Standing Committee on Health Care

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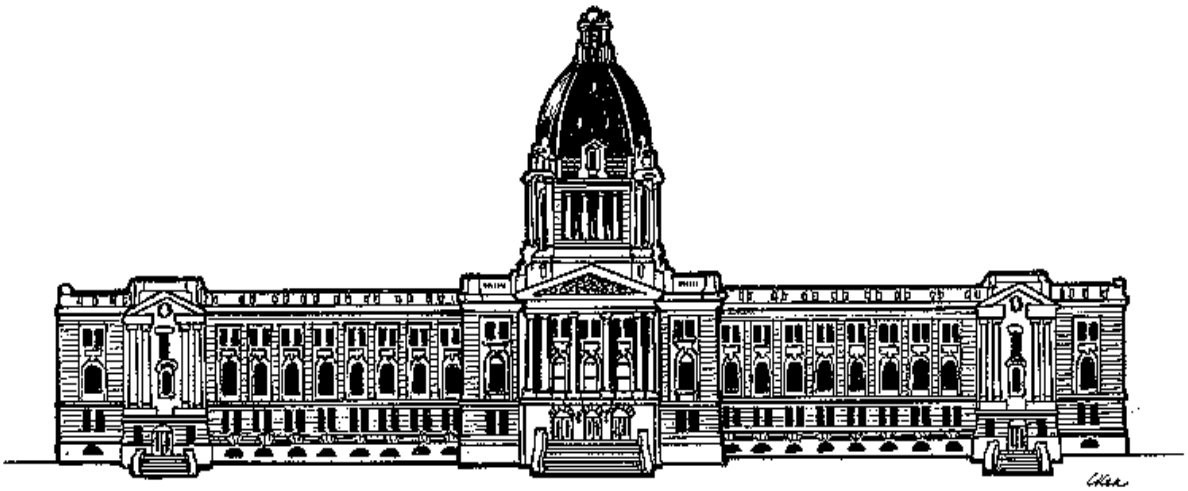

Legislative Assembly of Saskatchewan

Twenty-fourth Legislature

STANDING COMMITTEE ON HEALTH CARE
2001

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Saskatoon Northwest

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

The committee met at 10:03.

The Chair: — Good morning. Welcome to the Standing Committee on Health Care. The standing committee is a committee of the Legislative Assembly. Its first order of business is to receive responses to the Fyke Commission and to report back to the Legislative Assembly by August 30.

The committee is an all-party committee of the Legislative Assembly. I'm Judy Junor, the Chair. Dr. Jim Melenchuk is the Vice-Chair. Andrew Thomson, Kevin Yates, Buckley Belanger, June Draude, Bill Boyd, and Donna Harpauer are the members here today.

We've given groups about a half an hour for their presentation. And hopefully, you can . . . I know you've given us a written submission, so if you can highlight that, we might have some time for questions. And our members are usually interested in asking a few questions, so that would be appreciated.

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

Mr. Harrison: — Thank you very much. Thank you for giving us the time to present.

On my right is Ken Engel, the chief executive officer of SARM (Saskatchewan Association of Rural Municipalities); on my left is Neal Hardy, the vice-president, and Dale Harvey, the assistant CEO (chief executive officer) from SARM. And just to demonstrate how important we think this process is, the full board of directors of SARM is with us this morning.

My name is Sinclair Harrison, the president of the Saskatchewan Association of Rural Municipalities.

I'll make some comments about our presentation and then certainly we want to spend most of the time with questions and answers from yourselves. Certainly we have no medical expertise. We're just lay people, so we will confine our comments to two or three areas of the report. We will refer to it as the Fyke report, or the report.

The first area we'd like to deal with is the number of districts and reducing the number of districts that we have from 32 to 9 or 11, with three of those being located in the North, two in . . . well one in Regina and one in Saskatoon, leaving four or six districts remaining in the province. What this would mean for rural Saskatchewan is a major loss of local autonomy. Local residents would have little or no influence on the decisions made by the board of these districts.

At the annual convention in March, of SARM, the following resolution was passed:

> Be it resolved that SARM go on record as opposing any unilateral move to drastically reduce the number of health districts and that this opposition be strongly and immediately communicated to the Commission on Medicare, to the Premier and to the Minister of Health; any restructuring should be locally driven.

And you're quite familiar with the report, the maps. When you look at the size of the districts, people from Oxbow and Lanigan in the same district, there's little or no common knowledge of what's going on in those areas. So we would suggest either one of those models are totally unacceptable.

The report discusses whether members of the health district should be appointed, elected, or a combination of both as is the current situation. However the report does not make specific recommendations other than to say if the very low voter turnout persists, the government should retain the option of moving to a fully appointed board.

The apathy that exists in regard to health care elections no doubt goes back to when the health districts were originally formed. The implementation of the system of the health districts was a top-down process driven by the province despite protests from rural Saskatchewan.

When districts were first formed, the members of the health districts were appointed by the provincial government. It was not until some years later that a portion of the members of the board of directors was elected.

Voter turnout should not be used as an excuse to having boards of members appointed rather than elected. People will vote if they feel the vote means something. Health district board members should all be elected so they are accountable to the residents that are affected by their decisions.

Another area that we are very concerned about is centralizing of facilities. The report recommends that tertiary services be delivered in Saskatoon, Regina, and Prince Albert and 10 to 14 regional hospitals to provide basic acute and emergency services. No doubt there will be regional hospitals in the north part of the province so that will mean even less than 10 or 14 for the southern part of the province.

The Fyke report . . . If the Fyke report were to be implemented, up to 53 acute care facilities will be eliminated. This is unacceptable to the residents of rural Saskatchewan. And I'd like to repeat that. This is one that infuriates rural Saskatchewan. We've closed 52 hospitals already. To suggest that we'd be better off in rural Saskatchewan by closing another 53 is unacceptable.

The report states that there would be a maximum travel time of 60 minutes for 88 per cent of the population, and 80 minutes for 98 per cent of the population. These numbers do not take into consideration the fact that 40 per cent of the province's population live in Regina and Saskatoon. If you remove those numbers, certainly the numbers that we just stated are much and drastically different.

Without acute care facilities in rural areas, physicians would move to the larger urban areas where acute care facilities are located. Rural residents would no . . . would have to travel longer distances to access not only acute care services, but the services of a physician. There would be both a financial and a time cost to rural people.

Any substantial reduction in the number of acute care facilities

in Saskatchewan would be a major blow to the economy of rural communities. Besides the present jobs that would be transferred to rural communities . . . from rural communities to larger urban centres, there would be a much greater cost. When families make a decision on where they will live, there's two services that most take into consideration, and that is schools and acute care facilities. Communities that lack these services will find it that much more difficult to attract new residents and businesses. Rural Saskatchewan desperately needs economic development to make up for the challenges and changes being experienced in agriculture.

Last spring the provincial government set up the Department of Rural Revitalization with the goal of revitalizing the economies of the rural communities. The result of the reduction in the number of acute care facilities in rural Saskatchewan would be directly opposite to the goals and mandate of the new department.

The report recommends the development of a 24-hour advice system, and I guess we feel that that could be set up now, but having diagnosis done over the phone, having medical services provided over the phone is very limited.

Emergency services is something that is critical to rural Saskatchewan. The Fyke report only dedicates half a page to emergency services. It is much more important to residents of rural Saskatchewan than those living in large urban centres.

The report suggests key recommendations of the report of the emergency medical services review. One of these is centralizing province-wide emergency dispatch to coordinate both emergency medical services and medical transportation. This would only work if and when 911 services are implemented and operating efficiently in all of rural Saskatchewan.

The report recommends that ambulance fees should not be based on distance. We agree with this recommendation. The fees charged should be the same for everyone regardless of how far you happen to live from the required service.

The report recommends a minimum standard of one basic emergency medical technician and one emergency medical responder for each ambulance. This may not be practical unless these individuals can be deployed in nursing homes, community care centres, hospitals, or community programs because in smaller centres individuals spend a very small portion of their duty hours responding to calls.

The report does not recommend maximum time for access to ambulance services. As time is a major factor in saving lives in emergency situations, the distances from emergency services must not be increased. Funding to ambulance service providers must continue to make in a format that ensures that ambulance service is maintained and enhanced in rural . . . to rural residents.

Financial savings. The report states that expenditure reductions can be expected from a variety of sources. One of these sources is a reduction in the number of small hospitals. The report does not say how much would be saved. We expect that there would be a minimal saving for the closure of small hospitals. Large hospitals would have to be made bigger to make up for the loss in beds in the smaller hospitals.

The vast majority of health districts' costs are human resource related. Since there would not be a reduction in the overall number of employees if health districts or number of the facilities were reduced, savings would be minimal at best.

The report lists the following four other areas for savings: using all providers to the maximum of their scope of practice and using higher cost providers only when appropriate; less need for services through prevention, early intervention, and disease management; reduction in duplicate tests and inappropriate medications through improved information and prescription practices; and reduction in unnecessary emergency room visits through improved services and telephone advice.

The first three areas are common sense recommendations that can be implemented without a reduction in the number of health districts or facilities. They should be a part of all health care systems and should be a part of the strategic plan of health care in Saskatchewan.

The proposed telephone network would be one way of providing information to citizens, but whether it would save money is open to debate. There is a limit to what you can do over the phone.

The increased travel costs for rural residents must be considered when measuring any potential savings. Measurement of travel costs should include not only financial cost but the value of extra time that would be needed to travel further to obtain required services.

In conclusion, while some changes in the current health care system are necessary, they should not be at the expense of rural Saskatchewan as is the case with the recommendations outlined in the Fyke report. If the Fyke report were implemented, a two-tier health care system would be entrenched — one system for large urban centres and one for the remainder of the province.

Every citizen of the province deserves equal access to health care regardless of where they live. We urge the members of the Standing Committee of Health Care, as well as the elected members of the provincial government, to have empathy for the residents of rural Saskatchewan in making decisions regarding the Fyke report.

I would add one comment at the end. We understand there are a number of urban and rural communities, individuals on a waiting list to make presentations before this group, and council meetings in RMs (rural municipality) go from the 1st to the 14th. Your cut-off date was the 10th. There was . . . Some councils didn't make decisions till the 11th, 12th, 13th, and 14th of July and we would urge you to extend that deadline and hear everyone that has concerns with the Fyke report.

Thank you very much.

The Chair: — Thank you. Just a comment on your extension remark. The committee is done on the 27th of this month, this week, and we need time to put the report together.

What we've offered to those communities, and I think there's nine — and that's not all communities; there's a couple of groups in there too — is to present, as you have done today, a written submission which we will all read and take into account and the researcher puts into the report. So that's what's been offered to them.

Now we do have some time for questions. Mr. Thomson.

Mr. Thomson: — Thank you, Madam Chair. I'm intrigued by your closing paragraph in your report, the first sentence of which says, while some changes to the current health care system may be necessary. I'd be interested to know what SARM's perspective is in terms of what changes are necessary in rural Saskatchewan and what changes you would welcome.

Mr. Harrison: — Well I guess the one report we were very interested in was on the emergency services on ambulance care. Certainly there's great inequities in what it costs for rural residents to use and access ambulances. So we were encouraged by a universal fee, whatever that might be, so everybody is treated equally.

Mr. Thomson: — On the question of primary health care teams and the desire for more services or a broader cross-section of services in rural areas, I take it that would be welcomed by SARM also.

Mr. Harrison: — Most definitely. We met with SAHO (Saskatchewan Association of Health Organizations) yesterday. We've met with them on three occasions discussing the Fyke process and the Fyke report. And we understand they are going to elaborate on primary health care teams. We had a discussion with them, but certainly they're much more equipped to talk with that.

It escapes us how Mr. Fyke thought that doctors would stay in towns and areas where there were not acute care facilities. He was born and raised in this province, yet he seems to have lost some of his grassroots understanding of Saskatchewan since he's moved to the big city.

Mr. Thomson: — The second line in your last paragraph talks about us having two systems: one for large, urban centres and one for the remainder of the province. We had heard testimony from the Regna Health District that says about half of their patients that are treated here in Regina are from rural areas. Obviously rural citizens use the large, urban hospitals also, and not simply for advanced tertiary services but for some secondary medical procedures also.

Is your organization favouring us moving more of those services out into rural areas, closing off access to the urban hospitals, or moving more surgeries into rural areas?

Mr. Harrison: — Yes, certainly there are some things, and I think some of the rural hospitals are demonstrating some of the things that can be done out in rural Saskatchewan to take the pressure off the city hospitals. I don't think the people in the cities appreciate the time, the expense that people have to come into the cities for medical procedures if you lose your doctor, your X-ray — all those things that surround an acute care facility — with a broken finger, a broken toe, an examination, if you've got 50, 75, 100 miles in the wintertime.

These response times are based on ideal road conditions, which we have very little of in this province. You get into serious weather conditions, those can double, triple. Mr. Fyke unfortunately just didn't have an understanding of rural Saskatchewan in the year 2001.

Mr. Thomson: — One of the things that rural residents tell me, particularly older ones, is that they're concerned about the level of long-term care and the number of beds available.

Now in many facilities we have a large number of acute care beds that may or may not be utilized, but we have a shortage of long-term care beds. Do you think that there's some wisdom in us looking at perhaps expanding the number of long-term care beds or moving beds over from an acute care model over into long-term care?

Mr. Harrison: — I think there's several examples throughout rural Saskatchewan of integrated facilities where there's flex beds, I think they call them, where they can go from acute to long-term care. And certainly we support all those kinds of things.

Our population is getting older and there's higher use of those kinds of facilities. And to suggest that you can have a nursing home in a community where there's no doctor, it becomes extremely difficult because those people require a lot of medical assistance. So it drives those nursing homes also into the large urban centres.

Mr. Thomson: — I have one final question and then just a very brief comment. The question I have concerns funding. We've heard testimony that when people come from outside districts that the funding doesn't follow the patient. The funding stays in the districts.

Do you think . . . or would SARM be supportive of seeing the funding follow the patients so that where the patients are getting treated the funding should go also. Or should we continue to use a model, a funding model that basically supports or assumes the patients are getting services in their home districts?

Mr. Sinclair: — Well certainly we have to be consistent. And you need service wherever you get sick and you have to get paid for those services. And we have patients going from this province to Manitoba, to Alberta, just because of their proximity along the border. And we have people from Alberta and Manitoba coming into this province, and there's an exchange and people get paid.

To suggest that you only get paid for the patients you treat in your district and if someone goes outside the district for medical care, we're of the understanding we have universal health care in this province and you have costs associated with providing that, and those people that are providing the service have to get paid.

Mr. Thomson: — The only closing comment that I have is I just want to say thank you for presenting both the written submission and appearing before us today.

Mr. Boyd: — Thank you, Madam Chair, and thank you very much for your presentation, Mr. Harrison. I'm sure you're very, very familiar with the health care services provided in Moosomin — I believe your home community — and the model that I think that they are setting or have set for rural Saskatchewan in terms of a very positive approach to health care services; a team approach of health care providers that I think can and should be used as a model for all of rural Saskatchewan.

Can you relay to the committee the experience that your community is having with that team type approach that seems to be working so very well?

Mr. Harrison: — Well certainly I'm very familiar with that situation. I'm here as president of SARM and somewhat reluctant to refer to my own home community, but since you've asked, I will.

We're in a situation in that particular area where a hospital has been in very bad need of replacement for the last 25 years. And as the chairman of the union hospital district in the '70s and the '80s, we did studies and it was . . . we were told to replace the hospital then. We're still using the same facility.

There has been great effort from the area to bring in qualified physicians. And we have a team of six or seven, depending on who's there, but certainly South Africa has been very kind to us. We have a team of young, ambitious physicians. They've got outpost clinics in Manitoba communities, in all the surrounding communities.

We have raised most of our portion of the hospital fund, but things have ground to a halt with the Fyke report. Nobody knows where facilities are going to go if they're not going to go into areas like Moosomin. And we think there's probably 20 to 25 communities, 30 communities of that size that need those kinds of facilities with that kind of planning.

They opened the operating room. I shouldn't say they. We, collectively, with resources from the municipalities, opened the operating room so that procedures could be carried out there. They're doing some chemotherapy there.

But we call on you to act quickly and properly in this process because all of Saskatchewan's eyes are on this process and you must do it right; rural Saskatchewan has been stabbed too many times. And with rural revitalization we have to have health care facilities, and we would urge you to do something quickly.

Mr. Boyd: — So, it's safe to say that that is a model that the people of the Moosomin district, or Moosomin town and area are very, very strongly supportive of.

Mr. Harrison: — Exactly. And we have communities from Manitoba prepared to take taxpayers' dollars and build facilities. It's brought the whole area together. And as everyone knows, that's extremely difficult to do in difficult times.

Mr. Boyd: — On a more general note, last week we had a presentation from . . . an excellent presentation from two student nurses who said essentially that when you look at a critical decision-making process and you go through this decision-making process and you take into account the concerns and wishes of people from all over and you consult as widely as possible, and at the end of that very good decision-making process you make recommendations and you go forward.

And it was their conclusion as a result of the fact that this decision-making process as they set out was followed by Mr. Fyke, that as a result of that, good decisions had been made. Now I don't agree with that necessarily and I certainly put it on the record as my concerns in that respect.

But they insisted that it was progress; that Fyke has a plan. And because he has a plan and he's gone through a critical decision-making process, that the result of that process is his decisions are correct and that we should just simply accept it and move forward.

Now I want to go on the record once again as saying I don't agree with that. But I would ask what your view of that perception that it's progress and that we have to accept it and just move forward. What would your reaction and your association's reaction to that be?

Mr. Harrison: — Well if this committee chose to adopt Fyke in its entirety we would be violently opposed and we'll be back in this building immediately, is our initial reaction.

Mr. Fyke is one person. He's one person's opinion. Certainly he heard lots of submissions. He doesn't have to live with the results of his report. Is he going to live in this province? But everyone in this room, listening to this, has to. And we have to collectively come up with a system that works for urban and rural Saskatchewan.

In our opinion — and I suggest you've heard a lot of briefs and you've got a lot to hear from now, and if you need some more we can find them — but Mr. Fyke's report does not work for rural Saskatchewan.

We don't want to drive a wedge between urban and rural, but the big cities are big winners if you collectively move everything to the city. But that doesn't work for rural Saskatchewan. So, please, we plead with you to do the right thing — and I'm sure you will after looking at all the submissions — keep facilities in rural Saskatchewan and keep districts at a reasonable size.

Mr. Boyd: — Thank you, Mr. Harrison, and Madam Chair.

Mr. Yates: — Thank you, Madam Chair. I want to formulate my questions in two key areas: emergency services, which you have a keen interest in; and then the levels of care in rural Saskatchewan.

I want to start by telling members from SARM that when I was growing up in the town of Shaunavon as a boy 25 years ago, if I wanted to have an appendectomy or tonsils removed, you had to travel to Swift Current then to have it done; and Shaunavon was a community of some 3,000 people. Now over the years that went up and down depending on what physicians were in town and what services were available, but it was very inconsistent even 25 years ago, the services available in those communities.

And we also developed a model a number of years ago that met the health care needs of rural Saskatchewan perhaps 20, 30, 40 years ago; and one of the things that I think we all have to acknowledge, having lived our lives — you still live your lives in rural Saskatchewan and I lived the majority of mine in rural Saskatchewan — it's much different today than it was even a decade ago.

And so getting to the emergency services area, which I'm familiar with and worked for a number of years in the City of Regina here, today emergency medicine is delivered differently, even in the cities, than it was 25 years ago.

The report talks about having one emergency medical technician and one first responder on each ambulance as it goes to communities.

I'd like your opinion on the concept of the role paramedics might play in rural Saskatchewan as part of the health care team within a primary care facility and integrated with emergency care. Because paramedics today can administer drugs, they can defibrillate, they can do many things to degrees in emergency medicine further than nurses, yet can do the administration and medication and other primary functions that a nurse would do in a hospital.

And do you see a possibility to integrate service delivery models from different professionals to fundamentally change perhaps how we deliver some health care in rural Saskatchewan?

Mr. Harrison — Well as we started out in our opening comments, certainly we're not medical experts. We deal a lot in common sense and one size fits all not necessarily works for all of rural Saskatchewan. And we've got many voluntary, volunteer ambulances. They do their utmost to provide the best service. And if we're going to compromise our emergency services by going to one size fits all, we have to examine that very carefully.

Now if we can provide the same service for everybody at the same cost with the same expertise, that's our first goal. But if we're going to have to centralize those ambulances to such an extent that it's going to mean one or two hours for the ambulance to get there, that's not a good thing. And if you have on the ground volunteers that can provide some service till the experts, as you refer to, get there, we think that that's important. First responder. So the team approach, and they can complement each other.

Mr. Yates: — My second question has to do with the levels of care that should be provided in communities today that would have hospitals. Have you put any thought to what, if you were establishing a benchmark or a bar, the level of care that should be provided in those communities, in your own minds as an organization?

Mr. Harrison: — Well as a board we talked about distance and what's reasonable, and how far people should have to go to visit their mother and father. Or if you take those people out of their community and move them even 100 miles, the number of visitors that they're going to get is very limited.

So we have to have some compassion in this whole exercise as to where we provide these facilities. Neal, I know in Hudson Bay there, you've done some things through the Elks to provide . . . and maybe if we can get more service groups involved in some of the levels of care.

Mr. Yates: — Thank you very much.

Ms. Draude: — Thank you, Mr. Harrison. I just have one question. You talked about rural revitalization and I think that all of us in this room are worried about the future of rural Saskatchewan. And I know Mr. Yates talked about having to travel to Shaunavon to have his appendix out 25 years ago.

Well I had my appendix out more than 25 years ago but I only had to travel to Spalding, which was 4 miles away. And I think it underlines the fact that different parts of Saskatchewan have different needs and you can't just . . . just because we cover the same amount of area doesn't mean that we have the same needs and things are happening differently.

Can you give us from your perspective an idea of what's going to happen if we close some facilities down? What's going to happen in rural Saskatchewan when it comes to a business trying to determine if they're going to open up in Spalding, Saskatchewan if the nearest facility is 40 miles away? I know that you live out there and you know what people are thinking. Maybe you could tell other members.

Mr. Harrison: — Well anybody that's going to spend any amount of money on setting up a business or their current business, they need employees, and employees like to be where there are, as we said in our presentation, schools, hospitals are two of the primary things that they look for. And if they cannot provide their families with those kinds of services, perhaps they're going to go somewhere else in this province or to another province or to another country.

So health care is key to everybody's well-being. So it's critical that they have access. And we can't have one in every community. We realize that. And I hate to refer to where I come from, but that's the situation there. That area, and there's many areas in this province are doing exactly the same thing — 10 or 12 communities are saying this is where we should put the health care facilities, and collectively we will help finance them.

But if we don't have that, if it's all provided out of the cities, that's where business is going to migrate, and rural revitalization will not take effect.

Hon. Mr. Belanger: — Thank you very much. I just want to apologize. I was caught in cabinet for some business that took a bit longer so I didn't have the opportunity to hear your brief in full. But I appreciate the context in which you present your arguments.

It's very, very important that we have, in issues of health care, that we have a very good fight. It's something that we have to undertake. And there's debates that could loom for days in the Assembly.

My question to you is that obviously you operate a very

professional organization. And as you go through your budgetary processes as the province is in reference to health care, you would find maybe on one year certain costs are exceeding what you've budgeted for as an organization and you would take appropriate steps. And that's exactly what the fight on health care is all about to this day.

So my question to you . . . And before I get to the question, I also want to point out that in northern Saskatchewan we have similar feelings as rural Saskatchewan at times where access to medical attention sometimes is a plane ride in a snowstorm away. So it's really, quite frankly, more harrowing experiences accessing health care in northern Saskatchewan than it is for other places in the province. And that's not diminishing some of the challenges the province faces as a whole.

There's always the question that we talk about when Fyke comes forward and says, we're looking at quality, not quantity. So in relation to those points I'm making, my question to you in organizing a budget for SARM, in assessing your different priority areas, and looking at ways that you can improve your system — looking at quality, not quantity. These are some of the challenges that we have to listen to and respond to when we talk about the Fyke Commission on Health Care.

So my question to you for information's sake is that how much of a budget would you consider appropriate for health care when we're now at what? — 40 per cent. Is 45 adequate? Is 50 per cent adequate?

And the second question is, how do we make sure that quality is there for rural Saskatchewan, for northern Saskatchewan, and for urban Saskatchewan? And when you pass a community and you see the sign H, what does that mean to you?

Mr. Harrison: — Well certainly quality is a motherhood issue and we would never talk against quality. But some people seem to have the feeling that quality costs money and that's not necessarily the case.

And we would suggest that some of our old facilities are costing us a lot of money and some of the procedures, some of the . . . Mr. Fyke at his press conference talked about — and he's a druggist by trade — all the pills that are being issued to people that are utterly ridiculous. That's a cost to the system. It's a cost to somebody.

And I guess what we would suggest from rural Saskatchewan and from SARM and from anybody doing their budget, you have to bring balance and common sense. And again, a quality system not necessarily costs more money.

Hon. Mr. Belanger: — And the second question in reference to the H. As you drive through a community, as you drive past a community and you see the initials H on the road sign, what do you envision that H represents? What does it mean to you? Like what services do you think exist in that particular centre?

Mr. Harrison: — First of all, one would assume there's a doctor there and that there's medical services there; there's quality care there.

And certainly you don't get the same service at the end of every H sign. I mean, there's the same designation for every hospital in the province, and whether we should go farther than that I'm not sure. But if you're in need of a hospital, you're not going to look around. You're going to look for the first H and go there and hope to h that you get good service.

Hon. Mr. Melenchuk: — Thank you very much, Madam Chair. Just a couple of questions, and thank you for your presentation.

Sinc, you started off at the top talking about the district model. The old model that was in existence, there were some 480 separate facility boards, 45 home care districts, and about the similar number of mental health care districts. And there was a lack of co-ordination in terms of the facilities and how you managed some of those regional concerns.

Now we have a situation where we have 32, 33 districts, but some of these districts only have a drawing population of 10, 12,000 people, where the larger districts like Saskatoon draw on a population of 245,000 people.

So the question arises, is if we support a regional model, meaning there will be some kind of district model in Saskatchewan, what is the right number? Now you don't think the numbers that Mr. Fyke has put out, 9 to 11, is the right number. Do you have any idea what the right number would be?

Most of the experts in Canada would say that to support a regional model where you have primary and secondary services, meaning that you would have some specialist services and diagnostic services, perhaps a CT (computerized axial tomography) scanner, you need to draw on a population of roughly 50,000.

So what is the right number, and the boundaries too. I mean he's basically incorporated some of these current boundaries, but personally I don't agree with that. I think that there's something that has to be the right fit, but I don't know what that right fit is. Do you have any ideas on that at all?

Mr. Harrison: — Well certainly the people of Saskatchewan will figure out where the right boundaries are. And there's discussions going on as we speak, between districts, as what should go together. Some of them follow municipal boundaries. That not necessarily is the trading pattern.

But there was a discussion about a year ago went on in this province about municipality boundaries and how big they should be. And it was decided collectively that the people of Saskatchewan should figure out where those boundaries are. And it's our position that with health districts, the people of Saskatchewan are the best ones to figure that out — not someone from this building or some other ivory tower.

Hon. Mr. Melenchuk: — Now the question arises, when the original boundaries were determined, there was . . . people basically made their choices that this is . . . the only condition was that you needed to have a minimum of 10,000 population. And we ended up with situations where we have Rolling Hills surrounding Swift Current, and it seemed like that was the wish of the smaller communities, not to be incorporated into Swift

Current. But it doesn't allow for an integrated system.

Whereas Health Region No. 1, when it was first created, was an integrated system that allowed for the smaller communities to incorporate services into the larger communities and not feel threatened by that model.

So if you get into a . . . what I'm trying to say, Sinc, is that if you get into local politics in designing health care systems, sometimes it doesn't work out the way you want. And how do you get away from that so that you do have a system that is the right system for the province?

Mr. Harrison: — Well I guess my original comments . . . I guess if someone from a higher level thinks they have more wisdom than the local people, you're getting onto dangerous ground.

And I happened to be on the committee that designed the district which I live in. And I would suggest there was very little thought, time, and effort went into where those boundaries were. You started drawing lines until you got the right number of population. Nobody knew where the services were going to be coming from. Very little time and effort has been looked, taken to look at those boundaries since. But I think now that this discussion is on the table, people are starting to look at those boundaries. There's two districts, Moose Mountain and Pipestone; I know they've had discussions about what's, what's the best size of district. And those people should decide.

Hon. Mr. Melenchuk: — We've had some presentations where we've got three districts, for example, in the Northeast, shared services. They've developed a rational model that that would seem, with the normal trading patterns, that that might be a district on its own. Okay.

The second question I have — and you've spoken strongly on this — is the whole process of hospital rationalization. Currently you believe that the small facilities, hospitals in rural Saskatchewan, are providing a service that is well accepted by the rural community, and there's no reason to change that. If there were any changes to that model, what you would like to see is some enhancement of emergency response services and maybe some in the areas of primary care. Would that be a fair statement?

Mr. Harrison: — I think one thing we have to look at is the single practitioner — the backup, the rationale, the quality of life for that particular practitioner. I think it's fair to suggest that in the near future we will not see that as common practice. The team effect where you can get five or six people, physicians, that you can take some time off, you have backup, you have colleagues that you can confer with . . . and certainly you as a doctor must appreciate having other physicians to discuss with rather than sitting there independently. So we would suggest the hospital of the future in rural Saskatchewan is going to have at least two and preferably five or six on a team.

Hon. Mr. Melenchuk: — And my final question comes down to funding issues. We've had quite a few communities now talk about things like user fees, premiums, and ways of enhancing revenues to support an expanded health care system. Do you have a position on those sorts of items in terms of how you would get other revenues into the system?

