise, etc., maintenance positions, all those.

What we have found is, to our great surprise, an absolute resistance from employers on that, where we have nurse managers who build a wall around their facility and don't want the heathens to invade. And maybe that's a crude way of putting it, but that's the feeling that we get.

We believe that what Fyke talks about — a fully integrated team approach — is the way that we have to go; that we have to have health care teams that have the ability to cross sectoral lines with no resistance whatsoever and be fully trained to deal with all the residents, patients, clients, consumers that are involved in those systems. And we believe we shouldn't have to do that through the collective bargaining process; however, that's the only process that we have at our fingertips.

But it is an initiative that we're pushing through our collective agreement. It's an initiative that we're pushing through labour relations within health districts, and we hope it's an initiative that will be fully implemented within Fyke.

And the way that you attract people is through that process you create full-time, secure jobs and people will then come into the industry. I hope that . . .

Ms. Stadnichuk: — I'll just add that, that I would agree that that was an omission in our submission tonight was the discussion on long-term care, and because we really did feel quite strongly in our submission to the commissioner that there needs to be a long-term strategy put in place in the province. So thank you for bringing that up.

Mr. Thomson: — It's just that employees obviously that you represent play such an important role within those facilities that I felt it was worth commenting on. So thank you.

Hon. Mr. Melenchuk: — Just a quick question. In looking at your original brief, and of course the presentation this evening with regard to the concept of a Crown corporation as being a model in terms of governance and the quality council attached to that, certainly in Canada we have seen various models for governance management from regional health authorities to regional corporations. But what I found intriguing was your reference to how you fund health districts.

And currently we have a population demographic funding that really is a capitation type of system. But you really don't go on to suggest what would be a more appropriate way of funding health districts. And I'm just wondering if you have some suggestions along those lines.

Mr. Weldon: — When we mention the Crown, we just couldn't think of another word for it. I mean . . . so we used . . . we're familiar with Crowns in the province and so we're saying it should be a structure something along those lines, not necessarily a Crown corporation.

But when we look at the funding, part of the problem that we have . . . for example, at one time there were three . . . I don't know how many orthopedic surgeons there are in Yorkton at this time, but at one time there were three. And yet, 60 per cent of the orthopedic surgeries were either done in Saskatoon or Regina and Saskatoon and Regina don't receive the funding for those. They have to provide the services, but they don't receive the funding.

And what we see is that the . . . rather than the provincial government going through a department, so to speak, as they presently do and then those funds are allocated through some convoluted formula of needs or whatever, that the funding agency would in fact then be this Crown, for lack of better words. And that Crown would have to do an assessment then of where the flow patterns are, what are the problems that health districts are facing, and what type of funding is needed in order to provide the services that they're expected to provide.

And so it wouldn't necessarily be just based on a population basis or, for that matter, a needs basis on that catchment area. It might be based on the provincial needs basis. For example, the University Hospital services the province to a certain extent and the General Hospital now services, to a large extent, the southern population. So the funding formula would change quite drastically in the area that, well you get this much money, deal with it; to more along the lines of, these are the services we're expecting you to provide and here's the funding that we

feel is going to be necessary for you to provide those services.

Hon. Mr. Melenchuk: — One of the earlier presenters suggested that some of the implementation strategies would be dealt with by the quality council, that the quality council should be one of the first initiatives in terms of an implementation. And I think there was a suggestion as well that perhaps looking at the way districts were funded would be an issue of the quality council. I don't know what the answer is.

I mean, we've had . . . when we were 480 independent boards, it was line by line budgeting and the variation from year to year was less than 1 per cent. You could predict your growth based on your 480 boards.

Now it's impossible to determine what deficits are going to be until you actually see the bottom line.

So I'm a believer that we need to look at a different funding methodology that more reflects the services and needs of those communities and I don't think we have that just yet. And I was just wondering if you had any suggestions along those lines. So thank you.

Mr. Weldon: — If I had, I'd be here selling them to you.

The Chair: — Thank you. Any further questions? Seeing none, thank you very much for your presentation tonight and for sharing with us again your presentation to the commission.

Good evening and welcome to the Standing Committee on Health Care. I know you know . . . you've probably heard this — I think you were here while I gave my last introduction — that our first order of business as a standing committee of the legislature is to hear responses to the Fyke Commission or the Commission on Medicare.

