Standing Committee on Health Care

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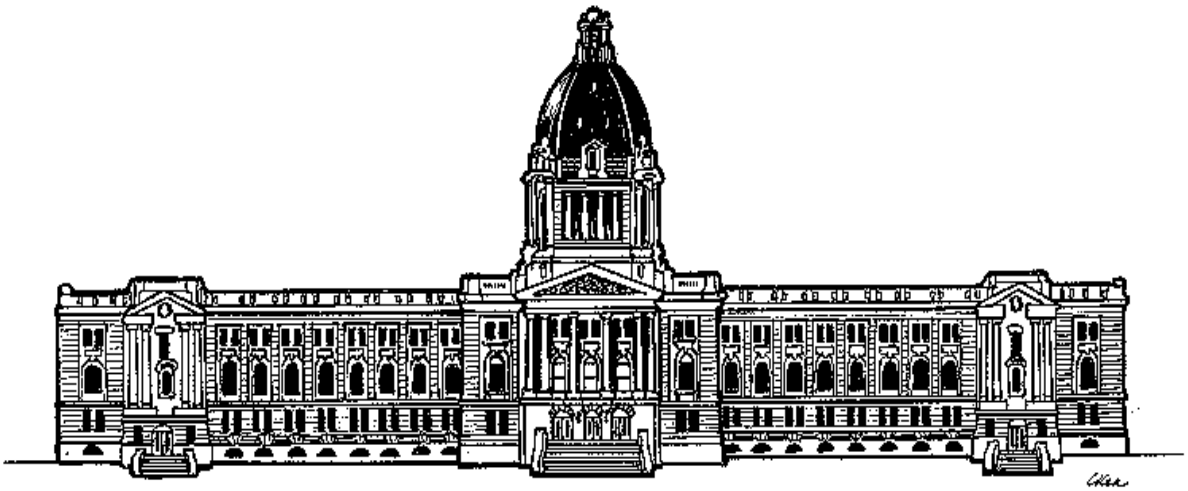

Legislative Assembly of Saskatchewan

Twenty-fourth Legislature

STANDING COMMITTEE ON HEALTH CARE
2001

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

The committee met at 09:03.

The Chair: — Good morning. This is the Standing Committee on Health Care. It's a legislative committee of the Assembly. It's an all-party committee. I'm Judy Junor, the Chair. The Vice-Chair is Dr. Melenchuk. Other members of the committee are Andrew Thomson. Today we have Deb Higgins, and Kevin Yates, Brenda Bakken, Bill Boyd, and Rod Gantefoer sitting in.

The committee's first order of business was to report on responses to the Fyke Commission so what we're doing now is hearing private citizens, groups, organizations, their responses to the Fyke Commission or the Commission on Medicare. And we're to report back to the Legislative Assembly by August 30.

So today we've got 30 minutes, and hopefully within that 30-minute presentation you'll leave us a little time for questions because sometimes the committee members have questions.

So if you want to introduce yourself, and if you represent somebody or some organization you can say that also, and then proceed with your presentation.

Mr. Gardiner: — Thank you, Madam Chair. My name is Nap Gardiner. I'm from Ile-a-la-Crosse. I'm representing myself as a private citizen although over many years the interests of many people that have taught me some good things over the course of my existence.

To my left is my wife. She's my driver. It's been a long trip from Ile-a-la-Crosse, but she's also a nurse, who's been nursing up north since the mid '70s. So . . . and I've had some pretty intimate relationships with health over the last number of years, being that she's been a nurse and took my first cast off my first leg which didn't need to be there, but at the same time, I've worked in the health system for about three or four years. I just left the health district up in Keewatin Yatthé not too long ago.

So I felt somewhat obliged being that I was such a fresh exit to make some representation to the committee, and I'd like to thank you for providing us the opportunity to be here.

If somebody hears me this morning, perhaps we can get some air scheduled service from our area, so maybe we can fly here once in a while.

I want to say thank you again for giving me the opportunity to discuss this critical issue of health care in this province. And I want to say it from the perspective of a Northerner. And I just wanted to mention first of all that this kind of forum provides opportunity for people I am sure to be able to learn a bit more about what's going on in the health system and what people are thinking; how they're thinking it.

And my hope has always been that people begin to see themselves within the system with a little bit more of a wider scope and understanding of what health and well-being is all about rather than from the sole perspective of what kind of pills and services can I get today or tomorrow.

My primary purpose here is to sort of speak to you as a Northerner. I was born in the true remoteness of this province, a place called Sandy Point, just five miles east of Ile-a-la Crosse. Grew up with the Gardiner clan, who grew up next to the Morin clan, and somehow we're all related and cousins.

We don't particularly like politics when we were growing up. There was no way to ease out of situations. I don't mean to be disrespectful, but it just didn't have any room for how we were growing up.

Survival was the name of the day. We were taught how to have vision when we were growing up. We were taught what to do, how to do it, how to work, how to respect the land. We knew how to snare and skin and cook rabbit. And it means a lot of things by suggesting that, because if one begins to understand a little bit of who they are, where they come from, they have a better way of making the future for themselves.

And I just wanted to suggest that these values and principles that we all grew up with, I'm sure will make some indication and impression on yourselves when you finally make your representations or your suggestions or your options or ideas after the work of this committee. And we believe and I believe that those kind of influences are integral to understanding ourselves as a people, as Northerners, as a people of this province and this country. But I think they also hold a lot of the keys for the future of the province.

And I was writing my notes the other day and I kept on thinking about riddles and then all of a sudden Harry Houdini entered by mind. And I just had to say this here today in the sense that sometimes I guess we all want to be Harry Houdinis. That in these riddling times, we want to sort of come out of tough situations and everybody applauds us and we all have a good time, we're all successful, everybody goes home.

But I think Harry Houdini, although was an illusionist — and sometimes I think this whole process and crisis that people talk about in health is an illusion — he knew what he was up to. He knew his environment. He planned. He prepared. He had a key all the time apparently. He knew the risks and he was successful in what he did. Although he died doing what he did, at least he believed in what he was doing. And we still talk about him and I'm still talking about him here today.

So I'm not exactly sure what point that would make, except the fact that sometimes, as I suggested, a lot of these processes are more illusionary than anything in the sense that we don't have enough faith that we can solve some of these situations that exist in this province.

And I know that health care is a significant challenge in Saskatchewan and I'm sure in this country. And I know it's even more of a significant challenge in northern Saskatchewan, as you understand, looking at the evidence that was presented to you in committee the other day by our leaders.

And I was going to suggest that no matter how much we think of the influences from the outside, whether it's greed or drug companies or because we say our treasuries are overburdened, be it because we say it's my right or because Regina's got it and Saskatoon's got to have it. At the end of the day, it's still our challenge in Saskatchewan. It's still our riddle. It's still ours to

solve. And perhaps we need not worry so much about whether we should solve it for Canada or the world. Roy Romanow will do that for us apparently.

Now I say how can we realistically frame what I call organic keys to situations. Organic meaning that we're people and things change at any given moment in time — minutes, week, day or whatever — to these very human and organic challenges before us in health care, and I'm sure other sectors in this province.

And I suppose what I'm suggesting is that we cannot fix the issues with just one remedy. There's a multiplicity of issues, as we all know. Indeed, we've already done a lot of what needs to be done through exhaustive and extensive exercises, and to what we now know as principles. There's principles of health care, medicare, principles of health reform, principles of practice.

And I guess if we accept this form of vision-building, then we should make up our minds about keeping what we have or changing them to fit the reality in our faith and what we're doing today. It is my view that if we do not instil such democratically important instruments then we will, I'm afraid, further commit ourselves to measuring our existence and our health through simple emotion, form rather than function, and inferior political options.

I think what Fyke had to offer Saskatchewan was a good start. It did what it did because I think it made us think a little bit in terms of what we should be doing. Nobody's perfect, after all, but my belief is that he provided us with bearings from . . . coming from situation of bearings to overcome challenges where we're always looking for these little things that jump over challenges. I think he gave us an opportunity for bearings to find solutions. So there's more of a positive approach to doing things.

And I think it was a little blunt and a little truthful, and I don't think a lot . . . some people didn't particularly like it. I did. I didn't like some of the things that he did say, but the other part of it was that I think he gave us up North the opportunity to suggest what it was that we think is realistic for ourselves.

He gave us a number of things that were a little earthy. And we are sort of human, I suppose. He gave us words like quality, accountability — everybody's throwing these things around nowadays — innovation, primary health care, integration, communication, inter-sectoral linkages.

He gave us words like equality, sustainability, efficiency, and he also gave us confidence. I think we all knew those. I don't think he needed to tell us those things because I think we're all . . . human understandings and they're all intrinsic.

But he also gave us some real general, sort of down-to-earth questions in a sense of how much money do we have? We all wonder about that. How many people do we have that can work? Or how much money do we have to train people that can work? How do we get back to a more people-oriented health system? What are the so-called determinants of health?

As I said, the report, although not perfect to me, had a decent supply of organic keys. And I see this as a process and not the search for the Holy Grail.

Now with respect to health care in northern Saskatchewan, I'm certain it is not such a difficult proposition if appropriate evidence-based decisions are made at the appropriate time on how best to engage a course of action.

Personally my feeling is that a long time ago appropriate decisions should have been made on evidence. And to me, to this very day, appropriate decisions have not been made based on evidence for health care in northern Saskatchewan. And Fyke submitted that he understood and endorsed the whole aspect of the northern health strategy, but he also couldn't provide us with a way to the process of making things happen except to suggest that perhaps Northerners might have some of the keys to making these things happen.

I always take the risk of sounding a little cynical, a little hard, a little tough, a little nasty and everything, but that's how we are. That's how we're brought up. I was whipped like a horse when I was a kid. I'm just kidding. And sometimes I sound a little whiny, but I guess I have to sort of suggest to people that I have to make some comparisons and some contrasts when life happens. And I have to make it in a political forum like this so contrasts need to be made because of accountability.

When you look at northern Saskatchewan, to me for many years there had been expedient descriptions of our, of our situations. A number of people went around, they talked about stuff, and they came and said we need you to meet with us. We need you to suggest to us what's the best way to solve your situations in northern Saskatchewan. They came up and they said, with this funny little books, well we really can't really say anything except that the North's unique. It's got special circumstances and we've got to talk about it some more.

So frankly, ladies and gentlemen, I'm getting a little sick and tired of that situation, especially when one considers the fact that all during those times we told them that we knew the answers and how to fix them.

So all these commissions and campaigns to adjust, readjust, or deal with health services and delivery in northern Saskatchewan I'm sure were good and the conclusions were all right for a lot of people, and I think a lot of people learned. But they never really took into consideration the reality and that potentially northern people really had some brains and some history and some influence, and wanting to do things from their perspective, and wanted to be a part of their communities and their families in this province and wanted to share a little bit of that knowledge potentially with people that might need to know some of these things.

So along came 1998, this whole aspect of health districts which I call throwing us on a moving train with no fingernails and hold on as tight as you can. Which is all right, you know, because after all these years of looking at how we can solve the issues up north . . . and I didn't bring the booklet but one of the health reform booklets suggested, well we're not going to do anything up north right away because it's unique and we need to look at it a little bit deeper. And we'll come up with something a little later because they have a lot to offer to their

province, including Aboriginal people, by the way.

So all of a sudden, 1998, this health district thing comes along after apparently a few meetings to suggest how many districts there should be, how big they should be, and how much money we should give them. It just so happens that it was status quo with one of the worst health status conditions in the province. And that was a solution; that was the consultation. These were the words that were listened to from Northerners after all these years.

But I don't want to be overly negative about the whole process. The people that took on the district concept in northern Saskatchewan understood what they were getting into. They understood that the situation was a little tough. They understood that the financial transfer may not necessarily reflect the reality.

But today I guess the understanding that equation of uniqueness from the northern perspective; people took on that responsibility and worked eight hours for the system and eight hours for themselves. Because as I always said, the reason why we're successful in the health district system up north is because we have our ancestors buried next door and we're from there. And the people running the health system up north are from the North. And it's moving.

So maybe in a way the health district transfer and the loaded off-load, as I called it, was all right. But the decision was still made on Albert Street, and although it seemed unfair, we learned a lot and I hope the people in Regina and Albert Street learned a lot from the process as well.

Like I said before, I don't really want to portray this as an unmeaningful practice and unmeaning people and cold-hearted people working deep in the dungeons of the legislature and the offices in Regina, they're all well-meaning people I'm sure.

But I still have to ask the question why to this very day that the health status of northern Saskatchewan is the worst in this province; why there is so many dark zones in this province? And I don't mean to suggest it was the cause of anybody or anyone or any government or any person; all I'm asking is that it still exists and it still needs to be listened to and it still needs to be worked on.

You know the whole aspect of bringing about a situation with the taking on the responsibility, I should say, with health districts. A lot of people have been very proud of what they've accomplished and most of the things, I think, we've done in my experience with the Keewatin Yatthé Health District was outside of what one would expect us to do. And I always say that there's a lot things that people are proud of there and I'll let them decide what they want to say in that regard, but they can pound the ribs off your diaphragm any day.

But I will say one thing, and what it is, is the whole aspect of being . . . feeling a sense of repowerment when it comes to extending a hand with something to extend with. And that is bringing together the thinking and energies of all the health providers and stakeholders and the people across the North. And that's what primarily today I want to here . . . to be here for to support which is the northern health strategy which my leaders — I'm proud of — were here the other day expressing it in a very sincere and sort of a learned-in-evidence based manner with their presentations on slides.

And I call that process and that concept sort of an organic key as well. Because it's a fine example of the boldness of character of northern people. Although we might be a little tough and every once in a while we whine — and I think a lot of people are scared of some people up there, there really is no need for that — but we're always looking for solutions. And despite the fact that we might have the toughest health challenge and some of the toughest socio-economic conditions in this province, we're still always looking for solutions.

And the other reason why I'm here to support the northern health strategy process is become . . . from the collective experience of northern health providers and northern people over many years. Now if they fail to understand how we can continue to overcome these challenges in health status, then I'm not exactly sure who will. I have to say to this point that Albert Street people don't necessarily understand our situation, so I have to give the benefit that my leaders and the people in northern Saskatchewan really do understand.

And recently I was heartened by the fact that there was some sincere interest in the bureaucracy over this whole process. I thank them for considering this.

Of course I don't really want to get into the detail of what the northern health strategy would be; I'm sure you learned about it here a little bit the other day. But I call this more as the organic key in a development process rather than sort of looking for the Holy Grail or the ultimate solution to all of this stuff.

To me, the health system is a process; any system is a process. And being human beings, we change. And systems and organizations should be as flexible as we are to change, as times sort of cause us or force us or for whatever situation causes us to change principles or direction.

The other intelligent part of what my leaders had to offer and the common sense of . . . was the suggestion that a process must be tied to the overall development plan of northern Saskatchewan. As was earlier referred to by the district presenters, health determinants seem to have a far broader and larger impact on people in the North. And I need not suggest the demographics and the situations that exist; I think you know that.

My hard and raw analogy used to go something like this. If there is weakened or lack of socio-economic development, then people come bloody to the door of health. And it's raw and it's hard. But the reality is if socio-economic development doesn't happen, people come more to the health system. And in order for the health system to be successful, the rest of the developments of northern Saskatchewan have to be equally successful, or the other way around, or the vice versa. They're all interrelated and they're all interconnected.

The work that's being done in the North from the multi-sectoral dimension that tests the understanding of Northerners' intrinsic sense of integration, working together, so there's no problem there. They don't have to run around, chasing us to work together.

We can teach you a few things about working together. And I'm sure we learned that from the barn building and the barn bees in the Prairies. When I was going in grade 1, I learned more about building barns and picket fences than I did about what we were up north. So those were good things there somewhere.

So I ask for support for such a process, and I ask for action — real action. And I also ask for appropriate allocations for this to happen.

I wanted to talk a little bit about programs but I'll refrain from doing that because it gets a little too specific. And we can all argue about how many districts we can have, how many hospitals, how many workers, who should train where, where the money should go. And I think we all know that there's a situation that's completely different in northern Saskatchewan than it is down south and that I think there's enough information there that suggests that things need to be done in a realistic fashion.

And sometimes I'm not exactly sure how to suggest, when people used to tell me that I was somewhat impatient with my perspectives, and how I wanted to do things. But when it comes to my view of northern Saskatchewan health I merely look at the health status and the demographics. And that alone suggests that I must at every opportunity, as a citizen, not only challenge myself to influence change, it must also include challenging the many powers that be out there to be more cognizant of this evidence of how things are done.

And if changes are not made with such knowledge, it begs to be asked whether enough sincerity and will exists to do something about it. Or perhaps there is not enough understanding and attention being paid to the North.

My comments are not intended to disrespect the efforts of countless individuals over many years who have attempted to carve a much better process for everybody, including northern Saskatchewan. Progress is being made, but is it fast enough? I don't know. I don't think so.

But there needs to be an investment made, a real investment, for there is value in our people up north taking responsibility for their health. And there is value for them to be more healthy. There is value for this province to learn from this process. And there is value for them to reawaken their strengths or as I say, re-power themselves to confidently journey to wellness.

I don't believe in the word empowering, I think it's sort of condescending and elitist. I believe that people have the power to do what it is they have to do. Every once in a while their sparkplug burns out a little, but you put another one in, and they begin to re-power themselves a bit again.

The northern strategy is strategic investment. The committee, being of wise extraction, does not need to be told of the consequences of no investment. I think it's obvious already.

I want to quote from . . . an excerpt from a book called Canadian Nordicity by a very well known French-Canadian by the name of Louis-Edmond Hamelin. And in essence, Louis-Edmond Hamelin has sort of been doing for about 60 years or so a definition of what the North is all about, and it provides some pretty clear and blunt perspectives of how the North should be treated. And the quote goes something like this:

> The North comprises a world of enormous variety. The polymorphism which is still largely unrecognized makes the rule of the majority unsatisfactory, for it is a principle that ignores all of these differences but that is nonetheless to be valid.
>
> Southerners have a role to play in the invention of a new administration model, which would allow all of these dynamic values to be harnessed and arranged to complement one another like the rays of the aurora borealis.

It's a heavy description of what he wanted to say, but I see that as being . . . There's a lot of things that northern people have to offer. And every once in a while we need a little bit of help going up those rough rapids, but it doesn't necessarily mean that you southern people have to take over the canoe and take over the river and throw us by the wayside and hopefully we can survive on the moose and all the scraps that exist along the way — which we probably can do.

So basically my point here today is I support the northern health strategy. I support the northern strategy being a part of an overall plan of the North, an overall plan of this government, and from a serious perspective because I don't think we have very many chances left to make a right decision or a decent decision any more. I think we've held off too long. There's too many people up North to ignore — too many young people to ignore.

So either we begin to understand the North or, if we don't have time to understand it, then we give Northerners the opportunity to solve their situations themselves because they have the bearings to solutions.

So I wish to say again, thank you for providing the opportunity to be heard. I see the various belts of Saskatchewan every time I drive from northern Saskatchewan. It's a wonderful thing to do, to feel all the realities of travel. Some were pretty good. Coming up the Qu'Appelle Valley, there's good roads. I'm sure the boys in those new ambulances up in our district would be really appreciative of that.

But I learned to appreciate this province by seeing it, by feeling it, by travelling it, by extending the thoughts that have been shared to me for many years by the leaders up North, by my grandfathers, by my mentors in that we have to stand up for something.

And that's basically why I came down here. I want to stand up for this province. I want to stand up for the people of this province. I want to stand up for the North. And I want to do it realistically. And I don't want to dilly-dally and try to find cheap political perspectives to get around the serious situation.

And enough of that stuff. Saskatchewan to me is not big enough to work from a perspective of some old lady needing some health care and we bring it up as something to use as a tool to

get what we want. I don't think that needs to be done. There's too much reality that needs to be discussed here. And we have to work together to find these solutions. And I'm willing to do it.

So from a private citizen, from the community of Ile-a-la-Crosse celebrating its 225th anniversary, from a Métis person, from one that's been involved in public service all of my life, thank you very much.

The Chair: — Thank you. And questions from the committee? Well seeing none, then thank you very much for making the trip down. It was . . . oh sorry, you have to wave.

Mr. Thomson: — You looked away, Madam Chair. I just wanted to say we did hear the northern health care presentation last week. And I said to the presenters, at that point, that I wish that people in southern Saskatchewan could understand more fully the situation in the North and understand just how good we have it in the South, and that it is time that we started to share the resources that have been shared with us.

So your presentation today certainly drives that home, and I appreciate that very much.

Mr. Gardiner: — That's good to hear. We try at every opportunity to extend the reality of northern Saskatchewan to people. And I know there are enough challenges in southern Saskatchewan to sort of take you away from understanding a lot of those things that happen in such a huge geographic region.

But sometime I think it's really crucial for people to stand up to make those realities known from those forums, to influence those people. I know we have all these comments all the time. People come to the northern health conference and they say all we got to do is bring 50 people to southern Saskatchewan and maybe we can solve all that whining and complaining down south. I said, oh gee, I didn't realize we whine so good up north. But I guess basically what they were trying to say is that although the situation is a little stark and dark, we're always willing to work to find those solutions.

And I appreciate your comments. I read it, by the way, and I appreciated all the questions that were there as well.

And like I say, I tried to overcome those because those things are rather simplistic and narrow when you start looking at more of the larger issue of how it is that we should proceed with the health system, rather than wondering how many districts we should have; how many hospitals; brick and mortar and all that.

Although those things are really important, there needs to be some fundamental stuff happening here, some fundamental belief in principle, and some commitment to some beliefs in principles.

After that, I think we can begin to sort of find a few more of those solutions. And some of those people that have been working hard, realistically so, and all these years will begin to come out and begin to again — I'm not just sure what the word is — breathe that real fire of existence that sort of Saskatchewan is known for.

So thank you.

The Chair: — Seeing no further questions, then thank you very much on behalf of the committee for taking the time to come all that way to talk to us and to share your views.

Good morning. Welcome to the Standing Committee on Health Care. The committee is a legislative committee of all parties. I'm Judy Junor, the Chair of the committee. Dr. Melenchuk is the Vice-Chair. Andrew Thomson, Deb Higgins, Kevin Yates, Brenda Bakken, Bill Boyd, and Rod Gantefoer are here today.

The first order of business of the standing committee was to receive responses to the Fyke Commission, so that's what we're doing with these public hearings. And we're having them in 30-minute blocks, and hopefully at the end of your presentation in that 30 minutes we have time for some questions from the committee.

If you want to introduce yourself and what you represent or who you represent and then proceed with your presentation.

Ms. McPhee: — Thank you. Good morning. My name is Jane McPhee and I am president of the organization that we're making a presentation on behalf of today, and that's the Saskatchewan Society of Occupational Therapists.

Ms. Woytko: — I'm Paddy Woytko and I'm also with Saskatchewan Society of Occupational Therapists and I'm the president-elect.

Ms. Lendvoy: — And my name is Suzanne Lendvoy and I'm a member of the society.

Ms. McPhee: — Great. First of all, I'd like to thank you for the opportunity to respond to the Commission on Medicare on behalf of the Saskatchewan Society of Occupational Therapists and the OTs (occupational therapist) of the province of Saskatchewan.

I guess any of you who are familiar with occupational therapists know that we never miss an opportunity to put our situation and our profession forward in terms of the kinds of things that we have to offer to the citizens of the province. And the Saskatchewan society is both the regulatory and the professional body representing occupational therapists in the province. There's currently about 212 members in Saskatchewan. Approximately 75 per cent of those are employed in the three major urban centres — Saskatoon, Regina, and Prince Albert.

We're going to address our comments this morning, our suggestions, and our recommendations to the recommendations outlined in the appendix B of the commission report in the summary.

So first of all, in response to some of the comments about everyday services, we certainly strongly agree with the emphasis on the establishment of primary health service teams. We believe that the team-based delivery of primary health service could provide a comprehensive range of services to the communities throughout the province.

We support the required changes to multidisciplinary and salaried health professionals working together as primary health care teams within those communities. The conversion of existing community health centre settings to support the work of these teams and to provide respite, convalescent, and palliative care, along with long-term care services, supports to clients, we feel, receiving appropriate services in their own communities.

A team of professionals in their own community will know best the needs of that individual and their community and therefore, respond most appropriately to meet those needs. And I think it's a good example of the right service, at the right time, from the right people, in the right place.

The enhancement of primary health services will require that more occupational therapists are available to work with individuals to prevent them from ever having to encounter the sick care system and to assist them in maintaining their health, which is one of the primary goals of occupational therapy.

We support the proposal that the public and health care professionals require education and time to allow team members to put the full measure of their skills to work as a team. And we think that the public really needs assistance in understanding more clearly the roles of health professionals and in accepting their own roles in maintaining health.

I think that this is probably one of the areas where we feel we have done the least good job in terms of health reform. I think people really need a better understanding of their own responsibility and the kinds of things that health providers can offer, other than just services within the sick care system.

For decades occupational therapists have worked with clients in their homes, workplaces, schools, and communities to enable optimal levels of participation in everyday tasks and activities of daily living. Simply put, occupational therapists enable occupation, which is a critical component of health in its very broadest sense.

The model of primary health care makes sense for occupational therapists, who practise from a client-centred perspective. Occupational therapists believe in empowerment and education of citizens in taking responsibility for their own health and quality of life. Other community-based clinicians would tell you a team approach is also the most effective way to deal with clients and families living with chronic illness such as degenerative diseases.

Occupational therapy services are often most effectively delivered at the primary level. A clear understanding of clients' needs and abilities, including physical, developmental, emotional, mental, and environmental components is necessary in considering the total needs of the individual. The occupational therapist may also assist clients with chronic diseases to stay in their communities through periodic intervention to enable the client to maintain abilities.

And occupational therapy provides a contribution to the work of the health team through enabling purposeful occupation, working with the family and community, and sometimes developing appropriate environmental strategies in order to promote health and well-being. And this is primary health care that is both client-centred and cost-effective.

Occupational therapists as team members may make referrals to other community support and social agencies and to advocate for environmental changes to enhance function, health, and well-being in communities as a whole.

We agree with the recommendation of organization and management of coordinated networks of primary health services by the health districts employing all providers. We also agree with the comprehensive and inclusive team, co-located where practical and feasible with a 24-hour telephone access. Collaboration between the primary health teams will use specialized expertise more effectively, especially in some of the rural areas.

One of the recommendations that is really exciting to the OT community is the closer integration between physicians and other health care professionals. We have long felt that by working more closely together we can understand each other's roles more fully and share responsibility more effectively which will result in improved quality of health care service to our clients.

In reference to the 24-hour telephone advice, our national association, the Canadian Association of OT, have had some experience in a service called Ask an OT that's provided on the Internet. And through this Web site the general public can receive answers from qualified OTs regarding health concerns and how OT can help. And this has been a really excellent example of how keen people are to access information about their health once it's readily available to them.

Our experience has been that in Saskatchewan the job of educating other health team members regarding the role of those health professionals educated outside the province is a challenge. Physicians and nurses are less aware of the occupational therapist role because they're not educated together as a health team at the University of Saskatchewan as they are in other health sciences colleges in Canada.

And we believe that to accomplish these changes, health professional human resource planning is critical in order for there to be adequate numbers of appropriately trained workers. And we're going to make some more comments about that in another area of this response.

In terms of specialized care, occupational therapists support the move to tertiary centres and a regional hospital network. It makes a lot of sense that some services can be delivered more effectively in a tertiary centre given the needs for the specialists required to provide that care.

We also support provincial coordination and planning for health human resource needs. From occupational therapists' experience of recruitment and retention, which is extensive in the province, we can support that there needs to be an openness to exploring creative alternatives in human resource planning. To use an example from our own experience, strategies such as purchased seats at universities outside the province and provision of bursaries to these students may benefit short-term recruitment but may not be that effective in retention of

experienced staff.

Our experience has been that therapists require the ongoing support of continuing education, academic researchers, and leaders in the profession to encourage them to stay in the province. The absence of an OT school in the province or support for post-graduate level academic pursuits means that experienced therapists may leave the province in order to pursue these endeavours with the risk that they may not return with that expertise.

We are familiar with the problem of recruitment and retention in both urban and rural areas, and although we understand the apprehension of rural citizens if downsizing rural hospitals occur, we do believe if the public is educated on the difficulties in recruitment and retention and of the benefits of primary health, that in time they will come to understand and appreciate these benefits. It is essential however, we agree, to have well-developed emergency services with highly trained EMTs (emergency medical technician) who are accessible in rural areas in a timely manner and available 24 hours a day.

In terms of making things fair, as stated earlier, occupational therapy is in support of further development of primary health services and stronger alliances with non-health related community partnerships. Currently, most OTs in Saskatchewan are employed in traditional health care settings but with our function-oriented training, we are well prepared for movement into more non-traditional settings and forming new partnerships.

In a primary health and health promotion framework, occupational therapists assist clients in the transition from being users of the health system to becoming contributors to its planning and implementation. For example, an OT could work with a community organization or neighbourhood to assess the environment, make recommendations to make it accessible and safe for the disabled and/or elderly population in that community.

Using his or her skills as a facilitator, the OT helps individuals and communities to develop the advocacy problem solving and planning skills needed to create solutions and work towards building a healthier neighbourhood.

And I think, in the document, there is some reference to the acquired brain injury provincial program and that's a really good example of where occupational therapists are involved in that role of community development.

By using the community development approach OTs foster self-help and mutual involvement with the result being less dependence on professional health services.

Regarding regular reports on defined and measurable health goals, occupational therapists background in clients and their practice make us good partners in this area. On an individual, group, and community basis, we're involved in goal setting to assist with measurable and defined outcomes. Occupational therapists are able to contribute to and participate in this process on a broader scale.

The difficulty in recruiting appropriate health professionals to northern communities is another challenge to making the system fair. Larger health districts have been in partnership with northern health districts in the provision of contract OT services. The services provided are costly, partly due to the transportation costs. In terms of getting people to the communities, they're minimal at best, and they're less effective because of the difficulty in establishing rapport with northern residents in such brief encounters as we have with them.

I guess the other thing that we really feel is important is the education of northern residents to enter the health professions. And I think that this needs to be a part of the health human resource plan.

In the area of getting results, SSOT (Saskatchewan Society of Occupational Therapists) is in support of the establishment of a quality council for the province. The cost of such an organization and its sustainability, I believe, needs some further exploration. The involvement of and the contributions of those currently involved in quality in the districts, might ensure a more effective change at a local district level than an arm's-length organization.

We are in agreement that the evidence-based practice decisions and interventions produce effective outcomes. As well as the support of the overall district quality and performance indicators, disciplines need to have research support for further development of quality indicators and assistance in implementation of necessary changes in practice.

As stated earlier, absence of occupational therapy program in the province has an impact on the lack of research support available to Saskatchewan OTs. Therefore, the implementation of a quality council could perhaps also offer support for professional research required to make changes to the way that we deliver occupational therapy services to the public.

And I guess one of our reasons for that suggestion is that our other provinces which do have OT schools have a lot more . . . a lot more possibilities and things underway in terms of research and implementation of evidence-based practice.

It would make sense also that as a part of quality, support be made available for continuing education of health providers. There may be efficiencies and benefits of partnerships for the provision of some continuing education through multi-disciplinary conferences, etc. This is an area where there may be benefit to all in the quality council partnering with the professional bodies in the province such as SSOT, and we certainly are more than willing to be involved in those kinds of partnerships.

In support of change, SSOT is in support of decreasing the number of health districts although we recognize that this change will not be immediately acceptable to all citizens. Success in this depends upon the public being appropriately educated on the benefits of the change and in the implementation of primary health teams effectively in their communities.

It's imperative that all professionals involved in health care provision, from front line workers to administrators, become open to change and be prepared to let go of processes and

procedures that are not effective so that we can work together to implement quality, cost-effective procedures and services. Professional associations, employers, and the province will all need to offer assistance and support for these attitudinal and more practical changes.

Fostering further relationships and alliances with the First Nations people of the province is essential, as well as encouraging education of their people in health sciences fields. This could be done at a grassroots, community level facilitated by collaboration between the health care, education, and First Nations communities.