Mr. Harrison: — Well I guess there's been suggestions that we have two-tier health now — and I know we're getting into dangerous territory here — but I mean we all know people that have gone outside of this province, outside of this country, to get medical services. And why are they going there? Obviously they have resources to go where they can get quick action. And our family has been south of the border just for that reason, because we couldn't get in to a specialist as quick as we have.

We have to change that if we're going to provide services for our people. So we have to examine how we fund health care. It's fine to say that everybody should have it at no cost. But when you have no-cost services, you get abuse. And the last thing we need in this province is abuse of a precious resource. And we would suggest, I think, that we do have some abuse.

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

Ms. Harpauer: — Thank you for your presentation, Mr. Sinclair . . . or Mr. Harrison, sorry.

You made a comment that it's impractical to think a physician would stay in a rural Saskatchewan community if there's no acute care service facility available to them. So that you had suggested that not only would you lose the acute care service, but the community would also learn . . . lose the basic care because the doctors would leave as well. And I tend to agree with that.

But from your perspective when you're talking to representatives from all of rural Saskatchewan, do you believe that rural Saskatchewan is asking for more services as far as surgeries and more complicated services? Or rather, are they being quite reasonable and quite practical in realizing that that should remain in the larger facilities or larger centres and that they just want to maintain and retain the basic services and acute care services that they have, and within reasonable distance? Are they somewhat content with that and just want to maintain it? Or do you think that they want more out in rural Saskatchewan?

Mr. Harrison: — I think it's fair to say, and I think we can demonstrate in many rural hospitals where they have expanded services and are providing good services and taking pressure off the city hospitals. So I would suggest, on behalf of rural Saskatchewan, that yes, we're going to have to expand the services we provide in rural Saskatchewan.

Ms. Harpauer: — Thank you.

The Chair: — Thank you. Mr. Thomson, you had one more comment?

Mr. Thomson: — Yes, thank you, Madam Chair. I'm sorry to put myself back on the list again, but I had two questions that I wanted to ask.

One, I wanted to follow up just to make sure I understood what SARM's position was in terms of reference to the 25 to 30

communities that we may want to see these hospital services; and I think, Mr. Harrison, you've made some reference to 25 or 30 communities in referring to Moosomin.

Mr. Harrison: — We don't know what the right number is. I mean, to say that all 53 hospitals that are in the report that Mr. Fyke refers to will be there in 25 years, I think all of us realize that's not the number. Whether 25, 30 regional hospitals outside the three tertiary centres are the right number; we don't have the expertise to say that.

But I think it's fair to say in the real world that we're not going to have all 53 hospitals, as we know them today, because there's not going to be a physician. Some of those are single-practice, acute care facilities, and the future tells us that acute care facilities are going to have more than one doctor. So just by that reasoning alone, we're probably going to see a lesser number of acute care facilities in this province.

Mr. Thomson: — You and I are both in the same business of trying to help people get the kind of services that they, that they want and that they need. And I think we understand some of the limitations are moving in those directions.

We have 65 communities today with hospitals. If we're looking at moving to 30 — or pick whatever number you want — how do you facilitate that change? Obviously it's easy to simply put out a press release saying Sinc Harrison says 30 hospitals should close or Fyke says 53 hospitals should close . . . (inaudible interjection) . . . Well I hope it doesn't say that either. I wish that it didn't say Fyke says shut down 53.

But how do you facilitate that movement, which I think you've laid out in a rationale way is likely to happen, where you move away from single-physician practice into larger teams. How do you facilitate that in rural communities?

Mr. Harrison: — I guess I could refer to my other colleagues to answer my question. Certainly there has to be consultation amongst communities, and it's very difficult for communities to take resources for their community and put them into another community so that they can have the health care facility and they can have the physician.

But when you look at closing 53 . . . And yesterday when we were with SAHO, they had a map of the current facilities, and then if you take Mr. Fyke's suggestion and you plot regional hospitals — the number he suggests — there's some tremendously big gaps in this province. And I guess what we're suggesting is there has to be some reasoning in between what we have today and what's in Fyke, and some compromise and some balance.

And the number that Mr. Fyke comes up with is certainly not the right number. The number that I threw out was just off the top of my head; so don't hang SARM or rural Saskatchewan with that number.

Mr. Thomson: — May I ask one other question, and that follows up on what Ms. Draude was asking, and I think that that's a very important question. She makes the observation, and I tend to agree with it, that people obviously want to locate in communities where they have health facilities there, particularly hospitals.

Recognizing that physicians are wanting to practise in larger practices, and recognizing that the health budget is there really to provide health services, how do we deal with the question of rural revitalization or economic development, or call it what you'd like, with the overlay of a hospital system? Should the hospitals be used . . . should the health care budget be used as an economic development tool, or should we use it strictly for health care? Are there other things we can look at to continue to make these communities viable after the hospital is converted or closed?

Mr. Harrison: — Certainly we all know from the comments we made that it is a critical factor in the survival of communities. And when we have the number of communities we have in Saskatchewan and we have the number of hospitals, certainly we've got a number of thriving communities that don't have hospitals right now. So it's not critical that you have a hospital in your community, but it's critical you have access to one in a reasonable distance.

So I think we can demonstrate on the Saskatchewan experience that it's not critical to survival of a community, but the reasonableness and the mileage is the one both for survival of communities and emergency services and ambulances that we really have to key on. And the numbers that Mr. Fyke has in his report we think are skewed because he's got the populations of the cities in there which your response time naturally is much less, so that brings your average down.

Mr. Thomson: — Fair enough. I want to thank the committee members for their indulgence.

Mr. Hardy: — Can I just add to that. I just want to add one other thing. As we look at rural revitalization and industry and value-added, no doubt a hospital is a key factor in any industry coming to that community. If you look around and see where industry is locating today and where it would even think of locating, it's very, very important we have . . . that's one of the factors that's really important to them because industry always can and does have accidents.

And I just think that, like Sinc says, it can't always be and you can't always have a hospital in every community. And I think they're going to look at that and read . . . maybe with the team approach, that will . . . as they're using in the Moosomin area, they will solve a lot of those issues on their own and they'll realize that here's better. We can have more in one spot and bring the smaller ones in. That may happen.

But industry and revitalization of rural Saskatchewan, if you start closing hospitals in large numbers, the only place you're going to have is around the major centres where you have that type of major health care. And I believe that's the important factor in the future of rural Saskatchewan.

The Chair: — Thank you. And thank you to the next group of presenters for their patience.

I just wanted to clarify one thing I think I heard you say, Mr. Harrison, is about the role of this committee to recommend. And the role of this committee is to listen and to hear and to

report what we've heard. So this committee will not make recommendations to the Legislative Assembly. We will report what we've heard from our presenters and give that information to the Legislative Assembly.

And I want to thank you, on behalf of the whole committee, for your personal presentations today and for your written submission. Thank you.

Mr. Harrison: — Thank you very much.

The Chair: — If our next group of presenters could come up to the table.

Good morning and welcome to the Standing Committee on Health Care. Thank you for your patience. We tend to run a little overtime on each presentation depending on the level of questioning from our committee members.

This is the Standing Committee on Health Care. It's a Legislative Assembly committee. It's an all-party committee. Its first order of business is to receive responses to the Fyke Commission or the Commission on Medicare, and report back what we've heard to the Legislative Assembly by the end of August.

This is an all-party committee. As I said. I'm Judy Junor, the Chair, Dr. Melenchuk is the Vice-Chair. Andrew Thomson, Kevin Yates, Buckley Belanger, June Draude, Bill Boyd, and Donna Harpauer are here with us this morning.

We've set aside half an hour blocks of time, and as you can see, they're a little flexible. But we hope that with your presentation we do have some written material, so if you want to highlight your presentations, and give us time for questions. And if you could introduce yourself, where you're from, and then proceed.

Mr. Walker: — Thank you, thank you, Madam Chairman, members of the standing committee. Thank you for the opportunity to present before you today our health care issues. My name is Bob Walker, and I'm a board member of the Saskatchewan Voice of People with Disabilities.

And on my far right is Bev Prescott, who is the executive director of the Voice, and Michael Huck, who is a member of the Voice, and a consumer.

The information package distributed to you includes of course the presentation; In Unison 2000: Persons with Disabilities in Canada, developed by the federal, provincial, and territorial ministers responsible for social services, as a stage for a new national consensus on disability issues that brings together all sectors; the Disability Action Plan prepared by the Saskatchewan Council on disability issues and released June 28, 2001, by Harry Van Mulligen, minister responsible for disability issues.

Our submission presents a synopsis of the population and social demographic trends of people with disabilities in Saskatchewan, a brief overview of the goals and health care interests of the Saskatchewan Voice of People with Disabilities, and the nature and importance of disability supports to individuals with disabilities. Disability supports are tools for inclusion and are key to meeting long-term needs of people with disabilities.

Our submission also reviews the Fyke Commission report from a disability perspective. The Fyke Commission report supports the importance of expanding and providing adequate resources for disability supports such as home care, support of housing options, and respite services.

The submission argues individuals with disabilities experience significant barriers to accessing everyday services and specialized services. Furthermore, to meet the health care needs of individuals with disabilities, the system must address both acute care and long care needs by implementing and appropriately resourcing disability supports.

The status in Saskatchewan. There's hardly a person, family, or neighbourhood in Saskatchewan untouched by disability. Disability is the one minority group anyone can join at any time. And approximately one in five individuals in Saskatchewan have a disability. In Saskatchewan the vast majority of people with disabilities are socially and economically disadvantaged. Compared to the general population, people with disabilities experience higher rates of unemployment, lower incomes, lower educational levels, and discrimination.

The Saskatchewan Voice of People with Disabilities is an organization of and for individuals with disabilities. We are people with disabilities speaking out about our issues and concerns. The Saskatchewan Voice was formed in 1973 at a Voice of Our Own conference. In 1978 the Voice was a founding member of the Council of Canadians with Disabilities. And in 1995 we were renamed to the Saskatchewan Voice of People with Disabilities.

And our goals? They are like every other citizen. We aspire to full participation in the social, economic, spiritual, and cultural life of the community. And as citizens we are self-determining individuals with rights and responsibilities and inherent value and worth. We are a community that fosters self-determination and inclusion of individuals with disabilities.

Self-determination is the right to create and make choices, to take risks, and to participate in decisions that affect the well-being of individuals with disabilities and the community.

Inclusion is the right to participate without discrimination in the social, economic, and cultural life of society and have the right to accommodate to ensure this participation . . . the right to accommodation to ensure this participation.

Health care is an important issue for everybody in Saskatchewan. And the concept of citizenship means full participation and inclusion in the community, including an access to health care. Full inclusion of people with disabilities in the social and economic life of the community requires that people with disabilities have access to health care services.

Our health care issues are that people with disabilities are experiencing significant physical, economic, and social barriers in accessing health care services. Individuals with disabilities require access to everyday services, specialized care, and long-term care. Disability supports based on citizenship and

inclusion are key to meeting the long-term needs of people with disabilities.

Disability supports level the playing field. Levelling the playing field means more than neutralizing barriers or discriminatory systems. It also means access to accommodations and required individual supports.

Mr. Huck: — I'd like to address in more detail . . . a little bit of detail what we mean by disability supports and the barriers to health care, as well as some observations on the Fyke report.

Disability supports are goods, services, and information. They allow us the opportunity to live in the community independently. Disability supports include a range of services, including attendant care, respite care, or technical aids and devices and programs that involve public awareness and so on.

In the simplest terms a person with a disability cannot be part of the world if you cannot get out of bed, get to a bus, leave your house, have an interpreter, or in some situations have someone remind you of what needs to be done.

People in Saskatchewan with disabilities, experience, as Bob said, physical, social barriers to health services and disability supports.

Physical access. Many medical offices are not street-level accessible; lack of automatic doors or hallways wide enough to accommodate power wheelchairs; examination tables and other equipment are not adjusted for height.

Economic. The cost of accessing health care services and supports as well as co-payments for disability supports increases the economic disadvantage of people with disability.

Extra costs of disability. There are indirect costs of disability including being required to pay a higher rent for suitable housing, or if you spend higher amounts for meals and transportation.

There's a lack of disability information. The health care workers often lack basic information about the nature of many disabilities and disability issues.

There are attitude issues. People with disabilities do not wish to be viewed as those people and have our needs devalued or dismissed.

Transportation is a major issue. The availability of accessible and affordable public transportation is a critical issue.

The accommodation of persons with disabilities is a collective responsibility shared by society in general. This understanding is reinforced through recent Supreme Court decisions: Eaton v. Brant County Board of Education and Eldridge v. British Columbia, 1997.

In Eaton the court ruled against parents seeking a fully integrated school program for their severely disabled daughter. However, the court established that full integration or inclusion is the starting point for determining whether or not an individual's rights to equality is being impinged.

In Eldridge v. British Columbia, three deaf individuals claimed their right to access public health services had been effectively denied when a local hospital refused to provide a sign language interpreter. The Supreme Court ruled that the failure to provide an interpreter was a denial of their Charter rights. The Supreme Court directed the Government of British Columbia to administer their legislation consistent with the Charter.

The court also established that the standard of reasonable accommodation rises with the significance of the service or function being provided. Access to public health services requires a very high standard because of the fundamental effect these services have on the lives of all citizens.

Health is more than the absence of disease or acute injury. It is also the relationship and interaction of social and environmental factors such as income, employment, social and physical environments, and personal health practices. For people with disabilities, disability support such as rehabilitation services, drug therapies, mobility aids, assistant devices, and home support services are also co-determinants of good health.

The traditional health care system needs to understand and appreciate disability supports as co-determinants of good health. The resulting shift in service delivery will achieve and maintain the goal of inclusion of individuals with disabilities.

When we talk about disability supports, we're also talking about certain principles which these supports ought to be based on. The definitions of these principles can be found in the appendix, but they do include self-determination of need, supports based on the individual need, reflect the changing needs of individuals, consumer control of disability supports, universality, accommodation to generic programs, portability and continuity of disability supports, appeal mechanisms.

Some of the implications of the Fyke report: to be truly inclusive the health care system must reflect the needs of all residents of Saskatchewan including, we believe, individuals with disabilities. Public funding of health care services ensures fairness and reduces administrative cost.

Disability supports are an integral part of everyday services and specialized care. Everyday services embraces emotional and mental health services and ensuring healthy community environments. Everyday services including disability support such as home care, supportive housing, and respite care need to be examined. Specialized care includes access to medical specialties such as nursing services, occupational therapy, speech therapy, mobility equipment, and other technical aids.

Everyday services should provide care for the whole person. This is consistent with person-centred approaches to health care where a broad range of the individual's needs is considered. Access to disability supports is critical to avoid institutionalization, and achieving a better quality of life. The goal is to promote independent living in the community.

Everyday disability support services such as home care and respite care need to be delivered close to home. Fyke also strongly advocates for the allocation of additional resources for home care to meet the requirements of high-need individuals with disabilities.

Self-managed care options need to be developed to allow individuals to manage their own care, resources, and determine their own caregivers. The terms of union collective agreements, according to Fyke again, should not create barriers to self-management.

Primary health service networks are the first point of contact to access the primary health services and information. This represents a one-window approach to a needs determination process, planning for wellness, and community-based service delivery.

Ms. Prescott: — As concluded by the Fyke Commission report, it is imperative that the Saskatchewan health care system serves all residents of the province and remains publicly funded and administered.

From the perspective of individuals with disabilities, the Government of Saskatchewan and regional health districts must work together to identify and overcome barriers experienced by individuals with disabilities in assessing everyday services and specialized services. In this respect, the ability to access disability supports based on citizenship and inclusion are key to meeting the health care needs of people with disability.

The direction of the Fyke Commission report supports the importance of expanding and providing adequate resources for disability supports. A health care system with these goals and fundamental principles is inconsistent with simplistic, convenient, and retrograde proposals such as service rationing, program cuts, privatization of uninsured services, and arbitrary spending limits.

These proposals would only serve to exacerbate existing problems in the health care system and do little or nothing to provide relief. These proposals do not address the fundamental health and social needs of people with disabilities. They are inconsistent with a publicly financed and administered health care system that conforms to the principles of the Canada Health Act and the goal of full citizenship and inclusion.

Disability supports are essential for achieving and maintaining inclusion. To achieve inclusion of people with disabilities, the Government of Saskatchewan and the regional health districts must adopt the following fundamental principles for the design and delivery of disability supports: self-determination of need, supports based on individual need, reflect changing needs, consumer control of disability supports, universality, accommodations to generic programs, portability and continuity of disability supports, appeal mechanism.

The Government of Saskatchewan and regional health districts must develop a coordinated, interdepartmental approach to needs assessment and individual planning, ensure disability support programs are resourced appropriately. Self-managed care options need to be developed to allow individuals to manage their own care resources and determining of their own caregivers, undertake barrier identification and removal of activities, take appropriate measures to protect human rights of disadvantaged groups, initiate disability awareness and education of health care workers. And the Saskatchewan government must ensure individuals with disabilities are represented on regional health district boards and negotiate with the federal government cost sharing arrangements for disability support programs.

Included in our package are letters of support from the Saskatchewan Deaf and Hard of Hearing Services as well as the Canadian Mental Health Association on behalf of the Provincial Interagency Network on Disabilities, or PIND as we know it.

My colleagues and I thank you for listening to us. And on behalf of the Voice, we'll take some of your questions now.

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

Mr. Boyd: — Yes, I just wanted to pick up on one point. You state in your brief that, on page 8 under disability supports as co-determinants of health, that health is more than the absence of disease or acute injury. It is the relationship and interaction of social environmental factors such as income, employment, social and physical environments, and personal health practices and coping skills.

Would we be safe in assuming that we could add to that by saying, regardless of location, where you live, whether it be northern Saskatchewan, central Saskatchewan, southern Saskatchewan, rural or urban?

Mr. Huck: — Yes. Basically people with disabilities want the same things as other people. They want to be in their own communities, live close to their families, where they work. That means we need access . . . You're not going to have access to everything, okay. But you need access to the same basics as everybody else.

You also want to have access to support services that are going to allow you to stay in your own community, that don't force you to migrate to Regina, Saskatoon, to have to live in an institution.

Mr. Boyd: — So following Mr. Fyke's recommendations of the removal of services in a number of communities, it would be your view, I would assume then, that that could impair the ability of disabled people to have service available to them?

Mr. Huck: — We're arguing that we need access to acute care on the same basis as everyone else, as well as the long-term care needs; that if that isn't in place, you're going to find the continuation of people with disabilities having to migrate to the larger centres.

Mr. Boyd: — Is that the case now? Are we seeing disabled people, as a result of services not being available to them, being forced to migrate to larger communities or indeed to communities . . . cities like Saskatoon and Regina?

Mr. Huck: — If you're living in a community that doesn't have any . . . a transportation system, accessible housing, you have no options.

Hon. Mr. Melenchuk: — Just one question with regard to your recommendation on self-managed care options and allowing individuals to manage their own care resources and determining their own caregivers. Do you see that as a key recommendation

for the disabled to basically apply throughout Saskatchewan?

Ms. Prescott: — Yes. This is something that we've been working on for many years because it has been identified by consumers that they want to self-manage their own care. We have people that have 100 people come through their door to provide private service for them. So this way if you can manage your own care, then as a result you could determine who it is that's going to actually provide this private service for you. This is an important issue for people.

Mr. Huck: — These type of personal care services are . . . well they're very personal. And you want to have control of who does what when. Self-managed care, individualized funding doesn't meet the needs of everyone. It's a part of the continuum where people relying on the regular home care system, where needs are different, we need to accommodate those, those needs.

Ms. Prescott: — One of the things too, with self-managed or individualized funding, this will again determine a number of people being allowed to stay in their own communities because they then can hire people from their own community to provide that service.

Hon. Mr. Melenchuk: — Thank you. We've had other presenters that have picked up on this point. And they've talked about the comfort level of the caregiver and the client or patient and also the continuity of care in terms of quality issues as well. So thank you very much.

The Chair: — Thank you. Seeing no further questions, I'd like to thank you very much for your presentation today and your written material that you've handed out. I also did want to pick up on what Dr. Melenchuk said. We did have self-managed care come and give a presentation, so we've heard that and we appreciate that as well. Thank you very much for coming this morning.

If our next group of presenters could come and take their seats at the table. I'd like to welcome you this morning and apologize for our lateness.

This is the Standing Committee on Health Care, and welcome to our hearings. This is a legislative committee of the Assembly. It's an all-party committee. I'm Judy Junor, Chair of the Committee. Dr. Melenchuk is the Vice-Chair. Andrew Thomson, Kevin Yates, Buckley Belanger, June Draude, Bill Boyd, and Donna Harpauer are with us this morning.

The Standing Committee on Health Care's first order of business as directed by the Legislative Assembly is to hear responses to the Fyke Commission or the Commission on Medicare and to report back to the Legislative Assembly what we heard.

We're not making recommendations to the Assembly; we're reporting back what we've heard from presenters — groups and individuals. And we've given people half an hour. Hopefully within that time we have time for questions from the committee.

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

Ms. Restau: — Thank you, Madam Chairman. To my right is Bonnie O'Grady. She's the board Chair for Twin Rivers Health District. And to my extreme left is Marion Hougham. Marion is the chairman of the Paradise Hill Advisory Committee and a community member at large. I'm Linda Restau, the CEO for Twin Rivers Health District.

I'm going to be presenting the view of the health district and Marion is going to be giving a small-town perspective. Bonnie's going to help us out with any questions that you may have.

I'd like to thank the committee for the opportunity to be here to be able to respond and present our views in regards to the Commission on Medicare.

Twin Rivers Health District welcomed the review of the health system in the province of Saskatchewan. The report that was put forth by Ken Fyke was reviewed extensively by the board and management staff. After extensive consultation with community members, we developed a response to the report. There's some information, demographics in the information that you have for your information.

Twin Rivers Health District agrees that quality of service provision must be the priority when determining the direction for the future of health services in the province of Saskatchewan. We recognize that changes to the health care system are necessary in order to provide a publicly funded system that is sustainable. We are concerned about service and access to service in rural areas.

We need to be certain that any changes will indeed result in a better level of client care and that the end results will be a healthier population. Before making any change, it should be demonstrated how that particular change will improve the health status of our population and how it will result in a cost savings.

Twin Rivers is not opposed to changing health district boundaries, but is opposed to changing boundaries as a first step. We cannot ascertain the appropriate number of districts until we've had an opportunity to implement changes, evaluate the effect on service delivery, and consult with stakeholders.

The commission states that a team-based delivery of primary health services is recognized around the world as the most effective way to deliver everyday health services. However, the report does not clearly identify how that system would be delivered in rural areas.

The World Health Organization has indicated that primary health services should allow for health care to be provided as close as possible to where people live and work. It is not appropriate to provide these services from a large centre that is located miles from the communities requiring the service.

We know from past experiences that shared services do not work. This concept requires several hours of travel during the day, which results in a very limited service in rural areas. Many individuals do not have . . . have not had experience working in the rural areas and feel isolated and unsupported. As a result, staff turnover increases and inconsistencies in program planning

and implementation are noted.

We need to ensure that an appropriate amount of adequately trained health care providers are able to provide the service, and that staff members are located within a reasonable geographic distance. These individuals must be available to facilities on a regular basis in order to meet client needs.

Before implementing any changes to health service delivery, there needs to be an assurance that the public understands the proposed changes. The general public is not aware of what the Fyke report says and does not understand the implications of the report. We need to ensure that decisions will be made in consultation with the stakeholders and the public.

There is a concern in rural areas that local diagnostic service and emergency services will be discontinued. Access to diagnostic services should be provided locally and consideration should be given to providing emergency services in some primary health care sites.

There must be an assurance that adequate long-term care is available locally. Currently there are individuals who are waiting placement in long-term care facilities throughout the province. The report suggests 25 to 30 community care centres. If we are unable to accommodate the elderly in long-term care facilities, they will look at other options. One of these options may be a personal care home. Unfortunately, many individuals cannot afford this. Because of this fact, there is a concern about this recommendation.

Consideration must be given to services for the elderly. Currently there are many individuals who are falling through the cracks. Enriched housing and day programs need to be expanded. There needs to be sufficient services such as home care, respite, palliative care, and convalescent care that are available close to home.

The district feels that the first step towards making change is to implement enhanced emergency services. Early intervention that can be provided by staff who are trained in advanced life support will result in improved outcomes for patients. An EMTA (emergency medical technician advanced) or a LAS (landed ambulance service) service with a response time of 30 minutes or less must be available to all residents in rural Saskatchewan before any changes that involve a decrease in acute and/or emergency services occur.

The Fyke report endorses the EMS review that was recently done by Dr. Cross and Richard Keller. The EMS review did not recommend an EMTA service for all rural areas in the province. An equitable ambulance fee structure must be in place for all residents in the province of Saskatchewan. Transfer rates must be reduced for residents in rural areas.

First responders' programs need to be revamped. First responders can have the most effect on patients at the onset of an emergency because they can respond immediately. There should be consideration given to expanding their role.

First responders could play a vital role in the provision of public education. Often what is done at the initial stage after an accident or an emergency determines the outcome for the patient. By educating the public in what to do and how to respond, lives can be saved in an emergency situation.

This program needs to be formalized with built-in quality controls and consistent education. Recognition and incentives needs to be a part of the formal program and funding for the program must be provided.

A 24-hour telephone advice line has been indicated in the Fyke report as one way to back up services to primary health care networks. Given our diverse population and large geographic area, this service may not work for everyone. Many individuals who frequent our emergency rooms do not have telephones in their home. There needs to be other ways of getting information to those individuals. They need an alternate method of accessing advice.

Physicians need to be included in the planning process. It's unclear how the movement to primary health care would affect physicians that currently practice in rural areas. Physicians need to be involved on an ongoing basis if they are to function as members of the primary health care teams. Failure to do this may result in a loss of physicians from the province and from rural areas in particular.

Specialized services concentrated in larger centres will need to be well coordinated. The needs of the elderly and other residents who lack mobility, residing in rural areas, will require consideration in order that the quality is not sacrificed due to distances from services. There are many individuals who depend on public transportation, and effort will need to be made in order to coordinate the services to minimize personal hardship.

The Fyke report indicates that a health service delivery model with 10 to 14 hospitals would ensure that 88 per cent of the population would be located within 60 minutes travel time from a regional hospital, and that 98 per cent of the population would be within 80 minutes. Most residents in rural Saskatchewan do not feel this is adequate.

Currently physicians in Twin Rivers Health District and throughout the province in rural areas are paid on call for weekend and evening coverage. The physicians when on call are required to be within 30 minutes of an acute facility and 45 minutes of a health centre. These travel times are more realistic and could be easily adopted as a guideline when determining the travel time the population should have to an acute facility.

We need to ensure that the infrastructure is in place for future changes. The availability of beds and health professionals in the regional hospitals is of concern to residents in rural Saskatchewan. We are concerned that 10 to 14 regional hospitals may not be sufficient. The shortage of nurses and bed closures in larger centres currently presents a problem when residents from rural areas are transferred to the city. Services do need to be accessible. Will regional hospitals be able to recruit and retain the required number of health professionals to carry out everyday business? It has been implied that staff members currently working in rural areas will travel to larger centres to work. Many members, such as nurses and physiotherapists that live in the rural areas are married to farmers. Many of them have families and commitments to their community and are not

interested in driving to the city for work.

The public needs to be educated as to the determinants of health and the benefits of health promotion programs. At present, there is little buy-in from the general public as to the benefits of health promotion. Health promotion builds on the concept of community development. Community development begins at a local level. Unless stakeholders and consumers are involved in identifying their needs and developing strategies to meet those needs, programs will have a minimal effect.

Strategies regarding health promotion and disease prevention do need to be developed. Health promotion planning needs to be fostered at a provincial level. Greater collaboration between various jurisdictions needs to occur in order to appropriately address the determinants of health.

Locally, strategies need to be implemented to educate all members of society from the very young to the aged. These strategies must have a family focus.

We do need the tools that will allow us to make evidenced-based decisions. We need to know that the goals we have set are being achieved and, as a result, the health of our population is improving. We need to be able to measure outcomes. The development of performance indicators that relate to clearly articulated goals needs to be ongoing.

A quality council which chooses an evidence-based approach at arm's length from government may be one way of achieving quality. The council must consist of informed, independent individuals rather than representatives of organizations whose particular interests they may be expected to advance. It must have a mandate to gather information based on evidence. Public representation on that council should be an equal mix of urban and rural membership.

The role of the department and of districts needs to be clearly delineated. Clear guidelines must be laid out in order to avoid confusion regarding responsibility and accountability. Health districts are held accountable and do have a great deal of responsibility. They need to have the authority to make decisions in order to fulfill that responsibility.

The number of districts should not be determined until services are in place. We cannot determine the appropriate number of districts until we've had an opportunity to implement changes, evaluate the effect on service delivery after those changes have taken place, and consult with stakeholders. This is the only way to ensure that the changes that we make do in fact result in an improved system of health delivery.

The argument can be made that you cannot have two systems running simultaneously. That would not be necessary. Changes can be implemented on an incremental basis. This allows for continuous evaluation and improvisation.

There is a fear that if the number of districts is reduced before services are in place something may occur which will halt the implementation of the rest of the recommendations. This may result in a similar system to what we currently have but with larger districts. This would [CORRECT] result in local input and control. If this were the case we would not see an improvement in the system of health delivery in rural Saskatchewan.

Health districts need to be able to deliver services close to home. Local input and control is necessary in order to foster the community development principle. This is necessary if provincially we are going to further the work in health promotion and realize health promotion goals.

Health district boards should continue to be comprised of both elected and appointed individuals. This supports community involvement and ownership.

The Human Resource Council is a positive step towards addressing recruitment issues. Throughout the province it's a struggle to retain and recruit qualified personnel. Districts are competing with each other as well as with other provinces and countries.