So we have an all-party committee of the Legislative Assembly. I'm Judy Junor and I'm Chair of that committee. Dr. Melenchuk is Vice-Chair; Andrew Thomson, Warren McCall, Pat Lorjé, Glen Hart, and Bill Boyd, and Rod Gantefoer are with us tonight.

We have 30 minutes for your presentation. If you want to introduce yourself and who you represent, and then begin your presentation.

Ms. Ehmann: — Thank you for your time. We'll try to be brief. I'm Sherry Ehmann; I'm with the Saskatchewan Individualized Funding Inc. And this is my colleague, Patrick Roszell. We will be fairly brief in our comments tonight, basically following the outline which you have in front of you.

Thank you for this opportunity. Health care is very important for a lot of people in Saskatchewan. We would like to speak to health care from the perspective of people who have disabilities. We want to speak specifically to the issue of self-managed care for people with disabilities who rely on home care to have their needs met for their daily activities.

First of all, who is the Saskatchewan Individualized Funding Inc.? It's a fairly long handle and we'll just call you SIFI from now on. We are a coalition of people of all ages who have a disability. We are their families, community workers, service providers, and business people.

While the work began long before our involvement, we have been involved since 1995 with a project that took a look at how the idea and the practice of individualized funding for disability supports could be brought about in Saskatchewan. We go back a ways and we will speak to activity since '95.

In '96 Choices for Empowerment, which was our same group, the name's changed a little through the years here, published the *Saskatchewan Blueprint*, outlining the core principles upon which disability supports should be provided.

These principles, otherwise known as the independent living principles, are as follows.

Self determination. Each of us has the right to choose how we will live and where we will live our life.

Individual choice follows from that principle. Each of us has the right to actively pursue life by making choices about how we will receive the supports we need to live the life we choose.

Consumer control. That the person with a disability must be allowed to control and direct the support they receive.

Right to risk. Each of us has the right to make decisions and pursue actions that might lead to risk or failure, just like everyone else.

Finally, de-medicalization. Having a disability is not the same as being sick. We get sick. It's not the same. The management of medically stable disabilities are a personal matter.

The *Saskatchewan Blueprint* asks the Government of Saskatchewan to initiate a demonstration project on individualized funding.

The issue. How can people who live with disabilities gain control of their lives? The question is rooted in the history of how society has responded to people who have a disability.

Historically, people with disabilities have been set apart from the mainstream. People with a disability were viewed as sick, therefore unable to decide how, with whom, or where they would live. Hospitals and institutions designed and operated like hospitals were the only option to the family home. This medical model of providing support to people with disabilities was the predominate model of the past century.

In the last 50 years this paradigm has been questioned and revised but not eradicated. Today a person with a disability has few options. For example, if a person living in Regina needs a wheelchair to get around and is unable to transfer independently from that chair without support, what should be merely an inconvenience becomes life defining.

This person may need help to get up in the morning and get ready for the day. He or she may need a half an hour at lunchtime to have a hand with getting meal preparation done or use the washroom. Maybe another hour later in the day to bathe and get ready for bed. Getting these three or four hours of

support will become an organizational nightmare and take away a person's ability to self-determine.

It is worth noting that in Regina, unless you can do all of these things in less than four and a half hours a day, you cannot live in your own home. If home care determines you need more than an average of four and a half hours of support per day, your option will be an institution. If you must have two people to help you transfer in and out of bed, then you have fewer than four and a half hours a day before you are institutionalized.

If you can manage on four and a half hours or less per day, then the next problem is who will provide this very personal and intimate support. You have almost no choice over who will provide this support; home care will assign someone to you.

If you want to be up for more than 12 hours a day, there's no chance that the person who helped you get up will help you go to bed. In fact in the best of circumstances, you will have two people each day and four per week.

In reality we have far more. People have as many as 30 people coming into their homes providing personal care; that means touching your body. With holidays, illness, or staff and staff turnover, you will have many different people coming in and out of your home each day, month, and through the year. Not only is this a serious privacy problem; each time someone new comes in and out of your home, they need to learn about your needs and your home, where everything's kept, and on it goes.

Then of course if you want to have a holiday or become sick, this brings up a whole new set of problems. Even if one morning you want to get up early or sleep late, you can't because someone else schedules your worker. Imagine having no opportunity to decide if you want to sleep late or go to bed early. What should be an inconvenience becomes life defining in large part because other people and organizations make many of your day-to-day decisions.