Coordination by a provincial body of health human resources would be of great benefit to occupational therapy as this continues to be a huge area of concern for us. We'd be eager to provide input to such a body regarding some of our experiences, and successes and failure of recruitment and retention strategies.

We're also really excited about the recommendation to spend at least 1 per cent of the health care budget on research. And we would strongly support that idea. This money will not only assist in further development of evidence-based practices but may also serve as an enticement for recruitment and retention, as I've mentioned, of health care professionals within and into the province.

We're in support of further development in the implementation of an electronic health record, although we realize the funding of this initiative will be difficult to prioritize. It's important that this electronic record be standardized across the province so that we're not reinventing the wheel in different districts. As well it will allow authorized access to client records by health professionals wherever they may be working within the province. And this becomes important with some of the networks of the primary health teams.

In terms of paying the bills, when investigating whether or not we're getting value for our money in health care today, all of the areas above must be taken into consideration.

There needs to be consideration also of the cost borne by informal caregivers, and systems created to support these individuals. Caregivers should be recognized as contributing to quality of health and life of our citizens. It's crucial that the government allocate resources to support informal caregivers in order for them to maintain their responsibilities.

And in conclusion, on behalf of the Saskatchewan Society of OTs, we'd like to thank you for this opportunity to respond to the Fyke Commission. There have been several areas that we have touched on today that we feel that we could offer assistance in implementation. We realize that implementation is the biggest challenge, and we would do what we could as an association to support these necessary changes. And we also appreciate the consultative approach that this committee's taking to the challenges of caring for medicare. And we thank you for that.

And we would be open for any questions that you might have about our report or about other aspects of our contributions.

The Chair: — I see hands going up all over the place.

Mr. Gantefoer: — Thank you very much and thank you for being here this morning.

My question is about your personnel and availability of your personnel across the districts. You mentioned that 75 per cent of your professionals are located in three major centres. Do the rural centres outside of those major three have a difficulty in recruiting occupational therapists and what do you see as constructive steps in assisting them to have the appropriate availability of your professionals?

Ms. McPhee: — Absolutely. I think the rural areas . . . there's been a big improvement in terms of the number of occupational therapists available in the rural areas since the implementation of the district. A lot of the districts have recognized the value of the particular contributions of OT and have created positions.

There is currently a national shortage in terms of occupational therapists. And you know, as with the other professions we have difficulty competing with some of the other provinces in terms of some of the financial benefits.

But I also feel that there is a big commitment amongst therapists that work in the rural areas in terms of improving their knowledge base and continuing education, and that's a really difficult thing for them in terms of retention in the rural areas. They just don't have a lot of access to continuing education. It's getting better as we have more opportunities for distance education but just the whole sort of collegial aspect of getting together for workshops and things is really difficult because of our small numbers.

And I do think there are . . . it certainly has improved and we also are offering from the more central, the urban areas, a lot more support to those rural therapists than we once did. There's a bigger recognition of the fact that we need to . . . when we help each other, we help everybody in terms of providing better service to the citizens in terms of continuity of care from those that come to the urban areas for their services and then return to their home communities.

So I think that we've improved some of the communication but there is still issues of numbers. And you know, I think we've addressed some of those in terms of the recruitment and retention issues. And we have been in communication with both Post-Secondary Education and Skills Training and some of the Health human resources individuals in terms of trying to work on some of those recruitment and retention issues.

Hon. Mr. Melenchuk: — Thank you very much for your presentation. The question I have is with regard to having an occupational therapy school in Saskatchewan. Now this has been an issue that's been out there for a long, long time. In fact I can recall being on a committee in 1985. It was the joint planning committee on long-term care and Walter Podiluk was the deputy minister at the time. And one of the 21 recommendations was to create a school for occupational therapy in the province of Saskatchewan.

Why has that not happened? Is it because the demand in terms of graduates would not support having a school here? How

many do we need in a given year? Is it 20, 25? You know, the question that I have in terms of why hasn't it happened when it's been a recommendation out there for such a long time?

Ms. McPhee: — It's a really good question, Dr. Melenchuk, and we continue to pose that question.

I guess in a time of economic difficulties in terms of the education system, we're not completely closed to the idea of continuing to support regional education of occupational therapists. But there are some issues around that. And some of those are, as I've outlined, the fact that in the absence of a school, we don't have the academic experts in terms of encouraging research, etc.

I really do believe that the main reasons we don't have a school are economic, and I don't think there's a lack of willingness.

The physio school at the University of Saskatchewan has always been very supportive of occupational therapy. And, you know, I guess it's just that the physio school can't offer the occupational therapy expertise that we need in terms of ongoing research and education of OTs.

I think that some of our . . . the University of Alberta and the University of Manitoba, with whom we have purchase seats programs, are very open to being able to provide us some more services. But the bottom line is, when people leave the province for education, that's where they make their professional community and their network and they tend to stay there. And I guess I believe that, in some ways, we need to continue to work towards having a school.

But we also get a bit tired of beating our heads against a brick wall and we've been looking at more creative alternatives. And, you know, I think one of the things that we want to look at with post-secondary skills and education is, what are we talking about now in terms of the kinds of costs for purchase seats and the bursaries, and if we were to look at that in terms of the number of OTs we could educate in the province for the same money, would it be worthwhile to look at that again?

Hon. Mr. Melenchuk: — Thank you. That's the only question I had.

Ms. Lendvoy: — I think along with that, you know, the whole issue of the rural and northern area, that may be more a better way for them to be educated as well, is in their own province and keep them here.

Ms. Woytko: — And I know it is a deterrent for when you are looking into going into occupational therapy program.

I was an adult, you know, what do you say, a mature student, and I know part of the detriment for me, deterrent, was going away from my family and my support base here. And so I really reconsidered it over and over for several years before I went away to school. And because I was, you know, true-blue Saskatchewan, I knew I was coming back.

But a lot of the people that do go away don't come back. And we're certainly . . . There's more women in the profession than men. And if, you know, they meet someone in Alberta, chances are that they're going to stay in Alberta.

So it would be of benefit to have our own school. But like Jane said, it gets hard when you're . . . you know, you can't keep banging your head against a brick wall.

Hon. Mr. Melenchuk: — Actually, I do have one other question.

Right at the last part of your submission you talked about incorporating informal caregivers into a payment strategy. Certainly when . . . part of Fyke's recognition was that there were tremendous pressures on the provincial government in its ability to fund the current health care system.

So I'm just wondering how you would see, in terms of an effectiveness, incorporating informal caregivers? Do you see that there might be some cost-savings eventually by doing that, and what's the rationale for that?

Ms. Lendvoy: — I think with that is that we have to recognize that the informal caregivers are possibly giving up work time and they're wearing themselves out. And I think that overall as a society we're going to see much more cost in that area.

So there needs to be some kind of formal recognition, whether it's payment or whether it's saying, you know, we'll give you more of a break with more home care services, more respite services, that type of thing rather than say a wage to those informal caregivers.

Hon. Mr. Melenchuk: — That's good. Thank you.

The Chair: — Seeing no further questions then, thank you very much for a very succinct presentation.

You just can come and take a seat at the table. We're just passing out your written submission.

Good morning, and welcome to the Standing Committee on Health Care. This is an all-party committee of the Legislative Assembly.

I'm Judy Junor, the Chair of the committee. Other members of the committee who are wandering around at the moment — Dr. Melenchuk is the Vice-Chair, Andrew Thomson, Deb Higgins, Kevin Yates, Brenda Bakken, Bill Boyd, and Rod Gantefoer are here today.

The first order of business of the legislative committee is to receive responses to the Fyke Commission or the Commission on Medicare, which is what we're doing with these public hearings. And we are then going to respond to the Legislative Assembly with a written report of what we heard.

The presenters are coming in 30-minute blocks. And we hope that with your presentation we have some time at the end of that 30 minutes or within the 30 minutes to have questions from the committee members.

If you'll just introduce yourself and where you're from and who you represent, then proceed with your presentation.

Ms. Harrison: — Good morning, Chair Junor, and committee members. I'm Liz Harrison. I'm the Chair of the Health Services Utilization and Research Commission. This is our CEO (chief executive officer), Laurence Thompson.

I plan to spend about 15 — hopefully — 15 to 20 minutes on the formal presentation of our response to the Fyke Commission report. And as you said, to allow a little bit of time for discussion. We have provided you with a summary of the presentation — most of it I'll follow — as well as some additional background information on the organization as well, which you may find helpful.

As you know, the Health Services Utilization and Research Commission, or HSURC, which I'll refer to, is an arm's-length provincial government funded agency. Our twin mandates are to assess Saskatchewan's health system and make recommendations for evidence-based change, which we understand you've heard a lot about during these proceedings, and also to fund health research in Saskatchewan.

HSURC was established in 1992. We're governed by The Health Services Utilization and Research Commission Act which was proclaimed in 1994. Our legislation empowers us to study the utilization of health services and to fund and stimulate health research in the province.

Our board is composed of members of health care professions, health care managers, and university faculty involved in health research. The membership of our board and a summary of our functions and our current resource allocation, actually, are in your appendices.

HSURC has nine years of experience reviewing the effectiveness of the Saskatchewan health system and 22 years of experience supporting health researchers. Based on that experience, HSURC strongly endorses the Fyke report and urges the government to move quickly on its key recommendations.

This presentation focuses on three key points within the Fyke report. These are investment in quality, the quality council, and investment in health research. So I'll touch on each of these points briefly.

An investment in quality is what will improve health care. The biggest improvements in health care will come from focusing on improving system quality not from providing more services. There's a large body of evidence showing that existing health services would be much more effective if they were better organized and managed, so that the right services are getting to the right people.

The following are some examples to illustrate the point. Antibiotic prescribing: as all of us know, many bacteria are becoming increasingly resistant to antibiotics due to their inappropriate use. Research has shown that drugs are not being prescribed in accordance with the latest medical evidence.

A Saskatchewan research project released in May tested education strategies aimed at doctors and patients to improve antibiotic prescribing. The study found evidence that Saskatchewan could have better health with 75 per cent fewer prescriptions for respiratory infections.

In regards to surgery. A second recent study led by Dr. Charles Wright, a former Saskatchewan surgeon, evaluated appropriateness and outcomes of elective surgery in Vancouver. Cataract surgery, for example, is the most frequently performed surgery in Canada, yet the researchers found 10 per cent of patients undergoing surgery did not have visual impairment sufficient to justify surgery, while another 20 per cent had only minor impairments.

Why is this a problem? Surgery, even minor surgery, is always a balance between benefit and risk. When the initial condition is not severe, the possible benefit of surgery is less while the risk remains the same. Wright's study confirmed that overuse of cataract surgery is of no benefit and can be harmful to patients. After cataract surgery, more than one-quarter of patients reported vision had not improved or was worse than before.

In regards to hospitals, as you will recall, HSURC did a study evaluating the end of acute care in 52 rural hospitals in 1993, and this study was recently published in the international scientific journal, *Social Science and Medicine*.

In this study HSURC found that the ending of acute care in these small hospitals did not adversely affect rural resident's health. In fact, death rates from heart attacks and motor vehicle accidents, which are emergency situation sensitive to response times and capacity, dropped faster in communities affected by the hospital conversions than in communities that kept small hospitals.

Continuing research confirms the general finding that many health services have better outcomes when performed in large centres or by doctors who treat more of that kind of case. And there are a few examples that we've given of a growing stack of research studies. Just to mention a few, a study of California hospitals published in JAMA, which is *The Journal of the American Medical Association*, estimated that 600 deaths per year could be avoided if patients for certain conditions were treated in higher volume rather than lower volume hospitals. Higher volume just means that they're seeing more of that type of patient.

Ontario researchers in a study also recently published in the same journal, estimated that about one-fifth of patients who died after treatment for heart attack by low-volume physicians might have been alive a year later if they'd been treated by a high-volume doctor.

Research on outcomes of trauma care in the United States have demonstrated that death rates were significantly lower for high-risk cases in centres that treated the highest volume of patients. And moving internationally again, a British study published in the *Lancet* found that 19 per cent more stroke patients treated in specialized stroke care units were alive without severe disability after one year than patients treated in a general ward.

So the way to improving health care is to ensure that the right patient gets the right care at the right time. It's a quality problem, not necessarily a problem of lack of resources.

Second key area is the quality council that's been recommended in the Fyke report. Health care professionals, managers, and support workers are in the great majority well trained, well intentioned, and very hard working. That is not sufficient, however, to guarantee a quality health system.

In the 2-billion-dollar-plus Saskatchewan health system, routine monitoring of outcomes of care is virtually impossible. If we can't measure system performance, we can't improve it.

Users of health care deserve the assurance that a scientifically competent, credible, and independent agency is looking out for interests and reporting publicly on health system quality.

Health care providers also deserve better. They deserve to work with accurate, relevant, and up-to-date feedback on the outcomes of their efforts. Feedback should relate performance to benchmarks based on the best efforts of peers and research evidence of best practice from the rest of the world.

Such performance indicators and benchmarks should be available at the individual, the unit, the program, and system level. An autonomous and credible agency should be producing the indicators, again based on broadly supported goals for the health system.

HSURC does have some advice on the structure, mandate, and operations of a quality council. And again some of this is based on our experience over the past years in our activities. We've provided supporting arguments and details related to this advice in appendices 4 and 5.

First of all, HSURC supports the establishment of a quality council, feel that the mandate of the council should be educational. A quality council should report directly to the public and the health system. A merger process as described in the Fyke report related to existing agencies such as HSURC should minimize disruption.

The budget of the council should follow the functions of the council. Establishment should be staged. The first stage obviously would be sincere and immediate public commitment.

The first task of the quality council should be reporting on quality. Effective, credible review must be based on autonomy, and accountability should be to the Legislative Assembly.

In regards to the functions of the council, performance reporting against quality standards should be the core function. Configuration of the health system is an important role, but we feel requires clarification. Quality assurance at a system level would be an important new function. And in regards to technology assessment, including drugs, we see that this should be coordinated nationally because it's the major initiatives that are going on in the country.

Finally investment in health research as an investment in our future. HSURC strongly supports the Fyke recommendation; at least 1 per cent of the health budget should be devoted to health research. Investing in health research is an investment in our health, educational, and economic future.

A serious investment in health research will allow Saskatchewan to develop an academic health science centre, continue to offer specialized health services, take advantage of federal funding — which we know is out there right now — for economic development, and offer educational opportunities for Saskatchewan students. One per cent of the health budget for health research would certainly put Saskatchewan back in the national health research game.

In our experience and based on our consultation with research community, there are key areas where Saskatchewan could invest this expanded research funding. And examples of these include scholar support, to allow investigators to work full time on research — currently this is not available in Saskatchewan. Our neighbour to the west, Alberta, supports several hundred health researchers using this particular model. Student support to develop future health researchers, again this is not available to Saskatchewan students. And support for infrastructures for research centres in areas of importance to Saskatchewan such as Aboriginal and rural health, health applications of the synchrotron, health services, and health policy. Currently there is support for some limited research centres in these area.

As well as support for health researchers, investments will be required in a health research building at the University of Saskatchewan. If Saskatchewan is to invest in new health researchers, there must be adequate space to house and support them.

Careful consideration should be given to the reporting relationship and governance of a new health research-funding agency. Health research funding crosses the mandates of the departments of Health, Economic and Co-operative Development, and Post-Secondary Education. The board of a health research-funding agency, we recommend, should also continue to be arm's length of government.

So in conclusion, in HSURC's opinion the Fyke report makes practical, evidence-based recommendations that will improve the quality of Saskatchewan's health care system. HSURC supports implementing changes as rapidly and smoothly as practically possible. Implementing the recommendations that we have highlighted will maintain Saskatchewan's leadership role in health care in Canada.

From our organization's perspective, we stand ready to help with the changes required to implement the Fyke recommendations including, which we understand, changes to our own structure and mandate.

Change is never easy. Established ways of doing things are always hard to change. However, the payoffs potentially are very great. The bottom line should be whether change will improve the effectiveness of health care in Saskatchewan. Based on our history of research on the Saskatchewan health system, HSURC's answer is that the recommendations proposed in the Fyke's report pass that test.

So thank you for the opportunity to present, and Laurie and I will be happy to answer any questions or hear your comments.

The Chair: — Thank you very much.

Hon. Mr. Melenchuk: — Thank you very much for your

presentation. In fact, some of the questions I had before you started your presentation were answered by the presentation. But I do have one question with regard to the surgery of the Wright patient — Dr. Wright's article.

Now in the United States with the Medicare/Medicaid programs, they have guidelines in place for insurance purposes where an ophthalmologist would not be performing cataract surgery on a particular patient who did not have the required vision impairment. Why do we not have similar guidelines for insurance purposes in this province?

Mr. Thompson: — That's a good question, and it's one of the areas that HSURC has been involved in trying to develop. And the term that we use is care pathways. And the concept of a care pathway is a pathway for the whole health care team — doctors, nurses, other people who are involved in follow-up and preparation of patients for surgery — as to what is the best model of care based on the research evidence.

The team then agrees on what that pathway is. You document that, and that becomes the norm of care. In order to stray from that path of care, you have to document the reason as to why you stray from it.

So it's still based on the clinical expertise of all the people involved in the patient care, and it doesn't interfere with their autonomy to participate in developing the guideline. But once the guideline is agreed on, that becomes the standard of care.

And that's the kind of concept that involves participation of those actually carrying out the health care rather than having it imposed from outside, but still insisting that it be based on the best research evidence.

That's the kind of model that we see as being most useful in Saskatchewan and we've been involved in some projects to try and implement some pilots of those care pathways in Saskatchewan.

Hon. Mr. Melenchuk: — So you see the best approach as to involving the caregivers and developing their pathways, and then basically have the follow-up options occur after that.

Mr. Thompson: — Yes.

Hon. Mr. Melenchuk: — The second question that I had was with regard to the quality council and you see your role as being incorporated . . . or some of your functions incorporated into the quality council quite easily then.

Ms. Harrison: — That's correct.

Hon. Mr. Melenchuk: — Okay. Those are the only questions I had. Thank you.

Mr. Gantefoer: — Thank you very much. One of the questions has been covered off by Mr. Melenchuk already.

One of the other questions I have is the question of applying theoretical research to a pragmatic reality.

Just looking at your comments about fewer hospitals are better and the greater volume of experiential practice that anybody has, the better you are at it, taken to its ultimate conclusion, we should only have one super hospital in Saskatchewan and that would bring the greatest number of people together in that experience. And of course we all recognize that that isn't a practical reality.

Fyke recommends the tertiary centres in Saskatoon, Regina in a primary way, and Prince Albert in a lesser way, and then a network of regional hospitals.

Given your research, is it practical to be able to staff and operate a core level of service in regional hospitals given the recruitment and the retention issues that are in the medical practice today?

Ms. Harrison: — I think that's an important issue relevant to two parts you've touched on. First of all is the type of care that's available and the specialized types of services that may be, for example, in tertiary care facilities. And the second issue which you discussed with the previous group is in regards to recruitment and retention issues in areas other than major urban centres.

I think it would be fair to say that HSURC really has not got into research related to the human resources area except in a minor role relative to the human resource project that was done just last year under the Backman report. So we really have not done very much related to that particular area, except from perhaps focus groups in areas talking about some of the issues.

In regards to providing specialized services within the areas, I think research that we have done relates perhaps to care for the elderly, the types of organizations, institutions that the elderly receive care in, some of the work that we did recently, as well looking at where particular services were provided for post-surgical patients in regards to acute care and home care.

So our research has not specifically addressed the issue of health human resources. It's more in the periphery, so I don't think we should . . . we could give you evidence to provide you with that type of information.

Having said that, there certainly are other organizations in the province that have done work in that area. And we certainly, as we present and report, would be interested as well in looking at the linkage with the new Health Human Resource Council that was recently established as well that deals with these types of issues.

Because it is complex, as you suggest. It's provision of services, including specialized services, and in addition to that is recruiting individuals to provide that service, and the training of individuals as well.

Mr. Gantefoer: — Thank you. In your third comment you talked about your support for an investment in research, at least at the base level that Fyke recommended of 1 per cent. I think he suggested 1 to 2 per cent as opposed to about a quarter of one per cent currently.

And you suggest that HSURC could move into the quality council and have a useful function and role in terms of the

evidence-based research about procedural issues, etc. In the 1 per cent, do you have any sense about how much of it should be involved with the evidence-based research as opposed to the pure medical research? And I think of the light beam kind of things, and molecular studies, the pharmaceutical kinds of studies. Have you thought of any breakdown in the way the 1 per cent may be allocated?

Mr. Thompson: — The short answer is no. In the four theme areas that we suggested as being important to Saskatchewan, the health services, health policy theme, and the Aboriginal rural health both are areas where you get more into health services research as opposed to bench research or biomedical research.

I think one of the advantages of Saskatchewan is that in some ways health systems research is . . . there are some interesting features of our health system here that would allow us to do interesting research that you couldn't do in much of the rest of the country.

Because of our integrated delivery system, you can actually follow . . . you can implement an intervention of care, like a care pathway, that crosses different settings, and then evaluate it and follow it through all those different settings. You can't do that in Ontario; you can't do that in many settings in the United States. So there's some unique features in Saskatchewan where you could actually do different kinds of research.

In terms of a split between the allocation of funds, no, we haven't thought about that.

Ms. Harrison: — Can I just add to that as well. One thing I think that . . . I think that's a very important issue to bring up is looking at health research — what is it? And in regards to allocation of funds, I guess that one thing we're seeing nationally being supported is a breakaway from the traditional breakdown into biomedical, clinical research to see some, what's called crosscutting themes, in CIHR, Canadian Institutes of Health Research, that the focus has really changed. This is really exciting for health researchers. Because what you'll find is folks like me who are clinical researchers now sitting with people who are in health policy, sitting with people who are in the biomedical research area and us talking together to decide what should we be working on as a continuum.

And I think one of the problems in the past, which certainly the Canadian system has started to address with this new Canadian Institutes of Health Research, is the realization that you can't have people in isolation working on projects, never coming together, everybody with good intentions.

So I think it's a really important issue that when we talk about allocation of health research, that we also talk about what does this research look like. And in the case of HSURC with our funding responsibilities, we've actually started to streamline our grants and awards to take on the perspective of looking at health research in the continuum, from the biomedical research right up to the application.

So I think that's a really important issue that would be nice to have discussion about so that we don't see that it's just allocated to biomedical gets this, clinical gets this; that we look at it from the continuum.

Mr. Gantefoer: — One final question related to research as well. And you talk about the need for facilities in addition to just the research dollars. And I think that the whole concept of the integrated health sciences facility that's being proposed at the University of Saskatchewan potentially could be that physical environment whereby research footage could be provided, if you like, for lack of a better word, and that's an important project.

The second part of that is the ability for the health sciences colleges to recruit and retain professionals that deliver those programs because research is one of the major components of what makes people operate at that level — the research, clinical, and the instructional components. And the research thing has been kind of lacking and overlooked in many ways in favour of the clinical and the instructional because those priorities have been greater.

Do you see the importance of this further commitment of research dollars having a beneficial effect in terms of the health sciences colleges, all of them — physiotherapy, and medicine and nursing and all the rest of them — having a positive effect in terms of all of these health sciences colleges able to retain and recruit professionals?

Ms. Harrison: — Absolutely. I think that sometimes research funding is not viewed that way and it should be; is, as you pointed out, the role of research is not only to improve the quality of health care in this case for the society, but also it's integral to the training of health professionals.

And again referring to colleagues from occupational therapy, I think they talked to you about the fact that not having an academic program and the research associated with that limits their potential from a professional end in providing quality service to their patients.

So I don't think you can ever separate health research and instruction, clinical education of health professionals. And I think another important aspect, as you've pointed out, is also from the recruitment of the best students, is that there is no doubt that if you have a facility that provides research opportunities, not just at graduate level, our students in the health sciences have good opportunities for research at the undergraduate level too. And in fact that is becoming very much of a requirement in the health science professional programs, that individuals have the ability to critically analyze research that's being done.

So without that being offered at the university, you certainly don't have individuals . . . We're here talking about individuals being able to take . . . uptake research findings. Well if you don't have exposure to that at the university level, how can you send professionals out to practise in that style? So I think again an extremely good point.

Health research has huge benefits that cross many, many aspects, factors, and one of them is in the improved training, quality of our graduates.

The Chair: — Thank you.

Mr. Thomson: — Thank you very much, Madam Chair, and I want to thank the officials for joining us today. Let me start by saying I'm a big fan of HSURC and the work that you do. I don't think we communicate it well enough to people, the work that is being done by your organization. I find it interesting today that the media gallery is empty. I doubt very much you're going to be mobbed by reporters when you walk out of here. I know that the reporters watch this on television.

But there is . . . I say this because I think it shows the disconnect and in many ways the problem we have, with moving to an evidence-based system from a system of entitlement.

The College of Physicians appeared and said they liked what they heard out of Fyke. The SRNA (Saskatchewan Registered Nurses' Association) said they liked what they heard. The LPNs (licensed practical nurse) said they liked what they heard; the chiropractors, the occupational therapists, you have — based on the evidence.

On the other side we have the town of Tisdale, Wadena, Kipling, Balcarres, Wynyard, Indian Head, Moosomin, Craik, Wadena, and Porcupine Plain, who have all said, don't close my hospital. How do we move from a system of entitlement to a system of evidence?

Mr. Thompson: — If I could respond, I think you've hit a key issue. In terms of HSURC's communications role, we invest a fair amount in our communications activities, but our target is practitioners within the health system. And we believe we reach them quite effectively. And the fact that you've got — from what you report — a consistent message from the different health practitioner organizations I think reflects that the different organizations are very much on the same page in terms of the evidence-based approach to health care.

We have not focused our efforts on the public. And there's been much less discussion at the public level about those issues. HSURC recognized that a couple of years ago. And one of our initiatives was to be the co-sponsor of a major health policy conference this fall. It's actually being led by the University of Saskatchewan.

But the idea is to bring some of these ideas that have been percolating within the health sciences community for the last 10 years and put them out before the public and have an interchange in a public forum between researchers, practitioners, university researchers, and so on. You're right. That debate needs to be held.

I think the difference of what a quality council would do compared to what HSURC would do would be to play much more of that public role. And that's why we suggest that the first stage should be quality or performance reporting.

If you put out a report to the public on how the health system is performing, district by district, service by service, you could actually identify factors such as . . . If you demonstrated, for example, that small hospitals should not appropriately be doing a particular procedure, that would show up in the quality indicators.

And then you could say to people, okay, you have a choice. You can have the service available locally, and this will be the quality you can expect. And it's not because the practitioners can't provide good quality service; it's just that that small a unit can't provide that good a service. They don't see enough cases. They don't have the equipment available. And they don't have the experience and training that you get when you do it every day. Or you could have that service provided in Saskatoon, Regina, or even in some cases, Edmonton. And then at least it becomes a matter of public debate.

And that gets back to your point earlier. We're not saying that we should tell the public you must . . . you cannot have a small hospital or you should have a small hospital. But at least let it be an informed discussion. If there's another policy objective above and beyond simply the quality of the health care — such as local economic development — make clear that that's the reason that you're keeping the small hospital. That it's not for effectiveness of health care; it's for some other reason or it's for access. And those are valid reasons, but they should be well informed by the evidence and by the debate.

And the contribution of quality council would be to put on the table: okay here's the evidence about the performance of the health system with 70 hospitals. Here is what it might look like with 20 hospitals or 10 or — I don't think anyone would suggest one hospital — and then you could have the debate.

Ms. Harrison: — Also I'll just add to that as well. I think you've hit on probably the number one problem that most of us have relative to communicating anything to do with health care.

I think a simple example would be in the area of health promotion. There isn't anyone in the public doesn't know that exercise, proper nutrition, and not smoking is important for them. They know that. The evidence has been made very consumer friendly. It's out there. It's in front of them.

However, the uptake of that is somewhat limited. There are strategies out there I think that — again, something like the quality council — would be able to look at, which are strategies that take into consideration, as Laurie said, informing the public and ensuring that there is buy in at an individual level.

Because I think one of the issues — and this is speaking as an individual who has a 91-year-old mother-in-law — at the individual level, the integration of what the evidence suggests versus that individual getting care in home care or in a nursing home today is very much missing.

The support mechanisms for that individual, say, the family members, if they were better informed, if there was a better communication — and that goes to public accountability as we've talked about — is that a quality council would bring a level that HSURC certainly has not had a mandate to do in the past.

So your particular example is an excellent one. And I guess we see the quality council as being able to take on that role much more aggressively than . . . certainly HSURC has never had that mandate. It's been very much, as Laurie said, focused at the health professional level and at the system level.

Mr. Thomson: — So if we moved to a quality council then . . . in your presentation and I think you said so verbally today that you would want it to report directly to the legislature but you don't want it to have a policing ability.

Now we've heard mixed opinion on this. SGEU appeared yesterday and said they thought that it should be the one to direct, basically, how the money was spent — to de-politicize it.

Certainly by bringing the reports to the legislature, I think you'll increase the awareness of members and policy-makers but how do you effect the change then? I think of the report that you did some years ago now talking about the overuse or the misuse of our emergency rooms in the major centres, in particular, in Regina, saying 77 per cent of our emergency room cases were not emergencies.

It's been five years now I think since that was done. We'd all agreed that we should have an ambulatory care centre here but never did it. How do we make sure that we move these things that we all agree on into reality?

Mr. Thompson: — Our experience is that despite its frustrations, the strategy of persuading, educating, cajoling, nudging, is the best long-term strategy for actually moving the health system along.

Now that doesn't mean that other parts of the health system don't have a mandate to police. Clearly, professional regulation is still important. And the Department of Health still has the funding levers to try and steer the ship at the broadest level, and the health district boards have the funding levels at the local program level.

What a quality council would do is put out on the table to the public that . . . a list of strategies and how effective they are in improving health. And then it's up to politicians, to the various managers of the health system, and to the public to put the pressure on to make sure that changes are implemented.

The problem is that when you mix the two functions together, when you mix the educational strategy together with the policing strategy, you become the policeman. And whenever you walk in or try to talk to anyone, you're seen as the policeman and the education strategy goes out the window. And your ability to co-operative and nudge and cajole people disappears.

So that's why we're proposing, again based very firmly on our own experience, that the two functions be separate. The policing function is still there. There's still the levers of control, but you need somebody who's seen as strictly having the educational role and the goodwill that goes with that.

Mr. Thomson: — My final question, Madam Chair, concerns budgeting. We spend about $9,200 per family per year to keep the existing system going. Most of the presentations we've heard say that they want basically what you'd call medicare plus: everything we have now plus primary health care teams; plus 1 per cent of the budget for research; plus a new health sciences centre; plus, plus — all within $2.2 billion. And that's not talking to the ordinary patients who still want to be able to go — when they want to — to go see their doctors.

There haven't been a lot of people popping in volunteering to pay more taxes. How do we square that circle? How do we increase . . . if the choice comes down to increasing the research budgets or keeping the rural hospitals open, what's your advice on that matter?

Ms. Harrison: — Well, I'll go first. That's a big question. I think that what we're recommending is that there are resources being allocated to services in the system currently that need to be carefully evaluated. And this is an issue of allocation of services.

To be very frank, I think that the decisions are not easy when you have individuals phoning you up, as somebody in your constituency who has an individual problem, that may be because their local facility is not available to them or they're on a waiting list for a certain procedure.

But in the broad spectrum of looking at allocation of resources in the province, I think that there could be some major decisions made. We gave a few examples of where we see that resources are not being allocated appropriately or services are being provided, and then you would find that there would be services available for some of the additions.

But also, even to reorganize some of the services so that they are delivered more effectively and certainly efficiently — which is what you were talking about as well — I agree with you.

I constantly think that you wonder . . . It could be quite easy just to throw your hands up and say the only way is to put more money in the system. I think we all realize that that's not the solution; that the solution is organization, management. And it does go back to Laurie's point, is education and persuasion at the individual level, which is the patient, the consumer; at the practitioner's level; and then at the system level. And without that buy in, it will be very difficult to move beyond that.