There must be a commitment to research and education, and a plan for a sustained and stable investment in information systems and technology with a focus on the development of an electronic health record.

The district is in support of a publicly funded system. This is the most efficient and equitable way to provide services to the people in Saskatchewan. In order to sustain a publicly funded system changes are imminent. We need to ensure that these changes do result in a better level of service and a healthier population.

The public needs to understand the proposed changes. Consultation with the stakeholders and the public needs to occur. Services should be in place before the number of districts is determined, or closures or conversions occur. In our opinion this will enable an appropriate infrastructure that can manage the changes that ensue.

I will now turn it over to Marion who will present the small town perspective.

Ms. Hougham: — Thanks, Linda, and I'd also like to take the opportunity to thank the committee for hearing our concerns.

Paradise Hill is a village of approximately 500 people, with a surrounding district of approximately 700. It boasts an active agricultural sector with many family farms being passed from generation to generation.

We are lucky to have a flourishing oil industry which provides jobs for many young people and provides off-farm income as it becomes increasingly more difficult to make ends meet on the farm. In short, our community is very typical of any small town in rural Saskatchewan.

Over the years as government has looked at ways to save money, we have seen a movement toward centralization of services not only in health care but in all areas. Paradise Hill at one time was home to a SaskPower office and a Department of Highways depot. Both have been closed. Our elevators are closed. The rail line won't be far behind. We are told each time that services will not be affected, but the fact is they are. Let me provide you with an example.

I live in a family farm about 12 miles from Paradise Hill and I work in town. Before our Highways depot closed, I do not recall one occasion when I travelled to work before our road had been cleared of a night's snowfall or salted after freezing rain. Since that closure, the Highways trucks have not once been down our road before I go to work. This is no exaggeration; it's a fact.

Now this has no importance in relation to the mandate of this community and I'm not here to lobby for better road maintenance. However, it may give you an inkling as to why we in rural Saskatchewan are hesitant to accept in blind faith that change will be for the better and that we will see no reduction in services.

The recommendations in this report appear to be another attempt at centralization. One, close hospitals and centralize 24-hour services, both acute and long-term, into regional centres. And two, amalgamate districts and centralize administration. These two recommendations will have the biggest impact on rural communities. I do not see in the report where Mr. Fyke describes how he will cushion that impact.

Let's look first at the impacts of hospital closures. The commission's report recommends a reduction in the number of hospitals to 10 to 14 regional facilities. We have a hospital in Paradise Hill that provides a wide range of services including emergency, acute, long-term, respite, palliative, convalescent, and rehabilitative care. What all of these services have in common is that they require a facility that is open and staffed 24 hours a day.

We recognize that acute care may be better suited to larger centres where there is access to more specialized personnel and equipment. We recognize that the truly acute patients do not remain in our facility long; that they are admitted, stabilized, and transferred to a larger centre.

We are, however, more than capable of providing care to what we call minor acute cases. Not only does keeping these cases in our home community promote quicker recovery, but it does not take up needed beds in larger centres where the availability is in such short demand.

Such is the case with convalescing patients. We can effectively care for those recovering from surgeries for example, again freeing up beds in larger centres.

Surgical patients are released much sooner in today's system than historically. What happens to the patient who has no one at home to assist them during their recovery?

Palliative, respite, and long-term care are much more effective when offered closer to home. The well-being of the patient is better maintained in a familiar setting and undue stress on family members from travelling to larger centres is eliminated. Proximity to family members benefits the patient and the staff because family is available to assist with simple tasks such as feeding. In short, the patient is happier; thus generally he is healthier. How often will family be available to visit or assist if there are only 20 to 25 long-term or community care centres in the province? None of these services would be available with an 8- or 12-hour centre, whether it be primary health or not. These services require a centre that is staffed 24 hours a day.

Adequate emergency service is essential and has definitely not been addressed by this report. Mr. Fyke concludes that, given the number of calls to which they respond, rural ambulances should be staffed with an EMT (emergency medical technician) basic. He states that 10 to 14 hospitals would ensure that 88 per cent of the population would be within 60 minutes of a regional hospital. Is 60 minutes adequate?

Consider this. How long is it between the onset of an emergency and the time a call is placed to the ambulance? For the sake of this example let's say it's 10 minutes, knowing that in some circumstances it could be much more than that. Allow 5 minutes between the time of the call and the time an ambulance leaves the bay. Using my home in this example — and there are residences in our district and I am sure many others that are much farther away from ambulance than I am — it takes 30 minutes for the ambulance to travel to my home from the ambulance site. Allow 15 minutes to prepare the patient for transfer and 60 minutes to travel to a hospital. That totals two hours that this patient is under the care of an EMT basic. Is that acceptable? How can you justify assigning an EMT basic in a situation where the patient may wait two hours to see a physician, while urban ambulances where patients are minutes from the nearest hospital are staffed with paramedics?

We are very concerned about our ability to retain a physician in our community, given possible closure of our facility. We have the infrastructure to provide a clinic, but without a facility to follow up with treatment the 24-hour centre provides, will there be a physician who is willing to stay?

Will patients be more likely to travel to a clinic where the physician can carry through with treatment after diagnosis? Will our local clinic become a clinic of convenience where patients go only to attend to minor coughs, colds, and prescription renewals? How will we encourage a physician to remain under those circumstances?

Without a physician, people requiring simple procedures will be forced to travel to larger centres. What used to take only a few minutes and little travel will now require extensive travel and much more time. The travel expense and loss of productivity penalizes residents of rural Saskatchewan who contribute to the health system on the same basis as urban residents.

How do we know that 10 to 14 regional hospitals will be enough? What will be done to equip these regional facilities to meet the new demands that will be placed on them? Do they have the infrastructure and equipment in place now to accommodate the increase in patient flow that will result from closures in small centres? How will you recruit the additional staff needed to operate these facilities? Nurses are in demand around the globe. Where are we to find them?

Is there a presumption that nurses from hospitals that are closing will relocate to where nurses are in demand? I hope not, because I don't anticipate that happening in many cases. In Paradise Hill a number of nurses are women who are tied to our community through their family farm. They will not relocate nor travel to find work. Some have told me they will retire.

Some of our nurses are working extra shifts, not because they want to but because we are short-staffed and they are dedicated to our hospital and their community. They won't go looking for work elsewhere. Of the nurses who do relocate, how many will stay in Saskatchewan? Will the promise of better pay and better working conditions elsewhere draw them out of the province?

In regards to amalgamation of districts, let me simply say that bigger is not always better. Will this amalgamation result in one central office, and if so how many management positions will it take to administer such large districts? Will one large office run more efficiently than a few smaller ones? Is the cost of the whole actually less than the sum of the pieces and if it is, do the savings outweigh the disadvantages?

Under the 11-district model, our newly formed district would cover an area that from east to west would take three and a half hours to travel. Under the 9-district model, our district would cover an area from north of Meadow Lake to near Regina. That is a six- or seven-hour drive, I suspect closer to seven. How loud or effective will the voice of small communities be in a district that large? It's difficult now to recruit local people to sit on district boards. Bigger districts will make that task impossible.

The report justifies larger districts by saying that the increase in district-wide population will provide the capacity to deliver more services within the district, removing multi-district service areas. In fact the general public does not recognize boundaries in their search for the best service. They will seek service where it's convenient for them. A larger district is not going to change that.

Currently Twin Rivers employs professionals who travel to seven communities and four reserves within our district. At best, they can spend half a day once a week in each centre. It is difficult for a therapist of any specialty to be effective if they are available only once a week.

Is a half day long enough to serve everyone in the community who requires treatment? How can bigger districts alleviate that workload? They may be able to attract more staff, but given a larger geographic area, increased travel will further limit the amount of time staff can actually spend on treatment.

What the report does offer rural communities like ours is a primary health centre. This appears to be a very positive initiative and warrants consideration. The concept of primary health centres has its merits but we need to understand how it will work for us.

The report describes how teams of health service providers will work together to provide a holistic approach to diagnosis and treatment. Where will all of these health professionals be based? Obviously not all in Paradise Hill.

We assume that social workers, physiotherapists, addictions counsellors, along with a host of other professionals, will travel from a central location within this newly amalgamated district. How far away will their offices be and how much of their time will be spent on the road? Given the geography of the districts described earlier, they may spend more time on the road than they do delivering treatment.

We are told that, under primary health, physicians will consult with other professionals to provide the best possible care. These professionals, on any given day, may be in the facility or in some other location within the district. What roadblocks are in place now that prevent that consultation from taking place? To my knowledge there are none; at least none that will not still exist.

We will, assuming we can encourage a physician to stay under this new system, have a physician in our clinic and other health care professionals who travel to and from our facility. How does that differ from what we have now?

As I see it, communication is the foundation of primary health care. What steps will be taken to facilitate communication between physicians and other health care professionals?

Will moving from a fee-for-service payment structure encourage the approach to treatment that primary health requires? Possibly. But how will we stop the exodus of physicians that may result? How will we get a unanimous agreement among the physicians in this province to accept a contract over fee for service? If the agreement is not unanimous, how many doctors will leave?

These questions must be answered before we can support the kinds of changes that are proposed. They must be answered satisfactorily and those answers have to be relayed to the general public, particularly those at risk of losing their facilities.

We won't accept primary health as a viable alternative to our local hospital until we have more than just an assurance that it'll work. The public has a right and a need to know how and why it will work.

The people in our community have made a choice to live in a small-town, rural setting. We enjoy the quality of life that only a small-town atmosphere can provide. We recognize and accept that given our small and sparse population we will have to travel to access services — particularly specialized services. However as taxpayers who contribute equally to the overall cost of health care, we also expect to be provided with essential services.

Our parents and grandparents who settled here and built the small communities that provide us with the quality of life we now enjoy have earned the right to live out their lives at home and be cared for there if that is what they choose.

Change is inevitable. It is a product of the world we live in. We will support change that will provide a better quality of care for all people in Saskatchewan. However we fear that the proposed recommendations fall short of that goal.

We fear that health care in rural Saskatchewan will be the sacrificial lamb that's used to control the increasing cost of health care in this province. Don't use rural Saskatchewan to balance the health care budget. Let's concentrate on change that will benefit all people in this province. Thank you.

The Chair: — Thank you. Questions?

Mr. Thomson: — Thank you very much, Madam Chair. I'd

like to thank the presenters for their written and verbal presentations today. They're very informative.

One of the questions I have about Paradise Hill, just so I have a better understanding of the community — how many doctors do you currently have in Paradise Hill?

Ms. Hougham: — We actually are part of a group practice that is based out of Maidstone, which is a community about 30, 35 minutes to the south. There is at the moment three doctors working in that and they're in the process of trying to recruit two more.

So we have one doctor actually who just arrived recently. She's based out of . . . or will be based out of Paradise Hill. She just arrived actually last week. And those three physicians are currently rotating throughout about six communities — six, seven communities. And as I said they are trying to recruit another one because another physician has recently left or will be leaving at the end of the month.

Mr. Thomson: — So to understand this. So Paradise Hill shares physicians with Maidstone. They're primarily based out of Maidstone?

Ms. Hougham: — I'm not sure if I would say that. Basically what happens is they're under contract with Municipal Health Holdings. That office is based out of Maidstone. The doctors rotate between clinics in Cut Knife, Neilburg, Lashburn, Maidstone, Paradise Hill, plus two Indian reserves.

Mr. Thomson: — But there's one doctor now in Paradise Hill.

Ms. Hougham: — There is one doctor who spends . . . (inaudible interjection) . . . Yes, one resident doctor in Paradise Hill. She lives in Paradise Hill. She also operates clinics in Maidstone, and I believe she will be in Lashburn. And there is physicians from Maidstone who come to Paradise Hill to operate the clinic.

Mr. Thomson: — Okay. I guess the question I had, and one of the things we've been listening to is particularly in communities where there is one resident physician, there's concern about how you maintain the hospital. Before your doctor arrived as a resident of Paradise Hill, what kind of hospital services were you offering?

Ms. Restau: — I didn't hear . . . before the physician arrived what kind of service . . . The same services that are offered now. Coverage was provided from one of the physicians that's in St. Walburg, plus the physicians that Marion mentioned from out of the Maidstone office.

Mr. Thomson: — The other question I had concerns this question of health centres. And I'd be interested in the experience in Twin Rivers, in terms of the quality of care given in both St. Walburg and Cut Knife, which have health centres. And I guess Neilburg does also, is that right? Neilburg doesn't, but Cut Knife and St. Walburg . . . Is the quality of care good?

Ms. Restau: — I think the quality of care is good. However, like every other district we have a real hard time measuring the quality, measuring whether or not the things that we are doing is improving the health status of people in those communities.

Mr. Thomson: — On the question of the district, it is located between Lloydminster and North Battleford, so I would assume that people would share, depending on where you live within the district . . . it would depend on which of the larger of those two centres you'd go to for more specialized care.

Does the district have a division that way, in terms of the number that would go to, say, Lloydminster? It would seem natural that the Paradise Hill people would more likely use Lloydminster services, whereas perhaps the people in Maidstone you would assume would also use Lloyd. Is Lloyd the centre, the regional centre, or is it split between Lloydminster and Battleford?

Ms. Restau: — Well you're right. People around Paradise Hill do tend to go towards Lloydminster, where the people on the other side of the district, if Maidstone doesn't meet their need, a lot of them end up going to Saskatoon, bypassing North Battleford. But some do go to North Battleford.

Mr. Thomson: — Are there service arrangements in place between Twin Rivers and other districts like Greenhead or Battlefords?

Ms. Restau: — There are some arrangements in regards to community services, public health supervision, and those kinds of things, yes.

Mr. Thomson: — Thank you very much.

Ms. Draude: — Thank you for your excellent presentation. Marion, you talked about the scenario of an ambulance coming out to your area and the time it would take. I'm not sure if the report, the EMS (emergency medical services) report made it clear that when they talked about 60 minutes for 88 per cent of the population, 80 minutes for 98 per cent of the population, the numbers don't take into consideration the fact that 40 per cent of the population of Saskatchewan live in Regina and Saskatoon.

So if we take that into the calculation it means that the percentage of population that live outside of these two areas, the number is actually considerably more. So those numbers, your scenario could be out considerably when we take that into consideration. So I think that is a concern that many people have brought forward as well.

The other thing that you had mentioned was paramedics. And I think one concern that we have also heard is that the paramedics are supposed to be in the cities, where it would make more sense if they were out in rural Saskatchewan. I don't know if you've talked about that, when a paramedic is just a few minutes away from a hospital in the larger centres, and in rural Saskatchewan where they're two or three hours away from the hospital, we have the EMTs or the EMTAs. Is that something that you've discussed?

Ms. Hougham: — We have lobbied for some time to see EMTAs in our ambulances. I don't think there's anybody . . . I guess I can't speak for other centres but I don't think that we are expecting paramedics in our ambulances. But we would like

to see EMTAs, yes. And maybe Bonnie or Linda can address how the rest of the district feels about that.

Ms. O'Grady: — I think that what is proposed in the EMS report right now and the assumptions that are made about the time it would take to respond to an emergency should the recommendations be put in place, that's where we're at right now. It takes up to the hour, two hours or so for an ambulance to get to a site where the ambulances are coming from at this point in time.

Should there be further reductions, we have done various calculations, and just in talking amongst individuals in the community, and the reality would be more like three hours and up if these were to be implemented. And again there's a great deal of concern out there should such a thing come to pass.

And again the level of expertise and training of those that are manning the ambulances is something that they're very concerned with. As they've pointed out, if you are in the large city and have a response time of about five minutes and another five minutes back to the trauma centre and you have a paramedic on board, that then is a very different level of service than what is being proposed for us in rural Saskatchewan.

I come from a community that is on the outlying area close to the Alberta border and we know that around the Turtleford area, around the lakes where there are huge numbers of people in the summertime, there is no way an ambulance could get to those sites and be back to Lloydminster or North Battleford in under three hours.

Ms. Draude: — I just have one other question for you. When we talk about rural Saskatchewan and the fact that we're out there because we like the way of life and we believe in the future of rural Saskatchewan, I wonder how you see your area. If the health system was changed so that it was 30 hospitals, could you imagine a scenario where people would be more excited to move to Paradise Hill, if they knew they had to travel further to get to the necessary services they'd have that were essential?

I guess I'm talking about rural revitalization and the fact that we believe it's possible . . . I believe it's possible to see it happen and flourish, but we need an infrastructure there. Have you talked about that issue?

Ms. O'Grady: — Many of our small communities now have quite large elderly populations and to a great extent they've been staying and retiring in their small communities. And I mean as you get older you know that you're going to require more health service.

What we're seeing happening even right now just with discussions around the Fyke report is that many people are questioning whether they should be already looking to move to a larger centre. There is always a certain amount of that that takes place; there always will be. But the proposals for the reduction in locally accessible health service is going to drive more and more people very rapidly out of rural Saskatchewan. There is just absolutely no doubt about that.

Mr. Boyd: — Thank you, Madam Chair. And thank you for an excellent presentation. I'm just curious to know — did you drive down this morning?

Ms. O'Grady: — No, we drove last night.

Mr. Boyd: — And if you were attending meetings all day today, obviously you'd be staying and going back tomorrow.

Ms. O'Grady: — Well that might be the case. But quite often, as rural folk, we would drive through the night to be home to work tomorrow. But . . .

Mr. Boyd: — So if we were looking at health districts, the kind of size that are being looked at by Mr. Fyke, we could expect to attend a one day meeting, it would require three days of your time.

Ms. O'Grady: — That's certainly very possible.

Mr. Boyd: — How many people do you anticipate in your area would be interested in a position of that type?

Ms. O'Grady: — My experience has been not very many.

Mr. Boyd: — I've had occasion a couple of times to be in Paradise Hill and it's a very nice community. And even living on the west side of the province where I do, it's some three and a half hours from my area to your area. It's hard to imagine services being centralized to the point where it would require people seven or eight hours just to travel to attend a board meeting. And I think many, many people would just simply dismiss the idea entirely of being a part of that type of process. Would you agree?

Ms. O'Grady: — Yes, I would agree. I think that part of the problem in getting people interested in positions on the district health boards has been, I think as was stated earlier today, it comes about from feeling that you have very little power and control. And if the districts are made even larger and those that represent you are even farther removed from the grassroots, you know — the people, the connection with them — it becomes more difficult to represent everyone and you get less feedback from those grassroot people. And there is less interest in taking on that challenge. That's been my experience.

I was a school board trustee for over 20 years and on a division board. And, I mean, there's been amalgamations in education; we've seen some similar things in that. And if I can too, we talked earlier about the professional health teams travelling around. And in education we've had considerable experience with shared services and how that's worked. And it has definitely been my experience that there are a great many problems with it.

I mean we could talk for hours around that issue itself and the pitfalls in that. And I think what we need to concentrate on is why we're doing it in the first place, and that is to provide service to the people. And that is where shared services runs into problems. In theory it sounds great but in practicality it doesn't work. You spend most of your time; the greatest percentage of your time is travelling.

What we have found is that recruitment and retention is very,

very difficult. There's a great deal of frustration in the professionals trying to provide that service. They don't get the time with the clients. It's very long before they see them again. They put in many hours of overtime because they try and . . . they're very committed to the work and they're trying to provide the service to the client so they stay there. And then on overtime they're doing the paperwork and so forth, or else you're constantly waiting on the report.

There are so many things around that, and I guess it frustrates me to think that in this province that we would repeat some of the mistakes that we've already been made aware of. And shared services is certainly one of them.

Mr. Boyd: — Thank you very much for your presentation. We certainly appreciate your input and we appreciate very much the time that you have spent to travel to Regina to put your views and your district's views forward. Thank you.

Ms. Harpauer: — I would also like to thank you for your excellent presentation. In the Fyke report, it suggests that local communities no longer have a role to play in recruiting doctors or physicians in the communities — that it should go to board level or provincial level. And I too live in a community that has just recently recruited a doctor, and I know that was mentioned in your presentation.

If we're looking at the large districts that Mr. Fyke has proposed, how difficult do you think or what is the possibility that you think that your communities, the size that they are and where they're located, would get a physician if we're looking at a huge district and the community itself has no input in that recruitment?

Ms. Hougham: — In the past our community took over attempting to recruit a number of years ago. The district had taken on that responsibility and we have found in the past that the community is much more capable of recruiting, it appeared, than the district. Larger districts is going to make . . . I think just accentuate that. I think the community can do a better job of recruiting than the district, yes.

Ms. Harpauer: — Just to expand on that, I know in the local situation that I'm in, that the community was definitely more successful not only in recruiting a physician but also the nurses that they needed than the board had been. And it's not a very big district.

But the hindrance that they found, and you just recently have a physician come to your community as well — one of the biggest hindrances they found was the fact that this Fyke Commission and that there had been no provincial decisions made to this point, was sort of hanging over the facilities and the viability of the facilities in the future.

They found that a huge hurdle to getting a physician to come into their community. It's left their community pending for now a great number of months, going well over a year. Did you find that in your circumstances as well?

Ms. Hougham: — Since our association with Municipal Health Holdings which is a group practice that I described earlier, a large part of that recruitment has been taking place out of the Health Holdings office. Claude hasn't mentioned to me that that's been an obstacle but I can't . . . I would have to speak to him to confirm that.

We do have a physician who is leaving the practice. He's going to Alberta. I guess you could say I've heard rumblings, if you want to call it that, that there are physicians who are considering leaving or who are leaving. Whether the departure of this physician has anything to do with this report or whether it's coincidental, I can't say.

I will say the thought has crossed my mind that the two are connected, but I can't say for sure that that's the case.

Ms. Harpauer: — Thank you very much.

The Chair: — Seeing no more questions, I too want to thank you on behalf of the whole committee for coming today and giving us your excellent presentations, both written and your personal presentations. Thank you very much.

Our final presenter for the morning to step forward to the table.

I'd like to welcome you this morning to the Standing Committee on Health Care. It's a committee of the Legislative Assembly that its first task has been to receive responses to the Fyke Commission. So we're reporting back to the Legislative Assembly what we hear from people in their response to the Fyke Commission.

We've set aside half an hour and we apologize for keeping you waiting. It's an all-party committee. I'm Judy Junor, the Chair of the committee. Dr. Melenchuk is the Vice-Chair. Andrew Thomson, Kevin Yates, Buckley Belanger, June Draude, Bill Boyd, and Donna Harpauer are here with us this morning.

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

Dr. Silver: — My name is Dr. William Silver. I have been an orthopedic surgeon for the past 31 years in Saskatchewan, and I would like to title my comments "The Fyke Commission: We Can Do Better."

I don't represent any group or vested interest, but I only will express my own feelings and my diagnosis of the ills that afflict our health care system and my prescription for its cure. I have enjoyed a varied medical career including small town family practice in Porcupine Plain, following which I specialized in surgery in Saskatoon and Calgary, did three years of full-time research, and then taught at the medical school for 20 years. And since 1988 I've practised orthopedics in Regina.

When I first went to Porcupine Plain, I really believed the community was glad to have two young doctors to replace those who were leaving, because the hospital maintenance man travelled right across town with a snowplough to clear our driveways free of charge. At that time there was a RM medical plan that covered farmers for all medical care, including referrals, and paid us $2 for each office visit. Mr. Fyke should be impressed with our primary care team, which included a staff with wonderful, experienced nurses, an excellent lab tech in a 22-bed hospital, and an efficient staff at our downtown office.

Patients who came to hospital during the night would be assessed by the nurse and she would call us immediately if necessary; otherwise, she would call us in the morning.

I'm amazed that we seem to have forgotten how to do this. The research money, the volumes of paper, and the time used by government and other agencies to promote the idea of advanced clinical nursing and primary care reform, we seemed to have a lot of these things working back in 1960.

While we were there, the ladies' auxiliary asked us what equipment could they buy for the hospital and we said an EKG (electrocardiogram) machine. They bought it, we learned to interpret the tracings, and eventually we charged for the interpretation. One board member became very angry, saying the ladies bought a machine to make the doctors' work easier and now the doctors are charging more for care. We had failed to warn him that medical progress is costly.

The public finds it difficult to understand what doctors do and if they're not well informed, they become suspicious that doctors are ripping them off. It's much the same today when we try to explain the priority of costly equipment such as MRI (magnetic resonance imaging) and PET (positron emission tomography) scanners and instruments to measure bone density. It's even harder now, as tensions are rising, for hospital boards to work with doctors in an atmosphere of mutual respect and trust.

I want to challenge our government to use its power to initiate a change in attitude. This would set the tone for all parties to acknowledge our many failings in the past, to get rid of this baggage, and consciously commit ourselves sincerely to the greater good.

I had the privilege of studying in Montreal; Tacoma, Washington; and Scotland. And I realized eventually that although Saskatchewan doesn't have many people, we do have excellent, hard-working people who know how to survive in a land that can be hostile. In times of difficulty, traditionally Saskatchewan people work together to solve problems.

The worlds of politics and of law are different. They are worlds of confrontation. Confrontational negotiations, as seen in labour/management disputes, are not solving our problems in the health care scene. If every interest group continues to lobby for their own selfish interests, decision making will be too slow to save medicare. As we discuss the difficult issues of health care, we must not forget our greatest strength is working together to solve problems.

When teaching at the medical school in Saskatoon, I was dismayed that there was so little emphasis on preparing students to serve our province in smaller centres. The responsibilities of a remote practice require some preparation. I was fortunate, having extra training in surgery, and it was a positive experience for me.

If the province chooses to do it, a well-planned campaign to encourage students to prepare to work in small centres would work. But it would have to include incentive pay, excellent facilities, and flexible contracts.

If we decide to do that, we will not follow Mr. Fyke's advice to close up rural Saskatchewan. Instead the government, together with our best doctor leaders, could open appropriate facilities to equip doctors to meet the challenge and spend the money that's required.

Since doing orthopedic surgery, a major problem has been getting our patients in for expensive joint replacement surgery. I remember in Saskatoon a lady, age 86, who was wheelchair bound, who needed two total knees to be able to walk. And if this was not done within about six months, she would not be able to walk. I made every effort to get her in for surgery, but I could not do this. This lady became depressed, her joints became permanently stiff, and she died, mainly from inactivity. I hope for a system that will provide timely care for the elderly.

In 1993, when I was in Regina, this rationing process of total knees came to the point where I was told I could do only one total knee and one total hip every month. When four of my patients were developing this permanent stiffness and weakness, I felt this was unacceptable particularly with the provisions of the Canada Health Act, regarding accessibility and comprehensiveness. I appealed to my department head on their behalf, but nothing was done. So I appealed to my representative on the Medical Advisory Committee.

When all this had failed, I felt I had to admit there was a problem. I wrote letters to each of my four patients to say, as far as I could tell, their inability to get treatment was because the government wanted to save money. And I sent copies of the letters to the Minister of Health, Minister Louise Simard.

I soon received a copy of a letter from her deputy minister, Duane Adams, to Dr. Kendel, registrar of the College of Physicians and Surgeons. Mr. Adams said, quote:

> Dr. Silver's letters cause us to question whether they reflect appropriate professional behaviour on his part. For this reason, I would request that you review these letters in the light of the College's standards of professional conduct. We would appreciate receiving your assessment as to their propriety. While we regret having to take this step, Dr. Silver's action has left us no other choice.

Ladies and gentlemen, at the time I thought I might lose my licence, and that represents over 12 years of training. At least I expected to be subjected to discipline. None of this came to pass. It is my opinion that this action by Mr. Adams, and his minister, Louise Simard, constitutes direct political interference with the practice of medicine and with my attempt to ensure the welfare of my patients. This shows contempt for patients, for myself, and for the medical profession. I think this is what we need to be worried about.

Governments must please the majority or they will be voted out of office. The majority of voters are those who are not sick and those who are not doctors. That means governments can antagonize these two minority groups and still retain power. Governments can use their expertise in communications to downplay complaints by patients and by doctors to give the healthy majority the impression that all is well, and that further budget cuts can be made without causing deaths that are preventable.

They can also mislead the public by selectively quoting research that supports their agenda.

Doctors have traditionally taken rightful pride in making an accurate diagnosis and recommending the best possible treatment.

Before medicare, the patient might well be unable to afford expensive care, so the best that they could afford was accepted. Medicare has removed the economic barriers in patient care and now patients want the most up-to-date diagnostic services promptly, followed by state-of-the-art treatment preferably at their convenience.

There's not enough money in the coffers of any government to pay for everything the public wants. We who are in the business, together with more and more of the public, realize that we do not have enough money to give everyone everything they want. The burning question however is, can taxes pay for everything we need.

Now Mr. Fyke does not differentiate between medical wants and needs. As a pharmacist turned bureaucrat, he does not know enough about the practice of medicine to do that. He does know a lot about politics and he's written a report that his political employers can use in the political arena.

Mr. Fyke says he knows how to save money, improve quality, and solve all major problems without any fundamental change in our government-run system. He's like Mr. Romanow saying that there will be a political cure. And if Mr. Romanow determines that the majority of voters would favour user fees, he as a politician might recommend that, saying it'll save money. This would be a disaster, and this has been clearly shown by health economists Beck and Horn.

We must therefore take great care. A confused public may favour user fees or some other simple but destructive innovation in their desperation to save medicare. Let the public hear all the facts and present them in clear distinction from opinions, which is something Mr. Fyke has not done.

Government must live within a budget. As our citizens are experiencing increasing difficulty in accessing the system for treatment that is scientific and predictable, we must ask government to reveal how much of our health care budget is being spent on various projects and services that do not deliver predictable relief to our citizens, what I would call non-essential care. We could then carefully define what is essential medical care and make the best possible arrangements for its provision.

To my knowledge, our government has not begun to work on this difficult decision, nor in fact has any government in Canada. Instead, they have pressured doctors to make the system work and to voluntarily reduce costs of patient care. This puts doctors in a very dangerous position.