What has SIFI been doing?

Mr. Roszell: — For the past five years, SIFI has been involved in discussions and negotiations around the development of a more individualized, responsive, and flexible home care model for Saskatchewan. These discussions have taken us on a journey from individualized funding to self-managed care.

Under individualized-funding model, as we originally proposed, money for disability supports from home care would go directly to the person with a disability. The individual would then be responsible to hire and manage the support they needed and account to home care for the money they spent.

SIFI became aware that the unions representing home care workers saw this proposal as unacceptable. In April of 1998, at the request of the Minister of Health, Mr. Clay Serby, SIFI sat down with representatives of CUPE to find out if their concerns and the concerns of the consumers could be reconciled. Out of these discussions came the self-managed care model.

Self-managed care has the same objective as individualized funding, but offered an alternative unique to Saskatchewan. The person with the disability would become a manager within home care rather than an employer funded through home care. This reduces some of the responsibilities of being an employer in exchange for those of working within the collective agreements.

A clear advantage of the self-managed care model was that it was agreed to by the Department of Health, the health districts, CUPE, and SIFI. Therefore, this past winter a number of pilot projects were initiated in Saskatchewan using the self-managed care model.

So what is the problem? While it is early in the life of the pilot projects and no evaluation has been done, it is clear to SIFI that if the present course continues, the pilots will not be able to service most of the people we expected they would serve. In short, the situation of a person in the example given earlier will not change in any substantial way because of the pilot. This will be the case because of a situation created by a combination of factors, including provincial legislation, health district rules, and collective agreements.

In the first instance, Saskatchewan labour standards require that when an employer calls someone to work, they must pay the person a minimum of three hours salary, even if they do not work for the full three hours. Therefore in the example given, when a person needs help in the morning, at noon, early evening, and at bedtime, it is our understanding that that is four hours of call-outs and the employee must be paid for at least 12 hours for the three or four hours work they actually did. This is a financial burden no one is prepared to take on.

The result is that to be financially efficient, home care must have its workers work for at least three hours and this means servicing a number of people in that time. It also means the loss of flexibility for each of the people assigned a staff person. The consumer will not be able to change his or her schedule and will have little choice over which home care worker assists them. Again, it will mean numerous different people coming into your home and providing your personal services.

The next problem is the limited and predefined days. Even if we could resolve the problem of the minimum call-outs, it would not solve the entire problem because the collective agreement says that a home care worker must have at least 12 hours off between shifts. Thus if the person wants to get up at 7 a.m. and go to bed at 11 p.m., he or she would require at least two workers, and this will increase the cost of service.

Of course the problem also has its root in how the needs are defined and resources allocated. First of all, services provided by home care are based on a medical assessment of need. They are based on how many hours of support you need to do things such as get out of bed, go to the bathroom, and eat. They are based on how many hours of support you require; you are allowed to have your own home or assigned to a special care home, personal care home, etc. All these problems together have meant that most people we had hoped to benefit from the pilot project cannot.

Two individuals who need support in large blocks of time have benefited from the pilot in Regina. That is 2 of over 10 that asked to be involved in the pilot. Most have been rejected because they want to go to bed more than 12 hours after they

get up. Thus, as it now stands, two or three hours of support would cost six.

Ms. Ehmann: — In conclusion we believe that our work over the last few years with the development of the self-managed care option within home care has been successful in developing alternatives for those two folks. We don't know yet — the final evaluation isn't in — but that's our hope.

We appreciate the work of our partners in this effort: Saskatchewan Health, CUPE, the health districts, and particularly the Regina Health District.

We also appreciate that the laws and regulations that have created an impediment to people with disabilities achieving their goal of self-determination are well thought out and necessary for the benefit of workers in this province and the effective operation of health services.

We do not appreciate that the legitimate goals of people who have a disability will be sacrificed to the greater good. We believe that other alternatives must be examined more carefully and specifically the alternative of individualized and direct funding must be put back on the table. This position is supported by the report of Commission on Medicare which said, I quote:

> Home care also serves adults living with disabilities and others with high needs . . . allow more flexible and customized service, a model of self-managed care is particularly important for individuals who may depend on services for many years. The terms of collective agreements should not prevent individuals who need care from managing their funds and choosing the caregivers that can best meet their needs.

We thank you very much for your time.

The Chair: — Thank you very much for your presentation. Committee members, questions?