But I do think, as Laurie pointed out before, that if individuals are given information clearly — and that's a challenge, to get the communication at that level — that people will choose to go certain routes if they're given information, access to important information. An example being antibiotics. I think people are now becoming much more aware of that, so you don't have the same issues at an individual practitioner level.

Mr. Thompson: — I'll be even blunter. We've tried the strategy of spending more money. Since the mid-1990s we've put $700 million more into the health system in Saskatchewan. You're the politicians who get the calls. Has it reduced the pressure on you? I suspect not.

So we tried that strategy. What we're saying is that there may be areas in which funding may need to be shifted and there may in particular be a need for investments in improving the long-term future of the health system, such as health research.

But overall the issue in the health system is not funding and it's not money; it's how well it's organized and managed. And one of the difficulties there is that we don't have the indicators and the tools to be able to tell what's working and what's not, and where we could reduce expenditure without affecting health or perhaps even improving health.

The examples we cited were an attempt to do that. If the public knew . . . The interesting thing about the Wright study, for example, is that's the first time in Canada that we've looked in a broad way across the health district at a number of surgical procedures to find out how many of them are appropriate and effective. It's the first time we've ever done it.

We have no reason to believe that the situation in Saskatchewan is any different. But what Wright found is the last 25 per cent of cataract surgeries did no good and in some cases did no harm. If we knew that and if the public knew that then we could say, let's make sure that cataract surgery goes to those people who could really benefit but let's not bother spending the money when it's going to be wasted. And we need to have good tools for assessing which patients will benefit and which won't, and who should go first on the waiting lists and which won't.

Those are under development, but we really need to develop those so that we can actually have tools to manage the health system.

The Chair: — Thank you.

Ms. Bakken: — Thank you for your presentation. I guess I have to agree with you that we do need to study where the money is spent.

And I would just like to make a point at this time that the Saskatchewan Party has been calling on a value-for-money audit for quite some time and that we do believe that the money is in the system. It does need to be managed better.

I'd just like to point to one of your statements. You said:

> The biggest improvement in health care will come from focusing on improving (the) . . . system quality (not from providing more services).

And I guess when I read this, I think of rural Saskatchewan and the proposal in Fyke to close 50 more hospitals.

The people in rural Saskatchewan that have come before us and that are concerned are not asking to provide more services. They're asking to retain what they have.

And I don't believe there's anywhere in Fyke that it shows that by closing these hospitals we will save any money to the system. I don't believe, from hearing them speak to us, that the quality of service will improve by closing those hospitals.

They are not asking to provide brain surgery in Redvers, Saskatchewan or in Indian Head. They're asking to retain the services that they provide now, which they believe they provide effectively and efficiently for the people of their communities. And they're very concerned about the time that it takes to get an ambulance, to get people to Regina or to whatever centre to provide care, if they lose the care that they now provide.

Many of the doctors that are in these centres will not stay if their acute care beds are removed.

So I'd be interested in how you can endorse Fyke closing 50 more hospitals and how that is going to improve the quality of care in Saskatchewan.

Ms. Harrison: — I think probably it's important to recognize that, in our particular brief, we didn't touch on the closure of hospitals. Not because we haven't had some experience. We have. As I mentioned, we did do research looking exactly at this issue around acute care services being provided.

One of the reasons that we didn't address that specifically is because we don't have the evidence, we feel, from our organization to go any farther than the support that we've already had related to acute care funding.

So the issue in regards to how much money would be saved in the system, again that isn't something that I think HSURC could answer for you.

I would like to clarify though that, as you said, the quality versus providing more services, I think it's important to recognize that in some cases if you reallocate services, in certain areas you may have more services and you may have different services in other areas as well. So it's looking at the system on a whole.

We tend to look at services I think as just a number, often, is what is available versus looking at what is the right service to provide in the right location. And so certainly from the work that we've done, we concentrated primarily at the acute care service area.

One other factor, based on as you've said, is I don't think we are surprised as well as at what you've heard from individuals at the community level. And certainly one of the issues that came out of our rural hospital closure was the fact that, despite our findings that health status did not change, there is no doubt that the community was very, very worried and continued to be worried about losing the hospital in their community.

So on the one hand, I suppose you could say those are two pieces of information that conflict; on the other hand, I don't think it's surprising. CIHI, Canadian Institute of Health Information, has basically done a project Canadian-wide that showed that Canadians have good health good care. Canadians who go to hospitals or receive physician services or health care services are satisfied with the service. However, we also know that people continue to be very, very worried about access to services.

So the two I think are very important issues. And one of the recommendations that came out of our hospital study, looking at the closure, was mechanisms. If, for example, there is a move to change, for whatever reason — more hospitals are closed or a change in the types of services that are provided — that there must be a good strategy for communication as well with the communities, the local level, in preparing for this. And again it goes back to the example of informed decisions for the community.

So I think . . . we wouldn't be surprised at seeing the two sides, which is that individuals at the community level will still be very concerned about closure or losing services.

Mr. Thompson: — I could add a bit to that. When we did our

evaluation of the acute care funding cuts in the 52 rural hospitals, we surveyed 5,000 people in those communities and got a very clear feedback on what they were concerned about. And the message to us was that you need to separate what people need for services and what they're asking for from how they traditionally are used to receiving them. That is the bricks and mortar of the building versus the actual services they were concerned about.

And what we asked them, in an open-ended question, what they were worried about. First of all, they admitted that their own health had not been affected. The overall majority — 90 per cent — said their own health and the health of their families had not been affected. But they said they were very worried about emergency response and they were very worried about access to physician services.

Those don't necessarily have to be tied to a bricks and mortar building in a hospital. But of course, if I lived in rural Saskatchewan and I was a long way from the closest hospital, I would be worried about both of those. And I wouldn't want to have to spend the day having my daughter-in-law drive me into Saskatoon for tests. I would want to try to have those available locally.

But I think that's the way we have to approach it. How can we make sure you have the services that will benefit you and that you're asking for? It may not be delivered in the way that you're traditionally used to having it.

Ms. Bakken: — Well thank you. And I hear what you're saying. I guess health care, as Mr. Thomson has indicated, should be about evidence. Health care's about people too, and about quality of life and about access and about security; about seniors being able to stay in their local communities and having family and friends around them and to support them.

So we can't look at this in just as isolated, technical way. We have to realize that we have a whole province to service. And those people pay taxes. They have a right to health care being provided to them as well. And we have to find a way to make that mix work. So thank you.

The Chair: — Thank you. Seeing no more questions and our next providers in the wings, I'd like to thank you very much. And we did have, as a committee, your report from September of '99 about the impact on the communities. We've had that as committee resource. Thank you very much for your written submission also.

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

Good morning and welcome to the Standing Committee on Health Care. This is an all-party committee of the Legislative Assembly and its first task is to receive and report back to the legislature on the responses of the community at large — individuals and organizations — responses to the Commission on Medicare. We have to have a report back in on what we heard; we won't be making recommendations but we'll be reporting back to the Legislative Assembly on what we heard by August 30.

It's an all-party committee. I'm Judy Junor, the Chair. Dr. Jim Melenchuk is the Vice-Chair. Andrew Thomson, Deb Higgins, Kevin Yates, Brenda Bakken, Bill Boyd, and Rod Gantefoer are here with us today.

We're giving 30 minutes, and hopefully there'll be time at the end of your presentation for some questions from the committee members. Introduce yourself and your organization and then begin your presentation.

Mr. Braun: — My name is Eric Braun and I'm the provincial president of the Canadian Mental Health Association in Saskatchewan.

Ms. Whyte: — Beside me is Dr. John Hylton, the executive director of Saskatchewan division of the Canadian Mental Health Association. And my name is Jayne Whyte and I'm the Chair of the Saskatchewan Advocacy Committee for the Canadian Mental Health Association, but I'm also a beneficiary of the mental health services since 1965. So I've been able to see it first-hand for a long time.

And I want to thank you for allowing us to come today to provide our comments on the findings and recommendations of the Saskatchewan Commission on Medicare.

Because we have 30 minutes and we want to have an opportunity to answer your questions, our presentation is purposefully brief. However, in the package that you received just as you started this, we've attached two papers that we commend to your attention because they provide much more detailed information about our perspectives and concerns.

The first is a detailed analysis of the Fyke Commission report prepared by our executive director. And the second is a report on recently completed provincial review of mental health services, completed by our association. That report is called *Making Sure Connections Happen*.

Mr. Braun: — I think we should start out by just explaining who we are. The Canadian Mental Health Association in Saskatchewan is the largest and oldest community-based non-government health and human services charity in Saskatchewan. The Saskatchewan division, the first provincial division of the Canadian Mental Health Association in Canada, was founded in 1915.

Over the years the association has grown. There are 15 branches of our association located throughout the province. There are some 1,500 members of our association and 2,500 volunteers assist us with our work. And 30,000 Saskatchewan citizens support us financially each year.

We serve thousands of clients and family members throughout the province every month.

Our association's mission is to improve services and the quality of life for all those who suffer from mental illness. We are also committed to prevention and early intervention, and mental health promotion. We achieve our mission through the provision of services to clients and family members as well as through public education, research, and advocacy.

Ms. Whyte: — The next information is to give you a bit of a background and information on the importance of mental health issues in our community. The mental health status of the people of Saskatchewan is a matter of serious concern.

For example, the latest information available from the ecological catchment area studies in the United States, suggest that 28 per cent of the general population have a diagnosable mental disorder at any one time. That's more than one-quarter of our population.

And our own studies suggest that one in three, or one third, of our population will suffer a serious mental disorder at some time during their lives.

The next statistic is very unfortunate. Suicide is now the leading cause of death among young people from ages 15 to 24 years in Saskatchewan.

And you've all heard of people off on stress leave. Disability because of stress and anxiety in the workplace is now the fastest growing category of Workers' Compensation claims.

As you've been hearing, rapidly increasing costs of health care are due in part to the societal costs of mental illness. For example, the most commonly prescribed and fastest growing categories of prescription drugs are those used for the treatment of depression and other mental health disorders. And more hospital beds are allocated for the treatment of mental disorders than for any other type of illness or disease. And that's partly because you don't recover from a mental health disorder as quickly as you do from an operation, I think.

Many general practitioners report that half or more of their practice relates to dealing with mental health conditions and the physical health consequences that arise from stress and mental illness.

Lack of information, lack of services, and stigma still prevent people from getting the services they need. So when we see these numbers, they don't reflect the people who didn't ask for help.

Mr. Braun: — We'd like to now outline for you some of our concerns, issues, and perhaps what we see as some opportunities arising directly out of the recommendations of the Fyke Commission report.

And we'll start out with primary health care. As the commission points out, mental health is often overlooked in discussions about health care reform. There has been a significant erosion in the levels of public support for mental health services for at least the last three decades.

And I just want to stop and say, when we say lack of or drop in levels of public support, I don't mean the support of people in the community. We're talking about funding and understanding and the perception and the stigma involved with mental illness. I think, if there was more public education and more understanding, you know, that increases awareness and increases understanding and in that sense there would be support.

Unfortunately, the commission is also guilty of failing to grasp the enormity of the challenge. There is virtually no discussion of mental health issues in the commission's report.

We support the commission's proposal to develop a comprehensive primary health care system in Saskatchewan and, like the commission, we believe that mental health services must be included within the mandate of primary health care teams.

Our vision of primary care extends well beyond the notion of nurse practitioners performing services that might otherwise be performed by physicians. We see mental health professionals working alongside other specialists as integral members of the team. Such a model, we believe, has the potential to increase quality of care, improve access to services, particularly in rural and northern areas, and increase efficiency.

However, the inclusion of mental health within the primary care model will require a concrete and aggressive human resources development plan, as well as the commitment of significant new resources.

Mental health's version of health reform or what has been called historically the Saskatchewan plan of the late 1950s and 1960s occurred some four decades ago. There is much that can be learned from this experience of de-institutionalization, both good and bad, that should be incorporated into current planning. The importance of standards in core services, issues related to recruitment and retention of staff, the necessity of providing bridge funding during the reform process, and many other issues.

We recognize the importance of primary health care, but we feel there's a need in mental health to go beyond primary care. The effective support of individuals and families coping with serious mental disorders requires a continuum of services that include our front-line mental health services, but specialized services available on a regional basis, crisis intervention services, and provincial programs such as the long-term care provided at Saskatchewan Hospital, North Battleford. It wasn't clear to us that these needs had been considered in the commission's proposals for the reorganization of acute care.

In the commission's model, how would mental health services for the people of Saskatchewan be organized? The effective support of individuals and families coping with serious mental disorders also requires more than medical care. This is where we get into the whole concept of the determinants of health.

Improving and maintaining health status and mental health status also involves attention to housing, income support, employment, and other issues. While the commission acknowledges the importance of whole health, our association is concerned about the absence of any concrete recommendations for addressing these determinants of health.

Mr. Braun: — The next area we'd like to consider is the voluntary sector. And as I mentioned earlier, we benefit enormously from volunteers. Volunteers are the lifeblood of our organization and many organizations like ours in the community-based sector in Saskatchewan.

We support the commission's view that improving health status involves much more than medical care. We are disappointed that the commission did not recognize the importance of the voluntary sector in addressing the determinants of health. Many health enhancing programs are regularly provided by voluntary organizations such as food banks, self-help organizations, charities, churches, non-government health and social services agencies, and service clubs. An enhanced role for such organizations and a closer relationship between them and the formal health care system is needed.

Ms. Whyte: — Another sector that deserves its own attention is the Aboriginal and northern mental health issues. And I know you did hear a good presentation from the northern health regions. But on behalf of the Canadian Mental Health Association, we want to reiterate that Saskatchewan's prosperity and success depends on the Aboriginal people of our province attaining their aspirations for self-government, economic self-sufficiency, and cultural and social vitality.

I come from Fort Qu'Appelle where the Okanese gathering is just getting into full swing.

The enormity of the social adjustment and mental health issues besetting Aboriginal and northern citizens cannot be overstated. There is a large and growing Aboriginal population in this province. And more than other residents, Aboriginal people suffer an excessive burden and physical and mental distress. Current strategies have not always proved that effective. Progress is difficult in part because of a variety of complex jurisdictional issues. It is critical that the government move forward to resolve these long-standing issues on a timely basis — and the time is now.

Mr. Braun: — We're going to close our presentation with four recommendations that we'd like to make to you today, or for you to pass on to the government and the Department of Health.

And the first one is regarding a plan. Saskatchewan needs a provincial plan for mental health services. This plan which should be established with the input of all concerned stakeholders should set out the vision, mission, and values of the system as well as standards of care and core services. The plan needs to show how mental health services will be integrated into the primary health care system proposed by the commission as well as into the other changes the commission is proposing in acute, specialist, regional, and tertiary services.

The Canadian Mental Health Association stands ready to be a full participant and co-sponsor of this important and long overdue planning process.

Ms. Whyte: — We believe that mental health services must be at the core of the mandate of primary care teams proposed by the commission. Mental health specialists should be key team members. For this to occur, the Government of Saskatchewan will have to develop a concrete human and fiscal resources strategy to address the current crisis in mental health services, as well as future needs.

We need people who have an interest and expertise and desire to participate in the long-term and acute care of people with mental illness.

Creative approaches, including heightened employer commitment to recruitment, to training, and to retention of mental health group professionals is urgently required.

Mr. Braun: — The Government of Saskatchewan should recognize the important contribution that the voluntary sector makes to the health status of the people of Saskatchewan. As other governments have done, we urge the Saskatchewan government to aggressively adopt plans and policies that will strength the voluntary sector, including partnerships with the formal health system.

Ms. Whyte: — And as I mentioned before, we need to address Aboriginal and northern health and social concerns, including mental health concerns. And we ask that those be moved to the top of the government's priority. Saskatchewan depends on recognition and attention to the Aboriginal population of our province.

Mr. Braun: — So in closing, I'd just like to thank you for welcoming us into your cool and calm sanctuary here today on such a hot summer day. And we would very much look forward to the opportunity of answering your questions. Thank you.

The Chair: — Thank you. We don't know what it's like outside. It's nice to hear that. Questions from the committee?

Mr. Thomson: — Well I was going to say thank you for reminding us that there is a beautiful summer day out there.

I am interested in this, I guess what is really the central point of your presentation today, is the need for us to make sure that if we are moving to a primary care model, that we have mental health professionals available.

Now I am reading John Hylton's report here on the detailed analysis and findings, and in it and on page 15, it says:

> Certainly most health care practitioners would feel ill-equipped to deal with serious mental health concerns unless they had opportunities to receive special training or experience.

How do we make sure that either access to those resources or that level of confidence and expertise is available, either to local practitioners or in the primary health care teams?

Dr. Hylton: — Well, Mr. Thomson, I think it's a complex problem. And the difficulties that we have been experiencing in Saskatchewan of course are not only in the rural and the northern areas, but even in the urban centres. And you would be very familiar with the on-again, off-again — usually on-again — crisis we've had, even in Regina, in terms of being able to recruit and retain psychiatrists in our city. So it is a provincial problem and it needs a provincial approach.

One of the important points that was made in some of the discussions that we had with our working groups leading up to the presentation was an identification of the fact that when we were in a leadership position in mental health — and for many years we were in Saskatchewan — it was partly because we grew our own talent in the province. We didn't rely on looking outside.

And perhaps the best example of that was the psychiatric nursing profession which was, in effect, created in Saskatchewan based on the commitments that were made by the Saskatchewan Hospital, North Battleford and the Saskatchewan Hospital, Weyburn.

So we had a philosophy that said we're not going to rely on going out to bring people in and then try and find ways of keeping them here, but we actually took young men and women from around Saskatchewan who were interested in a career in health care and in mental health care, and we found ways to provide them with opportunities to get the training that they needed. And their roots were deep in our community. Many of them are still working today. They have 30, 40, 50 years of experience working in our province.

The point has been made perhaps we need to look at the kind of commitment that we're making as a province, especially the commitment our employers are making, to grow our own talent. And there may be many opportunities for us to do that.

Certainly if we're going to go in the direction of primary health care teams where we're going to rely on people being out in areas around the province and having expertise in mental health, we're going to have to try some of those creative solutions, not simply have ads in *The Globe and Mail* or wherever and hope that people are going to come and want to stay with us. That has been not always a successful strategy, and there are other approaches that we've tried in the past that have been successful. Perhaps we need to look at some of those again.

Mr. Braun: — There have been some very creative approaches used in this province just in recent years. And I wish I could give them credit in terms of mentioning a specific community, but I think this would fit in with primary health care reform in terms of using nurses in rural areas and consulting with psychiatrists to kind of spread the, you know, resource and the specialist reach out into the community. And your minister's Mental Health Advisory Council would have sort of detailed information on this. I remember being on that council and discussing some examples of that, in the rural areas in fact.

So there are creative ways. I mean now that I think about it, it sounded like an aspect of the . . . or beginnings of some kind of primary care model at least in mental health.

Ms. Whyte: — I'd like to just comment on the way my mental health team fits together. And the team was created by me. It isn't that these professionals all decided that they were going to work together, but I insisted and have had enough experience that it's actually working.

I work with a psychologist at the Mental Health Clinic and so she has contact with a psychiatrist at the Mental Health Clinic. Now that's in Regina, so, you know, I'm travelling into Regina and all the costs of travel and meals and anything else, that's absorbed by me.

I have psychiatric prescriptions and I work with a pharmacist, and either my general practitioner or my psychiatrist will make those prescriptions. And I do benefit as a low-income person from some of the support that's available through the Saskatchewan Health Plan.

Because I live in Fort Qu'Appelle, which is an hour away from Regina, I also am in contact with the local mental health nurse, the psychiatric nurse, who practices in Fort Qu'Appelle. Now I don't see her on a regular basis but, when I'm in crisis, it's much handier to have someone that's three blocks away than 35, 45 minutes even by ambulance. She works very closely with the general practitioner so that if she has questions or concerns, she can contact him. He can contact her.

Then, I have a strong informal support network of friends and activities and so on.

But each of those people has a particular role in my primary mental health care team, and I need the expertise and the support of all of them in order to live an effective, interesting, and useful life.

Hon. Mr. Melenchuk: — Just a couple of questions. When you look at mental health services as part of the core of a primary care team and mental health specialists should be a key member of that team, what particular occupations would you see encompassing that role; say, for example, in rural Saskatchewan where you had a primary care team? Would that be a registered psychiatric nurse? Would it be a psychologist? What mix would you see there?

Mr. Braun: — Oh well you've started a good list there. Psychiatry, psychologists, occupational therapy, vocational counselling and programming, the voluntary sector, self-help — those would be some of the examples.

Hon. Mr. Melenchuk: — The second question I have: are you aware of, in existence in other jurisdictions, models that would fit this primary care team that we're talking about?

Dr. Hylton: — Yes we are, Dr. Melenchuk. There are a number of examples even within our own province where there have been good attempts to incorporate a mental health component. One that comes to mind are the community clinics where in a number of instances they've reached beyond purely the medical aspect to offer other kinds of services.

And certainly there are programs like that in other jurisdictions and a number of models, particularly in Ontario and Quebec. But we'd like to think that we have some really good examples right around Saskatchewan that if we adopted and expanded, we could build on in the way that we're describing.

Hon. Mr. Melenchuk: — And my final question is that when health care regionalization occurred in '92-93, there was a lot of discussion that there would be improved mental health services. And how would you rate the current district system as compared to the previous mental health districts in the terms of delivery of services and coordination of services?

Dr. Hylton: — I might just jump in very briefly on that one as well. I'm sure our president will have some comment.

I think the problem that we have goes back to the point that was made in the brief, that we're lacking a plan. We're lacking a vision. We're lacking standards and core services.

And what's that meant is that some districts have been able to

get quite effective and creative in developing services that are arguably more effective than services that were there before. But at the same time, the fact that we don't have a clear vision and standards and core services has meant that in other districts the quality of services and the access to services has gone down.

And so we have very much a patchwork system that doesn't assure the people of the province that wherever they go they're going to be able to have to have reasonable access to a core set of essential mental health services. So we've really gone more in a patchwork system because we haven't started from a basis of saying here's what we really need and now go from there, districts. So I think that has been a problem.

Mr. Braun: — You've really put your finger on an issue there, Dr. Melenchuk. And I mean to me it's a very mixed bag. I think originally as health reform unfolded, it looked very promising and there were some very good needs assessment done in some districts and a lot of excitement about how services could be integrated better and configured better to address needs in communities. But I think more and more as this has unfolded, again, we've seen the lack of a plan and a lack of coherence.

And I'm not sure what the solution is because I see if from both sides. I've served on a district health board and I know that tension of, you know, wanting to do things, you know, independently and based on needs in the community and having some independence from government.

On the other hand, I mean there has to be central kind of plan and a set of core services and so on. An example of this in fact is there's been an enormous amount of work done in the Department of Health on standards. There actually has been a lot of work done, grassroots work done, on mental health standards for our system, but they're not official. No one has said, the department has not said, the government has not said, no one has said — as I understand it — that these are our official standards.

Now just imagine if you had problems with water, say in North Battleford, and somebody said, well we had government standards but they weren't official. I mean that would be seen as a great lapse of accountability.

So I think that's an area where there's been tremendous work done. And I won't fault the department for that, but again I think the department is very much afraid of encroaching on the jurisdiction of the districts. And so you get into this back and forth and back and forth.

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

The Chair: — Any further questions? Seeing none, then thank you very much for coming today and for giving us all the written material as well as your personal presentations.

Our next presenters have a PowerPoint so it will take us a couple of minutes to set that up.

Good morning and welcome to the Standing Committee on Health Care. This is a committee of the Legislative Assembly, an all-party committee.

I'm Judy Junor, the Chair. Dr. Melenchuk is the Vice-Chair. Andrew Thomson, Deb Higgins, Kevin Yates, Brenda Bakken, Bill Boyd, and Rod Gantefoer are here with us this morning.

The first order of business of the standing committee is to receive responses from the public and organizations or individuals in response to the Fyke Commission, the Commission on Medicare, and to report back to the Legislative Assembly by the end of August.

You have 30 minutes, and hopefully, there will be some time left, at the end of your presentation, for comments or questions from the committee members.

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

Ms. Dornstauder-Grocholski: — Well we'd like to apologize for the delay this morning. We had a lovely PowerPoint, but our technology is not functioning the way it should. So we have our backup plan which is our overhead projections.

And my name is Candace Dornstauder-Grocholski, and I am a third year nursing student here in Regina.

And I'll just tell you a little bit about my involvement in nursing. I was a member of the students for nursing political action committee. I was a representative for the students' association executive of Wascana last year. I am now the southern student representative for the provincial nursing council and I've worked for seven years at Wascana Rehabilitation Centre, and in home care and social work as well.

Ms. Wotherspoon: — And I'm Chantel Wotherspoon. I'm also a third year nursing student here at . . . the Regina program at Wascana. I was also on the SIAST (Saskatchewan Institute of Applied Science and Technology) Wascana student association in the past year, and also a part of the south Saskatchewan nursing undergraduate society. And I have also worked for six years in long-term care and had various clinical experiences in other areas of health care.

Before we get started, I just want to let you know a little bit about why we're here today, and I'll just give you a brief outline as well.

We come to you today with a student perspective of how we feel that the Fyke recommendations will . . . how they'll do for Saskatchewan. And so we're going to talk a little bit about why we're here today.

We'll discuss critical social theory, critical thinking, and change strategy, as well as empowerment and ownership of change. And a little bit about active listening.

Candace and I became interested in communication and effective change about a year ago. And many of you may remember this. This was the rally that we participated in last January on a bitterly cold morning. This was in response to the proposed changes to the registration requirements for registered nurses in Saskatchewan.

As you can see, the overwhelming response that we got; there was over 400 students here that day. And it just exemplifies the passion that we feel for our education as well as for the future of nursing.

This presentation was originally prepared for a national nursing conference. We did it a couple of weeks ago. Basically that conference was entitled Canada's Nursing Crisis: Danger and Opportunity.

And so we wanted to ask this question after explaining why we had come to the conference, ask the participants why they had come, hopefully . . . in hopes of reminding them that, you know, at one time although things may be frustrating now, they did become a health care worker because they love what they do and because they're passionate about what they do and because they care about the future of people and of health care.

So we asked this question, hoping that they would be feeling that, you know, they're dissatisfied with the status quo, that they're seeking change, they have a desire to be a part of change, and that they have a genuine regard for what they do and for how it's done.

Communication is a vital part of change and we think that this is something . . . Candace will expand on it more as our presentation continues. But the current workplace setting that we have encountered is one where you hear of things like cutbacks and shortage and burnouts, stress, overtime, and increased workload.

And the same concepts can be discussed just using a little bit different terminology, and it changes the whole perspective of how people think about things and the environment that they work in. And if you use words like collaboration, challenge, effectiveness, opportunity, and maximizing potential, a lot of them can mean the same thing but just have a very different . . . give you a very different perspective of the environment that you're working in.

We have a few goals that we'd like to meet through using this and through doing this presentation today. We hope to stimulate thinking regarding positive change, determine ways to incorporate theories and process to create effective change, outline strategies for communication, encourage the use of active listening skills, and promote ownership of change.

Ms. Dornstauder-Grocholski: — So what we're here to talk about is communication and effective change and how to accomplish that. We've gathered some of the theories and principles and research behind these sorts of things and how it's done that nursing is based on. And the terminology seems somewhat unfamiliar, especially when we present this to people who are actually working directly. But what we tell them is that the terminology may sound strange, but what it really is, is common sense. It's things that people know and understand and do every day in their practice.

So when we say critical social theory, people wonder what it is; but when they understand what it is, they know that they do it and use it all the time.

What we would like to do is explain why we think that the recommendations from the Fyke Commission coordinate with the objectives of our presentation and work well with the strategy. So the first part of that is critical social theory. And this is the purpose of applied theory to identifying challenge, assumptions of oppression existing within social structures, and the goal is emancipation.

So what this actually means is to determine what is the status quo, what is the situation that we have right now. And it also helps us to establish who holds the power in this situation, where are the power and balances, and who are the people that need change, and why are they needing that change to come about.

This is a way to determine where the imbalances are and how to properly and effectively make change. It also helps to level the playing field so that everybody has a role in making that change.

We have five steps that we've gathered that are used to determine what critical social theory is. And the first one is to review the contextual issues — historical, economic, political, and social perspectives. That just simply means to determine what created the situation that we have now. What are the decisions that have been made; what are their histories; what are their pasts; what has brought us today?

And the second one is to identify assumptions, ideologies, and societal supports. Because within any environment and status quo you have something existing that keeps that in place. There is something that supports what's occurring now whether that's good, bad, or ambivalent. People believe things for a reason. And you have to know why that is to understand how to make it change.

And to analyze communication restraints, because whenever you have change, you need to make sure that you are prepared for communication breakdowns that might interfere with that change.

Speaking with oppressed groups, i.e., the targets of change in fellow disciplines. Now this is where you identify who is impacted by the proposed change and how to get them initiated in involvement.

The next part, critical social theory, creates the need to establish egalitarianism, health care as a right, conservation of resources, and serves to enhance communication between health care professionals and the clients that we serve. It also serves to empower the clients, utilize health care professionals to their fullest scope, and enables clients to choose the course of action. This is how we create change in a new status quo.

It's also how we examine the situation from an external focus. This is where we look at the situation outside of ourselves and what's happening in that environment. And this is also an important part of the process that we're involved in right now. This is where we establish what needs to be done and how to do it.

Critical thinking is the next part. And we consider that to be the bridge to established change. So what it actually is in a simple definition is thinking about your thinking. It becomes a habit of

mind and a part of your character when you do it often enough. And it provides a framework to practice critical social theory.

So what this really does is force you to become conscious of the way that you think and the way that you function within the environment so that we're no longer just going about doing things as we've always done it. Now we actually have to think about why we're doing things the way we do and how we function in this situation.

It's also a good way to get a hands-on, direct application of change and implementation. And we have five steps to determine the process of critical thinking as well.

Knowledge is the first part. So you say to yourself what do I know? What does this mean? And reflecting on the situation, why do I think the way I do? What assumptions do I make? What evidence do I have to support those assumptions? Am I incorrect in my assumptions and how might they need to change? What evidence do I have?

Can I prove that what I believe is true, or will I find out that maybe I'm not believing what actually is real? Do the theories and research and other people support what I have to say or is it something different? And am I open to the opinions of others?

And this brings us to action, involvement, evolvement, and improvement. So this is also a part that allows us to broaden our thinking, to restrict our . . . or to prevent us from being restricted to a narrow-minded view. It allows us to listen to other people, to examine what other people are doing, to examine the ways that other people are creating change.

It also brings the focus of change very internal. It forces us to look to ourselves and to decide what kind of a role do I play in this situation, what is my function in this environment, and what are the functions of other people's roles. What can my role be? How can I help to make this change?

It's also a way to bring people very . . . bring the focus of people in a way that's very responsible for change. It makes us all examine our role so we become responsible for the change and that way we own that change.

Ms. Wotherspoon: — The whole idea of change can be a very frightening concept and oftentimes people are willing to do things the way they've always done them, even though they might not be the best way, just because it's comfortable and that's what they know. So unless nurses are experiencing some degree of dissatisfaction with the status quo, change cannot occur successfully.

Change will not occur without involvement. All effective disciplines of change must be contributing involvement . . . must have contributed involvement and therefore ownership of change. And to illustrate the importance of this involvement and ownership of change, we use the example of Albert Community School, which is a community school here in Regina. This mural project was a community project. It was a collaborative effort between the students, the staff, and the community.

This is a neighbourhood where vandalism and litter are not uncommon. Things are not . . . property is not always respected. And this mural has become a focal point in that neighbourhood. It's been up for six years now and it's never been damaged, it's never been vandalized. And we can ask why. And really the reason would be that the community was involved in that, and it's a point of pride in that neighbourhood and they protect it.

Ms. Dornstauder-Grocholski: — So what we've been talking about up to this point is kind of the groundwork that we have for change. And what we're doing here and what the Fyke Commission has done is clearly established the need for change and how we begin implementing that process.

We've used McKay strategy, which involves four steps. Mostly we've chosen this one because it's simple, it's easy to use, and it's easy to understand, and it involves all of the proper actions.