Our government has the power to recruit the best advice from medical economists, medical doctors of any description, and any other professionals they wish to assist them in the above decisions. Instead, they have chosen to defer fundamental decisions, waiting for the Fyke report, hoping to find a simple, magical, political solution.

Mr. Romanow is building a new career looking for a political solution for medicare in Canada. It is not a political problem; it's a medical-political problem. The ruling party tries to cover their bewilderment by repeating the dogmatic statement that the system doesn't need more money, just better management, and they quietly order their bureaucrats to save money at all levels, while confidently telling the public they're improving the system.

They recruit and reward doctors who will say that certain tests are unnecessary, certain treatments are wasteful, and certain facilities can be closed. As time goes by, fewer and fewer dare to speak up for fear of losing their job. In Hans Christian Anderson's The Emperor's New Clothes, it was a child who had nothing to lose who stated the obvious truth, saying, the Emperor has no clothes.

I heard the other night the presentation by the Health Services Utilization and Research Commission, otherwise known as HSURC. This body does, quote, "research" for and is appointed by the Minister of Health and is paid and supported by government. Their publications have not convinced me that their, quote, "research" is objective and is aimed to benefit the public. It seems to be more aimed to further their own interests and their employer's interests.

The chairman of their board commended Mr. Fyke for making, quote, "evidence-based recommendations." My advisers in health economics tell me the opposite — that Fyke's recommendations do not have supportive evidence in the text of his report, nor in his bibliography, and they are simply statements of his opinion.

Let's not close hospitals across the province on the basis of the opinion of a man who doesn't even live here. HSURC's board Chair says that they are, quote, "at arm's length from government." When I hear the great praise she gives Fyke's report, when I note the report recommends that HSURC form the powerful quality council, and when I recall the many directives to save money that all doctors have received from HSURC, my impression is that HSURC and government are pretty much in the same bed. I fear this board would be quite ruthless in its control of health care and costs, and that it would be an agent of government in its definition of quality, and that it would discipline doctors who fight for their patients' rights.

When bureaucrats are encouraged by government, they can do bad things. The accelerated closure of the Plains Health Centre in the name of economy without consideration for patients was a disaster. Construction was carried out on the General Hospital while patient care continued. We had jackhammers going above the operating room, workmen mingling with patients in the halls, a sudden increase in numbers of critical care patients and surgeons all crowded into one operating area. And there was confusion. Parking was terrible for patients and staff.

This whole process was conceived by our health board chaired by Garf Stevenson, carried out by our CEO, Glenn Bartlett, who was well paid to do the dirty work and then resigned and left us with this bitter legacy. Such actions represent contempt for the sick. I hope and pray such actions will not be seen again.

Today, after nearly 40 years of a system planned by

government, operated by government, and paid for by government, Mr. Fyke advises the government to go further with the process called health care reform. I know that Mr. Fyke spent very little time talking to mainstream practising doctors. I think he failed to identify the fundamental issues that are blocking advance. And I have five.

One, lack of co-operation between the government and medical profession. Two, extreme shortages of active front-line health care workers of all types. Three, inadequate access of patients who need state-of-the-art diagnostic services and elective surgery. Four, extremely low morale among all health care workers. And the fifth classification I call poor management, although that would cover everything I've already said.

I've said poor management includes wrong decisions, decisions made too slowly, lack of accountability at various levels of administration, indulgence in partisan politics, and failure to provide clear statements of policy. I think these things are serious criticisms.

Mr. Fyke recommends on page 1, not only the use of teams, but quote:

> . . . the creation of truly interdisciplinary Primary Health Service Networks.

He also says, quote:

> . . . health districts have the mandate to organize and manage Primary Health Teams.

He doesn't say how this is to be done. I guess they could do it any way they like. And it seems that district boards will be appointed by government rather than elected. Will they be able to address the morale problem? Will partisan politics still be a part of everyday health care?

Every profession contains individuals who, if they're paid well enough, will break tradition and actually serve the state rather than their patient. Will district boards select doctors who are more loyal to the government-run system who pays them, than he is to his patients?

We're short of front-line doctors, both those giving primary and specialist care. Most family physicians I know cannot take new patients. Waiting lists for specialist care is sky high. We can have more doctors if we find them and recruit them from our own medical college or from other provinces.

Now let's see what Mr. Fyke says about recruitment. And bear with me while I read this quote. He says recruitment should be done by the recently created Health Human Resources Council:

> . . . to conduct research in the areas such as scope of practice, education, and magnet environments to name a few. The Council can also study the implications of government policy and planning on human resources in the province. It should also be linked to the national work on . . . human resource issues.

Does he understand the crisis we're in, in recruitment of doctors and nurses and other personnel? I don't think he understands it. All I can think of with respect to his remarks is that they are unrealistic, but I also think they're stupid.

We would . . .

The Chair: — Excuse me, Dr. Silver; excuse me, Dr. Silver. Dr. Silver, excuse me. The committee needs to recess before our next presenters. Could you just give me an idea of how much longer your presentation is?

Dr. Silver: — Five minutes.

We would certainly gain more manpower with less effort if we kept the professionals we already have. This is called retention. If conditions at work are good, few doctors will move away.

Dr. David Podgurecki had an unusually high standard family practice but was finding it more and more difficult to get his sick patients into hospital and to access diagnostic tests. He then decided to accept an all-expense-paid trip to Texas where there was an opportunity for him. His recruiter picked him up at the airport and as they drove downtown, David saw a sign on the billboard which said, welcome Dr. Podgurecki, with correct spelling of his name.

He accepted the position for various reasons and enjoyed it. And this was a lot of hassle to move with a family to a foreign country. And to my knowledge no one from the Regina Health District asked him why he was leaving and what it would take for him to stay.

Just a month ago we lost the chief of cardiac surgery in Regina to Calgary. He told me he experienced years of frustration in his efforts to improve patient care in a cost-effective manner. He did manage to achieve better efficiency when his advice to perform less complex procedures in a low-cost setting was finally acted upon nearly three years later. Why did our system resist his good advice for three years?

I think we need a dynamic, effective, retention program to maintain all our professions. They're in great demand all across the country. Money should be spent now to stop the exodus of our workers. They may be irreplaceable. We have to compete with and win out over other opportunities, especially at this time by Alberta.

Our medical school is in dire straits. When I left there in 1988, funding was a major problem. Compromises were required just to keep the program going. There was a freeze on hiring new faculty.

For a medical school to be healthy you must have new faculty coming in with ideas and you must have money to improve the program. If you do, the medical school can provide all the doctors you need — rural and urban, regional specialists, tertiary care specialists, and even faculty. If we provide a new mandate, more faculty, and an adequate budget, this will happen. But Mr. Fyke says all the college needs is research money.

I submit that we do not need research to identify the needs that are staffing, space, and equipment requirements and we don't have to do research to learn how to train health care providers to

modern standards. It's being done all across Canada. The provincial government has the responsibility and the power to mobilize the resources to achieve it.

If we support the Fyke report we support the government's present direction. This will reduce access to the system, especially in the country; give the health care workers more difficult working conditions; and increase the hazard of closure of our medical school. We must insist the government identify the best medical sources of leadership and give our public the benefit of a system that's run co-operatively by government and the various professions.

Doctors in British Columbia and Dr. Gratzer in his book *Code Blue* have shown how we can work our way forward in uncharted waters without falling into great mistakes such as user fees or other costs to be borne by the disadvantaged.

We may well find that we can work within the Canada Health Act to make our system the best in our country. We can define essential health needs and devise a way to pay for their provision, without hardship to the very young, the very old, the poor, and those with permanent disabilities.

I appeal to all in Saskatchewan to speak out now in favour of sound, scientific medical care, and against the Fyke report.

Thank you very much.

The Chair: — Thank you, Dr. Silver. And unless there's pressing questions, the committee will stand recessed. Mr. Boyd.

Mr. Boyd: — Thank you, Madam Chair; and I want to thank you, Dr. Silver, for your very interesting and informative presentation to the committee. I think it is extremely welcome considering the experience and long serving time that you have in the health care system to provide us with the insights that you have into the system; how it could be changed for the benefit of all; and how the recommendations, as you see them, of Mr. Fyke, fall short of meeting that goal. Thank you.

The Chair: — And thank you on behalf of the whole committee for your presentation today. Thank you for taking the time to come. The committee will stand recessed until 1 o'clock.

The committee recessed for a period of time.

The Chair: — We'll start and the rest of the committee will come in, I'm sure, from their lunch.

Good afternoon and welcome to the Standing Committee on Health Care. This is a committee of the Legislative Assembly. It's an all-party committee. And the first order of business that it was charged with from the Legislative Assembly is to receive responses to the Fyke Commission.

So that's what we're doing with these hearings, receiving the public's responses, either in groups or individuals, and we report back what we heard. We are not going to be making recommendations. We'll report back what we heard to the Legislative Assembly by the end of August.

And like I said, it's an all-party committee. My name is Judy Junor; I'm the Chair. Dr. Melenchuk is the Vice-Chair. Andrew Thomson, Kevin Yates, Buckley Belanger, June Draude, Bill Boyd, and Donna Harpauer are here with us today.

If you want to begin your presentation — we had some discussion about logistics and you can just flow through all the different presenters — and hopefully we'll have some time for questions at the end of the presentation.

Just introduce yourself and where you're from, and begin. And you have to share the mics on those two little wooden blocks, so if you're going to speak, cozy up to the mic there when the light comes on.

Ms. Anderson: — I'm Connie Anderson, Chairperson for the Pipestone Assiniboine Advocacy.

Good afternoon, Madam Chair, and hon. members. The Pipestone Assiniboine Advocacy regarding the Fyke report closing of hospitals is composed of rural citizens from the Kelvington, Rose Valley, and Yellow Quill Reserve areas from the Pasquia Health District of the province of Saskatchewan.

We are strongly opposed to the implementation of the recommendations of the report from the Commission on Medicare, *Caring for Medicare: Sustaining a Quality System*, also known as the Kenneth Fyke report, as this report recommends changes to health care that many of us — rural citizens, health board officials, and medical personnel — believe will be detrimental to health care in rural Saskatchewan.

Some of the people living in our health district and members of the Pipestone Assiniboine Advocacy were involved in the original public dialogue and discussions initiated by the commission in the fall and winter of 2000-2001. Many of them feel betrayed, as the commission has ignored and disregarded many if not all of the concerns and recommendations that were proposed by the citizens of rural Saskatchewan.

Many of the residents in our communities feel that they have been deceived by the commission in the past. When the Rose Valley Integrated Care Facility was slated for possible closure, citizens were told that they could oppose and possibly prevent the closure. Shortly afterwards, it was discovered that the decision for closure had already been made, and people felt that the discussions with the citizens of Rose Valley may have only occurred to appease the public while the facility was closed.

Mr. Kenneth Fyke has commendable credentials and 35 years of experience in administrative health care. According to his report, he has been involved in the restructuring of health care in Calgary, Toronto, Regina, and overseas. But we believe that he does not understand the needs of rural areas, and he has not heard the concerns and recommendations of the rural citizens of Saskatchewan.

It is our belief that Mr. Fyke has not identified the key challenges facing the people of Saskatchewan in reforming and improving medicare, especially regarding rural Saskatchewan and his proposed model and his recommendations for an action plan for delivery of health services across Saskatchewan through a model that is sustainable and embodies the core

values of medicare. We believe it will be detrimental to health care in rural Saskatchewan.

The Fyke report makes a series of recommendations which together constitute an action plan for the delivery of health services — a plan that will, when implemented, ensure that medicare is not just preserved but substantially enhanced and improved. We do not agree.

Fifty-nine per cent of all respondents, 50 per cent in rural areas, agreed that in the interest of quality, specialized services should be concentrated in fewer centres even if it meant some people have to travel further. People in rural areas were quick to point out that this would result in the burden of more travel from rural areas, and that waiting time in the three recommended tertiary hospitals — Regina, Saskatoon, and Prince Albert — would increase drastically for both urban and rural population. These concerns remain unresolved.

The Fyke report states that hospital closures are a necessity, but there must remain adequate ambulance, emergency, medical, technical support in the smaller communities. The recommendation of 24-hour telephone service and ambulance dispatch, which is already in place, is good. But the localizing of the ambulance into single locations removed from smaller communities and the closure of 50 emergency hospitals will result in needless chaos and distress for emergency personnel and their clients.

If ambulances are dispatched from a single location, clients may have to wait for an hour for it to arrive, and another hour or more to be transported to the nearest regional hospital for emergency treatment. This delay could mean the difference between life and death in a critical emergency situation. This recommendation is not acceptable.

The board and management of the Pasquia Health District support our view and concerns, and they have also identified that qualifications for ambulance personnel are not acceptable if the other recommendations of the report are implemented. It was their view that the qualifications contemplated by the Fyke report for ambulance personnel would be okay with the support of existent emergency rooms. However, if the closure of 50 hospitals occur, this standard is not adequate.

The Fyke report itself is often found to contradict the information gathered during public dialogue sessions and the mail-in survey replies. The summary of public dialogue demonstrates a majority; 52 per cent rural and 56 per cent urban of replies want a health system that makes special effort to reach out to senior citizens and poor families, rather than the 30 per cent who want to focus on helping individuals when they seek health care. But the recommendations of the Fyke report calls for seniors and farm families to travel further to get their medical and emergency care.

The summary of public dialogue also demonstrates a clear majority of almost two-thirds of the respondents — 63 per cent in rural areas — want to keep hospitals open in as many communities as we can. If the Fyke report is honest in its concern to provide accessible health quality care to many residents of rural Saskatchewan, why does it continue to propose the opposite of what the citizens want? Fifty hospital closures, acute and emergency room services in only 10 to 14 regional hospitals, as outlined in the report, are not adequate. Access to diagnostic services as outlined in the report are not adequate.

The Fyke report declares that our health system should treat people in a caring and compassionate manner, and yet the report breathes fear and uncertainty into the hearts of residents of rural Saskatchewan. The report acknowledges that while local residents feel more secure with hospitals in place and beds always available, it is important to weigh those benefits against the cost of maintaining small facilities.

Again, the recommendations of the Fyke report place costs before the emotional and physical wellness of rural Saskatchewan, and yet Statistics Canada shows that rural people cost medicare substantially less than urban people.

The team approach recommended by Mr. Fyke is a good system that will likely work very well in a hospital environment or in a city with multiple hospitals, but it is unclear how such a program will benefit rural doctors.

Many people are more comfortable visiting rural doctors as they get to know their clients on a more personal basis and clients don't feel as if they're just another face in a crowded waiting room.

Physicians and front line staff have also expressed their concerns to the Pasquia Health Board regarding the Fyke report's recommendations. Standards set for the distance to emergency room services are too great to provide safe emergency service. The distance to acute care, recruitment, and retention of health care professionals, access to remaining beds, economic viability of rural Saskatchewan, and contracting and payment of physicians by health districts are the concerns identified and summarized by the health professionals in the Pasquia Health District.

What would there be to attract doctors to the rural areas if they had no acute care beds available? As much improved as fewer health districts may be, it is our belief that the recommendations of the Fyke report and the implementation of the quality board will result in greater cost to Saskatchewan. Fewer, although larger, health districts will result in the same number of managers being reassigned to all of the new areas within each of the 9 or 11 health districts.

Furthermore, total costs will increase with the addition of new personnel employed by the quality board. We cannot shape our own health care according to what other provinces or countries are doing. Variables in these different areas often . . . are often deceiving and health care must be implemented to best serve the needs of our own province's communities.

While the board of the Pasquia Health District supports many recommendations made by Mr. Fyke, they have grave concerns about the provisions of health care in rural Saskatchewan if all recommendations in the report are implemented.

You have heard only some of the concerns from the many and various residents of rural Saskatchewan, including rural citizens, health care professionals, and the board and

management of the Pasquia Health District.

Many of the people of rural Saskatchewan are concerned about their basic health care. These people are suspicious and do not trust the commission or the government. They feel that their concerns, recommendations, and even their invitations to members of the legislature, have been ignored.

They are frustrated and struggling to provide for their families, giving away over 40 per cent of the income from farming to shipping, handling, the wheat board, etc. They are threatened by the forced implementation of changes that they do not agree with. They are frightened about losing the minimum of health care services that they presently have — hospitals, doctors, and ambulance service.

Everything the Fyke report recommends will further isolate rural Saskatchewan from accessible health care.

We maintained a better health system years ago. We feel we are going backwards instead of forwards. Mr. Fyke should have visited the rural areas to obtain more input.

The Minister of Health should visit the rural areas at a public meeting and hear first-hand what the people's recommendations are — not the underhanded way they are doing it now by sending out a facilitator to interview 17 or 18 individuals and then say, we have asked the people what they want and this is the feedback we got. That is very underhanded and not acceptable.

Health care must be implemented in ways that safeguard our responsibility to assure access for people to necessary health care and which will enhance the social capacity of families and communities to provide such care. We believe such a commitment is what is expected of governments under the charter of the World Health Organization to which Canada is a signatory, when it states:

> The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.

We urge you to hear the voices of those who have elected you to office. Please do not implement the recommendations of the Fyke report without considering the effect these changes will have on rural Saskatchewan.

Consider the words of our MLA (Member of the Legislative Assembly), June Draude, who wrote:

> This government also said they wanted the input of all stakeholders. If it is the government's goal to make recommendations to ensure the long-term stewardship of a publicly funded, publicly administered medicare system, does it not make sense to hear what the public has to say and then bring about the necessary changes in health care that will make Saskatchewan, urban and rural, a world leader in caring for its people, rather than a province who brought about forced changes onto its discontented citizens.

Rural Saskatchewan will be most affected by the proposed changes. Consider what we have written and please consider our concerns and recommendations. Give the citizens of our province some feeling of comfort and security that you will not force these recommendations through and take away the few health care securities that we presently have at our disposal.

We are sure there must be better ways to reform and improve health care, especially in rural Saskatchewan. Thank you, hon. members, for having given me the opportunity to express our heartfelt concerns to you.

Ms. Spray: — I am Sherrie Spray and I'll be speaking on behalf of the town of Kelvington.

Hon. Chair, ladies and gentleman, on behalf of the town of Kelvington, I would like to thank you for this opportunity to speak before you. As with many who have presented before us, we are disappointed about the way in which our government chose to advertise these hearings, but be that as it may, we will move on.

Kelvington, for those of you who aren't familiar with it, is a prosperous town and farming community located near the bottom of the Pasquia Health District. The town population is, according to the last census, 1,046. Kelvington Union Hospital currently operates 15 acute care beds, 1 pediatric bed, and 1 multi-handicap bed, bringing the total bed capacity to 17. Kelvington's first hospital was built in 1935 and the one we are currently using was built in 1972 and has 40 . . . Sorry. The one that we are currently using was built in 1969, with renovations in the late 1980s. The Kelvindell Lodge was built in 1972 and has 44 permanent beds and 2 respite beds. As with most nursing homes, Kelvindell Lodge accepts only level 4 patients.

May I point out at this time that the health system is already failing to accommodate the needs of the aged, as the waiting list for the Kelvindell Lodge is about a mile long? Home care doesn't seem to be effectively meeting the needs of those not quite level 4 rated and those who are, but simply can't find a bed.

The town of Kelvington has two very appreciated and well-trained South African physicians, Doctor Warner Gerecki and Doctor Kobus Bester. In the past 10 years or more we have not had difficulty in recruiting physicians to the community, as they have a very large and lucrative practice in Kelvington. The drawing area would be at least 20 miles in any direction, not to mention the fact that our doctors travel to Rose Valley three times a week for clinics and the fact that Kelvington acts as the primary health centre to the Yellow Quill First Nations Reserve, population 800 to 1000. The reserve is approximately 8 to 10 miles north of Kelvington and the majority of the reserve population lives on the south end. Thus, Kelvington is most accessible to them.

Our two doctors have expressed their concern about most aspects of the Fyke report. For one, the suggestion of no acute care facilities and no lab availability would hardly make it possible for them to practise quality health care. The lab and hospital beds, they feel, are imperative to their practice. Although they do not deliver babies in Kelvington, emergency obstetrics have occurred at least three times in the last six months. Tell me what or how this would have been possible if

Mr. Fyke's perfect world were in existence.

Our hospital facility has saved so many lives this past year, it would take me hours to get into details. But I will say that our community has faced many potentially fatal automobile, farming, and snowmobile accidents as well as numerous cardiac arrests, brain tumours, etc., etc., the list goes on.

These emergencies would have been fatal had Kelvington not had the facilities and doctors to stabilize them, this showing us yet another real problem with Mr. Fyke's recommendations. The ambulance ride to the nearest primary health facility, on our well-kept cow trails we have for roads, would not have saved real people's lives — guaranteed.

Our doctors hold minor surgery every Wednesday morning at the outpatients' in our hospital. This is a very busy day for them. People are lined up in the waiting room and beyond. Where would people go to have these minor ailments taken care of if we didn't have the facility? Will our people have to drive an hour and one-half to have a wart removed or a dressing changed?

Our location in the province puts us at least one and a half hours from any primary health facility in Mr. Fyke's vision.

On a personal note, during the month of May, I spent two weeks at my grandfather's bedside at the Kelvington Hospital. During this two-week period of time, there was in my estimation two to three days where the facility wasn't completely full. In fact one night the nurses were jokingly asking me if I had any bunk beds for them to use as they had 19 people in a 17-bed hospital. My question therefore is: where are these people going to go? The city is already over capacity and experiencing bed shortages.

Mr. Fyke suggests he will attain quality care if his recommendations are followed through. He suggests salaried doctors as a way of keeping physicians in rural Saskatchewan. The doctors here at present feel salary will deter them away rather than keep them here. It would seem Saskatchewan would be left with physicians inept to practise elsewhere. And therefore, once again, our quality of health care would drop.

The large and lucrative practices in towns such as Kelvington would no longer be a drawing card to physicians. Fee-for-services practices only reward the actual work being done. Thus I would suggest we have a higher quality of care in fee-for-service practice.

Kelvington, as with most of rural Saskatchewan, realizes we have a potential nursing shortage on our hands. Although at present Kelvington is holding its own with enough nurses, retirement in the next three to five years may change this. The Saskatchewan government is well aware of the difficulties recruiting nurses or keeping them in Saskatchewan.

Where then are we going to get the nurses Mr. Fyke relies on his recommendations? I'm not sure nurses will move back from Alberta, etc., to work twice as hard with more responsibilities in Saskatchewan.

The Saskatchewan economy is what has to change drastically in order to save Saskatchewan. Let's face it, nurses have families, husbands and wives, and statistics show they rely on two incomes. If the second party can't obtain work here, then why not move?

Our education in Saskatchewan needs to change. We need to put requirements on the new grads to send a . . . to spend a certain amount of time in Saskatchewan after convocation. After all, we are spending a lot of money on them to educate them.

Also rural Saskatchewan needs more accessibility to education. By this I mean there are many people in our area who want to become licensed practical nurses, or registered nurses, but because of their family ties, children, spouses, and reliance on jobs, etc., they can't access the education needed.

Saskatchewan has a huge network of technology. Surely we could educate those at home in our own communities and be more likely to keep our own people in rural Saskatchewan.

Kelvington and community have been holding their own as far as population is concerned. In the past 30 to 40 years, we haven't seen a fluctuation in population. Thus businesses are well established but very concerned with the prospect of hospital closure. Rural Saskatchewan towns tend to house retired folks, and Kelvington by no far . . . or by far is no different.

We as a community are certain to lose a large portion of our population to larger centres with more secure health care. Once again the question of larger centres being able to provide quality health care to a larger population seems impossible, as the city facilities are already crowded.

If people choose to stay in a community such as ours, they will be facing larger expenses due to travelling, and some people just simply will not have a way to travel to larger centres. The cost of ambulance services will fall on each and every one of us. Some people will be able to afford ambulance coverage and some will rely on government assistance. Is this a cost savings measure?

The most important point of all is you, each and every one of you, must make this decision or recommendation to government very carefully. You must consider very carefully the effect you will have on rural Saskatchewan.

We feel that if Mr. Fyke's vision were to be implemented, rural Saskatchewan will surely die. Is that what this government wants to see? Doesn't our government somewhere, deep down inside, have some pride in our province?

We seem to be losing people at a rate of about 50,000 per year. Maybe we need to boost our economy and make use of our natural resources or, at the very least, make or create government policy that actually saves money. Since Mr. Fyke already said his way wasn't about saving money, let's work together to find a way that will.

Thank you for your time.

Mr. Bjerland: — Madam Chairperson and members of the

committee, my name is Larry Bjerland. I'm the mayor of the town of Rose Valley.

When approached about being the representative for our community of Rose Valley and surrounding area, I debated as to what I could say or do to point out the need for not only the improvements to our health care quality, but the social, financial, and mental stability that has disappeared from rural Saskatchewan. In an effort to enhance our situation, I will use my own record as an example.

In this year of volunteerism, it should be pointed out that my personal contributions are insignificant compared to many others across the province. I have been a Scout leader 25 years, Legion member 30 years, on church board many times, on recreation board, 5 years on the provincial home and school executive, local school trustee, Saskatchewan seniors trustee, member of the Community Spirit Manor which is formally our integrated care facility, 4-H leader and mayor of the town of Rose Valley.

During my years in working with community projects, the one thing that has always impressed me was the sincere dedication of the rural people who gave of their time, labour, and money to enhance our communities by making buildings and services available to all. You should note there is no financial reward to any of these positions, only the knowledge that one has been able to contribute a small part for the betterment of all.

The saddest situation I can think of is veterans not having services locally and being shipped elsewhere to die, or the lady who worked first to establish our hospital, then 25 years as a volunteer caregiver, cancer volunteer, homemaker, teacher, and lifetime supporter of the NDP (New Democratic Party) Party becoming the first person to be moved upon our hospital closure to die in a neighbouring facility where she knew no one.

In the past, a great deal of time and money has been spent on fancy pins, parties, etc., to give some form of recognition to those volunteers. Even more has been spent on so-called cultural projects.

We in Saskatchewan have developed a unique culture as it is, evidenced by projects such as Telemiracle and others. People all over the world realize our culture and lifestyle is based on generosity and love for our country and fellow man. With this being a well-known fact the money wasted on cultural events could well be put to use to maintain our local health system.

Every day one hears of money being wasted on one program or another. I will concede that in some cases it is necessary to pay off some political debts, but not to the point of making people lose faith in the ones entrusted with responsible tasks.

It is my hope and prayer of those many fine people that I represent that this committee will recognize the serious impact that hospital closures will have on rural Saskatchewan.

Can you feature a diabetic having to drive 50 miles each day for tests? It may be possible when one is younger, however that leaves only one day a week to earn an income. Who will pay for expenses, lost wages, etc.? The elderly could not physically do it and so therefore their health deteriorates, placing further burden on family, friends, and government.

In Rose Valley we had the first integrated care facility which was, from the time of its beginning to its closure, was well supported and was financially secure. We had excellent staff and the people had confidence in our community.

We have since then lost members of our area to larger centres, only because of the unstable medical and financial situation that has evolved. A number of houses are moved and many are for sale at depreciated prices. As these services disappear, so do the businesses.

With the government cutbacks to towns and villages, our own taxes have had to increase to pay for services largely under government control. If government is to control our destiny it must be prepared to pay for it.

In summation I would like to know if there is anyone on the committee who would feel confident in being treated in a strange community and facility by a doctor or nurse who has driven 50 miles and had to work 12 hours in an unfamiliar environment and not knowing the patient. I would hope that the human element has not disappeared like our stores, schools, and grain elevators.

Thank you for the opportunity to express our concerns. It is our hope that this time the committee will take our suggestions and concerns into account, not like the last time we approached the government when they closed our integrated care facility, which has not saved the government 5 cents excepting for the profit on the sales for petroleum, and E&H (education and health) tax.

Also, when deciding the future of health care in our area, one should take into account our Pasquia District is not operating on a deficit budget like the ones Mr. Fyke wishes to enhance.

It has become quite evident that a feeling of despair in rural Saskatchewan is fast replacing the one of hope and pride we once had, as our communities and services disappear. If the city can't cope with providing the services now, think of how it will be when we all move into them. It would make a very interesting election period.

Thank you.

Ms. Franks: — My name is Margaret Franks. Hon. Mrs. Judy Junor, Hon. Dr. Jim Melenchuk, and hon. members. I am a survivor of the local primary health care. They have coped with all of my major health problems. And since I have retired from teaching in '84, I have dedicated a lot of my time and energy in health.

During our stay in Saskatoon, we purchased the first seniors' condominium for the city. I observed the difficulty seniors experience adjusting to city life. Costly community/government programs and services are needed to assist these newcomers.

We later moved back to Kelvington after my husband's health started to fail, amongst friends, family, and neighbours. And during his long stay at the long-term care home, they were treated by local, familiar people, which helped us through our more unbearable times.

I am an active member on many volunteer groups in our town. I realize and understand the importance of our existing hospitals, doctors, lab, and ambulance services in our town, and its importance to future revitalization endeavours.

We're located in Canada's breadbasket. Local industries and natural resources provide a stable economy. Our farmers produce a vast variety of grains. And farmlands are managed and operated by dedicated farmers.

Conservation and preservation techniques are diligently practiced to preserve this precious and vital resource for today's growing population, as well as future generations. Unfortunately due to low commodity prices, high input costs, and lack of attention and support from our provincial and federal governments, our farmers are struggling to support one family.

Potential farmers have had to abandon their interests in farming and hope that their parents can sustain the farms when they plan to return in their later years.

Livestock and food producers are making a great effort to diversify their operations at a great cost. Often one or both operators pursue off-farm jobs to earn the necessary cash flow to support their daily needs.

Accessibility to primary quality health care essential facilities and commercial outlets of goods and services is vital for their support and survival.

Modern technology and machines have greatly affected our way of life. Machines and technology are quickly replacing our human resources. A trend towards corporate business in all aspects of our society is evident. An ever-growing multitude of protestors all over the world are concerned about globalization and the rate that technology is replacing human resources.