Hon. Mr. Melenchuk: — In terms of the self-managed care option, are you aware of other jurisdictions and how they've been dealing with this particular issue — Ontario, Quebec, any examples there?

Ms. Ehmann: — Every other province across Canada is doing something in the way of either self-managed care or direct funding. We have taken a look at the models in Ontario, in Manitoba particular. Ontario has had a model of direct funding, it's expanded now. There's more than 700 people receiving direct funding.

Our view in Saskatchewan was to include everyone with a disability. The Ontario model is for folks with physical disabilities only. We don't see a distinction. You have a need, you don't need to get into categories.

Manitoba has a self-managed care model; again it's outside of the unions. The model that we developed in co-operation — I'll use that word — with CUPE here in Saskatchewan, we believe is the only one in Canada that we are aware of trying to work within the collective agreement.

Hon. Mr. Melenchuk: — Is the reason that you're dealing directly with CUPE is that they represent the majority of service providers that would provide the supports in a home care setting for disabilities? Is that correct?

Ms. Ehmann: — No. The reason we are working with CUPE is because in 1998 we were told to by Minister Clay Serby. He told us . . . in '92, there was funding approved for a direct funding. Treasury Board pulled that funding for a small pilot in 1992. We continued to work on that model, believing it was the best model for some folks in this province — direct funding.

We worked with CUPE in 1998 because we were told that, at that point in time, that was our only alternative.

Hon. Mr. Melenchuk: — So your preference as a group would be to open up service providers to go with the direct funding/self-managed care option to have greater choice and allow other service providers to access those funds that would be basically handled by the individual patient or client?

Mr. Roszell: — Our goal would be to offer as many options to the disability community in order to obtain an independent living style in which they can be on the same level, the same scales as each one of us do each night and each morning we get up. That is our goal.

And there are more than one or two options out there for this. The two options we have investigated and that we are quite certain are the two most efficient options is that of individualized funding and that of managed care.

Mr. Gantefoer: — Thank you very much, Madam Chair, and presenters. The answers you provided to Dr. Melenchuk's questions covered the areas that I wanted to talk about. So thank you very much for coming tonight.

The Chair: — Thank you.

Mr. Thomson: — Well you'll be surprised to hear this, Madam Chair, but they also covered most of my questions. However, fortunately I have one other question that was not covered and that concerned the pilot project.

Do I understand that . . . Let me ask you this way: how many people are involved in the pilot project?

Ms. Ehmann: — I maybe should clarify that. Our organization, our group, SIFI, has been predominantly working with the Regina Health District. However, through the years from '95 on we had been working on with six or seven different health districts. So there are a couple of small pilots going on in other health districts and I cannot speak to them. I do not know the details.

So the Regina Health pilot project, there was more than 10 people. We had agreed to a pilot with CUPE and the Regina Health District for 10 people. There was more than 10 people of course interested in that.

And to date, there's possibly two that may qualify because of the restriction of how many hours a day and when people need their help. If it's not in a block of three hours — and the

majority of people need to get up in the morning, have lunch at lunch time and go to bed at night — there's very few people that are able to have their number of hours done all at once, unless they're staying in their home.

Mr. Thomson: — I just want to say, although your voice here tonight in front of the committee is much more important than mine, that certainly this is an issue that has been brought to my attention by constituents also. Not simply disabled constituents, but as well seniors who are concerned about the revolving door that they find with home care and particularly some of the difficulties with having the same care assistants come back.

So this is a project that I think we're going to be interested in watching. I'm not sure what the other options are in terms of fixing this.

And so, as you move forward and evaluate with the pilot and take a look at what other options are available, I hope you continue to work with the department directly on that and not simply the district.

Ms. Ehmann: — And we are working with seniors. The Seniors Mechanism is part of our coalition.

Mr. Thomson: — Thanks very much.

The Chair: — Thank you very much. Seeing no more questions, on behalf of the committee, I thank you very much for coming tonight and giving us your perspective on this issue. Thanks for your written submission also.

I'll now entertain a motion to adjourn till tomorrow. Dr. Melenchuk. 9 a.m. Committee is adjourned till 9 a.m.

The committee adjourned at 21:58.

CORRIGENDUM

In Standing Committee on Health Care *Hansard*, No. 5, July 3, 2001, page 64, references to Ms. Wuiz should read **Ms. Wurz**.