The first part is participation, and participation is essential because it decreases resistance, it helps people become part of the change, it gives individuals a vested interest in the success of the change, which is exactly what Chantel was referring to — when people feel as though the change was owned by them and driven by them and decided on by them, they own it. They have a vested interest in making sure that that change is successful and that it is well accepted.

So if people are asked for their input it conveys respect and they respond positively to change. There's nothing more important than feeling valued and respected within this process. There is oftentimes . . . it's too often that people are left out; that they feel as though things are being done to them and not with them. And I think that this has gone a long way to establishing public involvement.

And the second part is communication. Now this is an absolutely key, vital part of success. The components of this are honesty, empathy, openness and trust, respect, and active listening.

It's better to overcommunicate than under and you need to have advance notice of the change. Face-to-face communication again increases the sense of value and respect. Communication is absolutely integral and the part about this that I like to stress is that oftentimes people mistake education for communication. We need to establish communication that is two-way, face-to-face, involved, and interactive.

Oftentimes people think that they are surveying and they're polled and they're questioned but, if you don't receive feedback from that, then you feel as though your input was meaningless and that it was devalued. So we need to make sure that everyone understands what their input was and that it did have an impact and that it was important in making the decisions that we came to.

Force field analysis is the next part. And that I think is probably one that will apply very well to this commission because you need to determine the driving forces that motivate the change and the restraining forces that impede the change.

Now this is going to be what you guys are going to be focusing on, I would think, because you're going to need to make sure that you have driving forces to increase the chances of whatever

decisions you make will succeed. And you also need to be ready for the barriers that will come when you make those decisions.

So the driving forces are things that you can focus on and get people to get interested in. Change is challenging. It might be tough, it might be hard, it might be a long road but it's challenging and people like challenge. It's stimulating.

People might be bored with the present or in this case dissatisfied and unhappy with the present situation. You can also focus people on the idea that there's a potential for growth, for achievement, for recognition, and for enhanced personal relationships.

If we are able to take this process and make a functioning, dynamic health care system, people will feel that sense of pride again in Saskatchewan. And Saskatchewan has a lot of pride in being the birthplace of medicare and there's no reason why they can't have pride in the changes that we can bring about here and now and make it an even a better system than it was before.

There's also having a vision of the impact of change. If people have an idea that this is going to bring about something even better than they had before, then that's a vision that will promote them to increase the change participation.

Restraining forces are the obstacles because any time that we try to implement change of any kind there's always some sort of resistance. Self-interest is one that we can look at with critical social theory. That's often people who have power within the situation are not often keen on giving that up. In many cases, people believe that they will lose more than they gain. And I think we've seen a little bit of that. People are not feeling very secure that they will be gaining a better system in this and they're thinking that they may lose what they've got and end up with not much in advance.

Misunderstanding of change and its implications, so this is where you come back to your communication and your participation — is it very, very clear what we're trying to do? Because that's essential in making sure that they understand what's happening; misunderstanding will increase the resistance.

Some people have a low tolerance for change and suffer from insecurity when it comes to change. I may not be happy with the situation that it is right now. I may complain about it, I may not like it, but at least I know where my comforts zone is. And when change comes along, it moves me out of the comfort zone, and if I'm not prepared to change, it will increase my resistance.

And then in the end there are always going to be people who just don't agree that change is necessary and you have to be prepared to deal with that as well.

Education is the last component of this strategy, and it is useful to provide information to understand the value and the impact of change. It decreases resistance and explains the need for change. It's helpful to implement drastically different processes and to teach new skills, which will always be required when there is changes like this.

The reason that this one is last is because it's the most commonly used strategy and it's the least successful. The reason that it's most commonly used is because it is the quickest and it's the easiest. And the reason that it's least successful is because it ignores the need to involve the other components of participation and communication, and to have that force field analysis to be prepared for what your obstacles are and to help motivate that change. It doesn't stand alone. It's quick, it's easy, but it's ineffective and it's often used and overused.

And it is often said that communication is education, but it's not. If I hand you a piece of paper to tell you how things are going to change, I'm not communicating with you, I'm educating you. I'm not asking for your participation. This is important, but it's the last and the smallest part.

So the final part to be prepared for is to look for the pitfalls of change. And that's to have a clear plan. To have a very definite clear plan, to have everyone know what that is, to have that transparency so that everyone knows what's going to happen and when it's going to happen increases their preparedness for change and their readiness to change.

And trying not to implement change too rapidly. This is another challenge that this group is going to face — is trying to strike a balance between creating the change quickly enough to help the situation and to create the change slowly enough to allow people time to adapt. People require time to understand why we need the changes that we do and time to adjust to that.

And there have been obvious examples of when change happens too quickly. Back in the '90s when change happened very quickly and very suddenly, people obviously rebelled to that because it just happened all of a sudden.

Choosing radically different programs are often another way that will increase resistance. So you have to be prepared to try and accommodate what's already in place and adjust it to how you want things to change. And even if it takes a little bit longer to get that process changed over, it's important to allow enough time.

Incorporating a social aspect of change is really important and that's another thing we've seen a lot of examples of. If people feel that their social environments, their communities are threatened, you need to help them to understand that this is going to be better and that the changes that will be made will be with involvement and participation and communication and will appropriately suit the needs of the community. You need to ensure that they are not feeling socially threatened within their communities and their structures.

Ms. Wotherspoon: — This slide is entitled the nursing process but we've discussed a couple of times that we need to change the title of that. Our audiences have always been primarily nurses before that and this is a very familiar process to them. But this is a process that is used in everyday life, in every aspect of everyone's life, and it's an ongoing process.

The only thing that's guaranteed in our life is that change is going to occur. And there's nothing that we can do to avoid change but we can definitely deal with it effectively.

Now Commissioner Fyke has assessed and diagnosed the current state of Saskatchewan health care. So he's used critical social theory, critical thinking, and he has made the assessments and the diagnosis.

And now we're into that planning phase where the plan of implementing the recommendations must occur. And in order to do that, we again used the same skills that we've talked about all the way through this, and the intervention and evaluation, again using active listening skills, using critical thinking, using critical social theory — all the same things — and it's an ongoing process. Evaluation must occur throughout all of the stages and it will just continue on that way.

We left active listening till the very end but it's actually a very key part to implementing change. Active listening doesn't just mean listening to what every . . . listening to what people have to say. It means actually really listening to what people have to say. Active listening involves all of your senses, not just hearing. It requires tremendous energy, discipline, and concentration and requires recognizing and screening out internal and external influences and barriers that interfere with communication.

So this is listening to what people are saying and listening to what they're implying and reflecting it back to ensure that what you're hearing and understanding is what they're intending you to hear and understand.

And the steps to . . . there's a few steps in active listening. These are just active listening skills — they seem very basic, but they're very effective — eye contact, open posture; encouraging others to speak; asking open-ended questions so that people don't feel that they're being directed in their answers; and reflecting the speaker's feelings to ensure that what you're hearing is what they want you to hear; and then summarizing again, just once again making sure that what you're hearing is what they want you to hear.

If all of these skills and these theories and everything is used effectively, the ideal picture would be this: we would be practising . . . having informed practice; we would have intersectoral collaboration, not only just within the health care workers themselves but with the public and everybody because everybody is affected by health care; and also effective communication.

A question that is often asked in any of these situations is, what's in it for me? And that's not just me or Candace or you; it's anybody in Saskatchewan because health care does affect everybody.

These are directed more towards the work environment but you would have a warm, supportive work environment where peers and managers can be trusted; the opportunity to do useful work to the best of your ability and continually improving the quality of the environment; and a chance to create a sense of value and respect for each other.

Now these statements are based on Dr. William Glasser's principles of lead management as opposed to that of boss management, the mentality of a boss management, where people work together rather than work for someone who is telling them how to do things.

Primary health care teams facilitate and support exactly this — communication and effective change.

Ms. Dornstauder-Grocholski: — This is the model that we've developed to coordinate with our strategy in our presentation. And it kind of incorporates and summarizes everything that we're trying tell the people that we talk to and the people that we address.

Utilizing the theories that we have and the resources really, is actually this part here. This is the resources that we have. We have the skills to establish what is the critical social theory and we have the skills to use critical thinking. We understand what change theory is.

And with active listening, using your critical thinking skills, an implementation of that nursing process or whatever process it may be in which you are assessing and planning and intervening and evaluating your functions, you can bring yourself to the goals of this plan. And that's to have that intersectoral collaboration and that effective communication and that informed practice.

And in nursing this is a little more applicable because we have this thing we call praxis, which oftentimes is a confusing word to people, but what it really means is that what you know informs what you do. And what you do constantly informs what you know. So you're constantly evolving and involving your practice and making it better and better all the time.

And what we believe, if people implement this properly, is that you will end up with a healthy environment in which to practice.

Ms. Wotherspoon: — So when you are making success of something, it's not work, it's a way of life. You enjoy yourself because you are making contributions to the world.

Ms. Dornstauder-Grocholski: — When we address nursing people and front-line practitioners, we talk about leadership issues. And when it comes down to change, what we always say is everybody knows we need change and everybody says somebody should do something. But the problem is, is that I have yet to meet someone named somebody who is willing to do something. So the question is: is who's going to do this? Who's going to make this change? And my answer is, is we are. We are the ones who need to do this. And everybody says, it's so overwhelming; the situation is so awful; I am just me and I can't do anything.

So the example that I use of leadership and what we need to do when we think to ourselves that we can't be leaders, is this person here. And his name is Nkosi Johnson. And I don't know if any of you know who he was, but he was a young boy in Africa who was 12 years old and died about three months ago now. This little boy from the time he was 4 years old was a leader and activist for the fight against AIDS (acquired immune deficiency syndrome). He was the first child that was allowed into the regular school system in Africa. And he was celebrated and mourned, his passing, by the UN (United Nations).

Now I've said to people you may think that you don't have a lot to work with but imagine being born into poverty, knowing that you have a death sentence hanging over your head, and becoming a leader anyway. So you might have a lot more to work with than you think you do.

Leaders are out there — and they're everywhere. And you might even be leading and not even knowing you're doing it. So trying to be conscious of it and trying to find who those leaders are and encouraging, that is going to go a long way in creating the change that we need.

And this is just one of our favourite little quotes, that "Men who say it cannot be done should not interrupt those doing it."

So in summary, what we have tried to do is to give everybody a usable way to deal with the challenges that our health care system faces. We believe that a positive attitudinal shift can create a new paradigm that will create enhanced communication and collaboration within the health care environment using the knowledge, experience, value, and respect that we have for each other.

To us, the Fyke Commission represents hope and progress. It's a definitive direction in which to plan our futures, and one that focuses on the goal of providing the best quality health care that Saskatchewan is known for. This is the place in which medicare was born and we don't want to see it crumble. We believe that here in this room we can help medicare to evolve into a system that's even better and that well serves the people of Saskatchewan.

We believe that the crisis we face is a challenge and that the Fyke Commission supports that Saskatchewan has everything that it takes to carry on with a dynamic health care system.

We as nurses, health care providers, public and policy-makers, we are the resources that we have to make this change occur. We don't need to look anywhere else. We have what it takes right here. And we are the leaders of change. There isn't anyone else. There is no they that's going to come along and do this. There is no somebody who's going to come and do something; it has to be us and it has to be driven by us. We believe that we can do this very effectively.

We also believe that Chantel and I are here and able to speak to you in a way today that none of the other presenters has been able to do. We are simply students — we have no ties, we have no organizations, we're not grounded to anyone, and we don't have any agenda. We're selfish. And that may sound funny but in the end what that means is that all that we want and all that we are motivated by is what's best for us and what's best for our futures. And that's what's best for nursing. Because in the end we want to make sure that we have the very best education, to work in the very best jobs, in the very best places, to provide the very best care, and we really want that to be here.

We want that to be in Saskatchewan so that we can continue the vision presented by medicare and with the assistance of the Fyke Commission and provide a vision that Saskatchewan is known for once again. And we really believe that this can revitalize and rejuvenate our province, and we can work with the resources we have and the tools that we need to overcome this crisis and create an environment of change and opportunity.

So to end on a happy note, since what we're talking about is attitudinal shifts and how to work with the resources we have, we believe that we're prairie kids and we know how to work with when we have a lot of something and a little of others and need something to . . . need to fill the gap somehow, so we have a Saskatchewan example of working with your resources to make the most of it.

So thank you for your attention today, and we apologize again for the choppiness of our presentation — it's usually a little more seamless than this.

The Chair: — Thank you very much for a very uplifting presentation. I'm not sure if we have your whole presentation in our . . .

Ms. Dornstauder-Grocholski: — No, there's only parts of this.

The Chair: — Can you leave the whole one with us or do you . . .

Ms. Dornstauder-Grocholski: — Sure, yes we can do that.

The Chair: — That would be great. Now we have some time for questions from the committee.

Mr. Boyd: — Thank you very much for a very thoughtful and, as Madam Chair says, uplifting presentation. I envy your spirit of optimism. Sometimes optimism however, is tempered by reality. And reality with . . . is difficult to measure when you have youthful exuberance such as you do. But accepting change with that spirit of optimism is, I think is right, is a good thing. But I don't think that many people would just automatically accept that change for the sake of change or change is always good. And I think I can think of many examples of that.

If you look at someone in the business world, for example, they go through all of the thoughtful analysis that you are prescribing that they go through in terms of a business decision. They look at all of the factors. They judge the market. They judge the product that they have. They design a product appropriately for the market and then they go to the marketplace with that product. And unfortunately, after taking and making all of those steps and consulting as widely as possible, they find that they're just simply wrong on occasions.

And I'm wondering whether . . . and I think you would find many, many people in Saskatchewan that have gone through various changes either in their lives, in their business, in their family relationships or stuff — things that have happened to them — look back and say to themselves, well I thought we were making the right decision, we maybe weren't.

A Witness: — Because we're human.

Mr. Boyd: — Yes, indeed we are. And indeed we are. And that's why I think many people would look at a change and say: yes, we can accept change; yes, we're optimistic about change; and yes, we agree that changes at times have to be made. But there are occasions when we make mistakes and we're wrong.

And I think what we have heard from many people in the last little while is that maybe, just maybe, Mr. Fyke is wrong. And they I think have gone through that same kind of careful analysis that your process calls for.

And I can think of people in communities that were affected with the last round of health care changes and they were told optimistically — very, very optimistically — by people within the department and within government circles and within the profession that these changes will result in a better quality of care for you. And they were optimistic I think, that maybe they were right.

But I think what we are seeing in the last number of days . . . and I think I could direct you to many of them, that I would hope you would be interested in speaking to, people within my community as an example, that when their facility closed they were told that they were going to enjoy better care. I dare say you would find . . . you would have great difficulty finding anyone within that community that would agree that that change was good for them and their community.

So what I'm just simply saying to you is I understand your optimistic look at change. As an eternal optimist, I understand the willingness to accept change and the willingness to want to go forward and be progressive, but I also want you to temperate it with the bitter pill, unfortunately, of reality from time to time.

Ms. Dornstauder-Grocholski: — I think that if you look at the changes that were made before, historically, people weren't allowed to have this amount of participation in it. I think that the way that this was done in surveying and speaking to people and groups goes a long way to initiating that process. I'm not saying by any stretch that that's the complete way to do it.

The other thing, too, is as for youthful exuberance, I've been talking about getting into nursing since I was four, so for 23 years I have been facing the negativity of people saying don't do that, why would you do that?

So it's not so much youthful exuberance anymore. I've been at this for 23 years saying, no, I can get into this and I like this and I love what I do. It is optimistic and it is exuberance, but maybe that's the part of it that people need to see.

And that's why we call it attitudinal shift. Maybe if you put that positive outlook on things and if you sit down with people and talk to them about the way things will change and allow them to direct it — and that's what I'm talking about when I talk about moving people outside of their comfort zone — and if they can sit down and help to plan how those changes occur, it makes them a little bit more secure in the way that those things will happen. They know what's going to happen; it's predictable; it suits their needs. And this is going a long way to accomplishing that.

Mr. Boyd: — Well I guess I would respond by saying I hope you're right. That the welfare of many, many people is at risk if we are wrong in our decisions here. And if we make mistakes here there are consequences associated with those mistakes that we'll all have to bear. And no amount of optimism changes those kinds of things.

And while I agree with you that the process now is a little bit different than it was previous, there is still some reasons to be concerned. For example, yes, we've had the Fyke report, and yes, he's made recommendations, and yes, there was a reasonably consultative approach taken at that point in time.

And yes, now we have this Standing Committee on Health Care, and there is again a pretty good, I think, process and a reasonably consultative process once again.

But we also have to keep in mind that at the very same time that this is going on, there is what is known as a parallel process going on which I have no knowledge of what is taking place there at all. I have no knowledge of who's embarked upon that process. I have no knowledge of who they are consulting with. I have no knowledge of what their mandate is. I have no knowledge of what their decisions will be based upon. And I have no knowledge of when they will be reporting. I have no knowledge of whether they will be sitting, as you are, before this committee, sharing their thoughts.

Those are reasons why, I think, that we have to be concerned that maybe the decisions are not going to be as a result of what we hear now, but have maybe already been taken.

And I think that would go very much against the basis of your argument.

Ms. Dornstauder-Grocholski: — I think that what we talk about is using what you have in place as a base point to get to your goals. So you incorporate change in a way that accommodates what was and eventually brings it to something that functions better.

The other question you have to ask is if we don't make the changes, is that right or is that wrong.

There needs to be some evolvement of change. Everything has to evolve, everything has to grow. It's a fact of life. If you do it in a way that strikes a balance that can make people comfortable with how it works, that they're driven to it and they're participating in it, I think that can be effective.

The Chair: — Thank you.

Mr. Thomson: — Madam Chair, it would appear from the last exchange that the opposite of young and exuberant is old and cynical, which I'll try not to be.

But my question is . . . And I want to thank you for the presentation. I was intrigued as I was listening to it at the level at which we need to work on the change mechanisms. Does it have to be at the workplace unit, do you do it on a community level, can you do it on an industry-wide basis, or can you do it on all of those?

Ms. Dornstauder-Grocholski: — I think that it needs to be done on all of those levels. Because I think if you don't do it on all those levels you neglect people. And I've seen it happen just within a unit, a ward, where they're neglected and the change kind of sweeps along and wraps them up and if you don't pay attention to that . . . and that's what I was talking about with social structure and that sort of security.

If you don't contact it on the micro-level as well as the macro-level, you create dissension within the ranks and people feel left out of the process. So there needs to be a way to incorporate all levels of change. It needs to be inclusive.

And I think that, you know, this strategy is simplistic, but it's useable that way because it can be used on a micro- and a macro-level.

Mr. Thomson: — I appreciate it. Thank you very much.

The Chair: — Any further questions? Seeing none then, thank you very much on behalf of the committee for your presentation. It was worth waiting for and I hope you can share the complete text with us, even though we do have it all on *Hansard*.

The committee stands recessed until 1 o'clock.

The committee recessed for a period of time.

The Chair: — I think we'll get started. We have a busy afternoon. There's a fairly large contingent of presenters. What we're going to do — and I've shared this with the Redvers community — is have you decide which groups come at which times. So you can come forward, and then somebody will tap you on the shoulder and it's bingo, you move off and the next group comes in. But that's up to your delegation to do that.

I'll have you reintroduce yourself each time you change presenters for the organization that you're representing. And we'll go to questions at the end of the presentation. So we have a time slot of 1 to 4. Hopefully by 20 to 4, quarter to 4, you can leave us 15 minutes so committee members might have a question or two. And we have to be done by 4 since there's another presenter coming in.

You're here before the Standing Committee on Health Care. It's a legislative committee, a legislative committee of the Legislative Assembly. It's an all-party committee. I'm Judy Junor, the Chair of the committee. The other committee members are: Dr. Jim Melenchuk is the Vice-Chair; Andrew Thomson, Deb Higgins, Kevin Yates, Brenda Bakken; and that is isn't Bill Boyd, that's Dan D'Autremont; and Rod Gantefoer are here this afternoon.

The committee has been charged . . . its first order of business is to receive responses to the Fyke Commission or the Commission on Medicare. So that's to listen to what people's . . . people's response are in either individuals or groupings and report back to the Legislative Assembly on what we heard. We won't be making recommendations. We'll be reporting back on what we heard. So that report back to the Legislative Assembly is due August 30.

Our groups have come in half-hour blocks because you have several groups coming from Redvers. That's why I've said you've got three hours and you, yourself, can determine how much of that, those half-hour blocks, you use for each group that you've brought along with you. And hopefully, that'll work to everyone's satisfaction.

At 3 o'clock, we should take a bit of a break just so we're not sitting for three hours straight. And I'll just say you know it's 3 o'clock. We're going to take a break for five minutes. And then we'll all come back and start again.

So if you want to introduce yourself, who you represent, and then you can being your presentation.

Mr. Sterling: — Ladies and gentlemen, introducing ourselves; beside me is Joan Raimbault from Redvers. Joan is the economic development officer for our area and a partner in farm operations. My name's Larry Sterling and I'm from Antler, Saskatchewan. My wife, Sheila, and I are business owners in Redvers and we operate a grain farm near Antler.

I'm delivering this brief to you today on behalf of the Redvers Chamber of Commerce. But more broadly, we represent the over 130 businesses that surround and keep our rural area healthy and viable.

What we are doing here today in our minds is to try and help you understand why we believe, as a business community, the Fyke report, if fully implemented, will have a devastating impact on not only our town but the whole area.

In the early '90s, acute care centres were closed in many neighbouring towns and we interviewed some of the people that suffered through this era. Many of the people we talked to, although they still had health care, had moved to Redvers to be closer to an acute care facility. Former business owners in every case reported loss of a customer base, many to the point of shutting their doors.

We in Redvers capitalized on part of their misfortune, but now find ourselves potentially in the same situation they were in. The difference in this case, however, would be mass exodus over several years for those able to leave and the remainder would have third-rate health care in a first rate facility.

Previously, when 52 hospitals were closed, people could still come to the nearest acute care centre as all were still within 30 minutes of travel time. If this report is adopted and ambulance centres are changed, many citizens in our area are going to find themselves between two and three hours away from acute care depending upon location. This is a fact and this very fact will push people out of the area for both health and business reasons.

I realize you really don't want to hear much about economic today. But if you have rural roots and live or came from a rural area, you will also realize that everything is tied to each other and you can't separate these facts.

At a recent town hall meeting in Redvers over 500 citizens came out to find out what implications the Fyke report would have on them. Everyone left very disturbed, disillusioned, and many very fearful.

This fear was because a great number of these residents had located in Redvers specifically for acute health services — health services now in jeopardy, they believe, in a health centre paid for locally and now to be possibly obliterated by an outside and seemingly uncaring force. They foresee not only the loss of acute care but loss of investment, both in property and time and

in their chosen way of life. Many of those who are able are already discussing the possibilities and cost of moving to where services meet what they may need in the future.

Lately, we have all heard government reps claim they aren't going to close hospitals. But think about this: if you take away the foundation, the building will collapse. In this case, the community is the building and the hospital is the foundation.

A doctor at this very same town hall meeting made this statement:

> A doctor without a hospital, x-rays, laboratories, and without a pharmacy is no better than any primary care worker. For a doctor to work without auxiliary medical services, not being able to admit patients or relieve physical needs, (and also) to get x-rays, would be a frustrating job. Doctors will leave. In this way, they will kill rural Saskatchewan.

This quote and aforementioned interview not only gives credibility to our fears, but verifies our deepest concerns. Doctors want to grow. We as a chamber wish to grow, and the town wishes to keep growing. If the basis for this new growth is removed, there's only one direction we can go. There are only so many hurdles rural areas can jump before they hit one.

Attraction devices that we as a chamber may access when trying to bring in new businesses are few and far between. The largest device we have by far is our hospital. When a potential business prospectus is being done, in every case and without exception, health care and acute care are among the main ingredients.

Yes, we would still maintain health care for a while, but without acute care the writing is on the wall. And that writing is that acute care is just too far away to get really serious about long-term investment and a potential retirement home.

We presently have 320 students in our school. And the main priority is to make our area attractive for at least some to remain and work at home.

Redvers recently established grass greens at the local golf course and this is already attracting tourists. Redvers houses a sports complex many large centres would envy. Our town recently boasted a parade at the community fair a small city would be proud of. Redvers is an innovative, vital and vibrant community.

As a chamber we are proud of our town and the many organizations and private citizens that came here today to try and protect it speaks of that pride. We ask only that government not be a part of any destruction process to that pride. Let us not forget the destruction has been the result in other towns when acute care was removed.

We aren't special. This will happen to us also. If acute care goes, doctors will leave, people will follow, businesses will suffer and the whole reason for investing and staying at home loses its shine. Yes we will still have the safety of rural Saskatchewan, the fresh air and maybe even some community spirit. Eventually though, as age gallops up on us, health care and acute care take priority and communities will decline and disappear.

If you look at the enclosed map — it's at the back of this submission — you will see a blue circle which encompasses our business area. The green circle represents the golden hour, something we've all heard of. The golden hour represents lives, something which has been neglected in the Fyke report. It's also been neglected in submissions entered by the various factions in health care that endorse the Fyke report. And we are not here today to condemn the Fyke report in its entirety, but we most certainly condemn what it wishes to do to us in the health service field.

Should this report be implemented as is, many areas within that blue circle — the business circle — will be beyond two and three hours from acute care. That precious golden hour is so far gone that a dispatcher had better send the hearse, not the ambulance. Whomever mentions time in their submission today, take note because the time factor cannot be stressed enough today. Human cost is going to be a certainty.

In the Throne Speech recently, a portfolio was announced that spoke of rural revitalization. Well there's nothing, absolutely nothing the government can do that would be more negative to rural revitalization than systematically cutting the acute care from all rural centres. There's nothing government could do that would hurt the rural Saskatchewan spirit more than adopting this portion of the Fyke report.

Urban citizens have no idea how this will affect them. No thought was given to the congestion that would take place in an already overcrowded atmosphere at urban hospitals.

As a chamber of commerce, we have the benefit of the whole district at heart — every organization here intersects and interacts with each other, working as a team. We have to — in rural areas — have to work like this to survive. We see nothing in this report that could benefit rural Saskatchewan.

In the report, it states enhanced health care. Enhanced health care — what is that? It's a word empty of meaning when it doesn't pertain to everyone. We talk about equality in health care. Many of our citizens unable to move or unable to leave financially will be the first victims here — human casualties in a regressive move nobody thought to think out. There's nothing equal where a traumatized patient has to spend their life savings commuting for help over long distances and on roads unable to sustain the traffic we have now.

Money, it is said, was not a deciding factor in implementing or whether you implemented the Fyke report or not. If this is true, then this part of the Fyke report should be eliminated. If money is the deciding factor, maybe it will save money in the end. But only because deceased citizens cost less to care for than sick or injured citizens. And there will be casualties — many of them.

In closing, our town attracts business from a large area, a unique area, an area located far from any large centre and over atrocious roads. Our acute care facility is new, fully equipped, and locally funded. Nobody is asking government for money to fund this centre, which handles approximately 7,000 separate caseloads.

As a chamber we are tremendously concerned, not just economically but mostly for the welfare of our residents, families, and the people too poor or ill to travel for help. We hope we are able to give you some insight into that concern today.

If you have any questions, Joan or I would be happy to respond. Thank you.

The Chair: — Thank you. We're going to save the questions till the end. We're going to save all our questions to the end. And you missed your third presenter, introducing.

Mr. Ewart: — Good afternoon, committee members. My name is Larry Ewart and I operate Courage Resources, an oil field production and management company consulting in southeast Saskatchewan. I appreciate the opportunity to express the concerns of the oil field industry in our district in regards to the changes proposed in the Fyke report.

I have contacted the RM (rural municipality) administrators for the RMs of Walpole, Mount Pleasant, Antler, and Reciprocity in order to gain an accurate count of oil facilities in the area. Walpole has 515, Mount Pleasant has 576; Antler, 258, and Reciprocity, 1,260.

There are over 2,600 facilities in our immediate area. The industry requires the service of foremen, operators, tank truckers, and service rig personnel for maintenance. I estimate there would be 60 service rigs operating in this area. There would be in the vicinity of 16 to 35 drilling rigs in this district, each employing around 16 men.

The industry also involves maintenance and construction crews, surveyors, and consultants. You can see the industry provides employment for well over 3,000 people in our area and adjoining districts.

The employment I have mentioned are jobs which could involve serious injury, where time is of the utmost concern — falls, H_2S (hydrogen sulphide) gas poisoning, burns, etc. An accident would probably happen in a location miles from the rural hospital, let alone from an urban centre.

This is a high-risk industry and I am very concerned that any reduction of service would put our employees in a position of reduced protection.

We have a strong industry base in southeast Saskatchewan and good jobs available. Young people are prepared to move here for employment; however, employees are not interested in moving to an area that will not be able to provide essential medical services for their families.

Employees presently living in Manitoba are not encouraged to relocate. We need these families in our communities to sustain our schools, our churches, and our cultural and recreational programs.

Another spinoff is employment made available for spouses when our nursing homes and hospitals are maintained.

It is my opinion that with the proposed recommendations in the Fyke report there will be a transferral of medical costs from the health care system to the individual and the employer. Rural areas will suffer considerably more than urban areas.

And if an employee or a member of their family is required to see a physician in a distant urban centre, it is necessary to take off the entire day and possibly the next day in order to make the trip and look after the appointment. The employee will suffer a loss of pay and the additional cost of travel, food, and lodging. This creates financial and emotional stress. As an employer, I must absorb the cost of lost time.

Persons with relatives requiring hospital care are not able to slip in and visit their loved ones after a day's work.

Saskatchewan has a reputation for their generosity and volunteerism. People of the community of Redvers and district have put their hearts into their hospital. I do not believe this kind of commitment will be transferred to a centre far from home.

In closing, I would share my personal experience and how important it was to me that fast quality care was available. I had the misfortune of being involved in an oilfield accident involving an explosion and fire. I was working on a site in a remote area. My face was severely burned, especially my eyes. Somehow I managed to drive myself to a rural hospital where my injuries were tended to immediately. My eyesight was saved because help was so quickly available.

I know it will be a challenge to continue providing medicare as we know it. Our provincial government encourages rural revitalization. This would encompass jobs, education, and health care. We are fortunate to have the jobs with both agriculture and the oil industry. We have the education facilities with both an elementary and high school in Redvers. We also have the Redvers Health Centre, an excellent new facility.

Will it not erode the formula for rural revitalization to remove one of these three core elements?

Thank you for considering these concerns.

The Chair: — Thank you very much. If you want to bring the next presenters forward?

Again, if you could just introduce yourself and what you represent from the community.

Mr. Eberl: — Good afternoon, Madam Chair. My name is John Eberl. I'm secretary-treasurer of the Redvers Health Foundation and a rural municipal administrator. With me is Pat Branigan and he's the Chair of the Redvers Health Foundation, and a rural councillor as well.

The Chair: — One other thing before we get started. You gave us a fair amount of material. If you have a written presentation, instead of us thumbing through looking for it, if you could hold it up and we could find it quickly. Just hold it up and we can recognize it from our pile. Okay. Good.

Mr. Eberl: — Well, Madam Chair, I was going to say good afternoon committee members left, right, and centre, and I

guess I'll still say that.

Firstly, I'd like to take this opportunity to thank two of the members of the committee for travelling out to Redvers to see first-hand what we're experiencing out there and that's Andrew and Brenda. Thank you very much for coming. We really did appreciate that. Thank you.

We'd like to talk to you about the impact of implementing the recommendations of the Fyke report on our rural health services. And in order for you to grasp the situation relating to health care services delivered to the residents of Redvers and the surrounding communities, and in order for you to understand the deep-rooted feelings of the residents who are faced with losing reasonable access to health care services, we'd like to begin by telling you about the unique relationship that the Redvers and District Community Health Foundation, the foundation, has with the local health district regarding the delivery of the aforementioned services.

The health foundation was formed at the same time as the transition from the old Union Hospital districts to the larger health districts took place around 1994, 1995. In the case of the Redvers Health Foundation — our foundation — seven municipalities, a town, three villages, and three RMs that made up the Redvers Union Hospital district joined together to form a non-profit and charitable corporation.