We cannot survive without quality food, water, or air. We must appreciate, promote, and take care of our dedicated citizens who manage our resources with respect and pride. The conservation and preservation of our natural resources for today and for future generations is essential.

Closing 53 more rural hospitals and reducing accessibility for health care and services in secondary and tertiary hospitals is not acceptable. Rural Saskatchewan should not be treated like second-class citizens. The Kelvington Hospital is a vital health centre. We are fortunate to have two highly skilled and qualified young doctors who provide quality, multi-dimensional service.

These doctors have saved the lives of several citizens involved in emergency situations during the past year alone. These are valued Saskatchewan citizens. The doctors, along with their accessible diagnostic facilities and technicians, were successfully able to make quick assessments, accurate diagnosis, and efficiently and effectively assist and direct these patients to the required specialists in the tertiary treatment centre.

The quick and efficient attention and treatment saved the lives of these patients and prevented extenuating consequences that could have required years of costly rehabilitation.

We appreciate our doctors and have great confidence in their multi-dimensional services. We have a large population of senior citizens. We have a 46-unit, long-term care facility. We serve a First Nations community of over 800 citizens. The Rose Valley community and Community Spirit Manor for levels 1 and 2 residents rely on our doctors. Our farmers and ranchers who work with a variety of chemicals and drugs, as well as large powerful machines, rely on our doctors.

We have a school population of approximately 400 who make extensive use of our doctors. We are surrounded by lakes, parks, and recreational centres that abound in tourists who come because they know that doctors are accessible in emergency situations.

Consider the water problem in North Battleford recently. Had the community not had doctors, staff, and facilities to cope with that situation, the consequences may have been astronomical. Today we may be confronted by unexpected emergencies at any time. We must be prepared to handle such serious situations.

Kelvington is at least one and a half hours from a city, four to four and a half hours by bus. Public transportation is very limited. We have a three-day outgoing bus service per week, including Sunday, and transportation to other cities are inconvenient for older citizens.

Most patients cannot travel long distances alone. Ambulance services for appointments is too costly. Inconvenience provokes hardships to patients, and many choose to put off medical trips to outlying areas. Delayed treatment or care provokes serious, costly consequences. This situation will be more costly and ineffective.

A health or community centre serviced by a nurse or ambulance service with highly trained EMTs will not be as efficient and cost effective. They cannot substitute for the multi-dimensional services provided by a quality . . . a qualified doctor who is also trained to perform minor day surgeries with limited equipment.

Remember our pioneers who immigrated to our land, surviving a horrendous, long sea voyage to escape the turmoil and instability in their homeland. They developed this virgin land, tree by tree, for you and me. They realized the importance of a public health system. In partnership with the government, they were able to design, construct, equip, staff, finance, manage, and operate a successful and accessible health facility and service. This amenity evolved over the years.

Today our government, that has undertaken the sole responsibility of managing our health system, is preparing to deny us accessibility to health care and services. This is a very sad situation.

Remember the young men and women who offered their lives for their country in World War II. More than 400 Kelvington and area patriots took up the call. Today our voice and spirit is on the line.

There are no local boards or representatives. Our health services are solely directed and controlled by our provincial and federal

governments and their bureaucracy.

The Pipestone Assiniboine area in east central Saskatchewan encompasses at least 2,500 square miles of stable industries. It abounds in valuable natural resources and recreation . . . recreational areas for tourism. It is an ideal area for revitalization. Agriculture can be more extensively diversified and reforestation can be promoted. There are so many opportunities that we should not overlook. We have a great opportunity to promote and encourage young and semi-retired citizens with energy and expertise in various fields to settle in this area and assist in revitalization projects. An accessible primary health facility with doctors, labs, staff, acute and long-term care facilities and 24-hour ambulance service would offer a great incentive.

The public dialogue regarding the focus on medicare has been somewhat deceptive and discouraging. Citizens were selected and expected to discuss a very important topic: medicare. Directed by a facilitator with a planned agenda, with no preliminary briefing or information, how can an uninformed citizen be expected to participate in a balanced, meaningful, and productive dialogue? We realize that change is necessary and we welcome positive changes. Let us become real partners in change.

Thank you for your attention and this opportunity to express my concerns. And in closing, on behalf of the Kelvington community and area, I invite you to come and visit our community. Arranging change on paper or computer is far different from the realities of our area. We will be pleased to arrange and accommodate your visit. Thank you.

The Chair: — Is that the end of your presentations? That's the end of your presentations? Questions from the members? Ms. Draude?

Ms. Draude: — Thank you very much. Have you, is there people building in Rose Valley or Kelvington right now? I'm asking this because I know you talked about revitalization and the fact that . . .

Ms. Franks: — Well most of our houses keep filled and we seem to get more and more people interested in coming and I think that we could accommodate a lot more if we had some housing. And a lot of people are wanting to retire in our town if we could stabilize our health care services.

The Chair: — Any questions? Seeing none, then I thank you very much for your material and your personal presentations today.

If the next group of presenters want to take their seats at the table here.

Welcome to the Standing Committee on Health Care. This is a committee of the Legislative Assembly and our first task is to receive responses to the Fyke Commission or the Commission on Medicare. So groups and individuals are presenting at these hearings.

It's an all-party committee of the Legislative Assembly and we will be presenting our findings or what we've heard to the Legislative Assembly by the end of August. We're not making recommendations, so we'll report back what we've heard from our presentations.

It's an all-party committee, as I said, and I'm Judy Junor, the Chair. Dr. Melenchuk is the Vice-Chair. Donna Harpauer, Bill Boyd, June Draude, Buckley Belanger, Kevin Yates, and Andrew Thomson are members of the committee that are here today.

If you want to give your names and where you're from and then begin your presentation.

Mr. Van Eaton: — I'm Jim Van Eaton. I'm Chair of the Shellbrook Advisory Committee. I was on the previous hospital committee during the amalgamation; in fact, worked on the amalgamation group that did the preliminary work to form the district. And so I have since become the Chair of the advisory committee and we have tried to do some work to help benefit our local area.

And with me is Clayton Agnew on my right, who at one time was our hospital administrator and has been on the advisory committee since he's retired from administration.

And on my left is Dr. Jack Spencer, who's on our advisory committee and greatly helps us because we get input from the medical side that we are unable to get as people on the street. Actually, Dr. Spencer will be reading our presentation.

And we felt that we had 30 minutes total time, so we kept our . . . as you noticed if you got our handout, we've kept our presentation rather short, feeling that people are more apt to pay attention to a short one than a long one, and not get bored and confused. So having said that, I'll turn it over to Jack who will read the presentation.

Dr. Spencer: — Madam Chairman, and members of the legislative Standing Committee on Health. May we preface our report by suggesting our understanding and the purposes of your committee . . . and I think we were wisely advised that this is not an area for turf protection. So we have felt that first we wanted to be here. If we don't present anything, then we can't criticize for somebody doing something or not doing something. But we have chosen to kind of generalize some of our opinions on Mr. Fyke's report.

With that understanding, we of the Shellbrook Hospital Advisory Committee, we are a major player in the Parkland Health Care District. And we wish to express our appreciation for this audience. Our members are as you have had introduced.

In perusing and assessing the Fyke report, and reading the summation of the report issuing from public meetings held locally by our district board, we agree with many of the conclusions, and the tenure of the feelings in the latter document.

However, several issues have surfaced and we have chosen to highlight but a few. In the light of earlier hospital closures and the proposed future closures, the concerns arise as to who actually has the right to judge that rural folk do not deserve local health care. Our system has supposedly been restructured

into a more manageable and efficient organization. Instead it appears politically motivated and heavily bureaucratic.

At the bottom end of the scale is the human being. Just because we're rural does not render us less human. Our health care, although it may not be perfect, has served the public for years. Dedicated people from various special team doctors who deliver their country style care, and nursing personnel who still do shift work and long hours and get very little credit; dietary, X-ray, lab, maintenance, housekeeping, health records, are all extended services. These are all of the unsung heroes.

Our administrative staff is headed by our DOC (director of care) who manages to coordinate despite the centralization into larger districts mandated by reform.

The previous was taken from our original submission.

We contend that reducing the health districts from 32 to 12 will contribute in large measure to a more cumbersome and expensive system, and we urge you to refer to our original letter presented to the Fyke Commission. A copy is enclosed with your package.

It is interesting that reducing the budget cannot address the areas of waste, unnecessary purchases, misuse of time developing services that are less than necessary, and financing meetings and agendas that are never ending. Surveys and bureaucracy steals valuable time and money that could be spent on patient care.

Instead of the proposed solution . . . the proposed solution is that we must yet cut more beds, but in so doing we lose more nurses and support staff and eventually we can no longer expect any medical practitioners to stay. The domino effect branches into the very fabric of our community.

Now we strongly feel that community hospitals serve not only as a valuable entity for local primary health care services, but in addition they perform an important role in rehabilitating post-operative patients back into our community, thereby releasing precious beds to the larger hospitals for new cases, and in small measure reducing waiting lists as well as costs.

In the early stages of the reform movement, Saskatchewan government issued a pamphlet called "A Saskatchewan Vision for Health." It may well be that it's too early to speculate on all of the problems to integrate such a plan. Reformed again, some eight, nine years ago, with the development of 32 health district and the shocking finality of hospital closures.

We have serious concerns regarding further closures and the development of mega-districts, particularly their value, their cost, their efficiency, and their problems. It would seem the logical result will be the development of smaller boards in each area, much as we had before, responsible to a larger governing board. But we don't know these things.

Boundary changes seem not to consider the natural flow of traffic to shopping and service areas. Will this be expected to change? We doubt it.

Funding is presently calculated on medical care performed within the district. If people choose to go out of the district, funding follows them. This is the way of budgeting, I understand. We question if there's not a better way. This does not have any bearing on referrals out of a district.

This leads to another concern. It has been suggested that the two large tertiary care hospitals in Saskatoon and Regina should in fact be provincial institutions governed and funded directly, divorced from the Saskatoon and Regina Health District boards, as they serve everyone in the province, not just those cities.

Home care has become an important function of the reform program. In our area we feel that this is performing well and smoothly. The initial wrinkles have been ironed out and we recognize that miles travelled contribute to increasing costs and we are concerned about the management costs of larger districts. The question returns, is why is bigger better?

Turf protection is a fact of life. It exists in our present district. It will be magnified three or four times, maybe more, in the new mega-district. And we can see this is as an unfortunate result. The government may well . . . Governing may well become a more important aspect of this and be overshadowed to the need of compassionate health care.

There has been a consensus during public meetings that too few taxpayers support too large a population. We feel that all citizens should be taxed for health care.

We also believe that ambulance fees should be unified. That is, equity for rural and urban patients. We strongly believe that all people in Saskatchewan deserve the right to timely and effective health care services. Rural residents should have the same rights as those in the urban centres. An extra 45 minutes to travel for health care is not a reasonable or a safe alternative. Indeed many people would be unable to make this journey without an ambulance or a major assistance. This is taken from, again, our original submission.

In closing, another paragraph from our original submission. Maybe we should close many more rural hospitals and build more wings onto larger regional hospitals and allow them to bureaucratically suck up the savings and still not have any money left for the patient. Maybe we could have more meetings and surveys and studies to study this problem; and maybe after much, much more study we will still have to conclude that maybe we still haven't saved any money.

Rural people are stubborn and a hardy bunch. You've probably seen that. We can see how money tends to get squandered under the guise of reform and restructuring. We tend not to be easily swayed by the city lights, or Mr. Fyke's report. We intend not to be bullied into believing that rural hospitals are not essential or vital. If that makes us bullheaded and politically incorrect, so be it.

We appreciate your indulgence in receiving this report and we invite any questions that you may have of us. Thank you.

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

Mr. Thomson: — Thank you, Madam Chair. I have a couple of

questions. First of all I guess by way of my background, I should tell you that my father lives in Shellbrook — and if he's watching today, he'll disagree with me — but I have an opportunity to visit frequently; he would say not frequently enough, of course. But it is a very successful town. I think a very . . . just a real success story in general.

I have a couple of questions though. You talked about the district arrangements that Mr. Fyke had proposed and I tend to agree that they maybe don't make as much sense as one would seem. It would seem to be natural that Shellbrook, if there were district reorganization, would look at being paired up with Prince Albert rather than, I think the proposal is to put it into the Battlefords area. Have . . .

A Member: — And to the border.

Mr. Thomson: — And all the way to the border, that's right. Has thought been given in terms of how reorganization might work within a district level, particularly in light of Fyke's proposal that P.A. (Prince Albert) take on additional responsibilities for tertiary care?

Mr. Van Eaton: — At this point we haven't really sat down and tried to study what the ramifications would be in that situation of moving toward the Prince Albert district. I believe in the beginning we chose to go into the district we're in partly because of, I suppose you could say turf protection, of fear of being swallowed up by the Prince Albert District and disappear, the same as Birch Hills hospital has disappeared.

We managed to get some very good lab equipment while we are still a free-standing hospital. And our hospital does most of the blood work and lab work for the whole district. And it's very busy. And a matter of fact, in 12 months, the pink slips, I'm not sure that includes out patients and lab work, etc., etc., we did 11,658 pink slips in one year in our Shellbrook Hospital.

Mr. Thomson: — I'm also interested in what type of services, for citizens of Shellbrook and area, how the flow would work; what things people would go to the Shellbrook Hospital for. At what point would they then go on to Prince Albert or go directly down to Saskatoon?

Dr. Spencer: — We have a unique situation — I suppose it's not unique, but it just seems that way to us — but you know we have some of our district that is into the Blaine Lake area. And if you live in that area, the flow of traffic goes towards Saskatoon; this is where they gravitate. We have people who are almost on the fence, in between Shellbrook and that area, and they can kind of go one way or the other.

But I mean we have the two larger centres, Saskatoon and Prince Albert, and people do gravitate. And we lose people medically because of our freedom of choice. And no amount of decision making is going to change that. We recognize that.

And it makes it rather ominous to try and figure out how we're going to work into the scheme of such a large mega-district. We aren't expecting I guess that we would change the flow of traffic in the line of service areas that way, but it makes us understand that we are losing people.

The way I've been led to understand, from our present board, that funding goes to the services. And if we are performing services in our district and so on, the funding is coming that direction. If the services are voluntarily going out — which it can't avoid doing being so close to Prince Albert and/or Saskatoon — we are losing that kind of funding. Maybe that's the logical way it has to be, but it seems a little unfair in some ways.

I'm not sure that answers your question, but we have not been geared to having input into the decision making as to whether we go one direction or the other. From the reports that we've had the line is drawn on the east side of Shellbrook and we're going to be in that district. I can foresee a lot of just local problems with governance, and a large, large district. Just a huge one.

Now maybe it's based on the fact that we have two major cities. You know, you'll have North Battleford and you'll have . . . well Lloydminster I guess would be the next one. That's right on the border. I don't know if that will go Alberta or . . . It's almost like saying to Lloyd people, do you want to go this way or do you want to go that way? It's very, very difficult to understand what will happen.

And of course medically we don't just gravitate by favouritism to one district or a larger hospital. We send it to the people that can perform the service for us. And so most of us have consultants in Saskatoon that we use, and consultants in Prince Albert that we use.

I don't know if that answers your question, but it's the facts as I see it at the moment.

Mr. Thomson: — I am interested to know whether you are supportive of the idea of Prince Albert taking on an expanded tertiary role as is reported in Fyke, or would you prefer that it simply stay with the two large centres as it is now?

Dr. Spencer: — Well I think there certainly has to be some restructuring in Prince Albert if they're going to take on a tertiary care hospital because they do not have the specialist qualifications there.

The specialists that are there are just great, but they don't have the . . . I mean, let's exaggerate it and go into cardiac surgery and neurosurgery or whatever. I mean, we have some orthopedics there, and we have internists. We have pediatricians and obstetricians. But there it kind of stops, and sometimes we just have to go elsewhere.

I'm not sure that that makes sense either but if it's going to become a tertiary hospital, it may have some variance because of that.

Mr. Thomson: — I'm not sure I completely understand your answer. In terms of Prince Albert taking on additional services, would you support that or would you just prefer that Saskatoon continue on as the main tertiary centre — from Shellbrook's perspective, from the rural perspective?

Dr. Spencer: — Well we're grateful for the amount of specialty services that we can get in Prince Albert primarily because of

the proximity. And I mean if we can have a half an hour of service to Prince Albert and it's an hour and a half to Saskatoon, that makes quite a difference on us. So anything that will be coming forth there, anything be coming forth to Prince Albert would be gratefully received.

Mr. Thomson: — I don't think I have any further questions at this point.

Ms. Harpauer: — Thank you for your presentation, gentlemen. You've obviously all been involved in the health care system for a number of years. And I feel that something that's very important to our health care is donation dollars and volunteer time, are critical to our health care system to operate. And it relieves the number of public dollars that we need, and that of course is the concern.

Having been involved in health care a number of years in your area, did you find that there was a reduction in donation dollars when we went to the health care districts due to the turf protection problems? And are we going to see another reduction of the donation dollars given if we go to these large, large health districts and there's no guarantee that your donation is going to stay within your community?

Mr. Van Eaton: — That's a very good question, and I'm not sure whether I have a good answer for you or not.

Actually, during the period that I was on the hospital board, we didn't depend a lot on donations, although there were several different groups that did things for the hospital. We had the — what's your wife on, Clayton? — the auxiliary. The auxiliary did things. And we've had, you know, several things like that.

And then when the board was organized . . . or the district was organized, nobody actually told us on the advisory committee what our terms of reference were or that we had any rights, and unfortunately we became dormant for a period of time. Or more dormant than we should have been because we didn't understand what rights we had. And then we got the district CEO down and she gave us the terms of reference. And we've become considerably more active since that time and we have volunteers being active.

I'm the Vice-Chair of another committee, and it's the fundraising committee for the facility of the Shellbrook Hospital. And we have . . . for about two years we've been fundraising in any way we can. We had an amateur hour that took in about $4,000. Not . . . A talent night would be a better display for it. And that night we had a 50/50 draw. An Indian gentleman won the thousand dollars, I think it was, and he donated half of it back. So we think that we have the public well behind us. We had a golf tournament which picked us up more than $4,000.

Many of these local groups are behind us. In fact if you got the Shellbrook paper, there wouldn't be many weeks go by but what there's a picture of one or the other of us receiving a cheque from somebody. And so at the present time, volunteers are working hard to raise money and to do what's necessary so that we can maintain our facility.

And of course, our long-term facility was built, one of the early ones. It's a 1 and 2 level, not meant for 3 and 4. And so consequently we have to raise money so that we can have a new facility and it then will be integrated with our hospital facility. And our government rep tells us that that would save about $250,000 a year by having all of the facilities under one roof — the kitchen facility, the laundry facilities, the cleaning facilities. And so therefore it makes sense that we do that.

The shape our farm people are in right at the present time and so on, those of us on either the advisory committee or the fundraising committee cannot bring ourselves to asking the municipality to tax land to raise this money. We would far rather people voluntarily donate, and people are donating and they're donating good sums of money. We realize we have a ways to go.

But on the other hand, we're getting money in when we aren't an approved project. And we think if we get to the point where somebody will make a decision and say yes, you will have a project, money will come in a lot easier.

And while we're on that subject, the last number of years we've had anywhere from six to nine houses built in our town every year. Since the Fyke Commission report came out, this year we're having one new house built and one house moved into town. People are saying, why do I want to build in Shellbrook if I don't know there's going to be health care.

And so consequently, indecision is one of the things that's killing us and we very strongly would like some decision made and not wait another 18 months for Roy Romanow.

Ms. Harpauer: — Thank you very much for that answer.

Hon. Mr. Melenchuk: — Thank you very much, Madam Chair.

Certainly I thank the committee and Dr. Spencer for giving us a rural perspective. We've heard quite a few perspectives in the past few briefings with regard to the importance of having the availability of acute care beds in rural Saskatchewan.

And the question I have for Dr. Spencer, recognizing that he spent a long, long time practising in rural Saskatchewan, do you believe, as we've been told, that the availability of acute care beds is essential to recruiting and retaining physicians in rural Saskatchewan?

Dr. Spencer: — Let me preface that by saying that I'm probably the oldest living structure in our hospital at the moment.

And I've had a . . . Clayton down here will probably attest to the fact that some years ago I said, you don't have to worry about me being an old doctor that's incompetent because I'm going to gracefully retire at 65. And they seemed to heave a great sigh of relief. Now that was three years ago — and I lied. But I felt that I wasn't maybe allowed to retire — maybe this is sounding too egotistical — but we didn't have a lot of physicians.

Right now we are doing very fine in our hospital. And right at the moment, we have five doctors, and that's pretty rare. Now I

don't know if I should leave and make it four or what to do. So it's one of those situations.

And I'm not sure how much relevance that has to answering your questions. But I think that the fact that we've got a facility, certainly, you know, it's just second nature to the fact that we have to have physicians to place it. And you know, they're just not necessarily having to go and go to districts where there's no hospital available to them. They just don't have to. They can go somewhere else because there's lots of vacancies for them.

And I think that it's of cardinal importance to have an operating facility. We've had a good operating facility. We've had the beds reduced. And we, without making too much noise, decided to do our level best with what we had left to work with. And I think we did a darn good job.

You know, just to give you the illustration. Before the reform system came into being, we were a 30-bed hospital. We're now 18.4 — whatever that means; haven't found a point 4 patient yet. But it makes a difference.

And we recently were threatened with losing another five beds and we really dug our heels in and we seemed to have some influence in not changing the status quo for the moment.

But we fear that this, if this is the situation, we are obviously the biggest and the largest . . . and the largest turnover centre in the whole district. And it's certainly earth shattering to think that that can be altered.

Some people say well we're just too darn close to Prince Albert — why does this exist? Well we can't answer that question other than the fact that maybe we're doing something right. I would be very upset . . . it would be a lousy way to retire if we lost everything. I don't think that has any bearing on it, but it's just a personal thing. I guess maybe I've just stuck with it because I'd like to see something happen positive.

I don't think I answered your question well but I feel better.

Hon. Mr. Melenchuk: — I think you actually answered the question well indeed. The second question that I have is with regard to long-term care. Now you have a long-term care facility in Shellbrook. Is there a waiting list? And do the residents of your long-term care facility come from Shellbrook and surrounding area?

Mr. Van Eaton: — I at this minute couldn't tell you about the waiting list because that's the other facility which I'm not on. But the residents mainly come from the Shellbrook area but we do on occasion take in residents from other areas, just as sometimes some of our residents have to go to other areas.

We have people from Shellbrook in Canwood, and we have people from Canwood in Shellbrook, and sometimes people from Shellbrook go to Leask because you wind up going to where there . . . when you have a bad need to go, you go where you can go. And sometimes when you get established there it's better to stay there than it is to move around because people get familiar . . . older people get familiar with help. And moving them closer to home where it's more convenient for family, and particularly if there isn't a bunch of family, just upsets them. And so we do have people in both the other facilities, and I'm sure there's people in Shellbrook from others, in fact I believe even from Debden.

Dr. Spencer: — May I just qualify that a little bit. When the nursing home was built, of course it was a special care home then, it was not for a level 4 facility. But when it was first built it . . . there was a lot of turf protecting too, but there were some people who got in from the outside and so on. But now this is all under health care . . . or home care, I'm sorry.

Home care supervises the admission to the special care facilities and the nursing homes. And so it's with this kind of a system . . . And this is one of the reasons why I say home care is working well in our area. I know that they've been a pain in the you-know-where in some areas, and we've never kind of been able to figure that out because we, I guess maybe at the beginning, decided to co-operate and get along and make this thing work. But home care has taken over the admission to the care homes.

And I think that this just integrates it a little bit better because they'll come up and they'll say, well so-and-so is in such a case now; we have to get her out of the acute hospital — what can you do for us? Oh you know we have a place in Spiritwood, you know — they know this — or we have a place in . . . or even temporarily, you know.

You can't really encourage people to die and that's usually the way they get out of homes, and so it's a matter . . . Now at one time we had a 30, 40 waiting list, because I was on that board for a long time. That doesn't exist any more. And the fact that we have eight nursing care . . . nursing homes in our district is a great tribute to that, the fact that we have that many. And some of them are nearby.

It's just that Shellbrook was one of the first ones, so we're the oldest one. And it's substandard now. The rooms are not the right size and all the rest of these things. The doors aren't the right size. And this is why there's the need for change there also. But it was one of the first. And we trained a lot of the nursing aid staffs, members in our place, and it's a great tribute to them.

But the list is not as long just because of this integration with the home care people. And I give them credit for that.

Hon. Mr. Melenchuk: — The reason I was asking that is that you do have a fairly large district geographically, and it looks like you do have coordinated assessment and placement of long-term care residents within your district.

We had an earlier presentation where there were some concerns that placing residents in long-term care settings outside of their community would not be desirable. And I guess it's not desirable.

Does that have as big an impact in terms of travel for relatives and support, or is it less of an impact? And are the benefits of having a coordinated placement system overriding moving some of these people out of their home communities into long-term care settings?

Dr. Spencer: — The logical and most immediate response would be certainly it cares. If I've been living here for you know 68 years, this is where I want to be. But I think that logically you can also realize that the need supersedes that. And if you are in need of a home, a nursing home bed, and this is the one that's available and . . . I'm just trying to say that the reasonableness of the coordinators right now are such that, we can put you up there now and that gets the hospital bed free and when a bed becomes available there's a shift. And they move them around.

But by the same token I can give you lots of illustrations of people that have gone out of the district and they make their home in that little enclosure. They're just fine and they stay there until the end of their time. That has happened many times and, believe it or not, sometimes you don't see some of your close friends when you're so close but when you get moved away a little bit you see them oftener somehow. That happens.

Your kids may not come to see you in your same city but if you move away then they come every second weekend. So I mean it's the same principle, I think. And we find that the visitors go very readily and some of your true friends will travel there too. Even the elderly will go to visit the elderly. That's the way I've seen it anyway.

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

Mr. Yates: — Thank you very much for your presentation. It was a very good presentation. I had a number of questions but Dr. Melenchuk asked several of them so I really have one question basically, of clarification so I understand. I'm fairly familiar with the community. I have a number of friends who live in the community.

I would like some sense from you, the utilization of your 18.4 acute care beds. Are they used for stabilization? Are they used for minor acute cases? Are they used for patients who really should be in nursing homes at times? Just some feedback if you could on how the 18.4 beds are utilized in your community.

Dr. Spencer: — All of the above . . . (inaudible) . . . We certainly serve that purpose. And you can't judge it from day to day because it's dynamic. It's always changing.

The thing that you may have left out and we have alluded to in our report is that we very willingly take back patients that belong to us from the higher care areas. And this has become such an important part. In fact we always get such appreciative letters, you know.

I mean I had a phone call just the other day and they said, so-and-so is, you know, we had referred here just a few days ago and we've done all we can here; can you take them back. And I says, you bet. I said, now whether I can get them today or tomorrow, I'm not sure. Well tomorrow will be fine. Well we got them in today.

So I mean that's just the way . . . that's our attitude and we have many times had it expressed as an appreciation from the consultants: oh yes, we know that you always take your patients back.

I presume that this is elsewhere but maybe since the question comes up, maybe it's not. I'm not sure. But we use these beds for all of these things. If we're not sure . . . and we use a lot of the observation beds now too and we've got a couple of these. And you know, we take somebody in overnight and very often that's all they need — sometimes just a few hours. Rehydrate them or something like that and get them going, get them moving. But we've been trying to work our releases in propriety, you know getting them out as quickly as we can and reintroduce them into the work area.

Mr. Yates: — Just to let you know, the reason I asked this question is to try in my own mind determine whether there may be a need for some level of care between the regional centre and the primary care centres in communities, if there's some level that Mr. Fyke may not have identified. Thank you very much.

The Chair: — Any further questions? Seeing none, then thank you very much for your presentations today on behalf of the committee and your travelling here and your written submissions. Thank you.

Mr. Van Eaton: — Thank you very much. We appreciate the opportunity.

The Chair: — Could I ask for our next presenter to come and take a seat at the table.

I think if we get started, we'll gather all our people back together.

Welcome to the Standing Committee on Health Care. This is a legislative committee. Its first order of business, directed by the Legislative Assembly, was to receive responses to the Fyke Commission from individuals and organizations. So that's what we are doing with these hearings.

It's an all-party committee. I'm Judy Junor, the Chair of the committee. Dr. Melenchuk is the Vice-Chair. Donna Harpauer, Bill Boyd, June Draude, Buckley Belanger, Kevin Yates, and Andrew Thomson are the other members of the committee today.

So if you want to . . . Our first order of business, when we receive these responses, we're not making recommendations to the government or to the Legislative Assembly. We're reporting what we've heard. So some people have come with a misconception that we're going to be making recommendations and we won't be. So our responses for what we heard will be presented to the Legislative Assembly by the end of August.

If you want to just give your name and who you represent, then you can begin your presentation.

Dr. Nilson: — Okay. I'm Ralph Nilson. I'm the Chair of the Board of Directors of Saskatchewan Population Health and Evaluation Research Unit.

Saskatchewan Population Health and Evaluation Research Unit, it's a new collaboration between the University of Regina and the University of Saskatchewan in partnership with Sask Health, Health Services Utilization Research Commission, and Saskatchewan Association of Health Organizations. So there's

five members, all who have representatives on the board.

The mission of SPHERU — as I'll call it, that's the acronym — is to be a centre of excellence in which research will create new knowledge and understandings of population health, contribute to health policy and planning, inform the public policy process at all levels of government, incorporate a population health perspective into the education of health and human service professionals, and be a resource for public debate on population health.

And we've initiated a number of research programs they're developing, and they're in five areas. One is the health effects of economic and environmental globalization. The second is community level of social and environmental health determinants. The third is health effects of multiple social roles: parents, spouse, worker, caregiver. The fourth is social and environmental determinants of healthy childhood development. And the fifth is determinants of Aboriginal health and well-being. So those are the five areas we've carved out for ourselves.