To start with, the foundation was transferred a pool of funds by the Union Hospital Board shortly after its inception. And that pool included accumulated surplus monies of the hospital board — surplus that they'd accumulated — money that had been raised through fundraising efforts targeted towards facilities in Redvers and district over the years, and other monies. And as well, money that was being contributed to the Union Hospital Board by the municipalities — there was a municipal levy at the time strictly for capital purposes — was eventually turned over to the foundation.

And finally we were given title to a home in Redvers, formerly owned by the Union Hospital Board, a doctor's residence which some of the rural union hospitals had owned and we eventually sold that.

Between 1995 and 1997, a great need was recognized in that replacement of the old Union Hospital building in Redvers was necessary. It was also recognized that if a new health centre were to be constructed, it should be physically integrated with the existing long-term care facility in Redvers.

Discussions were entered into with the Moose Mountain Health District, which is the district we are within, and applications were eventually submitted to the Capital Fund branch of Saskatchewan Health.

When it became apparent that no financial assistance would be forthcoming from either the provincial or federal levels of government, the foundation and the health district made the difficult decision to proceed with the construction of a new health centre using only existing funds of the foundation, which was accumulated surplus and fundraising monies only, and the commitment of the municipal members of the foundation to contribute to the cost.

Construction of the facility was completed in 1998; not very long ago. Grand opening day was October 10th, 1998. And Mrs. Junor . . . Madam Chair, you attended there and helped us open that. We thank you for that as well.

The facility is fully licensed by Saskatchewan Health through the Moose Mountain Health District. The health centre includes acute care facilities, medical clinic, lab and X-ray space, visiting professional space, local administration office, space for community-based health services such as public health and physiotherapy. And as stated before, the health centre is physically integrated with the Redvers Centennial Haven, the long-term care facility. And this allows the health district to integrate its operations and save costs by economies of scale and non-duplication of services.

In round figures, the funding for the . . . it was a $2.2 million project to build the new health centre attached to the long-term care home. And we had existing funds of the foundation to the tune of about 680,000. We directly raised via canvassing the community $450,000 — an amazing amount for a community our size. Municipal grants to the foundation prior to construction totalled $230,000. And amount borrowed to complete the project, $840,000. As I said before no provincial or federal money is in there.

At this point in time approximately $665,000 is still outstanding on the construction loan. Municipal grants from the six member municipalities of the foundation, totalling 133,000 per year, basically make the payments on the loan, and important to note that the final payment is not due until December of 2006.

Why are we taking the time to tell you this story? Well we believe that it may be unique that local people in municipalities — with budgets stretched paper-thin already — have committed to the entire cost of the construction of a health centre. And we believe that this commitment shows the importance of access to decent health services to the residents of our communities. We believe it shows that people know that they can't afford to lose the basic services we now have access to in terms of both financial and human cost, and we believe this commitment shows the need felt by local citizens for a long-term commitment to emergency and acute medical services.

The next section is entitled, "Aging, Access and Industry — Key Points for our residents." Demographically in rural Saskatchewan we are faced with the problem of aging. Our rural residents are aging, and our roads and highways are aging.

Recent discussions with Saskatchewan Highways and Transportation indicate that they have to look upwards of a 60-year lifecycle for some of their highways — and that's 60, not 16 — before they can replace the highways. Rural local governments in Saskatchewan have budgets that are stretched to the max also. Roads and other forms of infrastructure are suffering. The population trend, the aging, combined with the aging of the roads leads to a problem of accessing services for us.

The following is a quote from the final report of the Commission on Medicare which is attributed to public dialogue from the year 2000:

> Travelling to Regina or Saskatoon is not always an option. Some people can't afford it and have no means of arriving there. Rural Saskatchewan is left out in the cold.

If access to physicians, acute care, and other services is removed from rural centres, the problem of access to health services for all residents will be greatly magnified. Long distances, poor roads, prolonged and unpredictable winter weather means that quick access — or any access in some cases, as you'll hear later — to necessary services is often difficult and not guaranteed.

The map that accompanies this, at the back, shows the possible scenario for the residents of our municipalities if the recommendations of the Fyke commission were implemented. And as you can see, the closest centres are one and a half hours away at minimum, and that would be Brandon and Weyburn and Estevan. Those are the closest centres that the residents of our district are. And some of that travel I think is — as Andrew can attest to — is over some pretty poor highways. Much of this travel would be on secondary highways and rural roads.

On behalf of the people of our community that we represent, and all the rural communities, we question whose money will be saved or who will have access to the enhanced services supposedly gained via this proposed consolidation of services. Certainly we will be the losers if the commission's proposals are implemented.

It's our belief that some of the health services offered in rural centres should be enhanced rather than categorized and restricted. Why not allow the health districts the opportunity to globalize budgets and offer the services they feel are necessary from their rural health centres? Nurse practitioners and 24-hour telephone advice services, with all due respect, do not replace physicians, on-call emergency services, and other basic necessary services that we now have access to.

We understand that dollars are hard to come by — very much so — in providing health services to all the residents of Saskatchewan. We know that's a problem. However, consider the added financial and human cost to the rural residents if some of the consolidation recommended in the Fyke report takes place. The efficiencies that may be realized shall have an exponential cost to rural residents.

And I refer to a recent *Maclean's* magazine where the Hon. Roy Romanow . . . and the quote is:

> Concentration of services creates access problems for rural regions but it allows for better services.

But I think the key there is access problems for rural regions.

The province has recognized the need for rural revitalization. The catchphrase of the day is diversity. This means we need to attract more and different industry to our district.

Currently the two main industries in southeast Saskatchewan are agriculture and oil and gas. The nature of both of the industries is that they take place over a widespread area, not concentrated in one place. For example, an area around the community of Redvers measuring 25 miles by 30 miles, 750 square miles, contains nearly 2,000 oil and gas properties, as well as a minimum of 3,000 individual agricultural properties. In order to serve the people that work these properties, we need to provide access to health services for them and their families.

Also how do we diversify and attract new industry to communities that offer no or reduced health services? Often access to basic services is high on the list of criteria for new or relocating industry and their employees, as Mr. Ewart explained. We need to sustain the basic services we now have in order to participate in rural revitalization.

In conclusion, by telling you this story of the funding of the Redvers Health Centre, no provincial or federal government monies, and telling you of the concerns and problems facing rural residents of our district, we hope we have impressed upon you the importance that accessing basic health services, without having to travel huge distances, holds for us.

We hope that we have impressed upon you that we need the support of the province in helping to revitalize rural Saskatchewan, and that means not reducing the basic services, and they are basic services in health care that we now have access to.

We hope that we have impressed upon you the lengths that our citizens and our local municipal governments will go in order to ensure our residents have access to these services. And we hope we have impressed upon you that we are providing an essential, basic, and accessible service to our residents without straining a system that seems to be constantly overworked and attempting to operate at 150 per cent of capacity.

Please hear our concerns.

And as we spoke prior, Madam Chair, we'll be happy to answer questions later on if there are any. Thank you for the opportunity.

The Chair: — Thank you. And as I said, we'll keep the questions till the end.

I just wanted to observe for the record that one of our members from the committee, who isn't able to be here today, also went to Redvers. That was Warren McCall. And he did say to pass his regards on to you.

Mr. Eberl: — I understand that he's out of the country right now, yes. Thank you again.

The Chair: — Good afternoon, task force. Is this the task force? And when you're speaking, you'll have to share the mikes on the little box so you'll have to get fairly close to them.

Ms. Pederson: — Good afternoon, ladies and gentlemen. My name is Myrna Pederson. I am the manager of health services at the Redvers Health Centre. On my right is Pat Alelunas, a registered psychiatric nurse who works in long-term care at Redvers Health Centre. On her right is Dianne Blezy, the charge nurse for the Redvers Health Centre. And at my far right is Veronica Matthewson, who is a chamber of commerce member that sat on our committee. And on my left is Jacquie George, who is also a chamber committee member.

This is the Redvers Health Centre task report which is presented in order to maintain essential health services in Redvers. First of all, there are several positive points I would like to indicate regarding the Fyke Commission report.

These are: (1) the formation of the quality council which will commit to improving quality in health care; (2) an improved plan for the drug sector; (3) continuation of development of performance indicators; and (4) establishing primary health services using the team approach.

Quality health care in Redvers started in 1948 when the Redvers Union Hospital was opened. The Centennial Haven was built in 1967 to provide long-term care for our elderly. Our integrated health care centre was built in 1998, which was privately funded. It has maintained a valuable and reputable service to a large area through the hard work and expertise of physicians and health care workers.

Because we have had stable physicians over the years, we are able to maintain our continuity of service in the area, which brings patients from far and wide. We had a doctor who just passed away this last February who had been there for 25 years, Dr. Eleanor Pesenti.

Statistics from Redvers Health Centre indicate increased, improved service in most areas, using statistics from the last three years. You can refer to appendix B in the summary for this information.

Our average daily census as of March 31, 1999 was 6.28. As of 2000, it was 6.06, and as of 2001, it was 4.90. The above stats indicate there is a decrease in the average daily census. This proves we are better utilizing our team approach for services in health care at Redvers.

The Redvers Health Centre is a well-equipped facility with up-to-date diagnostic and emergency room services. We provide a comprehensive service of team-based delivery of primary health services, which Kenneth Fyke recommended.

We presently provide the following services. You will find a detailed documentation about each service in your written report. Because of limited time, I won't be able to review all these details with you, however, I trust you will take the opportunity to review this later.

We have diagnostics — lab and X-ray services. Redvers Health Centre has a fully accredited category V licensed laboratory. We have been enrolled in the College of American Pathologists quality assurance program and have maintained a certificate of excellence since our enrolment in 1991.

We have a modern radiology department, which is accredited, and participates in a quality assurance program. We operate according to The Radiation Health and Safety Act and all radiographs are interpreted by a radiologist with a written report.

We have minor emergency room outpatient services, dietitian services, physiotherapy, mental health, public health. We have a palliative care program and an alcohol and drug program. We provide pastoral care, home care, and wellness clinics which were started in August, 1998.

We have a volunteer coordinator. The role of this person is to obtain volunteers for health related activities in Redvers and area. We have a local volunteer ambulance service. As was said before, we are at least one and one-half hours from a major city that can provide advanced care to our patients.

We have EMO (Emergency Measures Organization) services provided by the Redcoat Mutual Aid. There is a well-developed emergency plan in place in our area which includes the town of Redvers, the villages of Antler, Storthoaks, Bellegarde, Alida, and the RMs of Antler, Reciprocity, and Storthoaks.

Our integrated facility utilizes our EMO to provide us with assistance in the event we had to implement our emergency disaster plan; for example to evacuate from our Redvers Health Centre in the event of an internal or external disaster.

We have the services of an adult speech pathologist and a diabetes educator. This reflects a multidisciplinary service with many visiting professional services who focus on health promotion and disease prevention. We have a visiting professional office on site for visiting professional use.

The medical clinic is adjacent to the hospital. We have had the services of two physicians in the past, and have just recently acquired a third. The complement of medical staff we now enjoy as of June 1, 2001 is one male and two females.

We have an excellent private pharmacy service provided locally.

There is one point of entry to our health service which makes it easier to access quality care the patients and residents need. The community and surrounding municipalities feel that because of the great distance to other larger centres such as Regina, Brandon and Estevan, the local population is best served by coordination and maintaining these essential services in Redvers, therefore providing service in conjunction with the principles of reasonable accessibility to all members of our health district, and the Canada Health Act, which requires public funding for almost all services provided by physicians and in hospitals.

The Redvers Health Centre is an integral part which serves a stable agricultural population, oil and gas companies, businesses, and as an excellent location for seniors to retire. Economic diversification includes many new businesses to augment the older existing ones. Examples are listed in your written report.

With agriculture diversification on the rise in our area, along with oil development, there is potential for future growth. Emergency services must be maintained and available at all times for any type of accident. Some of the oil companies involve high hazard work areas, which require a medical facility and/or emergency service in close proximity 24 hours a day.

The area we serve at the Redvers Health Centre has a population base of approximately 8,500 people. This includes the following areas: the town of Redvers, Antler, Storthoaks, Alida, the RM of Reciprocity, Antler, Maryfield, and the RM of

Storthoaks.

Patients are also seen from Arcola, Carievale, Carnduff, Carlyle, Fairlight, Gainsborough, Manor, Maryfield, Oxbow, Wawota, Parkman, Kenosee Lake residential area, as well as Saskatchewan tourists just travelling by on two main highways that join at Redvers, No. 8 and No. 13.

Our area is surrounded by four First Nation reserves which are Pheasant Rump, Ocean Man, White Bear, and Pipestone. We have a Mennonite population in Cromer who travel to our facility to seek medical attention as we have on staff two female general practitioners.

During the summer months, the number of people who may require our service increases significantly because of the recreational facilities at White Bear, Moose Mountain Provincial Park, and tourists visiting the Red Coat Trail. The log cabin tourist booth registered 4,000 Canadian and American visitors last year, and 5,000 the year before.

The reason for this decline in tourism is the poor road conditions along Highway No. 8. This highway was recognized as the third worst highway in the province of Saskatchewan in 2000.

We have 11 schools we provide health services to. These are Redvers, Manor, Bellegarde, Storthoaks, Alida, Gainsborough, Carievale, Maryfield, Carnduff, Cromer, and Reston, Manitoba. We see an average of two children per day in the emergency minor room at Redvers Health Centre from Redvers School alone.

In the last three years our Redvers Health Centre has served over 1,600 out-of-province patients from Manitoba. These patients live in communities such as Reston, where there is no longer a hospital and no acute care services offered; Sinclair; Melita; Cromer; Virden; Kola; Tilston; and Pierson.

Out-of-province statistics for out-patient services are listed below — basically these are from Manitoba — as of March 31, 1999, there were 495; of 2000, there were 504; of 2001, there was 611.

As you can see we have experienced a 23.4 per cent increase in providing care to residents of the province over the last three years. This has contributed towards our medical clinic obtaining the services of a third physician.

Appendix A of this report was prepared for the Moose Mountain Health District by Doug Elliott from *Sask Trends*. It shows the population projection on a regional analysis ignoring in- and out-migration from 1996 projected to 2016. As you can see, the population base is remaining steady.

The increase in services we are seeing is a result of catering to a larger service area. These people, for the most part, are from Manitoba. It must be noted here that these clients are accounted for in health services funding though it may be 18 to 24 months before you receive the funds back from the Manitoba government.

These clients are not accounted for in the Saskatchewan provincial population base. This adds to the operational side of the budget but not to the statistical side, which is used for developing local service programs.

We have many examples of incidents where acute care, close proximity to ambulance services, and diagnostics are required in order to save and preserve quality of life. These will be presented in a separate presentation.

If the recommendation of the Fyke report were to become a reality, our people in need of acute care services would have to travel 250 kilometres to Regina, 160 kilometres to Brandon, or 160 kilometres to Estevan, or 300 kilometres to Yorkton if the Redvers Health Centre did not provide acute care services. This distance travelled would be over roads previously noted to be in deplorable condition.

Many times you would see these people migrating to Brandon, Manitoba which is only one and one-half hours away instead of going to Regina, Yorkton, Weyburn, or Estevan. Many times in the winter the weather conditions are less than ideal to be travelling because of icy roads and blizzard conditions.

The required travel distance to other larger centres from Redvers makes this area unique in its needs. Rural residents must not have one level of health service and urban residents another. We are not second-class citizens in Redvers.

Some folks cannot just pick up their belongings and move on. These same people have made their homes in Redvers because they were close to quality health care services.

Ambulance response and travel times, depending on weather conditions, increases or decreases the time to arrive for emergency services to an acute care facility. When major trauma happens with life-threatening situations, such as heart attacks and accidents, health care workers operate in the golden hour for trauma. This time is very limited and very precious. Early intervention will decrease disability and further dependency on our health care system. Acute care services at Redvers must be a priority.

In the last needs assessment report for 2000-2001 done by the Moose Mountain Health District, concerns have been identified which contraindicates the recommendations in the Fyke Commission report. These concerns are itemized in your full written report.

This same needs assessment wanted to know what people in Moose Mountain Health District were most afraid to lose from their health system and why. This report is also in your full report.

Our proposed management plan is, number one, we need to maintain acute care services which will have beds occupied for at least 72 hours. Physician services are required for assessment and diagnosis, treatment, coordination, and referral. Preservation of health services in this area will not be possible if there are not enough support services remaining to attract and/or maintain physicians.

We need 24-hour nursing care with resident physician contact. Nurses must be skilled in assessment, trauma stabilization,

cardiac and respiratory care. Service to long-term care residents is required when these people are experiencing an acute illness. If you were to have no resident physician, you would soon lose your long-term care clientele as family members would not be keen on admitting their loved one to a home with no resident physician.

We must have 24-hour emergency/minor room examination and treatment available. Our nursing staff are presently triaging patients through skilled assessment for the physicians at the physicians' request.

We must have diagnostic services. Staff needs to be available for 24-hour call. We need to be licensed to perform on site all diagnostic tests which are essential for the acute care of patients and for the effective medical practice of the physicians in the Redvers medical clinic. Our X-ray technicians must be qualified to perform basic radiology as requested by the physicians on staff and referring doctors.

These essential services allow us to keep our three physicians, which is the minimum recommended number according to the Fyke report.

Number five, we must have long-term care beds. We need the new 32-bed, long-term care facility we are presently planning for. We are number three on the provincial capital planning priority listing. Once this facility is built, we would have room for expansion of programs; for example, the adult day program.

Number six, we need a developed adult day program to bridge the gap from home care services to long-term care services and to make transition from adult day program services to the institutionalized service much less traumatic for our clients. This will ensure these clients have socialization, nutrition, good health, spiritual support, and medication checks.

Number seven. We are the only facility who deliver newborns in the Moose Mountain Health District. The number of deliveries has remained fairly stable in the last three years. As of March 31 of '99, we had 15 deliveries; as of March 31, 2000, we had 12; and as of March 31, 2001, we had 14.

We must be able to continue to deliver newborns. This is essential because of the distance we have to travel, the poor road conditions, as well as the inclement weather conditions during the winter.

We must provide a chemotherapy program for our residents who are undergoing treatment for cancer. This is a very traumatic time in the life of the patient, as well as that of their immediate family. Treatment and support has to be available at the local level, which includes accessibility to diagnostics.

Number nine. We must be able to provide service to patients who have received surgery in the larger centres, who need somewhere to go for convalescent care, post-surgery.

Number ten. We must be able to provide immediate, emergency services for the Redvers Activity Centre clientele who are mentally and physically challenged. We are pleased to say that there have been great strides taken in making . . . integrating these services between the Redvers Health Centre, the Redvers Activity Centre, and the Town of Redvers Handi Bus Service, enabling us to provide for better health care arrangements for special-need clients.

We have recognized services and have not considered costs on a per diem basis . . . or per capita basis, I'm sorry. In our rural area we must consider a reasonable area as far as distance from services concerned, that these services are provided in a timely manner, and that the quality of service is first class.

The Fyke Commission report indicates containing costs is not in itself the goal of the primary health service network approach. The goal is to use health resources, both human and financial, to the best effect. We feel there is value for money spent in health care services here in Redvers.

Areas of concern we have are:

Number one. If we need to see a physician or a specialist in the larger centre, this may not be possible as these professionals are almost always booked up. We presently have a hard time getting in to these doctors. Many of these physicians are not taking new patients. Waiting lists are long now and they will not get any better if the Fyke Commission is adopted.

We are facing a shortage of nurses and medical staff at the moment in Saskatchewan, and it will definitely take time to get more staff trained.

Number three. With the closure of acute care rural facilities, major capital funding will be required in urban centres to meet the need of the additional acute care influx. At present, regional hospitals cannot handle the volume of patients from the rural area.

Number four. If the Fyke Commission report is adopted and there is closure of rural facilities, major restructuring takes place. There will be health care services based in three large centres. This would be like putting all your eggs in one basket.

The future strength of unions could cripple our provincial health services in the event of a strike, with no backup of doctors and/or health care workers in rural Saskatchewan.

There are patients being discharged home from surgeries too soon. Some of these people are not able to cope. There is a need for convalescent care, thus a need for these beds in the rural area. We can't supply this service without doctors, advanced clinical nurses, or registered nurses.

Convalescence care is provided in rural areas at a much-reduced cost as compared to the cost of providing this in the city.

Number six. The Fyke Commission states that the program is to provide no reduction in services to the rural people. We will definitely see a reduction if we have to travel in excess of 90-plus minutes for acute care services as opposed to 30 minutes at the present time.

Presently, 95 per cent of the Moose Mountain Health District population is within a 30-minute or a 30-mile radius to acute care, long-term care, and/or community-based services. Perhaps this 90-plus minute time frame should be reduced to 60 minutes

so service could be provided in the golden hour of trauma.

Number seven. There is an inherent problem in the funding formula for the long-term care beds in the rural area. Until this problem is corrected, we will always be over budget in providing long-term care services in the rural. This must be addressed.

We have a huge waiting list for long-term care beds. There are 66 people on our placement list in the Moose Mountain Health District as of mid-June 2001. This puts an unreasonable demand on community-based services in our area. People shouldn't be expected to accept any wider long-term care placements than they presently are. They are far enough away from home and loved ones.

There is a proposal that ambulance services will be provided at a flat rate. This would be fairer to the rural people. However, there are many financial implications to family members of a patient, which must be considered, such as: lodging, meals, transportation, time lost from employment during an acute phase of a family member's illness. There is a human side to this. Rural people should not bear an unreasonable cost to obtain health services.

We must consider the financial, emotional, and physical impact on seniors with an inability to self-transport. We do not have a daily bus service. The lack of emotional and social support during illness while away from the home community increases stress and/or depression.

Number nine. We will have loss of autonomy when our health districts are made larger.

Number ten. The roles of the health boards will change. They will have a stronger planning role. Compassion may be forgotten.

Number eleven. A broader definition of the four categories of health services is needed. We need to know what services will be attached to each level of service for tertiary hospitals, regional hospitals, community care centres, and primary health centres.

Number twelve. People have chosen to retire into areas such as Redvers which they are comfortable with. These seniors should not be required to move again.

Number thirteen. If there is a change in government, we will have a change in the present political party who will again make changes to the health system. We will never, never get to a stabilized health service if changes of this magnitude continue to happen.

We in rural Saskatchewan are going to lose — and lose big time — if this report is adopted. We feel that this document and the records of the Redvers Health Centre demonstrate the need to maintain this facility as a 24-hour acute care integrated facility. Our team approach would fully meet the needs of the residents of our area.

Residents in Redvers are a community, not simply a collection of people. The health centre is an integral part of the stability of the area. The Redvers Health Centre provides a basis of security for this population. It helps to meet financial, social, and health needs of the community.

To fulfill the government's promise for the preservation of rural Saskatchewan, the health services for our population base must be maintained. Redvers Health Centre must be kept functional. We must be allowed to continue to provide acute care services with appropriate diagnostics using our present team approach. We are more than what Fyke envisions as a community care centre. This system is working well for us.

Thank you very much on behalf of the committee for the consideration of this report.

The Chair: — Thank you very much for your presentation . . . (inaudible interjection) . . . I was going to say we figured that out real quick. Thanks.

So again, if you could introduce yourselves and who you represent.

Mr. DeGagne: — Good afternoon Chairperson Judy Junor, and other members of the Saskatchewan Legislative Assembly gathered here today regarding the Standing Committee on Health.

My name is Alain DeGagne, volunteer emergency medical responder or an EMR with the Redvers Health Centre Emergency Medical System or EMS and the general manager of the Redvers Co-Operative Association Limited.

With me today is Jocelyn Bedecs, emergency medical technician or an EMT, first responder instructor, and our EMS coordinator. And Paulette Godenir, an EMT with our Redvers EMS.

This is the Redvers EMS ambulance service task force report which is being presented in order to maintain or expand essential health and ambulance services in Redvers.

For over the last 40 years in Redvers we have operated a volunteer ambulance service on call, working 24-hour shifts, 7 days a week, 365 days a year. Today our schedules are created monthly, as requested by our personnel, for the days we want to volunteer. Only days we can fit around our primary jobs and personal lives are donated.

We participate in training sessions every two weeks in order to keep up our skills and education to meet provincial qualifying standards for the EMS. We currently have four EMRs on staff and three EMTs, whom are casually employed by the Moose Mountain Health District.

Ambulance service is provided to the following communities, with an approximate population of 8,500 residents. The area we cover, however, spreads over an estimated 800,000 acres. These include Redvers, Alida, Storthoaks, Manor, Wauchope, Parkman, Bellegarde, Antler, Fertile, White Bear First Nations, rural municipalities No. 61 Antler; Reciprocity, No. 32; Storthoaks, No. 31; and two divisions of the RM of Maryfield No. 91. We have also provided ambulance service in the last three years in conjunction with Arcola, Moosomin, Weyburn,

Yorkton, Oxbow, and Sinclair, Manitoba.

As you can see, we have a vast area to cover, and being taught the one hour golden rule makes us unique to the rest of this province as the aforementioned communities are at least 90 minutes or 160 kilometres, depending on weather and road conditions, from any major urban health facility, and are as much as 180 minutes, or three hours, from Regina.

Our health facility and ambulance service is in the middle of these communities. We have a team in place who are available to meet the entire continuum of patient care, treatment, and transportation when an emergency situation arises. The Redvers ambulance and health facility is crucial to our residents' survival.

I am sure you are aware of the urgent necessity of stabilizing the casualty being of utmost importance before the effective transferring to a major urban centre, and in our case, this would either be Regina or Brandon, Manitoba.

Over the last three years, we have driven our ambulance on 403 calls. We're averaging over 134 per year, travelling in excess of 100,000 kilometres.

Of these 403 calls, 60 of them or 14.8 per cent were trips made into the province of Manitoba; 57 of these were to Brandon. The hospital facility in Brandon is well equipped to handle emergencies and maternity cases. Brandon is much closer than Regina and Highway No. 2 and No. 10 are in much better condition than our Saskatchewan roads for safe driving. The remaining three of the 60 trips were to Winnipeg's Health Sciences Centre and the Grace Hospital. These ambulance trips in Manitoba have generated $7,500 in revenue towards our EMS service.

One other ambulance trip was made outside the province to Minot, North Dakota with a maternity case during a blizzard when all north, east, and west roads, highways, out of Redvers being closed.

Between April 2000 and March 2001, 73 of our 130 calls or 56 per cent were either serious or life threatening. — and that I would refer to this page that's included with your document. These are categorized as a code 4 by 911 dispatch.

In November 2000 an EMS development project report was submitted by Richard Keller and James Cross, MD (Doctor of Medicine) to Hon. Pat Atkinson, former minister of Health, and yourself, Madam Chair, Judy Junor, associate minister of Health. Mr. Keller and Dr. Cross suggested 24 system improvement opportunities to the Saskatchewan EMS system of which over 20 per cent are operational issues for the ambulance service of the future which will be decided at provincial level.

Eighty per cent of the recommendations are, however, already part of our day-to-day operation and procedure in Redvers.

I am about to comment on each of Dr. Cross and Mr. Keller's recommendations.

Recommendation number one was to establish emergency ambulance response target, time targets. These are reasonable and can be met in the summertime. However, road conditions such as construction and resurfacing and weather conditions in hazardous environments can and do impact our response time. To achieve a response time of 30 minutes for 95 per cent of our emergency calls is reasonable only because we are integrated with our health facility and are centrally located within our service area.

Number two: establish basic EMT and EMR as the minimum ambulance crew staffing level. This is a reality in Redvers even with our volunteer system. The only hurdle is the matching of the personal schedules and work. The solution to this recommendation would be the expansion of duties within our health centre as three of our volunteer ambulance personnel already have positions within our health facility.

This would create primary, not secondary, positions for our EMS personnel achieving a stable, normal course of operation for our EMS.

Number three is to develop plans to increase clinic certification levels of personnel on ambulance to EMTA and EMT, particularly in the rural and remote areas. We have at present three EMTs and four EMRs; one of our present EMRs is enrolled in the EMT course and should be an EMT by January, 2002. One of our three EMTs is enrolled in the EMTA course in January, 2002, and will continue her upgrading of skills.

We have on staff one EMR first responder instructor who teaches new skills and updates all ambulance attendants of new or revised techniques and protocols every two weeks.

Two of our personnel on staff have their CPR (cardiopulmonary resuscitation) and first aid trainer certificate.

Recommendation number four was to create one central dispatch centre for emergency medical services and medical transportation request. Our current method of dispatching emergency calls is 911.

Number five, create a provincial ambulance fleet. We are a part of Moose Mountain Health District with a 1998 Crestline ambulance with 92,000 kilometres and could qualify for the provincial fleet.

A portion of our volunteer services and service duties includes taking turns at checking regular maintenance operation of our ambulance as none of us want to get stuck out in the cold with a flat tire or a broken belt.

In our minds, Redvers ambulance could service the surrounding areas presently being serviced by Wawota, Maryfield, Carlyle, and Redvers, with the ambulance base being attached to the Redvers Health Centre.

Number six, with the centralized non-emergency inter-facility transportation services at locations proximal to receiving facilities. This discussion is a very interesting one as what happens when there are 10 or 15 inter-facility transfers at the same time from different communities within the South.

The logistics of this system seem to be challenging. Our proposal is to maintain our ambulance EMS in Redvers as a

fulltime 24/7 ambulance integrating our current employees into the health centre in order to provide the needed EMS for the residents within our area.

Recommendation number seven was to integrate air medical services into the EMS and medical transportation system. Air transportation is very challenging in southeastern Saskatchewan. We do not have an airstrip in Redvers for medical aircraft. There are custom aerial applicators in our area which have small airstrips of their own to serve their personal needs.

The closest medical airstrip is 42 kilometres away in Carlyle and is used very little in the winter as it is often snow-packed resulting in the closure of the airway. As we speak, there is a proposal in front of our local government to install an airstrip in Redvers.

If we were to compare the time involved between the air medical service and the Redvers EMS, between Regina and Redvers return, our EMS would reach Regina or the Pasqua in less time than the air medical service, of course under ideal road conditions.

Number eight was to locate ambulances in 67 core coverage areas for emergency response. We consider Redvers as a core service area with the quality of services we offer; and the team approach, we already have within a new facility built in 1998.

Number nine. Increase the number of full-time-staffed ambulances. We wholeheartedly agree with this recommendation. We could change from casual employees of the Redvers Health Centre to permanent employees working in conjunction with our health centre. Our duties could include working as nurses aids, housekeeping, laundry, scheduling, and clerical duties, as possible suggestions and additions to our job descriptions.

Recommendation number ten was to consolidate ambulance services in the South into 20 shared coverage areas.

Federated Co-operatives Ltd. had the Canadian Co-operatives Association do a survey for a bulk fuel plant they would want to locate in southeastern Saskatchewan. At the completion of the survey, it was decided to strategically place the twelve 90,000 litre fuel storage tanks two and a half miles west of Redvers in a core location. This bulk fuel plant would have the ability to serve the towns and co-ops of Arcola, which was 58 kilometres to the west; Carnduff and Gainsborough, 67 kilometres to the south; Wawota, 61 kilometres to the north; and 20 kilometres east, to the Manitoba border. This survey supports Redvers as the ideal central location for health and ambulance services, and illustrates the uniqueness of our service area.

Number eleven was to organize the consolidated, shared coverage areas into eight patient flow patterns. Real-life EMS in southeastern Saskatchewan and our flow pattern involves trips into the province of Manitoba as 14.8 per cent of our ambulance trips every year end up in Brandon or Winnipeg. Our ambulance should respond to 911 calls wherever they originate, be it Tilston or Cromer, Manitoba — reasonableness must prevail. We believe we have the EMS team and abilities to cover the southeast.

Recommendation number twelve was to fund EMS and medical transportation through a single EMS managing health district located in each of the eight patient flow patterns. Our response to that was as previously noticed in recommendation number 11, the province with the proposed flow pattern is the recognition of trips within the province of Manitoba.

Number thirteen. Require separate financial accounting of EMS medical transportation expenditures and revenues from the EMS managing districts and include performance requirements in the agreements with the districts. This is a provincial decision, however, we find no fault with this recommendation.

Number fourteen is to require EMS managing districts to employ administrators and coordinators to oversee EMS and medical transportation services in the eight patient flow patterns. This recommendation is already in place on a contract basis in Redvers. Our EMR instructor coordinates our EMS service.

Fifteen. Fund EMS activities based upon unit hours of coverage provided by ambulance services according to the overall EMS plan. Since we are a rural service covering 800,000 acres, our uniqueness should not be penalized and need to be compensated for the services we provide.

Calculation of the amounts of funds to be paid to our ambulance service should be based on the following combination of the cost of providing necessary coverage and adjusted for user-fee revenue generated through the service's operation.

Waiting time as recorded on the ambulance call report form does not accurately reflect true waiting time. For the period of April 2000 to March 2001, we logged six hundred and ninety-nine and a quarter hours on the ambulance. Of these six hundred and ninety-nine and a quarter hours, only 67 were accounted for as waiting time or nine and a half per cent. Within these 67 hours, four of 130 calls resulted in nineteen and a half hours of waiting. This represented 29.1 per cent of our total year 2000-2001 waiting time. If we factor these four calls out of our total waiting time, it gives us a net waiting time — on the remaining 126 calls for our ambulance — to 47 and a half hours or six and one-half per cent.

During these approximate 22.9 minutes, our ambulance personnel assisted hospital staff with emergency assessment and diagnostic procedures because of minimal hospital staffing.

Recommendation number sixteen was EMS managing districts should secure agreements with medical taxis. And our response would be: this is much better suited for urban centres. In rural Saskatchewan, the logistics and feasibilities of this recommendation make it unrealistic.

Number seventeen. Improve quality of continuing education courses and quality improvement activities. Our pride as a team of volunteer ambulance personnel does not diminish our enthusiasm to learn. We have two St. John Ambulance and CPR instructors presently on our team. We also have on our team, one person enrolled for the AED (Academy for Educational Development) instructors and BTLS (Basic Trauma Life Support International, Inc.) instructors' courses for upcoming fall 2001 and spring 2002.

And with the occurrence of multiple casualty accidents in the southeast over the last three years, the critical incidents stress training course will be attended by one of our EMTs this fall.

Number eighteen. Consider the results of the job evaluation process being led by SAHO (Saskatchewan Association of Health Organizations) in the future funding requirements of the EMS system. Employees in the Redvers EMS are involved in the SAHO job evaluation process for determining funding levels of emergency medical services.

Recommendation number nineteen was to establish all-inclusive rates for ambulance transportation. Excuse me. Even though this is a provincial matter, we agree with this recommendation.

Number twenty is draft appropriate legislation to accommodate changes in the EMS system. This is a provincial matter to enforce and support.

Twenty-one. Designate critical access plan areas in remote southern Saskatchewan, in the North, and develop integrated EMS plans with other health care providers and community resources to provide essential access to health services.

We are, in our opinion, your critical access plan to remote southeastern Saskatchewan. We have the team, the abilities, the resources, and the tools to be the extension of quality health care in partnership with our health centre. We are a first-rate ambulance service, centrally located in the southeast. Taking into account the flow patterns and into Manitoba, we are able . . . we are being realistic and are able to meet the expectations of our Saskatchewan EMS patients. Our pride in ownership ensures a quality and skill level of the emergency Redvers EMS personnel's ability, responding to any emergency situation.

Number twenty-two, encourage the development of additional first responder programs. We are fortunate to have a first responder trainer in Redvers as a part of our team and would encourage and support the development and promotion of a first responder program in each of our outlying areas.

Number twenty-three, provide Saskatchewan Health with the appropriate resources and implement the EMS plan and provide ongoing monitoring to the system. This recommendation is a provincial matter which seems very reasonable. Quality improvements and ongoing developmental training would only improve our EMS.

Twenty-four was to phase in the EMS system improvements over four years. With the investment in training, manpower, and development of a quality team in Redvers over the last few years, most of the recommendation within Dr. Cross and Mr. Keller's report are already a reality in Redvers.

With the provincial government's help, we could be compliant within two years of adopting Redvers as an EMS core area complete with full-time 24/7 staff, able to serve unique southeastern Saskatchewan within 30 minutes or 30 miles, 95 per cent of the time.

We have addressed and met 80 per cent of the recommendations made by Dr. Cross and Mr. Keller.

But another important aspect of successfully operating an EMS program in Redvers is the ability to work closely in conjunction with our Redvers' Emergency Measures Organization or EMO. We are very fortunate to have highly trained, competent volunteers manning this unit.

The Redvers' EMO response team is a part of the municipal fire and rescue services. They provide basic vehicle extrication, search and rescue, and emergency response to our service area. Whether our ambulance needs blocks, lights, jacks, spreaders, generators, the Jaws of Life or a Vacu Sled as provided by the Alida Fire Department for snowmobile accidents, our EMO unit helps us whenever called upon.

Together as an emergency team we strive to provide the best response we can in emergency situations. The partnership our ambulance service and EMO has with the Redvers health facility is truly amazing.

We are a mobile extension for medical services for the patients we serve and the residents of Redvers and surrounding communities. A true synergy is created from combining a first-class hospital facility, a well-trained, dedicated group of ambulance and EMO employees. To move or disband the EMS service in Redvers would have a negative impact to our 8,500 residents and the 800,000 acres we service. A life is too high a price to pay for relocation or consolidation of our EMS, north or west of Redvers.

With your support Redvers will be recognized as a core area of coverage with southeastern Saskatchewan realizing the uniqueness of our geographical location and proximity to the Manitoba, American borders and the distance to Regina.

Thank you for your time and attention.

The Chair: — Thank you very much. You can each have a mike. Welcome.

Ms. Blezy: — I am Dianne Blezy, the charge nurse at the Redvers Health Centre, and this is Dr. Greyling — he's representing the medical staff. Good afternoon, ladies and gentlemen, and thank you for hearing us this afternoon.

As I said my name is Dianne Blezy. I have been the charge nurse at the Redvers Health Centre for three years as a full-time position. And previous to this, I was employed as a staff nurse for 20 years.

In Redvers our health care facility cares for and treats a wide variety of people. From the elderly in our long-term care to the acutely ill on the ward, from day surgery, maternal and newborn care, home care, palliative care, and mental health, we do our utmost to provide quality care for all who enter our facility.

In the 23 years I've been employed at the Redvers Health Centre, there have been countless examples of incidents where acute care, lab and X-ray, and close proximity to ambulance and EMS services were required to preserve quality of patient care.

I will touch first on acute care. A young teenaged boy was helping his friend with baling when his shirtsleeve became

tangled in the power takeoff of a baler. The young boy was wrapped around the PTO (power takeoff), and in the seconds that this incident occurred, his right arm was severed at the shoulder, pulling muscle away from the back of his neck.

His friend brought him to us in the back of his van, arriving within 15 minutes of the time of the accident. The boy was stabilized at our centre and transported to Regina by ambulance, with a doctor in attendance. This boy survived the two and a half hour ride to the city because he received emergency medical care in the golden hour following the accident.

At Redvers we see and treat many cardiac or heart patients. In some cases we have had to administer lifesaving thrombolytic medications that dissolve clots that can occlude the major arteries of the heart, leading to heart attack and sudden death. By administering these lifesaving drugs, we can prevent major coronary or heart damage. The chances of the acute MI (myocardial infarction) or heart attack patient receiving these medications in time to prevent damage to the heart are greatly reduced as the distance they must travel to the acute care centre increases.

On record at the Redvers Health Centre we have administered these thrombolytic medications a total of 25 times. Of this number, seven have died. But 24 have survived because they were able to receive the medication in time.

A few years ago a farm couple living seven miles from Redvers were blessed with twin boys. Both babies developed upper respiratory tract infections after being at home for a couple of months. The colds turned into pneumonia, and both twins were rushed into our hospital while a relative, an EMT who was visiting at the time, performed CPR on one of the twins. They were resuscitated at our facility and rushed by ambulance to Brandon, Manitoba, where they remained for several days before returning home. We chose to transfer them to Brandon because it was an hour closer than Regina.

In our service area we see and treat many diabetic patients. They are treated either in hospital or on an out-patient basis, depending on the severity of their condition. We have had juvenile diabetics who are able to stay in school while they are monitored as outpatients at our facility. This would not be possible if they had to travel to larger centres for their treatment.

Diabetes is also a disease that can be life-threatening. A young woman in her 40s, who had been diabetic since she was a child, was carried unconscious into our facility by her husband. He had found her lying on the ground outside their home and she was unresponsive on arrival to our unit. She was in insulin shock and received massive doses of intravenous glucose, or sugar, before she would revive. To date this has happened to her twice. Both times we were able to treat her, but then she only lives 10 kilometres from Redvers.

Last year a young woman was travelling from Brandon, where she was attending university, to her parents' home. She was almost home when she lost control of her vehicle on loose gravel. Her vehicle rolled and our ambulance was dispatched to the scene. On arrival at our facility she was assessed and found to have fractures of both upper arms. She had extreme swelling of both hands and arms, suggesting internal bleeding around the area of the fractures, as well as head, neck, and back pain. She was stabilized and sent on by ambulance to Brandon, again one hour closer than Regina.

Our area has a high number of asthmatic and allergy sufferers. One incident I recall several years ago happened when a man collapsed at our emergency entrance. He had been stung by a wasp and in the ten minutes it took him to get to the hospital, he had gone into anaphylactic shock, meaning he was breathing, but not responding. He was given adrenalin along with other life-saving medications and survived.

Just a few weeks ago, the manager of our credit union in Redvers came to us complaining of swelling of his face. He stated that the only thing he could think of was that he had been bitten by some insect. He couldn't remember being stung, but he had had a similar reaction another time when he had been stung by a bee. He did carry an epinephrine or Epi-Pen with him, but he hadn't felt any sting so he hadn't used the pen. Within 30 minutes he was having trouble breathing and required medical intervention to prevent him from going into anaphylactic shock. He was treated and released the next day.

At this time I would like to also mention one of our long-term care residents. She is allergic to several things, most of them foods, and more than once she has reacted to something and had severe symptoms requiring medical treatment. How fortunate that we are an integrated facility, enabling her to receive acute care without an ambulance trip to a treatment centre.

Our long-term residents have access to medical care when they need it without having to leave the facility, as the medical clinic is adjacent to our acute care and long-term care facility. Otherwise, where would they go for their medical care and how would they get it with as little fuss as they do now?

In the Moose Mountain Health District we are the only facility that has physicians who provide labour and delivery services. Most newborns can be delivered at our facility, but when a mother goes into premature labour she is transferred to the city where she and her unborn child can be more closely monitored.

We had one such case this past winter that put all of our health care professionals at risk. A young 16-year-old girl was in premature labour and needed to be transferred to the city. Under normal circumstances this would not have been a problem, but all roads west to Regina and east to Brandon were closed by the RCMP (Royal Canadian Mounted Police) due to blizzard conditions.

After great deliberation between the doctor and the on-call obstetricians in the regional centres our ambulance headed out for Minot, North Dakota with the doctor in attendance. After a nerve-racking trip they arrived safely and were able to stop the young mother's labour from progressing. Without this assistance from the physician and the dedicated ambulance staff this young mother would not have made it to the city.

At the Redvers Health Centre we provide our patients with chemotherapy treatments that they would otherwise have to take in Regina. This is a very traumatic and stressful time in their lives. Treatment and support must be available at the local

level.

I would also include accessibility to diagnostics. Our out-patient department sees clients sometimes on a daily basis who have biopsies or surgical removal of growths done for the detection of cancer cells. At our facility they book a time with their physician that is convenient for them, have the biopsy done, and within two to three weeks have the pathology report back. Early detection of these cancer cells results in eradication of the disease.

Will we have the same guarantee if our regional centre is elsewhere? Waiting time for appointments just to be seen by a physician will be much longer than the time it takes to have the procedure done and reported on at our local facility.

We know that statistics tell us that one in three people will develop some form of cancer in their lifetime. At Redvers we treat and care for many palliative patients. One patient I remember in particular was a young 19-year-old woman. She arrived at our emergency department complaining of having difficulty breathing. She became critical very quickly requiring the insertion of a chest tube to help her breath.

She was transferred to the city with a collapsed lung from what we thought was a pneumonia. She spent many days in the city hospital to undergo a battery of tests that eventually diagnosed a rare form of lung cancer. She received treatments to try to stop the cancer, but they were unsuccessful.

After much discussion with her family, this young woman chose to spend the remaining time she had left with her family at home. We provided the necessary supplies they needed, as well as home care when they requested it. And when the family was no longer able to cope at home, they came to us.

Her parents, younger brother, older sister, and nephew stayed at our facility in the palliative unit, and were with this young woman until she died a few days later.

This case was particularly difficult for us because she was the daughter of one of our own home care aids. It was difficult for us, but how wonderful to spend your last days surrounded by people who loved you. This time with family and friends was our gift to her.

These are only a few of the reasons we need to retain the services we now provide at the Redvers Health Centre. We work in conjunction with home care to enable people to live at home and still receive necessary assisted care. We provide palliative care to patients and their family enabling them to be cared for in their dying days, or to die at home if that is their wish.

We have treated AIDS (acquired immune deficiency syndrome) patients who wanted to be closer to their family rather than spend their last days in a city hospital where they knew no one.

We accept post-op patients from city hospitals and provide excellent nursing care that is sometimes not always available in the larger centres due to the nursing shortages. We've had patients tell us stories of how the nurses in the larger centres are so overworked they rarely have time to stop.

By providing convalescent care in our health centre, we can relieve some of the workload of the city hospital staff, and why not. We are all working to provide safe, quality patient care.

The Redvers Health Centre must continue to provide the level of care our taxpayers insist on. Because of the large area we serve, the need for all health care services is great, and we must keep in mind our golden hour for treatment.

With extremely poor road conditions year-round, the time it will take to reach a regional centre farther away will result in the loss of lives. There is no doubt in my mind.

Dr. Greyling: — Good afternoon, ladies and gentlemen. I am Dr. Jaco Greyling, medical practitioner from Redvers. Thank you very much for giving me this opportunity as a physician in Redvers and area to share a few thoughts around the issues on the table.

I have only been in Redvers for 18 months, but I have been overwhelmed by Redvers as a very efficient and friendly town. Being involved in health care and after reading Mr. Fyke's report, there are a few things that we have to share today to hopefully add to the plan that will suit all parties involved.

I want to start out by saying that I do not have all the answers to the problems experienced in Saskatchewan health. But I would like to give a small glimpse of what we are dealing with in our community.

Saskatchewan with its big, vast, open spaces and scarce population puts us in a unique situation. Add to that a six-month winter with blizzards, minus 30 below temperatures, and you would expect that our statistics might be different or worse than many other provinces or countries.

In Redvers we believe that we have everything that a good health care team should be able to deliver. Services such as physiotherapy, palliative care, speech therapy, social services, mental health, home care, dietitian services, public health services, diagnostics and X-ray services, acute and long-term care, as well as an emergency room are all available to our patients.

We believe that we can care for most of our patients' needs. We already are what Mr. Fyke is wanting from a health care team, and more. We have the acute care. We can look after the acute needs of our patients as well as most other services that he or she might require.

In our practice we have a growing, stable, three-physician practice with between 6 and 7,000 active files. On an average day, we see between 80 and 100 patients in the office. Ten to 20 per cent of our patients come from Manitoba due to loss of acute care services in Reston, Manitoba, which is the first town on the eastern side of Manitoba border, approximately 40 kilometres east of Redvers.

We see between zero and five patients on weeknights, after hours; and an average of 40 patients are being seen over weekends.

We take pride in the fact that we can currently provide the

sufficient services to Redvers and area. With our current facility we believe that we can appropriately diagnose and manage patients accordingly.

Patients usually present as acutely ill, semi-acutely ill, or chronically ill. First I want to speak about the acutely ill patient. They can be diagnosed, stabilized, and transferred appropriately.

In some cases we need to keep the patient a couple of hours before transfer because the patient is too unstable to be transferred. Examples of these are for administration of thrombolytic agents in the setting of an acute heart attack. These drugs can reverse a heart attack. Streptokinase needs to be administrated within six hours after the first signs of a heart attack. The sooner this happens, the better chance there is of reversing the patient's heart attack.

The current Canadian protocols state that streptokinase is not allowed to be administered in an ambulance due to the fact that streptokinase can have potentially serious side effects, such as dysrhythmias. By that I mean abnormal rhythms of the heart, potentially fatal. Cardiac arrest, that means the heart might stop.

If these patients were to have the drug only in cities and regional hospitals after transfer, it will be too late.

Often the cardiologist on call in Regina General Hospital would advise us to take these interventions because this is the patient's only chance of surviving the heart attack.

Another example would be the insertion of an intercostal drain for a pneumothorax. We have had three patients in the last 18 months with lungs that have collapsed. Only with insertion of a tube can their lungs be reinflated. This is also a life-saving procedure.

Secondly let's look at semi-acute patients. By semi-acute patients I mean non-life-threatening emergencies. More than 90 per cent of these patients can be accurately diagnosed and treated accordingly at our local facility. If the diagnosis is unsure, the patient can be kept overnight and observed. With the help of X-rays, lab and blood examinations, and with observation, most of these patients do not have to go to a regional or tertiary hospital.

Examples of these are patients with abdominal pain. It is extremely difficult to say what is wrong with a patient with abdominal pain without being able to do blood work, X-rays, urine analysis, and to observe the patient in many cases.

Another example would be the simple musculoskeletal injury like a swollen ankle. All these patients need an X-ray. If you do not have diagnostics or X-rays, all these patients will have to be transferred to bigger centres.

Thirdly the chronically ill patient, by this I mean patients who are fragile, for instance the elderly. They often present with atypical signs and symptoms. An elderly patient with a urinary track infection or a pneumonia might present with confusion or dehydration. In most of these cases, with laboratory work and X-rays, a diagnosis can be made and the patient can be treated locally.

Again, if no diagnostics or acute care base are available to us, all these patients would have to be sent and admitted to a bigger centre.

Our conclusion will then be that we are more than the community care centre that Mr. Fyke would name in his report. I believe that another level of service is needed in between the community care centre and the regional hospital. We believe that we are a prototype of this level of hospital. We need a level of hospital that would still have acute care base. We do receive referrals from long-term care facilities and from the group homes for the mentally challenged.

With our diagnostics and X-rays available, we can in most cases diagnosis and treat patients. With that we take a big load off the already overloaded system in the bigger centres.

Our experience of the current referral system is that it is already totally overloaded. It is often difficult for us to contact specialists in the city. After that you have to convince them that your patient is ill enough to deserve to be treated in a bigger centre. My feeling would be that the specialists are so overworked in the cities, that they cannot afford to have patients in their beds that don't deserve it.

Often patients that are acutely ill like patients with heart attacks must be kept locally for 12 to 48 hours due to lack of beds in the tertiary care centres. I cannot see that all our semi-acute patients or non-life-threatening emergency can all be treated at the bigger centre with their current capacity.

I want to come back to acute care. It is unbelievable to see the number of life and death situations we've had in Redvers over the last 18 months. If we did not have acute care services, emergency room services, and well-trained medical staff, along with quick-response ambulance service, several of these cases might have had a fatal ending.

Over the last 18 months we have seen 11 heart attacks. All of these patients were transferred to the city with the physician going along in the ambulance. Intubation and ventilation were done in the ambulance in three of these cases. That means that a tube had to be inserted into the patient's airway to be able to ventilate the lungs.

We had one case of a ruptured aorta aneurysm. That means that the patient's aorta ruptured in his abdomen. This patient also had to be intubated and ventilated on the way into the city. Five cases of acute hemorrhage, for example, bleeding stomach ulcers, acute rectal bleeding, etc. We've had two cases of meningitis; 12 serious motor vehicle accidents. In two of these accidents, five patients were injured. In one of these accidents, three patients needed to be resuscitated.

We have had eight obstetrical or labour emergencies. For example, premature labour, antepartum hemorrhage, which means that the lady started to bleed before the baby is born.

Two cases of acute kidney failure, three massive strokes which needed to be transferred, four multi-trauma cases other than motor vehicle accidents, mostly from oil rigs and farm accidents.

All these cases were attended to urgently by a team of medical personnel. The fact is a well-equipped facility with trained staff in these situations are of . . . (inaudible) . . . and lifesaving importance.

If our emergency room should be taken away, small health centres like ours will still have to deal with drop-in emergencies. If the hospital disappears it does not mean that the patients will not become ill anymore. It does not mean that accidents are not going to happen.

If you are going to be alone in an insufficiently equipped minor room, having to deal with these type of emergencies without any help from trained nurses, you will not be able to deliver a good standard of care.

We all know that emergency medicine is one of the areas where litigation frequently occurs. This will become a big problem in this situation.

I do not think we will ever be able to compete with the richer provinces in providing similar salaries to our physicians. Physicians stay in Saskatchewan due to job satisfaction. You can be a physician in a small community and see everything from the acute care patients to the elderly. In that way you can provide total health care to the community. That is where our motivation and work satisfaction comes from.

I cannot see myself working in an area with a community care centre with no X-rays and diagnostics, where you have to refer all patients that have illnesses more severe than a common cold.

In addition to that, being a salaried physician would mean you would not be remunerated for really working hard. I can see a big loss of physicians to neighbouring provinces.

In South Africa a couple of years ago we experienced the same situation that Mr. Fyke is suggesting in his report. It did not work. Currently they are back to decentralizing their services.

I want to end by saying that in a situation like we have in Redvers, it is a win-win situation, both for the doctor, other health care professionals, but mostly for the patient. These services are definitely needed in our area. I believe that we are providing total health care for our patients. We provide quality care and with that I mean our services are accountable and I hope sustainable. As the local physician I feel these services are all needed.

Thank you very much.

The Chair: — Thank you. We'll take our 3 o'clock break right now before we start another group of presenters. We'll take a break for five minutes.

The committee recessed for a short period of time.

The Chair: — We're back and we have our next presenters ready to go. Okay, this book? If you can introduce yourselves and we'll carry on.

Mr. Gabriel: — I would like to introduce Marilyn Garnier, director of programs, and myself, Terry Gabriel, chief executive officer, of the Redvers Activity Centre in Redvers, Saskatchewan.

It is possible that the Fyke report forgot the individuals we serve or may not have been aware of our agency in Redvers. Our presentation will attempt to inform the committee of what services we provide.

The Redvers Activity Centre provides vocational, residential, and social programs for adults with developmental disabilities and chronic mental health problems. Our emphasis is on normal options of everyday living and assisting the individuals to achieve their fullest potential with the greatest degree of independence.

The Redvers Activity Centre employs an average of 42 employees from the town of Redvers and surrounding area. Several employees come from as far away as Brandon, Manitoba.

The centre operates on a million dollar per year budget — $700,000 of that is in salaries, $350,000 in other costs such as food, energy, vehicle operation, and other service costs are injected into the community. The Redvers Activity Centre is a major contributor to the viability of Redvers commerce.

The Redvers Activity Centre has been serving individuals with developmental disabilities since 1962. The activity centre is part of an ever-growing and united partnership where co-operation and understanding prevail with the Redvers hospital, home care and Haven, community living division, mental health, and local rural and urban governments.

This outstanding inter-organizational co-operation makes it possible for the Redvers Activity Centre to support adults with special needs to grow and develop as individuals and as citizens.

Ms. Garnier: — The Redvers Activity Centre operates or contributes the following programs: three 24-hour a day group homes, adult developmental centre, supported independent living; mental health department, Indian and northern affairs; acquired brain injury program, greenhouse, yard and lawn service, janitorial and catering services, craft sales, town of Redvers beautification project, housing of a private lawn and ornament business, SARCAN depot, oil recycling centre, and supported employment.

A proposal is in progress to develop a new wheelchair-accessible group home residence that would service both acquired brain injury and individuals with severe mental challenges. A joint meeting with the Moosomin health district, community living division, acquired brain injury, and local governments was held to establish the need for such a residence. Twelve individuals with severe mental health challenges and a possible 10 or more acquired brain injury individuals were identified.

The centre owns and operates three group homes serving 17 individuals. The group homes operate 24 hours a day with one live-in staff member at each home. Support staff work at two of the group homes in the evenings. Due to individual severity one group home also has additional staffing which includes shifts 7

a.m. to 3 p.m., 3 p.m. to 11 p.m., and 11 p.m. to 7 a.m.

The system of staffing at the activity centre gives individuals a chance to experience one-on-one programming and opportunities to do small group activities and attend social events without having to go as a larger group.

Independence is encouraged by learning to cook, do laundry, housecleaning, shopping, and socializing while supporting the individual as needed. Quality of life activities are very important. Skills are taught by breaking tasks into smaller parts.

Medical needs are high at all the homes and particularly high at one home. Some of our group home individuals were not expected to be alive at this time. But thanks to our excellent medical services such as the pharmacy, hospital, and ambulance, the individuals still enjoy a reasonable quality of life.

The supported independent living program is a combined program consisting of supported apartment and supported living areas. The individuals involved have the support of two staff to assist with and teach what is necessary to live alone. The supports consist of training in cooking, banking, laundry, cleaning, managing their medical care, and shopping for clothes and groceries.

Other skills taught are in areas such as behavioural management, life, job skills, and how to interact with others.

Leisure activities are very difficult for individuals to plan because activities have always been organized and planned by others. Now making decisions and choices are part of their life skills.

Home care is an integrated part of supportive living. The nurse assists with medication, monitoring blood pressure, and nail care. The home care aides provide personal care and assistance with cleaning their home.

Meals on Wheels service five individuals three times a week.

Mr. Gabriel: — The Redvers Activity Centre has one mental health worker who assists with individuals to maintain their health, medications and doctor appointments.

The mental health program also assists individuals in behavioural management, learning to shop, preparing meals, budget, maintain their personal files, and enjoy a good quality of life.

Programs such as anger management, social and life skills, being with people and cooking courses are provided yearly to build skill levels.

The mental health program is also supported by the mental health nurse, psychiatrist, and local doctors who also assist with anyone who has dual diagnosis.

The centre also operates a developmental program for several acquired brain injury individuals. The program works at assisting individuals to better integrate into the community in areas such as ethics, how to act in a restaurant, how to deal with other people, and learn to enjoy quality of life activities.

The Redvers hospital physical therapist also assists our individuals with acquired brain injury by helping them with their many physical and neurological problems.

Ms. Garnier: — The developmental program is the most difficult and challenging area in our day program. Our emphasis is on normal options of everyday living and assisting the individuals to achieve their fullest potential and greatest degree of independence.

This group requires much doctor and hospital care. Some are very fragile and many are getting older. Many of the individuals have dual medical problems and will often have seizures, which in the more severe cases require immediate ambulance service across town to the hospital.

The centre program also provides life skills, including job preparation, finding a job and maintaining it. To maintain jobs, many of our individuals require job coaches to ensure the individual learns the job, as well as assuring the employer that a quality job will be done. The individuals we serve have employment in such areas as the pharmacy, clothing store, Co-op hardware store, electronics shop, house cleaning, lawn maintenance, catering, painting, mail delivery, and yard cleanup. One individual has taken the daycare course and works part-time at the daycare.

At the Redvers Activity Centre we hire our own individuals to do janitorial, yard maintenance, exterior and interior painting. All our clients are paid minimum wage or higher for their work.

Mr. Gabriel: — The Redvers Activity Centre owns and operates the local SARCAN depot. The depot employs four to six individuals with disabilities. The number of people employed depends on the volumes and returns being made at the time. Programs include working as a team, proper work etiquette, and maintaining and keeping a job.

Redvers Activity has started operating a used oil recycling collection centre, which is expected to create more employment in the next short while.

Ms. Garnier: — I completed a survey on medical usage by individuals involved with the centre from June, 2000 to June, 2001. The results are as follows: blood tests, 108; ambulance trips, 7; medical checkups, 237; days in the hospital, 19. Total incidents of medical attention was 371, and that is just in Redvers.

A home care nurse delivers medications to the centre and also assists individuals with personal care issues.

Mr. Gabriel: — Redvers has a population of approximately 965. It provides a very accepting atmosphere for individuals with disabilities. Quality of life is enhanced by this acceptance. Individuals are known by name and are talked to by the local population on the street and in places of business.

There is a high level of respect for disabled individuals in Redvers. Some individuals have lived in Redvers for up to 27 years and are as much a part of the community as anyone.

In Redvers local residents will call the centre if they feel someone may be in trouble or if an individual even appears to be having a difficulty. This action is typical, caring, compassionate community.

A Five-Star Community Award is the highest form of recognition a community can receive for its all around acceptance and accomplishments, integration of persons and disabilities into community life. In 1990, Five-Star awards were presented in Quebec City to Redvers, Saskatchewan; Kitchener, Ontario; and Ottawa, Ontario. The awards were presented to the representatives of Redvers at a luncheon of the annual conference of the Federations of Canadian Municipalities in Quebec City.

Ms. Garnier: — I have a letter from one of our parents who is an older woman and also lives in Moosomin, Saskatchewan:

> My son has been a client at the Redvers Activity Centre for over 25 years. He has received excellent care and I feel secure about the future (or felt secure about the future). But now, the prospect of termination of hospital services in Redvers makes me uneasy and apprehensive. If this comes about, it will surely be more difficult if not impossible for the Centre to provide the level of care that is required to maintain the physical health of many of the clients.
>
> My son needs medical care on a continuing basis. He requires blood monitoring frequently. If this is not available in Redvers, trips elsewhere accompanied by a staff member would be necessary, (excuse me) involving time and expenses as well as stress to the patient.
>
> He is also on continuing medication for gout and thyroid conditions, requiring monitoring and pharmaceutical services.
>
> He has speech impairment. In his own community this is recognized and accepted. In a new and strange setting for medical treatment or assessment this would be a stressful and difficult situation.
>
> I feel it is important for our special needs individuals to have a secure and stable environment, and to have access to medical care without undue stress. Parents have struggled for years to obtain services for our handicapped children. Are their needs and rights and comforts about to be overlooked?
>
> Problems of distance, roads and weather are a fact of life in Saskatchewan. For dependent people, services need to be available in our community.
>
> The Redvers Activity Centre is a live and successful institution. Surely it should not be handicapped by lack of medical services when the means to provide it are already in place.

Some of the activity centre concerns are: one, where will individuals with severe developmental disabilities go? Back to the institutions; two, are we as a province centralizing now that we have decentralized just a few years ago; three, with extended travel to a far-away hospital, where will agencies such as ours get the money for operating vehicles, particularly with the uncontrolled increases in fuel? The government funds 18 cents per kilometre for vehicle use.

Number four. Families are aging as are the individuals. There is a great concern by families over what will happen to their loved ones.

Number five. We not only provide services but are considered family as well. One individual who could no longer stay in the group home moved to the Haven. A year later, the lady moved to the hospital before she died. As she had no family, we were with her when she died and made the funeral arrangements.

There are five other individuals with no family and no parents. As the individuals age, there will be more who consider us their only family.

It appears the Fyke report forgot the individuals we serve or never knew that centres such as the Redvers Activity Centre ever existed. We suggest that officials who will be deciding the fate of our community not just drive by, but drive into our town and gain an understanding of what we do and what our community is all about.

Mr. Gabriel: — Thank you to those who came to Redvers to visit our agency in the last few days. We really appreciate the chance to show you how well we do our business, how important the hospital and ambulance are to this agency, to the town, and the surrounding communities.

I'd like to draw your attention to the front page of our presentation. The individual on that front page has no family, was abandoned as a child, and we are his family. And secondly, he painted the picture that the front page is on; is quite talented.

In the attachments, there is a Declaration of Partnership signed by Social Services minister at the time, Lorne Calvert, and now Premier, and letters from various families stressing their concerns. It's interesting — they're from Moosomin, Gravelbourg, Manor, Estevan, and Oxbow.

We thank you very much for the time. Hopefully it was informative.

The Chair: — Thank you. And our last group of presenters?