And I will say that we're extremely proud in the short time that we've been in place that we have managed to attract national funding, scholar awards — three of them. Three of our faculty members that we've brought in now have national scholar awards to support their research. As well we have some scholar . . . some grants as well. So we're very, very pleased with that.

Our intention is to have everybody on scholar awards. And the intent that we had when we asked for the investment fund initially was to be able to develop a centre of excellence in population health here in the province, and I think we're on our way to doing that.

Certainly our approach to research is to be community and policy relevant and to help the capacities of citizens and community organizations to participate in and act upon its findings generated by research. The goal of our research is to help citizens and their governments to create healthier living conditions that are equitable for all and sustainable for future generations.

So our comments on the Fyke Commission report reflect our interests in the broader determinants of health and what role a reformed health care system can play in supporting actions on these determinants.

So the first section I'll talk a little bit about is ensuring equity.

The report's recommendation to transfer more rural hospitals in the primary health centres is welcomed, provided there is no net decline — indeed perhaps a net increase in employment. Rural communities globally rely on public transfers for economic survival. Many of these transfers come in the form of publicly provided health, education, and other services.

We may need to engage in public debate on just how much of our provincial and national rural society is worth preserving and at what environmental and economic costs. But our public programs do not simply promote health by providing medical services or educating students. They also transfer and redistribute income and help to create . . . (inaudible) . . . communities, both of which are core determinants of health from our perspective.

That rural hospitals are often a source of pride for community members means any transformation in the role requires care in kindling a new pride in what they will become. In order to gain wide acceptance, the report's reforms . . . of the report's reforms amongst members of the rural communities, the new service elements proposed in the report need to be in place before the old ones are fully removed. We believe that the committee should recommend to government that . . . now again, we came in with the notion that there was going to be recommendations to you, but certainly I think the point can be made, so we'll make this point.

The recommendation is that any changes in rural health care should not decrease the current number of health-related jobs. And again, health in the broadest context, not just health service . . . nor the amount of health-related income transfers. And new service elements must be in place before the old ones are fully removed.

The second area is ensuring a population health perspective. The report has been debated primarily for its recommendations to reduce the number of districts and transform more rural hospitals into primary health centres. Largely ignored has been the report's reference to research showing that health care per se plays only a small role in creating or improving the well-being of people in communities.

Access to education, employment income, healthy ecosystems, housing, and support of social networks, are more important to how healthy people are than whether the supply of physicians and nurses meets World Health Organization standards, or whether care is delivered in the home, in the hospitals, or in Saskatoon or Regina.

Moreover as the report makes clear, health care expenditures have an opportunity cost in terms we cannot invest in education, social services, employment training, housing grants, or environmental protection.

The heart of the problem for you folks, as politicians, such as all of you are on the committee, is this: people who get better after being sick or injured, notice the difference. People who stay well because of all the other programs and services working invisibly to promote health, have no difference to notice. The reluctance to let go of individual medical interventions in favour of collective social interventions is understandable. But people aren't ignorant. Ask people what they want from their health care system and they will tell you. More doctors, more hospitals, more treatment, because by and large that is what health care systems have given them in the past. Ask people what makes them and their community healthy, and they'll tell you. A good job, a decent education, a clean and safe environment, proper housing, less poverty, a sense of community.

So the political task that we see this committee faces, and one our unit SPHERU has already contributed to in the media and in public meetings on the report, is to make clear to the public that the most important health reform decisions we need to make now are to ensure that our health care system does not

unnecessarily drain resources away from those areas that we know are more essential to our personal and community health, such as education, housing, employment, a healthy ecosystem, etc. And that our health care system is better equipped to support work across sectors and communities to ensure all people have fair access to those fundamental health determinants.

This requires a more detailed population health strategy than was offered in the report. Past work by Sask Health, particularly the population health branch, the former Saskatchewan Provincial Health Council, and by organizations such as the Prairie Region Health Promotion Research Centre has done much to define what a strategy looks like.

Regarding such a strategy, we believe that the minimum that this committee should recommend to the government is the following, and again here's our recommendations even though you're not making them, but I'll state them anyway.

Community development. The most important contribution health care systems can make to improving health determinants requires funding protection. We don't see that it has funding protection.

Another point. Health care systems will always be under pressure to treat rather than to prevent. The potential costs of treatment will always exceed the available funding. Without earmarked funding for community development and health promotion efforts, perhaps 1 per cent to 3 per cent of the medical treatment budget, the temptation for health districts will be to shift community health personnel and resources into clinical roles. This has happened in community health centres in Quebec, Ontario, and internationally, and it is happening already in some Saskatchewan health districts.

Okay, the same need for protective health funding applies to public health services, either separate to community development and health promotion programs or rolled up into a 3 per cent to 6 per cent share of the overall health care pie.

In theory, primary care — there's been a lot of talk about — and public health, health promotion services should be linked. In practice they proceed from different assumptions and models. Primary care focuses on individuals and individual illnesses. Public health and health promotion deal with whole communities and social conditions. They should talk with each other, they should plan together, but they cannot be managed or financed of subsets of the same program.

Next, the community health centre model, such as Saskatchewan's community clinic, Regina's Four Directions clinic, has been well tested in many parts of Canada and internationally and should form the heart of the proposed primary care networks. Such centres usually get only a token nod by governments as engines of health care reform. The government's response to the commission presents a wonderful opportunity to seize their well-demonstrated potential. And it is well-demonstrated.

Next, primary care networks and/or health centres need to include, as core health disciplines, health promoters and community developers. Whatever form primary care networks take, they will need to expand upon the range of disciplines mentioned in the report.

Trained professionals in areas such as health promotion/education and community development are essential. These are the local animateurs who will be able to work with citizens on health determinants, and to keep the health system's focus on upstream prevention.

The next area is, health districts need the mandate and resource protection to engage in local and regional intersectoral work on population health determinants.

The Fyke report rightly notes that responsibility for most population health determinants lie in and across the mandates of many public sectors and private actors. No one sector owns the responsibility nor has the expertise or resources to tackle these health-determining conditions on its own. Intersectoral collaboration is the new governing order of the day, and it's been talked about by this government — and actually led by this government across the country — and this province for a number of years. But it hasn't carried on with it as well as it should.

It is also one where our unit has become . . . has already made training contributions to the provincial health's human services integration forum, and several health districts and regional intersectoral committees, the RICs. Saskatchewan is leading much of the rest of the world in experimenting structurally and programmatically in this area.

There are three implications this has for committee recommendations back to government. First is that intersectoral work like community development or upstream work, the upstream prevention I mentioned earlier, cannot be added on to already maximized health district responsibility. It needs to be specifically mandated and resourced.

Next implication is, whatever final decision is reached on the number of health districts, and I know that's been a consideration of the report, the boundaries should correspond with those of other human service ministries. Regional intersectoral planning and collaboration is easier when the region is the same.

This is an anecdote. I teach a number of classes at the university, and a few years ago we had an exercise where we took all the human service boundaries in the province and got a big Saskatchewan map and did a bunch of overlays. And you overlaid all the district boundaries, etc. Very simplistic exercise. But that simplistic exercise demonstrated the inability to address intersectoral issues because of a lack of collaboration on the boundaries.

And I think it's a simple exercise that speaks a volume of words and is well worth looking at. It makes intersectoral planning and collaboration much easier. The RICs are going a long way, the regional integrated committees that are currently interested . . . and we're leading North America, if not the world in that. But I think that there can be some structural boundaries pushed a little further.

Also I think another implication is that there's other provincial

ministries that have undergone comprehensive reviews in this province. And we've had the big review of government structures in the rural areas.

This committee should take a look at all those briefings from the various public inputs, and the officials responsible for those reviews, to ensure that any health care reorganization supports the directions being taken by those other ministries. And so this isn't done in a vacuum relative to all the other recommendations that are being put out in the various other ministries, because I think there's a lot that can be learned from all of those.

My final comments are relative to ensuring new health knowledge; and you heard this one and it's one that we saw in the report that we liked.

One of the report's recommendations is of considerable importance to us — and the us is SPHERU, that's where we're speaking from, but many others in the universities as well — the call for enhanced research funding equivalent to 1 per cent of the overall health care budget. This may seem a large sum, especially in light of the services that might otherwise be funded with this amount. In terms of international recommendations for program evaluation, often pegged at 10 per cent of overall program expenditures, it's very, very modest. We strongly support this report recommendation.

Saskatchewan, as all the committee members undoubtedly know, is exporting much of its health research talent to other provinces offering much more research funding opportunities. We don't suggest for a minute that Saskatchewan should compete with the funding levels received by larger universities with established research programs in biomedical areas. We just can't compete with all of them. But enhanced research funding needs to be administered strategically.

In keeping with the report's analysis, we believe a strategic focus on the social determinants of health, where our unit and other researchers are already creating both a critical mass, and the community-university relationships and partnerships, essential to such research. This would serve the interests of the province and allow Saskatchewan-based health researchers to attract the talent and research resources that help to build both local and provincial economies.

We also strongly support the call for more funding for Aboriginal health research, the terms of which must always be negotiating an agreement with the First Nations and Métis peoples and their governing bodies.

Thus we urge the committee to recommend the government — again my last recommendation that you can take and use as you wish — provincial funding for health research should be increased to 1 per cent of the overall health care budget with a strategic focus on the research, on the social determinants of health, Aboriginal health, and rural health. Thank you.

The Chair: — Thank you very much. Questions from the committee? Mr. Yates can start off.

Mr. Yates: — Thank you, Madam Chair. And thank you, Dr. Nilson.

My questions centre around the issue of co-determinants' boundaries or coordination of services. Have you or has your unit spent any great deal of time looking at what might be appropriate boundaries for co-determinants' boundaries or delivery of services through Social Services, Education, Health? You haven't studied travel patterns or . . . Okay.

Dr. Nilson: — We haven't spent any time researching that at all and it's not likely to be on our research agenda in the near future. But what we will say is that, from our perspective, as the reform goes forward and the potential for readdressing boundaries exists, that it's an opportunity to redress some of those inconsistencies, especially as it relates to the human services delivery and especially when there is already a mechanism that is working on regional intersectoral committees, the regional intersectoral committees. And so there's a lot of things that point and suggest that there could be a lot more done in human services in that integrated format.

So our research? No, we haven't done anything.

Mr. Yates: — And your last comments about 1 per cent of the provincial health budget going to research and your areas of priority, have you broke that down any further to look at what, like determinants of health in rural Saskatchewan and Aboriginal people, what should be studied within that or have you just broken it down into your major categories?

Dr. Nilson: — It's funny you ask that because right now we're busy between the University of Saskatchewan and the University of Regina and Saskatchewan Indian Federated College working very hard to get a proposal in the Canadian Institutes on Health Research for an Aboriginal health institute here in Saskatchewan.

So we're very busy working on that and indeed we have broken down areas that we're hoping to investigate. But we haven't finalized all those and they do focus primarily on the social determinants of health as well, whether it be chronic diseases, various other things that need to be addressed. Very much along the model that we've developed the Saskatchewan Population Health and Evaluation Research Unit where we see the need to build capacity in this province because we can collaborate in this province.

We can work together extremely well in this province and I think that we can lead the country, if not the nation, in developing models for addressing Aboriginal health issues in a manner that can't be addressed in other places and especially, what we're especially interested in, is developing the capacity of the Saskatchewan Indian Federated College because we have the only Indian-controlled, degree granting institution in the country.

And that school is unique, and with the support of the U of S (University of Saskatchewan) and the U of R (University of Regina), we can provide some very, very interesting opportunity for development of a very good group of individuals who can continue to research and develop in this area. So we're real excited about it.

But we can get external money but we — and we will pursue that very strongly — but we will also look for internal support

as well.

But it's a very interesting area and I think there's lot of opportunity.

Mr. Yates: — Thank you very much.

Ms. Draude: — Thank you, Dr. Nilson. I have three areas. I had four but we talked about coterminous boundaries already.

I think I wasn't hearing correctly at the beginning of your presentation. Did you talk about the net decline in employment would be something that would have to remain about the same in order for some of these suggestions that you talked about to be in effect, or had you talked about a decrease?

Dr. Nilson: — What we were talking about there and what the intent of our statements there are, is rural hospitals are a very, very important part of the fabric of rural Saskatchewan, and employment is a very key health determinant. And when hospitals, when hospitals are closed, there can be a potential loss of employment — can be.

What we're suggesting is rather . . . There's going to be new and different models that are going to have to be addressed to provide services. And what we're suggesting is that when we look at population health delivery and we look at what the key determinants of health are, we suggest that in terms of public transfers to rural areas, to sustain and support rural areas, that we would hope that the government can debate and not necessarily reduce the amount of public transfer to rural areas, but rather invest in areas that are going to address the key determinants of health and indeed enhance the health of the population in the rural areas, not just through treatment, but through the health determinants.

Ms. Draude: — Thank you. I don't know. I haven't been to all these committee meetings, but I don't believe that any of the people I've talked to have considered that the work within the health system is the reason why they want to keep the hospitals open.

I mean the jobs are great. But at the same time the real reason for having a hospital is for the health care. So I don't think that it's going to be something that would have a major impact on people's . . . If they could be equally as healthy and have the same care, I'm sure that they're not going to be concerned about the job aspect. Because if you're healthy, there will be other jobs out there.

And also I was just wondering about . . . You talked about employment and what really was important out in rural Saskatchewan. And I really believe that people will not build a home or build a business if they don't feel that the infrastructure that they need that they can't buy themselves . . . the same sort of thing that the pioneers needed when they came to this province. They wanted government to provide health care, highways, and education, and they would do the rest themselves.

So if the health care isn't something that they can bank on, that will have an impact on whether they're going to build or stay in rural Saskatchewan. Do you agree with me?

Dr. Nilson: — I agree that there's a certain level of public transfer of funds to support rural Saskatchewan, or rural environment anywhere. No question.

I also know that we've had a phenomenal transformation in this province relative to people in rural Saskatchewan. The change from The Homesteads Act days and the number of people who were coming into rural Saskatchewan to today and the number of acres it takes to support a family today as compared to the number of acres it took to support a family in 1920 or 1930 are dramatically different.

And as a result of those dramatic differences — okay? — as a result of those dramatic differences what we need to look at is new methods to support people who are living in rural areas, and new structures and new methods of delivery.

And what we're suggesting in this is we're not . . . we're talking that there has to be investment in health care. It's fundamental; we're not saying reduce that at all. But what we need to say is, what we want to say is, make sure that you look at the health determinants because the key health determinants are lost usually in the debates of these type. The determinants aren't considered.

And the determinants, the key determinants of health, are education, are income, are a community that's supportive — those types of variables. And those are not addressed. It's a constant, it's a constant. And we can't keep up with the increasing cost in health care. And it can continue to eat it up.

We need to look at some broader determinants and where we are going to see some dramatic impacts in the health of the population is by looking at some of the key determinants. And I don't think that debate has happened.

Ms. Draude: — I agree with you that whether it's health care or education or social services, whatever, none of them are stand-alone areas. They are all integrated. And you talked about intersectoral collaboration after and it is exactly that. We can't say that this area isn't important and so health care is in the same mix as the rest of the areas.

I just . . . I don't know if you realize after reassessment this year that the property tax paid by fewer farmers — but there's still the same amount or more land is opened and cultivated — our rural people are paying a tremendous amount of property tax and education tax, and their taxes are enormous. I think that would be one of the key agitators you would hear right now if you're talking to the people out there.

So I think that when you talk about transfer of funds, they are well aware that the funding that is coming from their own pockets is paying for a lot of the services that they do have out there.

There was one area that you talked about that I'm not aware of and I'd like you to tell me. You talked about primary health care centres, and there was two models here in Regina that you considered could be a model that would be seen maybe in other areas.

Could you describe that to me a little bit and tell me how you

think it would work in rural Saskatchewan.

Dr. Nilson: — I can talk a little bit about them, but not at great length. But it's just a community health centre model. And the two prime examples that I'll talk about are the Saskatoon Community Clinic — so it's not two in Regina — it's the Saskatoon Community Clinic and the Regina clinic; I think it's called the Four Directions clinic.

But they're community-based clinics that address primary care issues, but they also have local animateurs that are working within the community and addressing a variety of other community interests as well, related to the determinants of health. And those models I think are very important models to look at and understand more about.

There's some that exist here in the province — the two that I mentioned. There are some in other jurisdictions, and I think it's worth investigating those and looking at those as potential models to be used in the discussions on reform.

Ms. Draude: — Would they be a lot different than what we have in our area? It's called an integrated facility where we have the various groups coming in and working together, whether it's departments or areas of departments and community groups working through the school system and through services that are available in the community that are looked after by private individuals.

Dr. Nilson: — Okay. You're probably talking about the RICs now, the regional integrated committees.

Ms. Draude: — No, I'm talking areas . . . about models that we have in rural Saskatchewan that are called integrated facilities; something that we have right now. Something that they are . . . people are trying to keep together to keep their health care in their own community.

Dr. Nilson: — Oh I think . . . I believe that they're . . . and actually I've wandered through a couple of centres that are doing wonderful things in rural Saskatchewan. There's no question about that. But I'm not sure that there's . . . I'm not . . . I don't know enough about it to make a critical comment on it. But I would suggest that there can be more work done to look at the community clinic approach that has demonstrated very positive outcomes. And that's all I'm suggesting.

The Chair: — Thank you.

Mr. Thomson: — Thank you, Madam Chair. Thank you, Dr. Nilson, for the presentation today. I have listened to what you've heard, and I agree very much with the direction that you've outlined that we need to move in. The difficulty we have, of course, is convincing the population that they need to move in that direction.

In '93, as you know, when we started out with the first set of health care reforms called wellness, the entire objective was to start to move in that direction, taking a look at key determinants of health. And it didn't meet with much success.

Indeed, for those of us who have sat through most of these committee hearings, we find that while we've had several presentations where people have come forward talking about the need to invest in wellness-type activities, we find that there's little media attention, little interest. And as such it's very hard to justify moving more budget money over. As you know, the province has little control over discretionary spending in health care. Most of it is patient- and doctor-driven.

I guess by way of a question, what I'm interested in is what advice you have in terms of how we can start moving in that direction again. Most of the very compelling arguments we've heard are simply maintain the acute care facilities, maintain the illness-based system to make sure that we are able to treat the illness, and very little attention on how we move over into these preventative areas.

Dr. Nilson: — And certainly what we're talking about is the upstream prevention piece. You know, that's really where our interest lies because we see that that's where you can have a dramatic impact on the health of the population. And in terms of moving the population in that direction, it is a difficult challenge because it's very, I guess I'd say, very hard for politicians because the press isn't going to pick up on it very well.

Although this last five, six days, it paid an awful lot of attention to the size of everybody's girth — right? — in this province. And that's directly related, directly related to prevention. And it's pointing out some very simple facts, that this population in Saskatchewan has a challenge.

And it's something that we haven't paid a lot of attention to. And there's a lot of different rationales you can give about why it is. You can talk about seasonality and we love to be active in the summer but we hate to go outside in the winter. You know, a variety of different things like that. But they're all rationalizations.

But the fact is that there is attention being paid to this; there's more understanding being generated about this. But it's just not something that is picked up very well.

I would say that we were starting down a path in the early '90s that was good. I would say we stopped. And I'd say we stopped because we didn't keep the public debate going. We pulled back.

The provincial health council, in my estimation, had a whole series of recommendations that it put forward year in and out. It would come each . . . with an annual report with a number of recommendations that related directly to determinants of health. And it had over 100 people in various community groups around this province that were debating what those were and bringing forward these recommendations.

So what it was, there were local animateurs that were debating, discussion, and talking about determinants of population health and there was beginning to be an understanding, even at the health board level, of what the determinants of health really was and what that means in the context of a health care system — not that it was in competition with, but how was it in support of and parallel with and how . . . Because you couldn't get away from supporting health care and the health care system at all. That has to be in place. That's a fundamental aspect of health in

this province.

But looking in the broader context of health and what does it mean that I, as an individual with a good, healthy income, two growing girls that are very, very good — they got all kinds of choices in their lives and I've got all kinds of choices to do as I please — but five blocks away from me, there's a family with that same makeup. They don't have those same choices. They don't have the same opportunities. And it relates directly to some of the determinants that we're talking about.

But it's not the kind of stuff that the media picks up on, so then it's very difficult to get into the political debate. I appreciate that.

But I think what we need to do is bring more and more of that information forward and help people understand it and understand how important it is to be upstream on that prevention side, to get upstream and understand some of those issues.

Just the whole issue of power. If you think about power, it's an incredibly important issue in terms of an individual's health and their health status. And you look at some of the populations in this province and there's a variety of them that have very little power to change the circumstances in their life and some of it relates directly then, if you start looking at the health of the population, the various aspects of individual health, some of them relate directly to that.

So it's a very, very difficult question, but it's something that we don't understand as much about as I think we need to.

But there is a lot of information that has been generated. I think we should use what we have and support a further look at this and try and get the public debate going.

And that was a point that I wandered away from a minute ago. I think, in the mid-'90s, we were having quite a bit of public debate. We were raising a variety of different issues but we stopped it. And I think that stopping it was not healthy for us understanding more about how it fits in with this reform that we're going through now.

Mr. Thomson: — Well I appreciate what you're saying. I think that's a fair comment.

I was one of those politicians who said that we needed to move back to putting more money into the acute care system because that was what people wanted. There's only so many dollars and it's a case of this is what people wanted.

And frankly, I'm not sure, eight years into this, whether we're in any different position. It's very hard to convince people that we should move unused beds out of some communities into other communities where they may be needed. It's very hard to tell people that we may not be able to build brand new facilities in some communities because we need to build facilities that don't exist and never have existed in other ones. And I think of the Far North.

I'm not sure that we are going to have any more success in moving in that direction because people don't want to think about these key determinants. And I'm not sure how we move in that direction. So by way of that I'll simply say I'm sympathetic to what you're saying. But it's very hard to move people off of the other agenda.

I would appreciate — and it is related to this — if you would just clarify your comments in terms of the employment question in rural Saskatchewan. You're not advocating using the health care budget as an economic development tool.

Dr. Nilson: — No, not necessarily. But what we're saying is we recognize that the funding that comes through government ministries indeed supports communities, you know. And there's funds . . . there's public transfers of funds to various areas that contribute to the economic survival of those areas. That's a fact. And what we're suggesting is that those transfers of funds come in the form of public-provided health, education, and other services. Okay?

Sometimes in the whole health reform debate, and this has happened through the '90s, there can be a tendency to move on health reform to address simply the economic debate. Okay? Simply the economic debate. And it's so much more complicated than that. There's so many other variables in there.

But what we're saying is we need to continue to engage in public debate on how much of our provincial funding goes into the rural communities in support of rural communities — what are the environmental costs, what are the economic costs, recognizing that. But we are not simply promoting health by providing medical services and educating students.

There's that whole notion of transfer and redistribution of income and that whole notion of creating and helping to create communities, and the cohesive communities that are able to work together and generate ideas and work on that.

But there's a clear recognition that public funds are used in support of the rural agenda. But it doesn't have to be just health funding that is there. And it's not currently just health funding that's there. But there's a clear recognition that there has to be a strategy for rural Saskatchewan or rural anywhere that government provides public transferring of funds.

Mr. Thomson: — One of the things that this committee's heard time and again from groups presenting is that there is a large economic development or employment component in the health care budget. And people will come forward and say that one of the problems with pulling out the . . . pulling out health services is that you lose nurses. And losing nurses means that a farm family loses an off-farm income.

I'm not sure — while I appreciate what you know the argument is that you're putting forward — I'm not sure how we decouple the health budget from that component or from those who say we need to have a hospital in our town in order to attract businesses.

Dr. Nilson: — What we are suggesting is that before . . . or I guess the way we worded it was as the report reforms — or the acceptance of the report's reforms amongst rural communities — before it gets very wide acceptance, there's going to be some new service elements that are put into place that are government

funded. Okay. That's going to happen. Don't do them after the fact. Do them before or during the changes are made because that's the public redistribution of money. Right?

And so it goes directly to your point. You know, you're not pulling the money out. What you're doing is it's a different type of service. It's a different type of support. But it's going to be there.

So don't get rid of whatever you've got and then try something new. Work with the communities and develop something so that you can maintain and support that community as a cohesive, strong community which is a critical determinant of health for that community, and then move on the other ones. And develop strategies in that manner.

Does that . . . did I make sense on that one? Okay.

Hon. Mr. Belanger: — Yes, just a very quick question here. I just want to make a statement first.

One of the premises of Mr. Fyke's document talks about quality as opposed to quantity. And I'm assuming that a component of that quality is, envisions as he's put it, a greater focus on Aboriginal health.

Because there's no question that you look at some of the housing problems in some of the Aboriginal communities; you look at the accessibility, say for example the Far North. I look at the educational component that has been lacking in the Aboriginal community.

And you throw in a number of other factors, you can tell the specific focus on Aboriginal health, as you have indicated, is necessary, not to diminish other people's rights or needs to the health care system, but really the fact of the matter is that there's been some determinants of health that have not been incorporated in our overall vision of health care in the province that would be beneficial to the Aboriginal community and thus beneficial to the province as a whole.

So that being said, was there any particular studies that you have undertaken or, you know, any research that you've undertaken that would pinpoint, say, the five problem areas that the Aboriginal community or you must address alongside of the Aboriginal leaders to diminish the health care challenges of the Aboriginal community, and that of course includes the Métis and the off-reserve and the First Nations community?

Dr. Nilson: — There's a variety of pieces of research that have been done. I would say that there aren't five pieces of research specifically that I could name for you now. But what I will say is that this group of people that's working on this Aboriginal health institute proposal that's going in at the end of the month, we've identified four theme research areas at the present. They may change. But there are four areas that are social determinant areas that we think are definitely worth investigating. And those ones I think we'll carry forward.

The one is . . . they haven't been real well-defined yet but the one is addictions, a variety of things under addictions that can be looked at. But that's a broad area that can be addressed.

Another one is the . . . this one we haven't defined as well as we want to yet either — in fact there's some people debating it right now — is the environmental piece, both the built environment and the physical environment: whether it be water quality; whether it be the housing issues; a variety of different . . . sanitation systems, etc., etc.; a variety of different issues that need to be addressed there and can be looked at in that context.

The other one is the chronic diseases piece, generally under a broad . . . and that doesn't necessarily go directly to the population health or social determinant other than some of the factors that relate directly to those diseases do. And we'll take the example diabetes, whether it's . . . and we know it relates directly to nutrition and to physical activity. And there's a big transformation there.

There's another area that's evolving and being discussed around personal and collective efficacy; you know, the ability to make choices and decisions on your own — some discussions around that as well.

And there's one other one, and I just don't remember it just off the top of my head. But there is definitely some very important areas that we can investigate in this province, and they've been identified through discussions with the Aboriginal community.

The way this Aboriginal health institute is set up, the funding will go directly to SIFC (Saskatchewan Indian Federated College). U of S and U of R will be supporting partners, and the board will be made up predominantly of First Nations and Métis representatives.

I think it'll be a very interesting opportunity in developing capacity for people in the Aboriginal community to address issues that are specific to them and provide opportunity for development of scholars who can work — scholars from the Aboriginal community — who can work on issues.

Hon. Mr. Belanger: — I think that's very important. Just as a closing comment, I want to point out that I think this quality versus quantity concept in Fyke really hits home when you talk about some of the proactive measures that you have to undertake to really have a successful effort to try and diminish some of the challenges to the health care system overall, but specifically with the Aboriginal community.

So I think everything from diabetes to the smoking awareness challenges, to TB (tuberculosis). If you live in crowded housing, that's more prevalent amongst the Aboriginal community. You mentioned poor water that could create some stomach problems, and the list kind of goes on and on and on.

So I just want to commend you on your position, that in order for us to have an effective effort to reduce the demand on our health care system, we have to be proactive. We have to research. We have to look at the determinants and see how we're able to make a significant difference in this challenge. So I really want to thank you for your presentation and commend you on your foresight and wish you all the very best in your future work and hopefully see some of that work bear fruit and some of the results show positive turnaround in the future years for the health care system in the province. Thank you.

Dr. Nilson: — Thank you.

The Chair: — Thank you very much on behalf on the committee for appearing today and obviously generating a high degree of interest. And thank you for, hopefully, your written submission that we'll get here, or your e-mailed submission.

Dr. Nilson: — Yes, I apologize. That'll be sent over tonight. And we'll make sure you get it. I apologize that it wasn't here today. It was just a miscommunication between the director and myself. The director was off at a health promotion conference in France and then holidaying, so I was chosen.

The Chair: — Well we look forward to getting that too. So thank you again.

If our next presenters could come and take a seat at the table. We're just having your submission distributed.

I'd like to welcome you today to the Standing Committee on Health Care. It's a committee of the Legislative Assembly, and it's an all-party committee. I'm Judy Junor; I'm the Chair of the committee. Dr. Melenchuk is the Vice-Chair. Andrew Thomson, Kevin Yates, Buckley Belanger, June Draude, Bill Boyd, and Donna Harpauer are the MLAs are that here today.

The first order of business that the committee had was the instruction from the Legislative Assembly to receive responses to the Fyke Commission from interested groups and individuals, and to report back to the Legislative Assembly what we heard. This committee will not be making recommendations. They will be reporting back what we heard, back to the Legislative Assembly.

So there's a 30-minute timeframe for each presenter, and sometimes we stray a little, but we try to keep it to the 30 minutes and not keep everybody waiting in the wings. So if you want to introduce yourself and then your organization, and then proceed with your presentation.

Dr. Clein: — Good afternoon. My name is Lawrence Clein, and I'm the medical director of the palliative care service in Regina. And I thank you for the opportunity to address you this afternoon.