Ms. George: — Good afternoon, ladies and gentlemen. For your simplification we have actually two reports. One we'll read, which is this one, this is the report we'll be giving. This report goes along with it but we won't keep you here that long. And we know you have hardly any other paperwork to look at so we'll ask you to look at this in your leisure time.

But this one here includes some letters from Redvers citizens that we aren't able to read at this time. But we wanted to bring them to present to you for your consideration. So this one you can take home for reading. Thank you.

Good afternoon, ladies and gentlemen. My name is Jacquie George, and at this time I would like to introduce the rest of the presenters of the testimonial group, Right to Life. To my right, Doug Jonasson, Rayleen Eberl, Gail Irwin and Wanda

Cunningham.

We're here today to represent the citizens of Redvers, and the surrounding communities, but we feel we also speak for a much larger group. We speak on behalf of all people living in rural Saskatchewan; the people hospital closures will affect the most.

We begin our presentation by reading testimonials from people who for personal reasons are either unable to attend or present them. It is with their permission that we read them to you today.

The five of us also have our own personal stories, which we will relate to you later in the presentation. These testimonials you are about to hear are not to gain personal sympathy, but rather to help you to better understand the need for the services we have now at the Redvers Health Centre.

Mr. Jonasson: — This testimonial is from Bill Curle of Redvers, Sask. Bill would like to have been here today but did not want to leave his wife, Leona, for the day:

> On May 4th, 2001, my wife Leona and I were visiting the Redvers Centennial Haven which is attached to our hospital. Shortly after we arrived Leona had a heart attack. Had it not been for the immediate response of Dr. Taillard, Dr. Greyling, the nursing staff as well as Streptokinaise and the use of the shock paddles available at the Redvers Hospital, my wife, lifelong partner, and the mother of our two daughters would be dead. This is not my prognosis but that of Dr. Zimmerman at the Regina General Hospital where after being stabilized in Redvers, Leona was rushed to by Redvers ambulance.
>
> If Leona had died from this heart attack because of the proximity of Redvers to adequate health centre care, her obituary would have in all likelihood have appeared in the obituary section of *The Leader-Post*. However, had she died as a result of an auto accident on a single lane stretch of No. 1 Highway somewhere between Gull Lake and the Alberta border, I can assure you she would be a statistic that would be on the front page of that same newspaper. The number of people killed on that particular road is intolerable to the people of this province and the government is doing something about it.
>
> The implementation of the Fyke report would be even more intolerable and I cannot for the life of me understand why this report was not immediately relegated to file 13.
>
> In light of the recent health crisis in our family, I have been trying very hard to make sense of the possible closure of the hospital in Redvers and, quite frankly, it simply does not make any sense at all. I have asked myself are we in rural Saskatchewan expendable and but a minute statistic if our demise is a direct result of not being able to receive adequate and acceptable treatment in emergency and in a reasonable time frame?
>
> Are we in rural Saskatchewan to become the Canadian version of the outback? I can assure that is exactly what will happen if this report is implemented.
>
> If the powers that be are adamant in their belief that the Fyke report is the way to proceed, I would suggest with due respect that they take this report one step further and close all the hospitals in the province and split what would be left of our health care dollars between Manitoba and Alberta.
>
> Our government is on record as opposing a two-tiered health system. But I ask you, would our health care system not be two-tiered when one segment of the population would be able to access treatment in a matter of minutes but, in our case, treatment would be hours away?
>
> Would the death of my wife be the price I would pay for living in this part of the province?

Ms. George: — This next testimonial is submitted by the family of David Poirier.

> September 7, 2000 dad was admitted to the Redvers Health Centre feeling unwell. The following morning dad went into cardiac arrest. Because of our skilled staff and being in the care of the facility, dad was stabilized and transported by ambulance to Regina under the care of our local ambulance team along with the doctor on call.
>
> Dad's story would have been very brief and possibly tragic if it hadn't been for the role of the health centre played in his life-threatening situation.
>
> After two weeks of care under the Regina Health District at the General he was diagnosed with acute kidney failure, prostrate cancer, and a stroke, which occurred while receiving kidney dialysis.
>
> Dad returned to Redvers. Once back in familiar surroundings and personal care of our facility, along with family and friends, he was given the will and determination to cope with his illness and impairments from the stroke. He regained enough strength to return to Wascana for therapy and soon after home to Antler, Saskatchewan.
>
> Since last fall, he has been a patient of the Redvers palliative care unit periodically. Dave Poirier and his family strongly support this unit and our local hospital for reasons such as convenience it provides to us, as well as the knowledge and compassion displayed by the staff makes patient comfortable and content while being hospitalized.
>
> There's a special kindness and warmth a small town facility provides that the larger centres cannot provide and this is truly therapy of its own that many patients will miss if our small centres are closed.
>
> Unfortunately none of Dave's family was able to be with us today, as Mr. Poirier has been re-admitted to the Palliative Care Unit in Redvers and his family is with him.

Ms. Eberl: — The next one is the testimonial of William Mathewson. Bill is with us today and I would like to ask him to stand at this time.

> For 17 years, I have had chronic kidney stone problems. In 1984, while I resided in Brandon, Manitoba, was my first surgery. When I have these attacks, there is no time to wait.

Severe pain, but besides that, the danger of a stone moving, blocking the tube, causing kidney failure, is a real concern.

Since 1998, I have had to have 4 different surgeries for this and four different treatments of lithotripsy, and at present I am possibly looking at another surgery.

Every one of these situations have been an emergency. Our local doctors have made the proper contacts and/or have hospitalized me until I could receive immediate treatment in larger centres. It is a great trust and faith we have in our local Doctors. They ensure that we have prompt professional care at all times.

My Father and Mother both worked hard all their lives to support our local health facility. They both passed away there, with the compassionate care of our Doctors and Medical Staff, and the loving support of all family close at hand in familiar surroundings. My family is not the only family that this has happened to.

I am now 70 years old. In some years from now when I am unable to drive, how then, with no ambulance, no Health Care Facility, and no Doctors, am I going to receive the health care I may need, enabling me to reside in my own home, if an emergency occurs?

The possible closure of our facility and loss of our ambulance really frightens me.

I need the professional care of our local Doctors.

I need the availability of the ambulance if the need arises.

I need the follow-up care of our local Doctors after surgery and after treatments.

I need the re-assurance that these services will continue to be here for myself in my senior years, my family, and my loved ones.

This is one reason I moved to Redvers to retire. These services were all here. I am not alone thinking this way. Please do not, I beg you, do not take our Health Services from our Community.

Regardless of what the Fyke Commission has presented, please listen to the people in smaller communities. We are deeply concerned and we care about our health now and for the future for us and for our families.

Ms. George: — This next testimonial is about a young girl from our community. Attending today are her parents, Donald and Valerie Revet, and her brother Troy. We would like to introduce them to you at this time. They are standing in the gallery.

This is our plea in memory of our daughter, Kimberly Dawn Revet.

Because of our local hospital, the doctors, nurses and staff, we were fortunate to have our precious daughter with us for an additional 11 months. Our daughter was but 19 years old, getting ready to move out into the world. Her dream was to help troubled kids until she was told there was no cure for the cancer that was taking her away from us.

One day she told me, "Dad, one day I'm making decisions of an 18-year-old and now I'm making decisions of a 90-year-old." And then said, "I'm glad it's me and not one of you."

She was more concerned of what we were going through than what she was dealing with. That's when we knew that she had been blessed. Her knowledge that there was a better life on the other side gave her so much strength.

In those 11 months we had a special bonding. We never left each other's side. She loved so much to be home with her family. The love we all shared together as a family will never be forgotten.

Having a hospital close by — 10 miles — made it possible for us to look after our daughter at home for almost all of her illness. In the worst times of her illness in our local hospital we were allowed to stay by her side 24 hours a day; a place where family members could come and comfort us, a place where her special nephew could come and put a smile on her face, where school friends and her boyfriend could come just to talk; where her local priest could come and give her prayer, comfort and peace.

The professionalism, compassion and comfort we received from the doctors, nurses and staff meant so much. We will always be thankful for the care and compassion they had given to our daughter.

We strongly beg you please to reconsider the closing of rural hospitals. Any government allowing these closures to take place should be dealt with in the same manner as Robert Latimer. You will have made the decision on who lives and dies in the province.

You have no right taking our families away from us. That is not what we elected you for.

Yours truly,

Kimberly's family.

Ms. Irwin: — Good afternoon, my name is Gail Irwin from Sinclair, Manitoba. My testimonial is on behalf of my husband and our family.

I have been extremely saddened by what I am reading in the papers lately concerning the possible closure of our acute care facilities at the local hospital in Redvers, Saskatchewan.

I am one of the 1,600 patients from the RM of Pipestone on the Manitoba side of the Redvers hospital catchment area. To the Fyke report, 1,600 Manitobans is a mere statistic. Let me assure you that we are indeed more than a mere statistic. We are real people with real needs and now real concerns for our future medical treatment.

To doctor in Redvers is already a 52 kilometre round trip.

Anyone living in urban areas of Canada could not imagine driving 52 kilometres for a doctor's appointment, a blood test, or for emergency medical aid. We do because Redvers is our closest acute care facility that meets our needs.

Redvers has three wonderful, caring, and knowledgeable doctors with very supportive staff and community. There was overwhelming financial support from the local community when their new hospital was recently constructed. It is hard to believe that a government could overlook this community support and the staff's excellent service. Why would you close its doors and put even more distance between us and the medical care that we need?

You will find that patients will not doctor at a hospital without acute care facilities. Another local hospital at Reston, Manitoba lost its acute care status. It has no emergency doctor, but full nursing staff. It has few patrons left.

Patients feel that they need health care most when they are in an acute health crisis. With no emergency doctor then they would have to deal with new doctors and staff at a critical time. It just makes sense to doctor at a hospital with acute status from the beginning.

This theory of closing acute status hospitals in rural areas has been tried and does not work. In closing rural hospitals, there will be a larger demand on urban centres with the influx of rural patients.

Ironically by reducing our rural medical facilities, it increases our overall medical costs at a time we can least afford it. We will have greater distances to travel for appointments, tests, hospital stays, and visits to our hospitalized loved ones. There will be increased travel, meal, and accommodation expense. Further distances results in lost wages at work and more daycare expense at home.

The distance you are suggesting we travel for acute care will be of no benefit to us in an emergency situation. We will then just become fatal statistics.

Such was the case recently in a Winnipeg hospital waiting room when a patient died waiting for diagnostic treatment. What is even more shocking is that the medical media referred to this as acceptable care. Is this what Canadians deserve while governments continue to announce billions of our tax dollars for foreign aid?

Each of us rural statistics, whether from Saskatchewan or Manitoba side of the Redvers hospital catchment area, are requiring an acute facility much closer than what you are suggesting.

My husband suffers from a rare genetic and potentially life-threatening blood/liver disorder called Erythropoetic Protoporphyria, EPP, for short. He lacks the gene to break down his protoporphrins into the heme part of hemoglobin of his blood. The accumulation of these protoporphrins under his skin causes severe sun sensitivity. Exposure to sun can trigger excessive production of protoporphrins.

There are few doctors that know about this disease. It has taken years for doctors at Redvers to understand EPP and to do what is best for Lynn. When he is having an acute attack, it is impossible for him to travel for doctor appointments or regular weekly blood tests during the heat of the day.

In the last five years the excessive blood protoporphrins have accumulated in his liver causing his liver to shut down several times. When this happens, Lynn is hospitalized at Redvers to be stabilized with intravenous and drug therapy, and Redvers ambulance crews arrange to transport him to local airfields to be airlifted to Edmonton. It is Edmonton because if it doesn't come back, he has to have a liver transplant and possible bone marrow transplant.

This explains . . . okay . . . The Redvers hospital plays a crucial role in quick life-saving treatment and transportation. In the beginning of his severe attacks, Lynn was transferred to Winnipeg by ambulance from Redvers. Our local Redvers doctors spent hours locating the liver and transplant specialists needed in Winnipeg so that he could be admitted under their specialized care.

Rural doctors have difficulty placing their patients in beds at any health science centre in Canada. This task becomes more difficult for someone suffering from a rare disease.

After 48 hours, Redvers doctors succeeded and Lynn was transported and admitted to the Winnipeg Health Sciences Centre and eventually referred to the liver transplant team in Edmonton.

If it is that difficult for a doctor to find the help that Lynn needed, I am sure we, his family, could not have made the connections in time to have saved his life.

Twice since he has had a more direct air route from Redvers to Edmonton. We understand the importance of Redvers hospital and acute care staff. If it wasn't for this hospital, my five children would not have a father nor I a husband today.

His life is in jeopardy if the hospital closes as his disease is progressing and another hospital and group of doctors would not understand this disease in time to save his life. Changes at this time would be critical for him. He needs to be hospitalized quickly when the attacks happen and it's very difficult to get an appointment, let alone a bed, in a larger centre.

Remember that because of the sun sensitive nature of the disease, it becomes very difficult for Lynn to travel during the sunny hours for regular lab and doctor appointments. Redvers understands and accommodates us. It is the likes of us that will fall between the cracks if the acute care facility closes in Redvers. We fear for his life.

Fifty years ago, schools were built to accommodate us baby boomers in rural Canada. This same large population is reaching their senior golden years after having worked hard and contributed heavily in tax dollars. There will be maximum utilization of our acute care facilities. This is not the time to be closing our hospitals.

Rural Canadians often feel second class, as more and more is taken from us. Yet we are a big part of the foundation of this

country. If you believe in your own Bill of Rights and the Canadian Constitution in which all Canadians are equal, then please treat us rural Canadians accordingly by allowing us to have our acute care facilities a reasonable distance from home, at Redvers, Saskatchewan.

Closing acute care facilities at Redvers would dramatically decrease the quality of our medical treatment and will be detrimental to our lives. It doesn't make health sense.

Mr. Jonassen: — I'm Doug Jonassen and the story that I'm about to share with you is in regards to how our daughter Kristen's life was saved by the actions of the staff at the Redvers Health Centre. My daughter Kristen and my wife Jackie are here with us today.

Kristen was born on February 27, 1996. She was a healthy eight-pound one-ounce girl. When she was only three weeks old, she came in contact with a virus called RSV which is short for respiratory synthial virus. This virus attacks the respiratory system and can and has been fatal among some infants.

On the morning of Monday, March 18, 1996, we took Kristen to the Redvers Health Centre as she had been up a lot of the evening with a cough and wheezing while she was breathing. Once at the Redvers Health Centre, Kristen took a sudden turn for the worse and was actually gasping for air, blue in colour, and her oxygen concentrate was in the low 40s. A normal three-week-old's oxygen concentrate is between 95 and 100 per cent.

The staff on hand reacted very quickly and did what they had to do to stabilize her. She was put on oxygen and then placed in an incubator. The doctor on duty called ahead to Brandon General Hospital and Kristen was set to be rushed by our local ambulance to Brandon General.

On my way out of the hospital, I met the doctor on the stairs. He informed me that it didn't look good and that Kristen might not make it. Imagine one of yourselves being told this about one of your children. It is a moment in my life that I will never forget.

My wife Jackie went to go with the ambulance and I went to let our parents know what was happening with Kristen, pack a suitcase, and follow the ambulance.

Once the ambulance left, Kristen's breathing improved on route to Brandon as a result of being put in the incubator, which was giving her oxygen. Once we arrived in Brandon, Kristen was placed in intensive care for four days, continued with the oxygen and IV (intravenous) therapy until she was released five days later.

Kristen would not be here today if we would have had to drive more than 30 minutes to a health centre.

We don't have dollar figures or statistics. We don't have graphs or charts to show you why we feel that it is so important to us to keep our local health centre. We have living proof; we have our daughter Kristen.

Ms. Eberl: — My name is Rayleen Eberl. In sharing my story I hope to relay the importance and necessity of a hospital with acute care services for people just like you and me in rural Saskatchewan.

I'm 35 years old . . .

Ms. Cunningham: —

I am 35 years old and eight months ago I was diagnosed with cancer. Had it not been for my local physician, I would not have received the expedited care for which I am so grateful. Not only am I a young mother with cancer, but every minute that you wait is physically, mentally and emotionally agonizing on not only the patient but the family as well.

Within two days I was scheduled to see a surgeon. Three days later they removed the lump. After finding out it was cancerous I was booked for surgery. Throughout this time I had uncomplicated access to my local physician who provided me with various options and a personal opinion which I was unable to obtain from my surgeon in Regina. You see Dr. Greyling knew my family as well as myself as a friend; therefore, he was more personally involved in my case, even though he had only been in Redvers eleven months. I would not have received that type of care if I were doctoring in a larger centre.

Upon completion of my surgery, I was required to attend my local physician for post-surgery care. It was our local physician who monitored my incision for infection and removed both my drains and stitches. Once my chemotherapy sessions began, I was again required to visit my family physician once a week as well as have weekly blood work done. These tests increased to every other day when my blood counts were at a low. This close monitoring is necessary with chemo patients for the reason that something as common as a flu can be deadly.

It is imperative to make two points at this time. The first being that had . . . (it) not . . . (been) a hospital with acute care services and laboratory facilities, I would have had to travel two hours, one way, to receive these services. Secondly, our hospital is providing outreach services for the Allan Blair Cancer Clinic by doing these services.

Had I not had access to these services, I would have had to return to the Allan Blair clinic for these tests, thus booking up a already swamped centre.

At one point shortly after chemo treatment I contacted the flu along with my chemo side effects. I became very ill and in turn dehydrated, as I was unable to drink the necessary fluid intake to flush the drugs out of my system. Because of the direct access to medical care, I was able to receive intravenous fluids immediately over the next 48 hours, as well as home visits from my physician to monitor my progress.

Because we have moved to Redvers, we do not have any family in close proximity, which we could utilize for child care. Therefore the freedom to stay at home and maintain our family unit was a godsend.

In conclusion, my ordeal is neither unique nor rare, but it is special in that it is my life and to me that is worth more than any price tag. Having access to acute care services right in our community has not only provided me with all my primary care, but has saved us time and money.

I know that I am not the only one to need these services in our community; everyone has needed them at one time or another. I understand finances are strained, but until you're in a life-threatening position there's no value you can put on health care. It is our lifeline in rural Saskatchewan.

Good afternoon, my name is Wanda Cunningham and it's with great concern today that I be before this hearing committee. It has to do with the Fyke report and how it'll affect my family's life and the life of our community.

I speak from personal experience knowing how crucial it is to have a hospital in our community. Along with the ambulance, there are trained and dedicated EMO, plus the doctors, nurses, and the personnel that a hospital needs. Had it not been for each and every one of them, our son would not be with us today.

My husband and I have been in Redvers for 22 years and have raised four sons here. We farm, and own and operate our own machine business.

One son had a serious eye injury and needed immediate attention before being sent to a bigger facility.

My husband had acute diverticulitis and needed emergency care and an ambulance to rush him to the hospital. He required several lengthy hospital stays to fight the infection before having surgery. He was able to have these treatments in Redvers due to our hospital, its skilled doctors, and staff. This was a great comfort to us, as I was trying to keep the farm and the business taken care of.

In February 2000, our son Ryan was involved in a serious auto accident. He was thrown from a vehicle and found laying face down in a slough full of water. The accident happened eight miles from the hospital. Ambulance attendants did not know if he would survive the short distance.

Once Ryan was stabilized at the Redvers hospital, he was taken to the trauma unit in Regina. Again the skills of the EMTs of Redvers ambulance squad kept Ryan alive until he reached Regina. He spent several days in ICU with life-threatening injuries.

After several months in Wascana Rehab Centre, Ryan is now trying to put his life back together. Due to his injuries, Ryan has some disabilities to overcome and our health facility is helping him.

There is access to physical, mental, and speech therapy, along with the dedicated doctors and nurses. Ryan knows these people, which gives it a personal touch.

We are not the only family in this community that have a story to tell where a loved one was saved because of the hospital and all it entails in Redvers and we won't be the last.

Please, don't take the hospitals from the rural areas. Life is much too precious to gamble with.

Ms. George: — My name is Jacquie George and this next testimonial is that of my own.

If any of you have a teenage son or daughter you will agree that one of your worst fears is to receive a call that he or she has been in a motor vehicle accident.

On June 1 of this year my husband and I received such a call. Our 18-year-old son, Steven, was in a single vehicle rollover along with the driver and three other friends. At approximately 6:45 p.m. these five young people were travelling on a gravel road three miles south and three miles east of Redvers. The vehicle hit an approach and rolled. The driver and the other three passengers managed to crawl out, but Steven, who was unconscious at the time, did not move.

You can imagine the panic these young people must have felt. Thankfully one of the girls had the presence of mind to call 911 from a cellphone. The Redvers ambulance was dispatched immediately. And after calling for help, this same girl called us.

This accident was only five miles from our home; we were there within minutes. Upon seeing the truck we knew it was bad. The ambulance attendants were at the scene and informed us that they had called for the EMO and the Jaws of Life.

Not knowing his injuries, they didn't want to take a chance at pulling him out for fear of neck, back, or spinal injuries. Steven was in and out of consciousness during this time. The attendants managed to get an oxygen mask on him to help stabilize him. We tried to stay calm and assured him that help was on its way. After all, we were only six miles from town. The Redvers EMO unit would be there within minutes.

Minutes soon turned into an hour and that hour became an hour and a half. Because of a kink in the 911 system, the Carlyle EMO unit, which was 40 miles away from the accident, was dispatched and not the one from Redvers. We had waited with our son for an hour and a half.

Moments after the Carlyle EMO unit arrived, our own Redvers unit was on the scene as well. It didn't take long for these trained volunteers to get our son out. Finally, we were on our way to the hospital.

As we pulled up to the hospital doors, there waiting for us was Dr. Thalliard, Charge Nurse Dianne Blezy, and lab and X-ray technician, Dorell Church, along with the regularly scheduled staff. Steven was whisked away to the emergency room and lab for X-rays. He ended up spending two nights in the hospital and miraculously had only minor injuries.

His friends, Derek, Amber, Robbie, and Jackie were all taken to the hospital and released that night with minor cuts and bruises.

Other than having missed several weeks of work to heal his shoulder and bruises, Steven's life and ours are pretty much back to normal. However, not a day goes by without thinking of that night. My husband and I drive past the site of the accident every day on our way to work. And we are so very grateful for

what we have and what we had that night.

First of all, we have our son, Steven.

Second, we had a young girl who remembered 911; she didn't know the hospital number but she knew to call 911. This service had only been available to our area just a few short weeks before the accident and 911 does work.

We had our ambulance just minutes away. But we also had an hour and a half wait for the Carlyle EMO. Not that it was any fault of theirs, but if we waited that long for a unit to come from Carlyle, the next closest town to us, how long will we wait for a centralized ambulance? We are too large an area and too far from everywhere not to have this service.

We had and we still have a 24-hour acute care centre; accidents don't always happen from 9 till 5. We have doctors, nurses, lab and X-ray technician who are there at a moment's call.

Being that this happened so close to home, we all had the support of our family and friends.

And most of all on June 1, 2001, we had quality health care, just as we do every day we keep our hospital open.

I consider myself and my family to be average, everyday citizens. My husband and I both work full-time and we have four sons, three of whom were born in the Redvers hospital.

I would be here for far too long if I were to recap every time over the past 26 years that our family has had to use the hospital. We've been through casts, crutches, cuts and stitches, fever, ear aches, and asthma attacks. We've experienced what most other families go through.

When I look back, although none of these things were life-threatening, I can't imagine having to travel an hour and a half to a hospital each time something came up.

How many employers will give you a day off to take your child to the doctor. And if you are lucky enough to get the day off, it is still at your expense — the loss of a day's wage, and the travel expenses. Many families cannot afford this type of health care.

As a parent, my main concern is for my children. My oldest son lives here in Regina, and as much as I am here representing rural Saskatchewan, I also have concerns for the urban centres of our province. If rural hospitals are closed, will he have adequate care as urban centres are now flooded with the rural people.

As I mentioned before many of my examples were not life-threatening. But what happens when they are? What happens to rural Saskatchewan when time is a factor? Correct me if I'm wrong, but I don't believe any government wants to play God in life and death situations.

Geographically Redvers is one and a half hours from its closest larger centre. That's already a half hour longer than the golden hour allows. Ryan Cunningham, Leona Curle, Kristin Jonassen, and hundreds of others in rural Saskatchewan did not have the luxury of time. They needed treatment, they needed a hospital with doctors, and they needed ambulances, and they needed them right now.

It is my understanding that the Fyke report is not entirely about money, but rather about improving the quality of health care in the province. We already have quality care in Redvers, so I would think that Mr. Fyke would have suggested ways to improve what we already have — possibly by adding more services to help relieve some of the urban centres — but not to take these services away from us.

Due to the time factor we are unable to read all of the testimonials and letters that we have brought with us, however we have enclosed copies in this booklet, and we would ask for you to read and consider these written presentations.

Rural residents have the same right to life as urban residents. Please don't take these services away from us. Human life is too precious to play a numbers game with.

We appreciate the time that you have taken to listen to us today, and we hope that you will look closely at all seven presentations as you make your report. Thank you.

Mr. Eberl: — Madam Chair, if I could just say a few words to summarize, if you'd allow that.

The Chair: — And you'll introduce yourself?

Mr. Eberl: — John Eberl, I'm secretary treasurer of the Redvers Health Foundation.

Madam Chair, and committee members, and visitors here today, I guess it wasn't our intent to overemphasize our own personal situations, but certainly we wanted to give you a chance to walk in our shoes for a bit — being two and a half hours away from Regina and over an hour and a half away from the larger centres. And we hope we've done that today. That was part of our intent certainly.

And it's my pleasure to summarize the seven groups that presented here today.

In summary today, we hope we've given your committee a variety of presentations covering the full range of health services that are delivered in Redvers and surrounding area. We feel that with our community moral and financial support we can continue to provide the required health care services for southeastern Saskatchewan.

Due to our geographic location, we feel that with having Redvers continue at its present level of services, the long-term financial effect for the province of Saskatchewan will be positive.

We may not fall exactly into a particular slot present in the Fyke report. However, what we hope to have portrayed today is to explain how we fall into the health care picture overall. We have worked through past health cuts and restructuring. And we feel that we run a very efficient operation in Redvers, which is a benefit to the provincial government and to all the people of Saskatchewan.

We're dealing with people's lives every day in the most efficient way possible. Any reduction in our existing health services will have a domino effect. It's a big fear for us. Other health services will fall, and eventually our community will be greatly affected.

We have worked with the changes and have built a health care system that works for our area, for rural Saskatchewan. Rather than further cuts, please use our system as a model for other communities in the province. We're not asking for further; we're asking you to maintain and allow us access to what we've got out there. And we believe that Redvers can be the leader for rural Saskatchewan in the 21st century.

As I said before, that was our purpose — is to put you into our shoes and allow you . . . present to you the services that are offered. We appreciate the opportunity to be heard. We hope you're listening. And we hope you take it to heart.

And, Madam Chair, as well, if you have questions, I would field them on behalf and direct them to the people as well, if that . . . with your permission.

The Chair: — We do have a couple of people who want to ask questions, but if someone else answers other than you — because there's people watching on TV and because our technicians need to identify who's speaking — if you could introduce yourself before you answer.

And I'd like to just remind everybody that our time is up and that we do have our next presenters waiting in line. So if we can make our questions and our answers short.

Mr. Thomson: — Madam Chair, I'll defer to Mr. D'Autremont if he, as the member for the area, wanted to make a comment or had questions. But otherwise I certainly will proceed.

The Chair: — I actually didn't see Mr. D'Autremont's hand up. I had Mr. Gantefoer next, but go ahead, Mr. D'Autremont.

Mr. D'Autremont: — Thank you very much, Madam Chairman. I think the people that have made presentations here today have clearly expressed the concerns both of their own community and of rural Saskatchewan in general. One of the issues that I think has been brought forward by many of the groups is that if the hospitals that currently exist across the province cease to provide acute care services, that pressure is going to then be transferred over to the remaining acute care, both the tertiary and the regional hospitals.

And I guess if I did have a question, it would be to the doctor. If that occurs and the hospitals across the province no longer provide acute care, how much pressure is that going to put, in your estimation, on the urban centres; and will there need to be an expansion of those regional and urban hospitals?

The Chair: — For the record, you'll just state your name again.

Dr. Greyling: — I'm Dr. Jaco Greyling. Mr. D'Autremont, like I said in my report, as our current situation like we have now, we already have trouble getting patients into the major centre. I can just see that even more of the rural facilities do close down, that the pressure on the major centres is going to be unbelievable.

I don't think the people in the major centres, the city folk, the people living in Regina, Saskatoon, Prince Albert, even the regional hospitals like Yorkton, I don't think they know what they're up for. Because like some of the people said here, they're also going to have to wait in line because you're going to wait for a bed that's then already occupied with somebody coming from a rural area.

I can see that if they would like to have all the services centralized, let's say, this is regional as well as tertiary would at least have to be doubled.

The Chair: — Mr. Thomson . . . oh, Mr. D'Autremont, are you done? Mr. Thomson.

Mr. Thomson: — Actually, before Dr. Greyling runs away, I would maybe just invite him to take his seat. I have a couple of questions.

I want to start by just generally saying a big thank you to the people of Redvers who have both come here today and who on Friday took time out of their schedules to show me around the community and through the various facilities. I was both pleased to be down there . . . Part of me feels like I now need to give them a tour of my town here in Regina but I'm told they're on a tight schedule so I won't do that.

Dr. Greyling, in your presentation today, you made the comment — and I think it's worth repeating — you said, we already have what Mr. Fyke is wanting from a health care team and more.

And I have to say that when I was taking a look at the Redvers centre it was very much what I thought of in terms of a primary care model. We had a team of doctors who were qualified. We had lab technicians. We had home care. We had physiotherapists. We had a public health nurse.

In many ways I think that that does serve as the kind of model of what we want to build in rural Saskatchewan. Now one of the things which I'm interested in is the relationship between the type of clinic that you have, the clinic facilities, and that relationship to those acute care beds.

Now when I was through on Friday I think there was only one patient in the 12 beds. Obviously your daily count is about five. To what extent are those beds used? To what extent do you need to make sure that you have access to the number of beds that you have within that facility now?

Dr. Greyling: — I think our average is somewhere around five. If you were there a week earlier, we were up to full capacity. We certainly do try to limit — I think we discussed it when you were down there — we try to limit the amount of patients that are non-acute. Sometimes we do get stuck with patients who might be needing chronic care, waiting for a placement in the chronic care facilities, but that's more the exception than the rule.

My feeling would be that there are . . . In this case there are statistics. In this case we'll just speak for ourselves, yes, that

we're running at about half of our capacity most of the time.

But it's more about the integrated services that we're trying to stress today. That you need the acute care facility, you need the emergency room. You need trained staff as well as nurses and doctors. You need diagnostics. You need X-rays to provide proper service.

Mr. Thomson: — Madam Chair, I've obviously had a chance to talk to many of the people who were here. And I simply want to say I am very impressed — both with the community of Redvers, which reminds me a lot of Shellbrook where my dad lives. It's a very healthy, strong community; good economy. Real sense of community to it and a real sense of community spirit and I think that speaks very highly for the folks in Redvers.

Secondly, I want to say that I think what they've built down there in terms of a health centre, and an approach to health care is one that we need to think about very seriously as we consider the Fyke report because there are a lot of things in there that, I think, are already demonstrating the advantages of primary health care. And I think it's been implemented in a very successful way in the community of Redvers.

Thirdly, I want to say that we need to be, in my mind, mindful that sometimes when you take a look at the maps and draw circles, putting your compass in at one point and drawing within the radius, it doesn't always reflect what things are like.

The good folks of Moosomin, for whatever reason, directed me down Highway 8 to get to Redvers. I'll tell you if it hadn't been for the fact, I think I was still looking for my bumper and muffler, I probably would have taken down some of the highway signs myself.

We need to understand the patterns of how these communities work. There's a strong east-west pattern, a good strong connection with many of the communities in Manitoba.

And I want to congratulate the presenters today for, I think, bringing forward a very broad-based understanding to us of what is going on in their communities. And I want to congratulate you on really a very good presentation and having very good health care out there.