Although there is much in the Fyke report that is innovative, we are concerned that there is virtually no serious reference to palliative care or palliative care services. Now we'll start with what palliative care is all about.

The World Health Organization defines palliative care as the active, total care of patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms, of psychological, social, and spiritual problems is paramount. I'm not going to read it all; I'm just going to pick out a little bit of this.

Palliative care affirms life and regards dying as a normal process. It offers a support system to help patients live as actively as possible until death. It offers a support system to help family cope during the patient's illness and in their own bereavement.

Palliative care has become a speciality, and like other specialities, family practitioners are expected to be well-acquainted with the basic principles, referring only the most difficult cases to specialized units. Palliative care offers a multidisciplinary approach to the total care of the patient's suffering at the end of life, and the artificial boundaries between active treatment of the disease and care of the dying are disappearing as the scope of palliative care medicine increases.

Fyke states on page 23 that more than 80 per cent of the population uses medical services in a given year, a figure I personally question. However the mortality rate per person remains at a 100 per cent. And it is during the last six months of life, which is the time frame during which 75 per cent of patients die, that modern-day palliative care medicine is required. This is why this last six months of life is the most expensive. Yet Fyke makes virtually no provision for this in his report.

There are references to palliative care in the report — I mentioned the pages — where in each case it is mentioned in association with convalescent care and respite care as though it were the same thing.

In the two, major, tertiary centres in the province — Saskatoon and Regina — palliative care is lacking in personnel and resources and is behind the majority of other provinces in the country. There is only one physician practising full-time palliative care medicine in the province, and the same physician is the only one who has the advanced qualification offered by the American Board of Hospice and Palliative Care Medicine. Ideally, both Saskatoon and Regina should be staffed by four such positions. And although it's not written in here, I will mention to you that in Edmonton, Alberta, for example, the province supports 10 palliative care positions.

My colleagues will be bringing you up to date with the problem in rural Saskatchewan. I would like to refer briefly to what is called the Carstairs report, and that's entitled, "Quality End-of-Life Care: The Right of Every Canadian." I will emphasize that again: the right of every Canadian.

This report published in June of 2000 was a follow-up to an initial report made in 1995. The updated report was particularly concerned and critical that no action had been taken by federal or provincial governments in response to the recommendations made in 1995. The situation described to the subcommittee in June 2000 with a respect to death, disease, and palliative care was as follows. Over 220,000 Canadians die each year; 75 per cent of all deaths occur in people over 65 years of age; 75 per cent of deaths take place in hospitals and long-term care facilities. Each death potentially affects the well-being of an average of 5 other people.

Only 5 per cent of dying Canadians received integrated and interdisciplinary palliative care. About one-quarter of the total deaths in Canada are related to cancer, but cancer patients account for more than 90 per cent of those receiving palliative care. The number of institutional palliative care beds has been cut as a result of health care restructuring.

Few provinces have designated palliative care as a core service with a specific budget. People are receiving significantly

different treatments in various institutions across the country. People over 65 years of age are less likely than younger people to want to die at home. Rural residents have considerable less access to palliative care than residents of large, urban areas. Most of the costs and other burdens of home care are assumed by the family. Palliative care relies disproportionately on charitable donations for survival.

The Saskatchewan Palliative Care Association strongly endorsed the Carstairs report and recommend that the provincial government study it carefully and do everything in its power to support community programs that target quality end-of-life care.

Thank you for listening to me.

Ms. Parrott: — Madam Chair, committee members, I'm Edna Parrott, president of the Saskatchewan Palliative Care Association, and I do appreciate this opportunity to come before you. The mission of Saskatchewan Palliative Care Association is to strive towards achieving comfort and peace for persons across Saskatchewan living and dying with a terminal illness. Our goals are quality, comfort, dignity, and hope.

Palliative care is a subject that no one wants to talk about but everyone will need it at some time in his or her life. When clients and their family require palliative care they require it immediately.

Saskatchewan is a leader in health care as well as palliative care, not only in Canada but also throughout the world. We have in place many benefits for those who are living with a terminal illness. We provide free palliative care drug coverage, free nutritional supplements, and free incontinent supplies. We also provide free end-of-life care including palliative care oxygen. These policies developed by Saskatchewan Health in consultation with Saskatchewan Palliative Care Association has lessened the burden for patients and their families to remain in their own home.

Saskatchewan also has introduced a provision to ensure that an employee's job is protected for a specified period of time when he or she is providing care to family members. And again Saskatchewan is leading the provinces in health care by reducing the burden for families to provide for their loved ones. Saskatchewan must continue to be a leader in health and palliative care by anticipating and meeting future needs of this very important topic.

Saskatchewan must ensure there are provisions for palliative care for the whole patient and their families and friends in the new health care system. We cannot ignore this important aspect of health care.

Here are some facts. End of life care is an expensive part of health care. That is a well-documented fact, and the last six months of a person's life is usually the most expensive as far as health care spending. Palliative care demands that patients and their families are well informed about their disease process and are part of the decision-making process.

Palliative clients living in rural and northern areas are often subjected to second-class care for several reasons. The specialist physicians are in the larger centres. The family physicians are often reluctant to consult or follow the advice of these specialists. The drive to these major centres is often prohibitive in the later stages of terminal illness. Adequate medication supplies are sometimes difficult to obtain in smaller facilities. And home care services are not as readily available in rural areas due to cost and utilization concerns.

If we are going to treat the person and not merely the disease, we need to look particularly at the needs of the whole palliative patient. Their time is limited. They want to spend as much time as possible near their family and in their own community.

Having them admitted to community care centres for respite would cause hardships for the following reasons. Many would be far from their family and friends. Family and friends would have very little respite relief if they had to travel to these centres to visit their loved ones. Older family members would incur additional costs and stress as they would need someone to drive them to visit their dying family member or friend. Social support systems would be removed, for example, their church, their clubs, and social involvement. Strangers and new policies would dictate the care of these people, adding to their stress.

And, if a palliative client had an acute episode, they would have to be transferred to a regional centre for pain and symptom management, for respiratory distress, and so on. This would cause an increase in apprehension and agony for both client and family and would remove them even further from their support systems. Primary health care teams would not be able to meet all the needs of the palliative client. Access to these teams would be from 8 to 12 hours per day. Telephone access after hours would not always meet their needs.

I can give you an example of a situation with a palliative client who had a difficulty with his catheter, and I made a home visit and saw him for a 15-minute catheter irrigation and he was fine, but the prospect of having to send him by ambulance to a larger centre for this 15-minute procedure would be very difficult. There are other situations such as the subcutaneous injections for pain management if the site should get infected or need to be changed.

Home care would receive funding to enhance and provide support to the elderly according to Mr. Fyke — the elderly, the disabled, and the mentally ill. But what about funding for palliative care? Twenty-four hour home care nursing would prevent unnecessary ambulance trips to community care centres for the palliative patient. But this is not available in rural Saskatchewan.

Necessary treatments could be managed easily at home. Treatment such as changing the site for subcutaneous injections and irrigating catheters, emergency response to manage sudden pain break-through, a visit from a nurse to alleviate the fears and concerns of both client and family — these services would provide necessary treatments and comfort for the palliative person with minimal disruption to their shortened life.

The contribution of family members as caregivers would reduce the cost to the health care system at the end-of-life stage. It would give some comfort to those who are dying, knowing they will receive consistent care from family or friends, people with

whom they have developed a relationship. To allow significant others to tap into Employment Insurance funding to stay at home with their loved ones would provide this. It would also greatly reduce the need for institutional care, as well as the apprehension of the client.

The silence of the Fyke report regarding palliative care is deafening. This topic, in effect, has been ignored. We must change these Fyke Commission recommendations to include palliative care so that we as a province may continue to improve palliative care and as a result continue to maintain our place of leadership — not only in Canada but also throughout the world. Thank you.

Ms. Holton: — My name is Peggy Holton. I am a member of the Palliative Care Board, and I'm also a nurse that works both urban and rural Saskatchewan.

As a board, we have some proposals to present to you today; the first one being that the Saskatchewan Palliative Care Board needs to work with the government in an advisory capacity to speak on behalf of those patients that can't speak and to speak for those families who are often too exhausted to speak out.

We have a multidisciplinary board. We have physicians, we have nurses, we have clergy, we have social workers, and we have volunteers on our board. We have also formed a networking group throughout Saskatchewan, and this could help facilitate the information flow throughout the districts and throughout the areas.

We currently have a membership of over 400 individuals that have access to our newsletter, which is another avenue to provide good communication.

It is sort of ironic to note that the Canadian Palliative Care Association was one of the first groups Mr. Roy Romanow consulted when seeking advice for his commission on medicare. Saskatchewan Palliative Care Association was not consulted or invited to submit a report to Mr. Fyke.

Secondly, we need to address the lack of trained and available multidisciplinary caregivers in Saskatchewan. It is essentially important as the first step that we develop rural physicians that are trained in palliative care. We need physicians with palliative care expertise throughout Saskatchewan. We must be proactive, include palliative care as part of the undergraduate and postgraduate education for all of our physicians.

We should sponsor short-term fellowships in Saskatoon and Regina allowing physicians to spend a couple of months with palliative care physicians. Adequate funding must be in place to cover all out-of-pocket expenses while participating in this opportunity. We also should look at sponsoring a two-week palliative care course. One that ensures no out-of-pocket expenses for our physicians and also gives them educational credits.

Thirdly, we must address ambulance fees. It should not be a hardship for our patients to get to the hospital when they need to get there nor should it be a hardship for them to get home to die.

Fourthly, we need adequate facility access for acute and non-acute palliative care. There is an incorrect assumption in the Fyke report that palliative care only requires access to community care centres.

Palliative care patients also need to access acute care for pain and symptom management. If hospitals are going to be fewer, than patients will be further from home and their families. The proposed national norms of palliative care, which I am a member of, suggests that patients and families should have equal and timely access to palliative care services when they need them.

It suggests essential services are available for these people 24 hours a day/7 days a week. Palliative care services are available within a reasonable distance from the patient's home and these are the guidelines that we're trying to implement through legislation by fall of this year.

Fifthly, emphasis must be based on respite care both in the community care centre and respite at home. The majority of those who are living with a terminal illness want to remain in their home. They do not want to come to hospital.

The potential for caregiver burnout is high and the costs . . . and will cost the health system millions of dollars down the road. Therefore, respite care must be available for our families.

This report, the Fyke report, contains very little information on home care. Home care needs adequate funding. Access to 24-hour care is essential to our palliative care patients in order that they remain at home.

While we generally support the public having access to a telephone advice line, palliative care individuals often need to discuss their issue with a health care professional. And Edna has gone into that with the examples of the catheter and the subcutaneous injections. And if we ask them to take an ambulance to go to an acute care facility, not only will these families get additional financial hardships by transportation costs but also emotional hardships as they must watch their loved ones suffer in discomfort and pain during their transport.

There needs to be a look at the job protection for the family care giver information. The Labour Standards Act allows at present a 13-unpaid-week leave for people wanting time off to take care of their loved ones at home. Now this is more than any other province in Canada. But Saskatchewan needs to continue to be leaders in this area and to think of ways to assist families financially in caring for their loved ones at home.

Volunteer care givers are our greatest asset at this time with the shortage of health care professionals, and I want to give you an example here. Last September my mother-in-law, in a period of one week, went from being an independent, vital, vibrant human being to one of total dependency. We were told at the end of the week; you have no choice. She is going to die. She is palliative. Your choices are you can take her home. You can place her, which won't happen in her lifetime, or you can leave her in an institution which will cost at the university hospital about 800 to a thousand dollars a day.

With the caregiver information protection, and what we're

driving there, is that if you were to pay me as a nurse, my nursing salary which is substantial, to stay at home and look after that individual, in four days you would have recouped your cost of what it would have cost me to stay at home. Technically, you would save about $20,000 a month for one individual by paying me my salary to stay at home and look after that individual. You multiply that by a year. You are looking at almost a quarter of a million dollars. That's a huge savings in costs.

So before you go in implementing changes, I would implore that you have programs in place where these people can go when they become palliative. I walk through the halls of St. Paul's. I walk through the halls of rural Saskatchewan. The beds are full of palliative and chronically ill people. Where are they going to go? Families cannot afford to take time off work and look after their loved one at home unless there is some programs in place that will allow them to do that.

And I sit here as a dying individual, as do we all, and I want the right to die with dignity. I want the right to have good end-of-life care. And I want the right not to be a burden to my family. And you are the people that can change these things. And that's why we are speaking out. And I do have the right at this point to speak out, and I can, but down the road I won't be able to.

So in conclusion, when Fyke describes the continuum of care, he neglects to include palliative or end-of-life care, and with our aging population and increased number of individuals living with chronic illnesses, and in light of the fact that in Saskatchewan, as in all of Canada, the mortality rate of our people is a hundred per cent. This must be addressed.

And we realize that the last six months of care is usually the most expensive as far as health care spending. And the Saskatchewan Palliative Care would like the opportunity to work with the government to ensure that palliative care patients are treated with appropriate treatments and reduce the number of futile and uninformed treatments or intervention thereby reducing unnecessary expenses. Thank you.

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

Hon. Mr. Melenchuk: — Thank you very much for your presentation. I have a few questions. The one question I have with regard to the proposal for a two-week palliative care course, and I'm just wondering is there any movement on the part of your association to try and develop this course or to seek the resources? And where that might be located? Is there any movement from your association with that regard at this point of time?

Ms. Parrott: —At this point of time, we have looked into that. We have . . . there is a program in place that doctors can take. It's called the EPIC program they can take on their own.

And then we thought that it would be good for them to come into the cancer centres and the palliative care centres in Regina or Saskatoon and spend a couple of weeks with a physician, the reason being that the older doctors, those that have graduated a few years ago, have been taught very clearly that morphine is not a good drug, that it depresses the respirations and the new paradigm of care for palliative care is that morphine is a good drug. There are other drugs as well of course, but that the respiratory depression is not an issue. So they need to get this information and they need to see how it works.

We don't have the funds personally as an association to do this, because we would feel very strongly that if a physician was to come in and to take this course, we would need to cover his out-of-pocket expenses, his wages and lost revenue that he would incur as a result of that. So that is part of the reason we haven't done that but we do feel it's an important matter that needs to be addressed.

Hon. Mr. Melenchuk: — And some of your comments led me to the second question. In your brief you commented that of the palliative care patients that we have in the province, 90 per cent have a diagnosis of cancer. Well there are a lot of other terminal illnesses, and I'm just wondering why there seems to be so much a discrepancy in terms of the weighting towards cancer patients.

Dr. Clein: — First of all, cancer patients are the ones that appear to suffer most. They certainly are the ones that suffer pain. There simply isn't the resources to look after every dying patient who might require palliative care. There are 12 beds in Saskatoon, 9 beds in Regina, and you know the number of patients who are dying every week — ideally a lot more patients with terminal heart failure, respiratory diseases and so on. And of course, we fortunately are blessed with not having a large number of HIV (human immunodeficiency virus) patients dying that some other parts of the world have, but we still have a few of those. The cancer patients because they seem to be the ones that suffer most and need the treatment most, and it's sad.

Hon. Mr. Melenchuk: — The other point that I was trying to get at was: do you think that perhaps in the minds of physicians and other caregivers that with the diagnosis of cancer, there's a quicker . . . almost reaction in terms of needing palliative care and perhaps for other terminal illnesses that there may be an inherent bias against providing palliative care?

Dr. Clein: — Yes, I think so. Treatment for cancer, whether it's surgical, radiation, or chemotherapy is all very unpleasant, and patients often require symptom management very early on with their disease, and when it reaches the point that it's no longer curative, then palliative medicine is basically the only thing left for them.

Hon. Mr. Melenchuk: — And my fourth and final question is with regard to rural Saskatchewan. We've had some earlier presentations from small communities with acute care facilities that were providing in-house palliative care, and one touching example of a very young woman in Redvers who received palliative care at a local hospital with the support of her family. Do you see the removal of 50 of these acute care institutions as being quite destructive to palliative care in rural Saskatchewan?

Ms. Parrott: — Yes, I do. I think in my. . . I come from Assiniboine Valley Health District, which is a very rural health district. And if we went back to the 30 community centres that Mr. Fyke is proposing, it would mean that some of my palliative care clients and their families would have to drive

almost two hours to get to somewhere for acute care management. And that's quite a burden on the family dealing with the dying process with their loved one.

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

Ms. Draude: — I thank you for your presentation. I really appreciate it. Do most of the health districts in place right now recognize the need for increased palliative care?

Ms. Holton: — Not at present, but we have a real mix. We've done several surveys over the last few years and initially, when health reform started, palliative care was part of the essential services, so people didn't have even a palliative care worker in place or some sort of coordinator in place. And at present we found . . . We did one just recently last year and that has changed. They have maybe a palliative care worker that is .1 or .2 of a full-time position. And so palliative care has been put on the back burner.

I come from Prairie West Health District and we have never ever had a palliative care worker. We do palliative care and as nurses we will always do palliative care but we don't have the expertise. We don't have the people to sit down with the families and discuss the treatments and explain to them the process of death and dying.

So we'll always continue palliative care — that will never stop — but we don't look after the whole patient; we don't look after the whole family. And that has declined through rural Saskatchewan. And I think because of it people are making uninformed decisions. They are deciding to treat at all costs. They don't realize the whole ramifications.

When I work in St. Paul's, I feel there's tons of times people don't understand what is going on, and if people don't have time to sit down and talk to them and explain . . . and that's with chronic illness because chronic illness can go on for months and months and months. If it's cancer we often view it as more of a short-term thing, so we don't always interact as well. And so we do sometimes a lot of unnecessary treatments rather than explaining to the person the ramifications of our treatments and allowing them to make that decision to maybe have quality of life instead of quantity of life.

Ms. Draude: — Thank you. Your report also talked about the increased number of patients that are wanting to die at home now. So with the increased need for palliative care, what is the biggest need? Is it personnel?

Ms. Holton: — It's personnel. It's like in my situation; I looked after my father-in-law until he died at home. And I was willing . . . in the '90s we had . . . or home care was structured a bit differently back then and I was able to get home care in when I went to work. I went and I worked, and when I came home I looked after my father-in-law. Nowadays, with home care restructuring, there isn't the personnel, there isn't the time, and people can't take the time off work any longer to go and look after their loved one.

We are in a society of a two-income family and if you take away one of those incomes, it puts a lot of stress on that family. And therefore the job income protection, if we could do that with Unemployment . . . or do that with our EI (Employment Insurance) benefits, something that we could give the people some financial assistance so that they could care for their loved ones at home, it would reduce a lot of stress.

If we reduce that stress, we will reduce that stress down the road because those same people will be able to cope better. They will be able to cope psychologically, emotionally, and that would directly affect their health down the road.

Ms. Draude: — I notice that again part of your proposal was suggesting that there should be an increase in Employment Insurance funding to stay at home. Is this something that your association has talked to the federal government about? Because EI is a federal issue, so . . .

Ms. Holton: — We are working at that at a national level. The Canadian Palliative Care Association is working at that at a federal level.

Ms. Draude: — And you talked also about free palliative care drug coverage and free nutritional supplements and so on. Is this paid directly from the provincial government, or how is it paid?

Ms. Holton: — The health districts are the ones that cover the cost for those but . . . at least for the nutritional supplements. The drugs I think is from the provincial.

Ms. Draude: — And I have . . . the last question: you talked about the potential for caregiver burnout. And I know this is also dealing with EI and the fact the burnout can be not just financial, it can be emotional and physical as well.

Are you finding that it's mostly the spouse that is being involved with someone who needs palliative care, or is it the children, or where are you seeing the real burnout?

Ms. Holton: — It varies, depending on the family structure, depending on the availability of who is around in that family to look after it. Sometimes it is a friend that takes on that role. It depends on who assumes that role of caregiver.

And some families . . . we live in an era or in a society now where we have fewer children too, so there is less people to actually look after us. We don't have like ten people in our family any more that can even take turns. So with the reduction in the amount of even siblings, it often puts the stress on one or maybe two caregivers to assume that role.

Dr. Clein: — It is also staff who can suffer from burnout, particularly when we're understaffed.

Ms. Draude: — Thank you. I know that this is a very important issue and we do appreciate you presenting.

The Chair: — If there are no further questions, then thank you on behalf of the committee for appearing today, and for your personal as well as your written submission.

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

The committee recessed for a period of time.

The Chair: — Good afternoon, and you got set up pretty quickly.

Welcome to the Standing Committee on Health Care. It's a legislative committee and it's an all-party committee. My name is Judy Junor; I'm the Chair of the committee. Dr. Melenchuk is the Vice-Chair. Andrew Thomson, Kevin Yates, Buckley Belanger, June Draude, Bill Boyd, and Donna Harpauer are the MLAs sitting today.

This committee has been tasked by the Legislative Assembly to hear responses to the Fyke Commission, or the Commission on Medicare, and we're doing that in hearings such as this, and then we'll present what we hear back to the Legislative Assembly. The committee will not be making recommendations back to the Assembly; we'll be just responding or reporting back what we've heard. So we've set aside 30-minute presentation blocks and if you want to introduce yourself, you can begin your presentation.

Ms. Helm: — First, I would like to thank the Standing Committee on Health Care for allowing us the opportunity to present to you today. All three of us will be speaking, and to my right I have Greg Hadubiak. He's the CEO for the Lloydminster Health District. And I also have Roger Brekko to my left and he is the city commissioner for the city of Lloydminster. And I am the Chair of the Lloydminster Health District and my name is Vicki Helm.

We realize that 30 minutes is a short time to do a lot of presenting so we have actually given you the brief that is more detailed than what will be presented here today.

We intend to cover off a number of key items in our presentation and we will be giving you a district profile. And we'll speak a bit about the relationship with Saskatchewan Association of Health Organizations. We'll talk about the general position on the recommendations of the Commission on Medicare and we'll also address some of the concerns.

We realize that there are some things that weren't covered by Ken Fyke in his report and we would like to address those to you today. We'll also talk about the key supports, the things that we are supportive of in the commission. Then we will talk about how we see Lloydminster's role and how it would fit into the restructuring of health care in the province of Saskatchewan. At the conclusion, we would hope that you would ask questions of us and we'll be anticipating those from you today.

Our district profile. The Lloydminster Health District is one of 32 health districts in Saskatchewan and it serves a primary population of over 20,000 people. We are very unique in the aspect that we serve both Alberta and Saskatchewan residents. This is due to the fact that we are situated right on the border of the two provinces. So as well as serving people on both sides of the border, we also continue to draw a large population from the surrounding area that we provide health services to as well. And we will speak about that a little later on.

Our relationship to SAHO. The Lloydminster Health District is a member of the Saskatchewan Association of Health Care. And SAHO is our provincial association who provide leadership, a common voice, and also member services. SAHO will be presenting to you, the standing committee, as well, and that of course is a collective position from all the health districts. We had input into that paper as well, however, we felt that there were some unique issues that affected Lloydminster and felt incumbent that we present those to you. With that, I will turn more of the presentation over to Greg Hadubiak.

Mr. Hadubiak: — Thank you. The Lloydminster District Health Board I think wants to make clear from the start that they support a need for change. Once the recommendations of the Commission on Medicare were presented, the board took the opportunity to review those recommendations, expressed their support for change and the recommendations in general as a base for positive change, and expressed that in a letter to the Minister of Health in a letter dated May 16.

As Ms. Helm has indicated, we have provided with you a couple of submissions that really give further detail to how our perspective is on those recommendations. One of the attachments to the presentation as well, details recommendation by recommendation our perspective on the commission.

Essentially, as the board reviewed the recommendations, they felt that a lot of the issues that were identified again were not surprising. They were issues that had been talked about or had been in the forefront of discussion for quite some time in Saskatchewan. And in a similar vein, a lot of the solutions that were identified were also historical in nature. I mean things that had been talked about for several years if not longer. Certainly issues like primarily health care and population health have been with us for quite some time, so no surprises.

And on that basis, the board really felt that again it was time to move forward, time to move forward with some recommendations, time to move forward with some change. So very conscious of the fact that the status quo could not be allowed to prevail, it is time, in fact, to take some action to move forward.

It's also recognized, and I think certainly in the course of the presentations you've received to date and will continue to receive over the next number of days, is that consensus for the kind of change that's necessary in Saskatchewan's health system will not come easily. And I guess that's why you're sitting in these chairs and we're not.

The leadership for change, however, is required and the change will happen one way or another. If we choose to not take action there will be changes, I think just basically by default. And that is probably a concern for our board is that kind of change that might occur in that circumstance may not be any less painful than what might be contemplated through some sort of planned approach and in fact we end up with less desirable results than if we took action on our own.

We really believe that the primary driver for what should happen in terms of health reform, health restructuring, should be the health needs of our population and the demographics of that population. Certainly Saskatchewan's population has not changed significantly in as far as a total number over the last number of years or decades, being fairly static at 1 million.

What has changed obviously is where that population is living, the makeup of that population. And we believe that the health care services that we provide need to respond to that reality not try to alter that reality or modify it. And I think that's where again we see some concern with health services being viewed as an investment in economic development and would not support that approach to health care delivery.

Emphasizing very much again population and demographics as a driver for the structure of our health care system. We also would try to emphasize that we must not only recognize the current reality of what our population is and what our demographics are, but also where that population is headed and the issues they'll be facing in the next 5, 10, and 15 years. We need to take a very much forward-looking approach, considering what changes will be occurring regardless of what steps we take. Otherwise if we fail to take that into account we'll again be revisiting our reformed positions in very quick order.

Now having said that there is general support for the recommendations on the Commission on Medicare, there are also a number of areas of concern that we believe need to be pointed out. Certainly I think that a lot of the issues that you're seeing, a lot of the concerns being raised, reflect of a lot of questions around the actual implementation of the recommendations. What will the detail of this look like? How will these elements work together? How will primary care connect with diagnostic services? How will primary care connect to secondary and tertiary level services? How will all of these services connect to each other? Where will emergency medical services come into play?

So there are a lot of questions, a lot of uncertainty about how this plays out in reality. And obviously a very daunting task to try to put that together. But that's really I think where some of the questions are coming from; I think that is where some of the fear is coming from and if we can do something to address that and provide a greater degree of detail of certainty that may go some ways towards ameliorating some of the issues that are there.

We also believe as a board that there were a couple of areas that were fundamentally missed. Mental health was one, and continuing care was another. We see in a number of different circumstances mental health issues impacting a variety of segments of our system right now, and we had really had hoped and expected that mental health would have been given more attention and more emphasis within a review of a health care system in Saskatchewan.

You can certainly go and speak to any physician in the province in terms of some of the issues that they see. They're coming as physical manifestations in some case, but really the root cause or a secondary driver is some mental health issue, and that's the same in terms of emergency departments as well. You will inevitably find some issues attached to that as well.

Continuing care in the same token given again the changing demographics of Saskatchewan's population, we've heard a lot about the aging population, the baby boomers moving through our system, and yet that seems to have received very little review within the recommendations from the Commission on Medicare.

We look back at some of our own situations right now in Lloydminster back in the month of May of this year. We were running something in the order of 50 per cent of our acute care beds were occupied by people waiting placement or not acute care but didn't have any other supports in the community to support them. So it's not an acute care issue that presented a problem for us on that particular week. It's an issue of continuing care, proper support of living, differences in supports, family supports, what have you.

So I really think Saskatchewan needs to take a very comprehensive look in continuing care services as it reforms the system.

Again Lloydminster District Health Board however does find a lot to commend the Commission on Medicare recommendations. The district does support the move towards larger health districts, based on one or more regional delivery centres, linked to specialized services, and with a strong population health and primary health foundation. Again we have detailed our level of support for a whole range of recommendations, but this is one that we felt particularly strong about.

We believe that there are a number of reasons why we can go towards or should go towards larger health districts. Some of the really . . . population health issues as we look at the size of districts and the populations that they serve, in many cases is very difficult to conduct analysis on very small populations and have any kind of confidence that you are seeing a true issue or are you just seeing a blip that occurs in a given year?

You talk about accident statistics. You have one major car crash or one major injury event and that just skews your results and you're not really sure if that's what we should be tackling or not.

In addition, districts don't have often the ability, or the justification for that matter, to deal or to hire the right resources to deal with some of these population health issues, and that's where service areas have come into play across the province to try to collaboratively bring together districts to make that work. They have some pluses and minuses, and I think in some cases there are still too many administrative logistical barriers to make those entirely effective.

Certainly as well, we think that we are facing, and I think you've probably already heard this, recruitment issues in a number of different forms, and one that I think that gets overlooked or is dismissed is the recruitment of qualified administrators and management personnel to assist us in dealing in an ever more complex system. As we go out, especially as even Lloydminster is not that large a health district, try to go out and recruit for people and compete with a number of different jurisdictions just is a very difficult task.

And by the same token, having the right size of district is really a matter of economies of scale. Every district has a certain minimum requirement for what they should be doing and what you find, certainly again even our district, the size that it is, is at the . . . you can't afford to bring in the kinds of resources that

you need even though you do have to perform those functions. Some of the examples would be to get more into information technology, which we're well behind in health care, having the right resources and technical expertise to run our systems and develop our systems, having the right financial skills, having right communications and public relations infrastructure.

We also believe that there needs to be a stronger commitment to training and development of our health care personnel in this province. And that's not just from the standpoint of some of the upfront work that has already been undertaken in this province and across the country. We seem to be doing a better job of opening up spaces for nursing students and medical students and so on, but we need to try to provide better support to our staff, our employees over the longer haul.

Again health care is constantly changing, technology is constantly changing, and yet when you see some of the budget crunches that districts face, one of the first things that goes is in fact the education funding for training and development. Those are seen as soft dollars. They don't immediately impact health services or the quality of care being provided, but we suggest that they should be seen as a strategic investment and not just for the clinical but also for the administrative personnel that are running our systems.