I have to conclude by saying what I tell everybody which is that number one, the government hasn't decided what if anything out of the Fyke report will be implemented. This is part of the process we're going through is to try and hear what is good out of it, trying to hear what the limitations are, try to hear what is happening throughout the province because there are many innovative things happening in our communities. And that is one of the functions of this committee today and, as such, your time is much appreciated.

So with that I'll simply say thank you.

Mr. Gantefoer: — Thank you, Madam Chair, and I'll be brief. First of all, I would like to express my thanks to everyone from the Redvers community, not only for the excellent presentations, the excellent material, the presenters, and the very, very touching testimonials that make us more sensitive and increasingly aware that health care isn't just a theory, it's a people thing. It's about people and not just money.

I also want to say that it's not just those that presented but all of those that took the time out of their lives to come here today that epitomize what rural Saskatchewan communities are all about and gives the people of this province through this process today a real sense of the concern and worry that exists in rural Saskatchewan about access to quality health care. So thank you very much.

I have one question for you, Dr. Greyling, in terms of two lines in your presentation that I think are important to see if you could expand on. And that is that you said, near the end, that in South Africa a couple of years ago they experimented with centralization — and I think it was underlined when you said it did not work — and now they're moving back to decentralization.

I wonder if you could, for the record, and from your experience, describe briefly, at least, what that experiment was, or that experience was, of the centralization and why it didn't work?

Dr. Greyling: — Sorry, I didn't know that I was going to answer so many questions today. But my feeling with . . . (inaudible) . . . in South Africa that it failed due to the problem that the big hospitals were swamped with so many patients, some really acute, some semi-acute, and some just straight walk-ins.

The problem was that the guy was really acutely ill, like they have now happening in Winnipeg, he was just lying in the corridor. And somebody else who was not as ill was being tended by the doctors.

So that the system of primary, secondary, and tertiary care is working there; that the primary care screens the patient, and they control and treat the ones that they can. If they can't treat them, they send on to secondary level. If it still is not being treated there, the special cases, only go through to the big centres.

And South Africa has been going back to that way of treating the patients.

Mr. Gantefoer: — Do I take it then, briefly, that they actually went away from the primary and secondary services, and tried to do everything in the large hospitals?

Dr. Greyling: — That says they didn't try to . . . they tried to treat patients according to the way they live, and not according to primary, secondary and tertiary levels. So that's why often in the big hospitals, they would have walk-in clinics.

The problem with those patients is they were often over-treated. The patient who came in with a very minor illness would often have to go through a battalion of tests just because it is available. Where the person who is living rural will just have the opposite affect, because services are not available; because the services in the city are overloaded, they get a second grade type of management of the diseases.

The Chair: — Thank you. Ms. Bakken, if you could end this

presentation.

Ms. Bakken: — Madam Chair, I just would like to thank the people of Redvers for your excellent presentation, and for your hospitality when I was in your town last week. And it certainly was an inspiration to me to see your community work together and your concern for the people that live there and providing care for them in whatever means they need it.

I think it's timely that you're here today, not only to give us as elected officials but the people of Saskatchewan that are not fortunate enough to live in rural Saskatchewan, to see what rural Saskatchewan people face every day and the challenges that they have to provide health care in their centres.

And I too had the privilege of driving over Highway No. 8, Mr. Thomson, and we also need to be aware that the people of rural Saskatchewan have challenges with their highways every day. So we need to keep that in mind as well.

I think that Redvers is but a mirror of the other 50 communities that are also concerned that they're going to lose their hospitals. And we've heard other presentations that are very similar.

And so I'd just like to thank you again for coming. And may we never forget that health care is about people, real lives, compassion, and caring, and not just get caught up in dollars and policy. Thank you for coming.

The Chair: — I see no more questions. It's almost redundant, but I do want to, as Chair of the committee, thank all of you on behalf of the committee, all the presenters for the very comprehensive snapshot you gave us of southwestern Saskatchewan . . . or southeastern — I have the map too — community — and I've been to Redvers. Thank you very much for giving us that very comprehensive snapshot and presenting the various views of your community.

I want to particularly thank the people who shared their very difficult personal — and very personal — stories with us. And I want to thank all the community for coming and participating in gathering the information and presenting it.

And I just want to say that on behalf of the community we . . . on behalf of the committee, we did hear you.

Applause.

The Chair: — Welcome to the standing committee. I'm sorry we're a bit late. I just want to give you a couple of beginning comments, that this is the Standing Committee on Health Care. It's a committee of the Legislative Assembly. It's an all-party committee.

I'm Judy Junor, Chair of the committee. Dr. Jim Melenchuk is Vice-Chair. Other members are Andrew Thomson, Deb Higgins, Kevin Yates, Brenda Bakken, Bill Boyd, and Rod Gantefoer. I'm not sure if Dan D'Autremont will be back or not.

The committee's first order of business is to receive responses to the Fyke Commission or the Commission on Medicare and to report back to the Legislative Assembly by the end of August what we've heard. So that's what we're doing in blocks of half-hour presentations.

And we welcome you here today. And you can just state your name and where you're from and begin your presentation.

Mr. Korte: — Thank you and good afternoon, Madam Chair, and members of the committee.

Allow me to introduce myself, as you requested. My name is Dennis Korte and I'm the mayor of the city of Humboldt, past Chair of the Central Plains Health District and St. Mary's Villa nursing home.

First of all, I want to thank you for the extra sittings you have allowed to accommodate us and others so we can speak on behalf of our people regarding the Ken Fyke report on medicare.

My presentation is not lengthy. I want to comment on recent health developments in our area of east-central Saskatchewan around Humboldt and the Central Plains Health District from a layman's viewpoint. I also want to tell you of the energy and vitality of my city and district as it relates to our hospital needs.

Sustaining a quality system. How can the words of a small city mayor influence a major report like that presented by Mr. Fyke? He has experience in health administration and 26 pages of bibliography to back up his findings and recommendations.

We in rural Saskatchewan also have experience of the practical kind regarding sustaining a quality system. I don't mean to infer an unappreciation of Mr. Fyke's credentials at all, but to suggest that we have practical experience of a different kind.

I was one of a group of people who organized the Central Plains Health District, and as its Chair for a term, made and watched great adjustments in the lives of people, and specifically the communities of Watson, LeRoy, Spalding, and Cudworth.

People of our region have experienced traumatic times — and that's not an overstatement — as we agonized over closures, amalgamations, and changes to health centres. Through all this change during the past decade, the backstop was the current full-service hospital in Humboldt and the parallel planning to replace it. Currently in Humboldt where we have 10 doctors, full public health services in the centre of this large service area.

This planning that led to the abovementioned hospital has been important and vital for our region. We fully expect St. Elizabeth's Hospital to be a regional hospital, to continue in Humboldt as we currently offer, if not all, most of the services as proposed for a regional hospital in Mr. Fyke's report.

In support of this planning Humboldt has recently grown to city status, and equally important has been the strength of our rural and city industries. We know of industry expansions that will spur job growth of near 250 by July 2002, further expanding the 29,000-plus people in our utilization area.

Humboldt is a progressive growing community in the midst of a stable area. We've had over 28 million in building permit activity in the last five years, many private condominium

projects in our downtown core that will further accommodate Humboldt as a strong retirement centre. Also in early June of this year, 2001, Sask Housing Minister Ron Osika helped us open a million-dollar-plus public housing project to add to our already significant inventory of public housing homes.

In a 1995 study, University of Saskatchewan professor Jack Stabler found that rural Saskatchewan is in the midst of great change and that only seven communities or thereabouts would become full-service centres. The study predicted that our community is a full-service centre and it will continue to progress. Health service is a key to us.

We've been planning for our new hospital since 1992. We have nearly seven and a half million dollars of local funding in place. Our functional programming and design work is nearly complete, and our region anticipates approval. Plans call for a full-service hospital health centre, a one-stop place for patients, outpatients, therapy, public health, home care, resident staff and surgeons, and day surgery programs.

I believe you're going to have a presentation from the Central Plains Health District; they can expound further on the numbers that support those programs.

I'm here before you today to say yes to our regional hospital as you respect the needs of our rural region and its critical mass of people. We are still a rural province and much of Saskatchewan's prosperity hinges on strong rural service clusters. As a friend of mine said, we have to do things to put up with ourselves.

Mr. Fyke has proposed solutions and as a society we need to balance sustainability and need. Governments are in place to do things that benefit us that we can't do ourselves. You really can't pick and choose which of you, which of you in the major centres or those of us in rural Saskatchewan are more valuable. We also need services and we're part of the future too.

In closing, I want to thank you and Mr. Fyke on behalf of our community of Humboldt for the hard work put into this business; and also the larger region of nearly 29,000 — on their behalf — that we serve, for considering the points raised in this presentation. I sincerely thank you for your time. Thank you.

The Chair: — Thank you very much. We have now lots of time for questions.

Mr. Thomson: — Thank you, Madam Chair. And I'd like to thank the mayor for coming in today.

I'm interested in . . . This is one of our first opportunities as a committee to really talk about regional hospitals and what Mr. Fyke might envision and what the communities might envision us being able to build in around the regional hospital system — this enhanced system he's talking about.

I'd be very interested to know what you would think should be a component of that regional hospital; what sort of enhanced services we would see over what we currently have in Humboldt today.

Mr. Korte: — I think the report of Mr. Fyke clearly outlines what he sees in a regional hospital. And our hospital, as I know it — as I prefaced my remarks, from a layman's point of view — I believe we do have most of those services that a regional hospital would require.

We certainly have therapy. We have obstetrics. We certainly have the day, the day surgery programs — physicians from Saskatoon that come out and . . . So not being able to fully answer your question, we have many of the amenities that a regional hospital would, in my opinion.

Mr. Thomson: — Thank you, Madam Chair. I guess to the mayor I should be honest and say it was a nice way of asking what services do you currently have.

But one of the questions I also was interested in was in terms of the expanded diagnostics. We've had some discussion — I guess this is the second discussion we've had since Swift Current — we've had some discussion from them about the regional centres.

What kind of expanded diagnostic services would you be looking at? Or are you currently well served being sort of, it looks like, equidistance between Saskatoon and Prince Alberta — CT (computerized tomography) scans, MRIs (magnetic resonance imaging).

Mr. Korte: — I'm not sure where we would go with that, sir.

Mr. Thomson: — Thank you, Madam Chair.

The Chair: — Thank you.

Mr. Gantefoer: — Thank you very much, Madam Chair, and welcome Mayor Korte. And let me take this opportunity. It's the first time I've met you or seen you since you became officially a city in Saskatchewan. So congratulations to the city of Humboldt as well.

As you know, I'm reasonably familiar with the services Humboldt hospital provide. Most recently my mother passed away in your facility so we've spent a fair bit of time there, and I want to thank you and the staff of St. Elizabeth's for the very caring and compassionate care that they gave.

But it also indicated, spending time in the facility, that indeed it does need replacement. It's seen its useful life and I think the plans that you're making as a regional centre that you've outlined are very responsible ones.

One of the relationships that also is unique in Humboldt is St. Elizabeth's Hospital is actually owned by the Catholic health system and operates with the district as an affiliate, as I believe you are aware.

From your experience, does this relationship create any impediments to the replacement of St. Elizabeth's as a regional hospital? And is the affiliate agreement working well with your health district and community?

Mr. Korte: — I believe it's a workable situation. It has worked for us in the past and I believe that the plans are that the current arrangement would continue.

Mr. Gantefoer: — In terms of services that are provided, are you looking at a particular expansion of services? And you named a number of them from, you know, physiotherapy, obstetrics, gynecology, and a various number of surgeries, both from family physicians that are resident in the community and also a pretty complete day surgery and itinerant surgery program from specialists out of Saskatoon.

Are there any services, that your study group in doing the functional planning for the replacement of the facility, that I have identified, that you need to look at attracting to the community or are you pretty satisfied that the range of services that are now provided are meeting the needs of that area?

Mr. Korte: — I know the functional programming has taken place. I have not been part of that, of the functional programming. But I know that . . . I was on the committee when it started five years ago and I am not part of that now. I know that it is ongoing and that progress has taken place but exactly what those functional programs are . . . I didn't allude to them at all.

And I didn't do any research on them because I know that the Central Plains Health Board and their planning committee will be here and they can certainly provide you with information that is current, succinct, and really accurate.

Mr. Gantefoer: — Thank you very much.

The Chair: — Any further questions?

Mr. Thomson: — Sorry, Madam Chair, and fellow committee members, I've been so quiet this afternoon, I thought I'd get in twice on this.

I wanted to ask about district reorganization. In the two possible configurations Mr. Fyke has outlined, Humboldt and Central Plains fall into two different areas. Now I'd be interested in knowing, setting aside Mr. Fyke's report, how you would see the districts working together if we were to move to a district consolidation? Well, number one, should we move to district consolidation? And number two, what would be a natural catchment area for Humboldt?

Mr. Korte: — I like the idea of reorganization. One thing that I find a bit unusual in the Fyke report just from my reading of it, is that the reconfiguration would follow existing boundaries that are there now and they're kind of jigged-jagged. And so I would think that the number that he requests, that he suggests — 9 to 11 — would work. I think that the 11 would work.

But our catchment area extends from Bruno primarily east; it follows our Central Plains District.

So we have no natural ties to either, either one of these suggested boundaries. One of them is being tied to Yorkton and the other one would be an affiliation with Prince Albert, if we went to that one. We really don't have a natural trade with either one of those. But if it's — I'm not sure how it would work — if it's an administrative thing, of course it would work however it's put together.

So I really agree with the downsizing of the districts. I was part of the group that put them together and there were too many. I think that's a correct move. But just how to configure them — I suppose that would follow services, sir.

Mr. Thomson: — Thank you.

Hon. Mr. Melenchuk: — Just one question. In a bit of follow up to what Andrew Thomson was getting at, in terms of the role of a regional centre, you would see Humboldt as filling that role. And as a natural service area, is there an expectation that your catchment area would actually increase from the current 29,000?

Mr. Korte: — I'm not sure what they would do. I'm not sure what would happen with other facilities in our vicinity. I really don't know where that would go.

We have 29,000 now. Our catchment area, when we use those numbers, it doesn't go as far east . . . like we draw from Kelvington, as far away as Kelvington; they come to Humboldt for professional services. So I think it would expand out there.

Hon. Mr. Melenchuk: — And just to follow up, certainly it's Mr. Fyke's intention with regard to the regional centres that they would provide services that would be over and above I think what are currently in existence in Humboldt.

He would talk about the basic specialities being located on-site, such as an internal medicine specialist, such as a general surgeon, which I think you have had — I don't know if you currently do — perhaps an orthopedic surgeon; but not the subspecialties, like rehab specialists or cardiologists or things of that nature.

If that was the case, would you see your drawing area increasing?

Mr. Korte: — Yes, I certainly would then. Absolutely.

Hon. Mr. Melenchuk: — That's all the questions that I had, thank you.

The Chair: — Seeing no further questions then, thank you very much, Mayor Korte, for appearing today. And thank you for your time and for your effort to get here.

Mr. Korte: — Thank you.

The Chair: — Our last presenters today are from the Moose Mountain Health District. Welcome, nice to see you again.

This is the Standing Committee on Health Care. It's a legislative committee of the Assembly and . . . Or a committee of the Legislative Assembly. It's an all-party committee.

I'm Judy Junor, the Chair of the committee. Dr. Melenchuk is the Vice-Chair. The members are Andrew Thomson, Deb Higgins, Kevin Yates, Brenda Bakken, Bill Boyd . . . no, Dan D'Autremont — it just keeps moving all over the place on me — and Rod Gantefoer.

The committee's first order of business was directed by the Legislative Assembly, to receive responses from groups and

individuals on the Commission on Medicare, the Fyke report. So we have set aside individual . . . or 30-minute blocks for people to do that. And I welcome you here today to do your presentation.

We have to respond back to the Legislative Assembly on what we heard. We're not making recommendations; we're responding back with what we heard from individuals and organizations. And we do that by the end of August.

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

Mr. Arthur: — Well thank you, Ms. Junor, Chairman of the Standing Committee, and members of the standing committee. My name is Alan Arthur. I'm the Chairman of the Moose Mountain Health District. And accompanying me today is Ms. Lynn Brady — Lynn is the Vice-Chairman of the health district — and Mr. Warren Wallin. Warren is the CEO.

The Moose Mountain Health District is configured in the southeast corner of the province, comprising the main population centres of Kipling, Wawota, Arcola, Carlyle, and Redvers.

And I feel somewhat as the man who brought a sandwich to the banquet after listening to Redvers presentation. I suspect I may well fall short here today.

As the board of the Moose Mountain Health District, we find that we cannot argue with many of the comments contained in the Fyke report. Where we have difficulty in accepting some of these recommendations is in the model of the service delivery that is being proposed.

Since the time of health reform and amalgamation, our district has made great strides in improving the integration of comprehensive health care service delivery. From its earliest days this board has adopted the philosophy of delivering a comprehensive range of services within 30 minutes and 30 miles of 95 per cent of the people in our district.

And I would like to repeat that. Services delivered within 30 minutes and 30 miles of the residents of our district.

Throughout this brief we'll share with the committee the strides that we have made in delivering these services and compare them to the concept that Mr. Fyke has recommended in his report.

Our format for this brief will articulate first of all the services we need to provide our residents, who needs to provide them, what infrastructure is needed to provide these services, where Fyke says we should be, and where our district actually is.

Let us begin with the services we need to provide. Our concerns revolve around providing basic health services to the residents of our district. Basic health services include but are not limited to the provision of acute and emergency services, long-term care, home-based services, diagnostic services, mental and public health, community therapy, dietitian, nutrition, respite and palliative care.

Across the ages certain things are required to maintain health. Beginning with the prenatal and flowing through the stages of aging, we need the services from medical consultation, the community programs, acute care, long-term care, and finally, palliative care.

It is our responsibility as a larger community to ensure that there is an infrastructure in the communities to deliver these programs.

Let's begin at the beginning. Prenatal care and counselling are provided throughout our district. We provide labour and delivery in one facility. Post-natal follow-up, early maternal discharge programs, baby clinics, early childhood development programs, and it carries on from there, are delivered through the district by home care nurses and public heath nurses.

Basic acute care services, treating common illnesses in the young and the not so young such as gastroenteritis and respiratory infections, and these could carry on, are available to our districts. Families and individuals who suffer from such illnesses should not be expected to travel great distances to receive these very basic acute care services.

Traumas occurring on our farms, in the oil industry, on our highway system, as well as cardiac emergencies all receive immediate and appropriate medical attention through our current emergency department.

Our facilities are the sites where stabilization and evaluation, the decision to treat in our facility or to transport, is made. Stabilization and timely intervention in a medical incident enhances the possibility of a positive outcome. We believe that this saves lives and reduces the long lasting effects of trauma, stroke, and heart attacks.

Our facilities provide post-operative acute care, convalescent care, and rehabilitative care for people discharged from the tertiary care centres. These services are provided in a local environment at a decreased economic burden on the health delivery system without compromising quality care.

Our facilities provide acute care services for the low end or the sub-acute cases — the cases which require institutional, professional care but do not require specialist services. These services are essential to our people and in our view are best delivered, both from a viewpoint of economic and quality care, at our local facility.

The availability of long-term care in our district has been problematic. The principle . . . the provincial average of long-term care beds is 121 beds per thousand of people year 75 and over. And at present our district has 83 beds per thousand persons 75 years and older.

Even though we provide wellness clinics throughout our district, promote healthy lifestyle workshops and seminars, nothing can change the fact that we have an aging population in our district. And we will continue to have a need to provide long-term care services.

At the present, we have a list of over 65 persons waiting for long-term care placement in our district — 65 persons that are

categorized as heavy level 3 and level 4 people. People that require institutional care.

We have an active home care program whose demand for services outstrip our ability to supply them, both from a human resources and from a budgetary viewpoint. This problem is exacerbated by the shortage of long-term care beds and respite beds in our district.

The board sometime ago made a commitment to provide palliative care in each of the major communities that we serve. It is the intention of the board to keep care close to the family and have adopted . . . and we have adopted the philosophy that we should not have to ship people many miles down the road away from their home for these services.

Who's going to provide the service? A team approach is needed to provide all the services that are required in the district. At the present time, we have a professional staff in our district which includes physiotherapists, public health nurses, dietitians, community and mental health nurses, acute long-term care and home care nurses; combined lab and X-ray technicians. And the list goes on.

However, being in rural Saskatchewan, recruitment and retention of competent staff is always a problem. In order for any system to work efficiently, we need to have some incentive to make it attractive to staff. While wages is, and always has been, a large part of that incentive, job satisfaction factors high on that criteria. We need to have a proper and adequate facilities and equipment to create an acceptable work environment.

Physicians as well are a part of that team. Without adequate facilities, equipment, and a competent support staff, it is impossible to attract or to retain physicians. The availability of diagnostic services and the ability to admit to acute care is imperative in making it functional for the physicians to practice. Without both of these services available, physicians will leave and they will not be replaced.

The infrastructure. Through teamwork between our communities and the health district, a solid infrastructure has been developed. In the majority of cases, it has been the local communities who have raised funds for the construction and/or the renovation of the facilities, as well as for the purchase of needed equipment. Through this co-operative attitude, not only much needed capital has been raised but it has already led to a sense of pride of ownership of the services and of the facilities in the community.

What does Fyke say? In his report it states doctors, nurses, therapists, and social workers operate as an interdisciplinary team, each contributing unique skills which, taken together, ensure a comprehensive range of services.

In our opinion we are providing just that kind of service. In the appropriate communities, a full range of services — from acute care, long-term care, emergency, community, mental health, public health, palliative, home care, and other community-based services — are being offered. We believe that those services are currently being provided in our district, and provided as a team.

Regarding long-term care, Mr. Fyke's report states that the distribution of beds will need to keep pace. Timely and careful measured access to long-term care and home care is a key if we're to avoid having seniors admitted to the hospital and staying far too long because there is no alternative available in the community. We couldn't be in more agreement with Mr. Fyke in that report.

The provincial average of 121 beds per thousand over 75 years and the provincial utilization of 100 beds per thousand over 75 years is a fact of life in Saskatchewan. And in order to keep pace with that, the 121 and the 100, some enhancement to our present situation of 83 beds per thousand is necessary.

You've heard today the comment of the emergency services report from Redvers and I would say that that report pretty much echoes the situation in the rest of our district.

We currently have five ambulance systems in our district with a response time of less than 30 minutes to anywhere in our district. Geographically, from receiving the call, we are within 30 minutes of being on site 95 per cent of the time, weather and roads permitting.

These services are dispatched through the Regina Health District emergency response department. We believe that this is a sustainable and effective emergency response system.

In the Fyke report it states that specialist services and acute care services will be delivered out of tertiary care and regional care facilities. As a result of this change, a number of the acute care hospitals will no longer function as this will result in further increased demands on available acute care beds in these tertiary and regional centres.

We presently offer a valuable service that takes the pressure off the larger acute care centres whereby we admit post-op convalescing patients and early discharges, those people that still require acute care but do not require care at the level of regional or tertiary care hospitals, thus freeing up those beds that could be used by the more acutely ill.

Accessibility. The distance to travel and the availability of the beds when one arrives at these centres is of a significant concern. Long-distance travel for the very acute service . . . for the acute services is a hardship on seniors and for the very young patients and their families. There is also the problem of weather and roads when long-distance travel for these very basic services are required.

District amalgamation. And in fairness, I should state that we are probably one of the smallest districts in this province. And we don't want to equate small with loss of quality — small is a geographic term for us.

The report suggests a much larger geographic configuration, and we believe that this will result in loss of community input and decision making which would impact negatively on the community health board relationships.

We currently enjoy good working relationships with our communities and our local governments, both rural and urban municipalities. Their co-operation and support in the capital projects, in the equipment replacement, in program delivery,

and the philosophical support that they have given us is essential to the delivery of health care in our district.

In conclusion, we are in agreement with a number of the recommendations in the report such as quality council and the team approach to health care delivery. However, we have concerns about accessibility and availability of acute care, emergency and long-term care. We believe that the needs of our residents can adequately be met with a revised model of services that continue to allow us to deliver acute, long-term care, community-based services, and emergency services centred closer to our district residents.

Thank you.

The Chair: — Thank you. We now have some questions.

Mr. Thomson: — Thank you, Madam Chair. I have a couple of questions. One I already know the answer to, so I will ask it again; I'd asked you last week when we talked. Could you just describe for me the working relationship between Moose Mountain and some of the surrounding districts, in terms of whether there is one with, obviously Pipestone, South East, South Central, which are all sort of surrounding you? Could you just elaborate on what the relationship is like?

Mr. Arthur: — Well the Moose Mountain Health District is surrounded on the north by Pipestone, on the west by South Central, and on the south by South East. So we're right in the middle.

We have a service agreement arrangement with South East and South Central whereby the host district, which is South Central, provides to us services on a shared basis that none of the districts could actually support either financially or recruit to, alone. So we have that arrangement. We provide to South Central some public health services on a shared basis as well.

Pipestone is in a different service district than ours but we have some agreements with them; for example, pharmaceutical services, and some physio and occupational therapy services that we have on a shared arrangement.

Mr. Thomson: — One of the reasons I ask is as I look at the Moose Mountain District; I see Redvers, Arcola, and Kipling. Now it seems that Kipling is awfully close to that Pipestone district, and I was wondering if there was a natural relationship in terms of the sharing. Does the district split along those lines, or is it really one where the services are shared throughout?

Mr. Arthur: — The services that are shared from Pipestone would be, as you suspect, more to the north and to the west, in terms of human resources. The pharmaceutical services, which are headquartered out of Moosomin of course, is on the very eastern end of Pipestone, and on the eastern end of our district as well. So I think we share back and forth quite nicely.

Currently in Wawota, we have a situation where the family practice, which is a group of physicians from Moosomin, actually provide the medical care for Wawota.

We move back and forth across the boundary quite freely, and have enjoyed a really good relationship that way.

Mr. Thomson: — My final question, Madam Chair, concerns the services offered in Kipling and Arcola. I have learned a great deal about Redvers of late, and would be interested in knowing more about Kipling and Arcola and what type of services we have there, the size of doctors' practices, and how stable those would be.

Mr. Arthur: — If we can begin with Arcola-Carlyle. It is a two-physician practice there. And basically we offer, with the exception of labour and delivery services, all the services that you heard described today out of the Redvers facility would be offered out of the Arcola-Carlyle facility.

In Kipling we have a three-physician practice. And again, with the exception of labour and delivery, that full range of service that was described — delivered out of Redvers — would be delivered out of Kipling.

Mr. Thomson: — I should actually correct myself. My short-term memory's going. But obviously we spent a good deal of time yesterday with Kipling. So as it's mentioned to me, it's all coming back to me now. So thank you for that.

The Chair: — Thank you. We do have a stack of paper. Any further questions?

Mr. D'Autremont: — Thank you. I'd like to also thank you for your presentations especially as a follow-up or in conjunction with the Redvers' presentation, which outlined for us the services that are available.

One of the things that was mentioned in Redvers' presentation, and I believe in yours, is the amount of money that the community has put forward for health care. And I believe that's not just the case in Redvers, but the case in the other communities across the health district.

I wonder if you could outline for us some of the involvement the community has had in providing services. What they have paid for? How this compares to your operating and capital money that comes from the province? And how you view that in relationship with the other districts across the province?

Mr. Arthur: — Perhaps we could start with the capital projects and work our way through the operation side after that.

I'll start with the Redvers' project because that's close to home. It was a $2.3 million project for the acute care side of our integrated facility. And that was funded entirely by local government and the communities. That is being funded as we speak.

The proposed long-term care addition in Redvers, which would be about a 3 or $3.2 million facility, will be cost shared, we understand, by the provincial government according to the 65/35 formula. Which in that case would require $1.1 million local money.

Carlyle in 1998 opened the long-term care facility; an addition to the long-term care facility of 16 beds. That was funded according to the 65/35 formula. And it required somewhere in the neighbourhood of 800,000 local money and 16 — I was going to say 16 million but that may just be a bit high — 1.6

million of government money.

Arcola did an extensive renovation of the acute care facility there in which the 1928 wing was destroyed and an addition put in place, as well as updating and modernizing the rest of that facility. That was a $1.1 million expenditure. And that was funded entirely by the Brock Union Hospital trust or non-profit corporation.

Wawota moved the Wawota Memorial Health Centre or memorial hospital to adjoin it to the long-term care facility. It actually moved the building across town and attached it to it forming one building. And that was approximately $750,000 and that was by the Wawota Foundation.

Kipling is currently in the process of developing an integrated facility or a plan for an integrated facility. It's difficult at this time to say what scope that would be, but we are anticipating that it would be in the neighbourhood of five and a half — given the cost today — five and a half million dollars. We remain hopeful that it would be shared 65/35.

The capital replacement, which is basically our ambulances and our machinery, our lab machinery particularly, and furnishings — if I can speak of lab equipment — we aren't funded in line-by-line funding in the Health budget for replacement of lab equipment. We frequently go to the foundations in the district to provide funds to buy the lab equipment. And to date we've been very successful in doing that.

The ambulances are replaced out of our capital reserves that we have accumulated or that had been transferred to us from the union hospital long-term care and ambulance associations. I don't know if I missed anything on that but I think that would give you a general idea of the scope.

Mr. D'Autremont: — Well, thank you. Looks like from your numbers that the communities and the Moose Mountain District have put over $6 million in the last couple of years into health care in their area and potentially that much again in the future. I'd like to congratulate you on that.

Thank you.

The Chair: — Thank you.

Hon. Mr. Melenchuk: — Thank you, Madam Chair. My question . . . we've heard a very good, a very comprehensive, basically, presentation yesterday and today in terms of the services provided in the Moose Mountain Health District and also how those services are delivered.

The question I have is with regard to funding. The current demographic population-based funding system that we have in place, whether you see that out-migration perhaps is penalizing your district or whether your district receives adequate funding for the services you provide? And perhaps you could suggest perhaps a model that might be a little more efficient in how to fund the district. A little bit of a controversial question.

Mr. Arthur: — I think it would be fair to say that we'd accept more money any time.

We have a number of things, and as you allude to, first of all, address the out-migration part of this because as you're aware the funding formula depends heavily on weighted cases. And for example, for pneumonia — and these may not be the right numbers — but it would take five or six pneumonias to equal one small heart attack. And that's sort of how the formula is weighted.

We suffer from a lack of a large specialist area in our district, and so for most of the very complicated, and therefore the heavily weighted cases, we transfer out either to Regina or to Brandon. Or to Saskatoon in some cases.

So we have a continual out-migration factor in the acute care funding. We have an equally acute problem in the long-term care funding formula because of out-migration as well. We have a waiting list of 65 people as of yesterday, and these people have really very few options but to take the first placement that's available. And in some cases, and in a lot of cases, that would be placement outside our district.

When you place outside your district there is a penalty involved for them having to move outside your district. The funding follows the people. It also means that we aren't able to generate the revenue from the facility itself.

The respite circuit or the — I shouldn't say circuit — the respite beds are located for the most part outside our area. The demand for our respite beds is so heavy, because of the 65 waiting list that people move outside our district, and it's necessary by the formula to be penalized for that as well.

So the funding formula does not treat us in a light that we wish it would. The other complicating factor is, because we sit along the Manitoba border, we have a catchment area and provide outpatient services to the Manitoba people, and they are not included in the demographics for our formula.

The First Nations on the other hand are included and are good users of our facilities and our services.

We are . . . in our opinion we need more money to operate, particularly long-term care. We're doing reasonably well in acute care. Community services and particularly home care services are a real problem for us. Delivering home care in a rural environment is both an expensive way of providing the service, and it's very difficult to recruit trained professionals to provide home care services.

The funding formula could work if it was actual demographic funding, and a further departure from what the traditional funding portion of that formula would be.

Hon. Mr. Melenchuk: — Thank you very much. That was the question, yes.

The Chair: — Seeing no further questions, then on behalf of the committee, thank you very much for coming today. And nice to see you again.

Mr. Arthur: — Thank you.

The Chair: — I'll entertain a motion to adjourn. Mr. Thomson.

We’re adjourned until Tuesday, July 24, at 10 a.m.

The committee adjourned at 17:04.