At this point I'd just like to turn the presentation over to Mr. Brekko, and he'll speak more on the strengths and unique aspects of Lloydminster.

Mr. Brekko: — Thank you. Ladies and gentlemen, the notes I'll follow will be those have been handed out. First off the written narrative will give you a bit of background as to certainly why this issue is very important for citizens of Lloydminster.

By way of background, I've been in Lloydminster some 30 years — 7 as a city engineer and the last 23 as city commissioner.

The brief we're presenting is hopefully to highlight the importance of health care service delivery in Lloydminster and the area, how it fits in with supports and services, to growth and the development of the area.

Lloydminster's growth was well under way when the two provinces were formed and the provincial border was placed on the fourth meridian dividing the community. Despite this barrier, the community continued to grow and with the Lloydminster amalgamation Act of 1930 and the passage of the Lloydminster charter, the city has flourished to a population of over 22,000.

The provinces acknowledged and supported the growth and the sustainability of the community and have worked to overcome many of the diversities of the border, with a net benefit to all in the process.

Health care delivery is no different than a lot of other services provided in Lloydminster where ultimately compromises are made and a seamless uniform service is provided to the public regardless of the province of residency. Health care is a significant infrastructure needed in a growing city and region. It is very important to us and that is why we are here today.

The April 2001 *Caring for Medicare* report recommended a network of 10 to 14 regional hospitals in Saskatchewan and 9 to 11 health districts.

It is my objective to provide you with the background on Lloydminster's unique border situation and to demonstrate that Lloydminster is a natural fit for regional services and in particular regional hospital status. With Lloydminster's current employment services, trading patterns, and growth projections, the decision is very beneficial for all of Saskatchewan, Lloydminster, and all of Alberta. But you have to look at the whole picture of Lloydminster, not just half.

The most recent report on recommendations on regional economic areas is entitled *Functional Economic Areas in Saskatchewan: A Framework for Municipal Restructuring* by Jack Stabler and Rose Olfert, dated March 2000. The report notes — and this is very similar to many reports that have been done over the years; certainly this is the last and most recent report done in Saskatchewan through Municipal Affairs — "a functional . . . " and I quote:

> A functional economic area . . . is an area that is relatively closed or bounded with respect to the income-producing activities of its residents. It is also relatively closed with respect to a cluster of everyday consumer-oriented business outlets and common public services. Almost all the labour resident in the area is employed within the area and most of the everyday goods and services consumed within the area are purchased within its boundaries. Similarly most of the K-12 student population living in the area attend school within the area and most of its residents obtain routine health and medical care within the area.

The report does a good job of the review of regional drivers in Saskatchewan. It does not, however . . . or I should say, it does however, have a limited mandate and that's with the limits of the provincial boundaries of Saskatchewan. Certainly, Lloydminster is unique and it's on that basis that we feel there is a more detailed review required in the Lloydminster area.

This is a common problem Lloydminster deals with continuously and we need to make this commission, the standing committee, and the province aware of the entire needs of Lloydminster and region. The resultant decisions on regional hospitals and health districts has a significant impact on Alberta and Saskatchewan residents in our Lloydminster and region.

It is on this basis the attached PowerPoint presentation was evolved. It will hopefully provide you with a better background and understanding why Lloydminster requires specific review.

The most significant drivers and development of regions are employment. In addition to the projections shown in the presentation which you will shortly see, projects like the proposed $1 billion expansion of the Husky Oil Upgrader on the Saskatchewan side should not be . . . and I should state understated not underscored. Plans have been completed to double its capacity and the associated oil well feedstock development bode well for future employment in the area.

Cogeneration of 220 megawatts was recently constructed at the upgrader — that's slightly less than 10% of your power supply in Saskatchewan — and additional generation with the upgrader expansion is just one of the many more industrial opportunities. Other opportunities include a large industrial eco-park, a catalyst regeneration, a greenhouse, sulphur processing, coke processing, manufacturing materials, and a whole range of petrochemical and industries.

I think there's a corridor along north Saskatchewan that many of you may not be aware of. There is a study done in Alberta from Fort McMurray all the way to the United States border in the 1980s and Lloydminster was included in the east-west corridor, and certainly the existing upgrader is a credit to that study and this future potential.

The practical reality is that the city has negotiated its 30-year water supply agreement with the upgrader and it's some 6 million gallons a day. That will handle 60,000 people. Okay? And it's for raw water. And so the upgrader has been designed, it's been . . . processes reviewed, and it's just a matter of happening. We had a similar situation when the first upgrader was built. It was a billion six and has certainly significantly contributed to our economy.

If you can refer to the presentation, I'll just flip through it quickly. I appreciate . . . I sat on a meeting yesterday in Edmonton going through gas prices, presentations for aggregation. Lots of PowerPoints. And so we can make it. This is exciting. There is a opportunity. It's a challenge. But I also know what it is like to sit all day.

First of all, the first page covers the overview. Really a community profile. Current activities, trends, future projections, Lloydminster trade area, summary, and conclusions. You maybe ask yourself, what's this got to do with health? Well health care is a significant component of building a city. We are building a city in the region of Lloydminster, and we need it. It's very important.

The first slide is a picture of Lloydminster. The red line is the fourth meridian. We are Canada's only bi-provincial city. Municipal government operates under the Lloydminster charter adopted by both provinces. We do follow Saskatchewan education system, for example. Everything in Lloydminster has to be agreed to and developed and worked on. You have to know what you're doing or problems will arise.

We're a heavy oil resource community. We're a regional retail and service centre, and our present population estimate is at 20,842. I use a number of 22, and this is a situation of my economic development department is less optimistic than the commissioner. However we have had the last five years averaged 120 single-family homes per year plus apartments, and so we're very close in our numbers.

The second page, employment by industry trends, should bring home a message to you about where there's jobs, there's people. And if you look at 1983, the blue is the resource sector, manufacturing, and that includes agriculture and all the other various interrelated manufacturing industries. Government and utilities, yellow, that includes the health sector; and service sector is in red, business, retail. And so you can see our growth from 1983 in total jobs is from approximately 7,000 to 10,000. And that's why Lloydminster has been growing, because there's been jobs.

Our construction activity changed. In the next slide, in the yellow bar graph, just shows that the last five years . . . we tend to look at five-year budgets and five-year cycles. In 1996 we had levels under 20 million. In 1999-2000 we topped over 45. To date, we have, in 2001 we have 24 million, and we're projecting about $44 million. So there's lots of construction activity as we speak. There's pavers and water and sewer lines being installed in our community.

At the heart though of what's happening, the next graph shows the population growth trends, and you'll see from 1951 to 1996 population, the triangle of Saskatchewan, in light green, Alberta is the red square, and Lloydminster are the diagonals. In fact since 1981 to 1996 the Lloydminster growth is 37 per cent. That's two and a half percent per year. We have some high years. We have some low years. It's a little bit like farming; it doesn't rain every year but certainly the average over the years has been good. It's been a very healthy community.

The next page shows a population growth trends just from '91 to '96. Unfortunately we're getting a census this year but it'll be probably two years before the data is available, so we have to utilize '91-96 data. The point for putting this in . . . the full light blue is Lloydminster, Alberta and Saskatchewan. Both sides are growing and developing. But '91 to '96 overall is a 9.6 per cent increase in population. By comparison in Saskatchewan, Estevan grew 3.9 per cent and Saskatoon 3.8. In Alberta, Grand Prairie grew 10.1 per cent and Calgary 9 per cent. So although it was the toughest five years we've had in a long time in Lloydminster there still was a 9.6 per cent growth.

The next slide covers projected populations. There's an age group distribution and the coloured overhead would really probably pop this out. But Lloydminster has been a very young community. You heard mention of the treating seniors, we do have seniors and we are now getting into what we call empty-nester homes and senior's apartments. We're starting to attract people for retirement.

However, the majority of our population you'll see the light blue. We have a young labour force, 20 to 44 years of age, and with that of course comes along lots of children so the elementary school populations are fairly significant.

The 15 year projection that we've used in Lloydminster — we just completed our general plan which is a plan for the whole city — the high projection is based on five years of growth, the last five years were fairly high. That's a short time frame to look at.

Then we looked at the low ones for a 10-year. In the 10-year period we had 1993-94 and not too many us will forget that. Governments cut back, we laid off about 38 per cent of our management staff, union boys, etc. And we had a cut and we did it. So we've used a medium projection here. It's called a Haly model. It takes a look at the number of deaths and births, in-migration and out-migration, and it also takes into account cycles in the economy. And we've been at this business 30 years and projections are only projections but certainly middle

of the road has paid off in the long haul. The 2016 number would be in the order of 25,000. That previous graph I showed was about two and a half percent and that's where that would be. It's optimistic but it's a pretty direct comparison.

The next line — and there's only three left — is the trade area population. You can see from 1979 it's risen from something around less than 35,000 population to 116,000 population. And of course in that same period we've gone from 9,000 population as a city to close to this 22,000, 21,000 population. The reason that slide's in there is that trade areas relate to, and economic areas relate to, and service areas relate to, and hopefully some of the public services we provide relate to the same factor such as income production, the employment that's in the area, the consumer orientation of residents, where they buy their goods and where do they get their public services. Once they have a job they need the public service.

The trade area is just attached, it's a snapshot in time, it's done every five years and we update the statistics. But you'll see it slips all the way over to North Battleford. At one time Meadow Lake had a more significant sample, and it was part of that same trade boundary.

So that boundary comes and goes. And really, if the truth were known, my personal opinion is you just should flip the Alberta side over and that's probably the real trading area of Lloydminster. And it will vary from time to time when you do surveys and depends on consumer trends, etc.

That's a similar analysis, in my opinion, that has to be done for a functional economic area of Lloydminster — not just ending at the Saskatchewan border but looking at Lloydminster as a whole. We do contribute to the provincial welfare, and certainly the other services that are in that same study and modelling include health services.

The economic development CD (compact disc) I passed out is just a little snapshot of Lloydminster if anybody is interested in picking up more of the beat of what's going on. It includes . . . It's done by the Big Gully REDA association — that's the rural economic development association with us — Community Futures, and Industry Canada, and of course our own little city.

Summary and conclusions. Very short. We have experienced historic growth trends, immediate growth pressures, and projected long-term growth. We've been in the business for some 30 years and certainly we will hit short, unexpected cycles, but we seem to bounce back, and there is good potential in Lloydminster and area.

Lloydminster is a bi-provincial growth centre. That's something different. Sometimes when one side is growing the other side doesn't grow, and vice versa. So our strength is in having the two provinces. That's why Lloydminster is unique and that's why it's also strong.

Lloydminster represents the largest regional employment, service, retail, and health centre between Saskatoon and Edmonton. It's a little bit like a Red Deer, except we're on the border. Lloydminster is well positioned as a sustainable regional hospital district.

And with that, I'll go back to the last comments on my sheet. Thank you for listening and thank you for the opportunity to make the presentation. We'd be pleased to answer any questions you may have.

Our mayor, Ken Baker, was just unable to attend. He had some commitments. But this area is important and certainly he said, you get the plane and come down to the health district and make your case. Ken sends his regrets, but he also sends his strong support for developing Lloydminster as a regional health centre and working to maintain Lloydminster as a seamless community.

So I would hope . . . The other softer issues when you look at regional services — and those are things that are maybe the hard side of the business plan — but when you have a regional centre you need to provide other services when people come to do regional business. Things like 1,100 businesses and a diversified economy, 900 hotel rooms, a full range of recreation and leisure centre services.

And there are advantages. What may seem to be a disadvantage to you, this Lloydminster border situation requires a little more review, a little more detail analysis, but there's an advantage in that, and that's with the cost-sharing, the 50/50, you can actually provide a better and more service for the same dollar and match it.

I leave you with another example. The health care, I believe, is about 50/50, but for example, we have a community college in Lloydminster. It has university transfer courses, full-time equivalent, about 600 students. I think it's part of the Vermillion Lakeland College, and it provides, it probably puts in about 5 per cent of the revenues of the entire college system. Alberta's paid for the infrastructure, the building, the backbone, everything, and so it certainly supports many Saskatchewan residents in the process, and we know finances are part of the whole picture on all services we provide in Saskatchewan, so we're part of the family, and we hope if you have any questions, please feel free to ask. Thank you.

Mr. Hadubiak: — I'll just try to quickly conclude. Roger's already pointed out some of the research that's been done by the city itself. That's also supported by work that's been done outside of Lloydminster and done provincially. We've attached to your brief the HSURC study that was released in April this year as well. It projects, just for the Saskatchewan half of Lloydminster, a 14 per cent growth through to 2015. And it's significant. We look at what Saskatchewan is doing as a whole for that same time, through that study, is a 1 per cent growth.

In addition, Lloydminster is surrounded by other areas that are also growing. It's not just a local factor. And the significance of that is that, again as Roger's pointed out, Lloydminster is serving more than just Lloydminster. What we see — and these are just a couple of the examples — is that 40 per cent of our in-patient activity in our hospitals outside of Lloydminster proper. Fifty per cent of our day surgery is from outside of Lloydminster proper.

We talked to our physicians and look at some of the work they're doing. We've got about 25 general practitioners. They feel they're serving about 90,000 unique individuals, and so

obviously that's more than just what's happening, arising out of the city of Lloydminster.

As Roger's also pointed out, some of the base, strategic factors for Lloydminster is that it is halfway between Edmonton and Saskatoon. Now there are some challenges to that, but we also think there's some significant benefits. And Roger's also pointed out some of that as well. He's indicated that, the sort of the half price solution, that 50 per cent of the dollars currently as we operate comes from Alberta and from Saskatchewan. And that works, I think both for in terms of capital and in the ongoing operating costs, so it's both up front and an ongoing possibility.

We also see right now we've got some significant capacity opportunities and particularly as we think about what are the future service requirements in that area both for Alberta residents and Saskatchewan residents is in fact an opportunity for new diagnostics and that includes CT scan or MRI in that area.

So in conclusion from behalf the Lloydminster Health District Board, we see the Commission on Medicare as being a positive step forward, if in fact the recommendations are moved on. Certainly again we recognize that there are some tough choices ahead, but some of those choices have to be made or they will be made for us in one way or another.

We believe that you must focus on what meets health needs as to opposed to any other factor. We believe if you apply that logic or that criteria that means Lloydminster is a regional referral centre and the hospital as a regional hospital. The population will drive it that way in any event, and certainly we look forward to being a positive force for change in that recommendation.

The Chair: — Thank you very much for your presentation. We have some time for questions from the committee.

Mr. Boyd: — Thank you. Thank you for your presentation. Do you think you would feel the same way if Lloydminster wasn't identified as a community that might be the regional centre?

Mr. Hadubiak: — We mentioned that earlier in our presentation. Obviously the impact is very highly variable across the entire province. We look at obviously our situation; we understand will be variable impacts so.

Mr. Boyd: — Today we have had numerous presentations, one after another, of communities from around Saskatchewan saying pretty much exactly the opposite of what you're saying. And they are saying that there is a need for health care services within their area and community as well.

So would you agree with the view that some communities, while Fyke presents some opportunities for them, it will be at the expense of other communities?

Mr. Hadubiak: — I guess that I can't speak for on behalf of other communities. I guess that's the simple answer.

Mr. Boyd: — Thank you.

The Chair: — Any other questions? Seeing none, then thank you very much for your presentation and for your handouts. We appreciate your coming.

If we could have our last group of patient presenters come forward. Welcome to the Standing Committee on Health Care. You probably heard this opening twice now because you've been here for a while. But this is the legislative committee on health care and we're hearing submissions or responses to the Fyke Commission or the Commission on Medicare. It's an all-party committee, and I'm Judy Junor, the Chair. Dr Melenchuk is the Vice-Chair. Andrew Thomson, Kevin Yates, Buckley Belanger, June Draude, Bill Boyd and Donna Harpauer are here today.

We are going to submit what we heard from presenters, and I think you've probably heard me say this a couple of times, that we're not making recommendations to the Legislative Assembly. As a committee we're here to listen to the responses to the Fyke Commission and report back what we've heard. And that's our task and that's what we'll be doing by the end of August.

Do you want to introduce yourself, where you're from, and begin your presentation?

Mr. McCallum: — Thank you. My name is Don McCallum. I'm the administrator of the RM of Cut Knife. On behalf of the councils and taxpayers and residents of the town of Cut Knife and the RM of Cut Knife, I offer these remarks on the April 2001 report produced by the Saskatchewan Commission on Medicare.

When the last reorganization of the provincial health care system was planned and adopted in the first half of the previous decade, Cut Knife was one of the first communities to suffer the loss in its hospital, a facility only 10 years old. Our residents were fortunate that the community leaders had the foresight to plan the hospital with an ambulance garage and a medical clinic combined in one building. They were also wise enough that when a care home was built in 1986, to have it connected to the hospital. It was sensible that the residents of the home have easy access to the hospital. Utility services were also combined.

After our hospital closure, the adjoining care home continued to operate and part of the hospital is still used for health care purposes. Over the years there has been some erosion of services due to fiscal restraints but the community has, with some difficulty, managed to function with the care home, medical clinic, ambulance services, and a laboratory. The care home still has respite and palliative care, and ambulance service has been upgraded with the training of EMTs.

However, review of the Fyke report gives us cause for considerable concern because it puts all of the Cut Knife health care services in peril. The care home could be closed, the ambulance service moved to North Battleford, and the loss of these facilities, the medical clinic would likely close.

The result would be the residents of our part of the province having to drive in excess of 50 kilometres to see a doctor or visit family members in the nearest care homes. Ambulance service would be regressed to what it had been before 1979

when our local service was organized. We would have to wait for an ambulance to travel from North Battleford. This would mean at least — at the very least — a considerable inconvenience experienced by more than 2,000 people. At its most dangerous, it could put lives at greater risk due to longer travel times before the ambulance could attend the site of emergency. Our residents would hardly call this progress.

The rural residents of this province do not expect to have the same services that their counterparts residing in the cities, but they do expect a reasonable level of health services to be provided by their provincial government. In our humble opinion, these should not be reduced from what we have right now but expanded. Our minimum needs are emergency services with diagnostic testing facilities, a medical clinic that is open at least five half days per week, a care home with respite and palliative care facilities, community-based ambulance service with advanced EMTs able to administer IVs (intravenous), home care, community service providers, for example public health, mental health, and addiction counselling.

There are recommendations in the Fyke report worthy of serious consideration, but there seems to be one glaring omission. We cannot see any mention of a suggestion for a serious study of the function and duties of the Department of Health personnel to see if there cannot be a reduction in numbers. Any cost savings from such a reduction would free up funds for use in expanding the number of health service providers in the province. After all, they are the ones of which there is . . . residents of this province suffer the biggest shortage, and the ones that are the most needed.

The commission recommendations for reducing the number of health districts to nine to eleven has us worried. It leaves us with the impression that we would become little cogs in a big machine and so become lost in a huge maze. It was less than 10 years ago that the existing district organized at the behest of the provincial government with the claim that it would save money on administration. If these savings have disappeared, I can only assume that reorganization was a failure. What assurances do the people of this province have that another reorganization will fare any better than the last? The same government with perhaps the same senior employees as the ones who ran the show a few years ago is in charge now. This does not inspire us with confidence with the new reorganization will improve the provincial health care in the long term so that any fiscal savings will still be visible in five to ten years' time. If that is so, what will the response of the government be? We suspect it may endeavour to conduct yet another reorganization.

The Chair: — Any comments from the committee?

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

I have just a couple of questions. One concerns the districts. You had mentioned this in your presentation that you're concerned about district reorganization. But in your presentation, you also talk about making use of services in the North Battleford area. Currently you're in the Twin Rivers District, right on the very edge of it. Has any consideration been given as to whether it would make more sense to be able to coordinate services with North Battleford?

Mr. McCallum: — I think that they actually do some coordination to . . . actually our hospital right now is in Maidstone. Yes, so most of our people go that way, but we are assuming that if there's a change in reorganization, we'll likely be in the North Battleford area.

Mr. Thomson: — I'm interested in terms of the clinic that you make reference to in your presentation. Do you have resident doctors, or do they come out from other communities?

Mr. McCallum: — Actually there's a joint practice out of Maidstone that travels through Cut Knife, Neilburg, Paradise Hill and Maidstone, and we actually do have a doctor now that lives in Cut Knife, but he still is part of this joint practice.

Mr. Thomson: — I guess as I look at the presentation and I look at the situation in Cut Knife in the report, I wonder why you think there'd be any change based on Mr. Fyke's recommendations from what you currently have?

Mr. McCallum: — Yes, our concern is that we don't know. We're just hoping we can keep what we have.

Mr. Thomson: — But at this point as you read Fyke, you would figure you fit into which of his categories? Into the primary care or the community care?

Mr. McCallum: — Community care likely.

Mr. Thomson: — Thank you very much.

Ms. Harpauer: — When the initial report was done to the health care which you mentioned was less than 10 years ago and your hospital had been closed, was there open meetings with the government at that time, and if so, did they give some promises that you'd be able to maintain what you presently have now?

Mr. McCallum: — I'm not aware of any. I don't think there was . . . there probably were some meetings with the provincial . . . I wasn't involved with it. But I don't think there was ever any assurances given that we would keep what we have.

The Chair: — Seeing no further questions, then thank you very much for coming and presenting today. We will entertain motion to adjourn. Sorry, that's right we will recess to 7 o'clock.

The committee recessed for a period of time.

The Chair: — Good evening and welcome to the Standing Committee on Health Care. It's an all-party committee of the Legislative Assembly. The first order of business for the committee is to report on what we hear the public and groups' responses to the Fyke Commission or the Commission on Medicare, and we will be reporting back to the Legislative Assembly by the end of August. We're not making recommendations. We're reporting back what we've heard, so it's a listening process.

And my name's Judy Junor; I'm the Chair. Dr. Melenchuk is the Vice-Chair. Andrew Thomson, Kevin Yates, Buckley Belanger, June Draude, Bill Boyd and Donna Harpauer are here

with us tonight.

So we have a half an hour set aside for presentations, and we have your written submission. If you want to introduce yourself and where you're from, we can get started.

Dr. Karras: — I'm Bev Karras; I'm the president of the Saskatchewan Medical Association, and I live and work in Nipawin.

Dr. Scharfstein: — And I'm Briane Scharfstein; I'm the executive director for the Saskatchewan Medical Association.

Dr. Karras: — So we're pleased to take this opportunity to meet with the standing committee and provide some commentary on the final report on the Commission on Medicare. The Saskatchewan Medical Association supported the establishment of the Commission on Medicare in the hope that the work and recommendations of the Commission would address the multiple challenges currently facing the health care system in Saskatchewan.

We do have some concerns which we will address both in our brief and also some comments. We found it difficult to try and put into one brief all that we might have to say on this area, so these are just comments. We are hopeful that through continuing dialogue among all the stakeholders together with commitment to restoring the health care system to its traditional strength and stability that we can address both the issues that are in the commission report but also some that we felt that were missing.

As you are aware, the Saskatchewan Medical Association is the voice of organized medicine in Saskatchewan. And we do represent a membership of approximately 90 per cent of all specialists, general practitioners, residents, and medical students in the province.

We welcome opportunity for collaboration and meaningful contribution that can help to develop and implement better policy and practice in our province. It's not our intent to provide a detailed critique of the entire report. We would like to highlight eight themes. Physician/SMA (Saskatchewan Medical Association) involvement in the health care system change. Contracting physician services. Recruitment and retention of physicians. Primary and acute care delivery, including rural acute care. Health system quality. District health board structure and function. Access to care and waiting lists. And some of the unanswered challenges: workforce morale, public confidence, and sustainability.

The SMA collectively, and its members individually, have become frustrated over a number of years at the extent to which practising physicians have been excluded from important health care decision-making processes and change. We've, as an association, repeatedly indicated our willingness to work with Saskatchewan Health and others to develop effective models of care in things like primary care and to explore and negotiate payment mechanisms other than fee-for-service. Most physicians will be intimately affected on a daily basis by the commission's recommendations if adopted, so we feel that it is important that we are consulted not just this one time but as this process unfolds.

There are several recommendations from the commission that have a greater potential to directly effect physicians and the care that we provide. And these include recommendations that health districts contract the services of general practitioners and specialists; that many of the existing hospitals in the provinces be converted to primary health care centres or community care centres and integrated into primary health networks; and that tertiary services be consolidated and delivered in Saskatoon, Regina, and Prince Albert; and that basic and acute care be provided by network of four . . . 10 to 14 regional hospitals; and that a quality council be established.

So we will discuss that in a little bit more detail, and I'll ask Brian to talk a bit about contracting for physician services.

Dr. Scharfstein: — And just again by way of quick overview, we'll just highlight briefly some of the comments we've made to leave more time for discussion and questions because as Bev has said, there's an awful lot of material to cover because so many of the recommendations have a direct implication for physicians.

This one in particular, contracting for physician services, was actually one that we never did discuss with Mr. Fyke. It wasn't raised during the two meetings we had, so it hasn't been an issue that we've had an opportunity to provide any feedback or information about.

It's one that's been very important to us for many years, and as a matter of fact, many years ago, we attempted to develop a framework agreement that would facilitate bargaining non-fee-for-service contracts. That agreement has never really been put into place in a way that could be really effectively utilized. I would simply emphasize that for the SMA the idea of contracting is not a problem. There are many physicians today, both general practitioners and specialists, who are contracted. All of those contracts are with health districts and those physicians function quite effectively in that environment.

What we would emphasize, however, is that if that is to be the preferred way to contract for physician services rather than through the predominant one being the fee-for-service model today that there has to be a collective bargaining process in place that is fair and reasonable, and that isn't the circumstance today in non-fee-for-service. It certainly is in fee-for-service, and as I'm sure you'll be aware, we regularly bargain that contract and have a dispute resolution process in legislation. We would see a need to have something similar if we were going to look at contracting more generally for physician services and, as Mr. Fyke's recommended, that general practitioners and specialists might both do that.

So we're certainly willing to meet to discuss that, to look at options, and we have many of our members who would be interested in contract, but they certainly won't be unless there is a fairly clear and well-defined process that is perceived to be fair and that it would involve both a central table, which currently doesn't exist, as well as an opportunity to bargain locally with district health boards.

Dr. Karras: — On the issue of recruitment and retention, this is always a challenge for our province. We are at a unique disadvantage position at this time when there is a shortage of

physicians across the country and actually across many countries. Of all the provinces, Saskatchewan has the oldest average physician age which means that retirement issues will add to this whole workforce problem sooner in our province than many others.

In addition, we have at the present time 54 per cent of practicing physicians in our province who are foreign trained. This dependence on international medical graduates has been necessary and in the short-term will continue to be necessary. It's valued; they provide excellent care to the people of Saskatchewan. But this reliance has resulted in a higher turnover rate of positions in this province, which impacts many things.

Historically when concern has been expressed regarding the loss of physicians, the response to this concern almost always points to the total number of physicians in the province, which has been fairly stable over the last number of years.

It doesn't tell however the story of the physicians leaving the province every year and those who replace them and how long they may stay. It doesn't accurately portray the intensity of the distress, the turmoil, and the cost to patients, the physicians remaining in the communities, and the communities themselves trying to cope with the repeated loss of valued physicians.

There really is a physician's shortage in this province. This problem must be addressed. Maintaining an adequate physician supply is essential to a quality heath care system and to allow for sustainability. We find it inconceivable that the government would even contemplate mandating change to physician practice without adequate consultation with the profession in a way that would appear to be negative or threatening in this environment.

Change to physician practice will only be effectively and successfully managed if the changes are jointed developed and implemented in collaboration with the Saskatchewan Medical Association and the physicians that will be affected.

Unfortunately problems with recruitment and retention which have been addressed fairly successfully in rural areas with the committee on rural practice programs which are appended to your brief, there are now problems in regional areas as well as urban areas including specialities. In recognition of this, the committee on rural practice has been expanded to be a committee on rural and regional practice. And with the last contract a new fund has been established to start working on specialist recruitment and retention issues, and this is an ongoing process.

Many of these programs are just really starting to show some benefit. And it does show that the Medical Association and Department of Health can work collaboratively in problem solving.

On issues related to primary and acute care or everyday services, I think that we subscribe to the concept that the ideal primary medical care system is built on the relationship between patients and their physicians that's founded on trust and respect; emphasizes quality; provides personal and comprehensive coordinated and continuing care; takes into account the health needs of individuals, families, and their communities; and integrates the care provided by all health care workers, including primary care physicians.

We support the commission's observation that the time has come to develop a comprehensive strategy for the future of primary care delivery, including a clear definition of provider roles and responsibilities, coupled with a range of payment options.

In their role as patient advocates, physicians willingly accept our responsibility to work with others to provide deficiencies . . . to improve deficiencies in the primary health care system.

Unfortunately, to date, models that have been implemented on a one-of basis with little or no SMA involvement may not turn out to be appropriate, looking at a system-wide approach. There is a need to look at evaluation and to assess these programs in great detail before implementation on a system-wide basis can occur.

Physicians recognize and value the contributions of other health care providers, and contrary to suggestions in the Fyke report, physicians do recognize the importance of and actively participate in a team approach to patient-centred care. Good examples of this would include such things as palliative care, long-term care, and management of chronic conditions.

Based on education, training, and skills, we believe that family physicians are the best able to function as the principal coordinator and preferred point of entry into the medical care system.

As options to primary care delivery are explored, evaluation will be a critical component.

Looking at rural acute care, given the impact on the commission recommendations on rural Saskatchewan, we wish to highlight certain issues surrounding primary care and everyday services as they relate to rural communities. Our committee on rural and regional practice helped us to identify some issues they felt were especially important for us to look at.

Integrated teams of health care providers already do occur in rural Saskatchewan. They are often on a less formal basis than what the Fyke Commission has envisaged. But they are based on efficiency, mutual dependence, and a combined interest in the people they serve — or we serve — and they are already in place and working and functioning well.

We feel that the commission has underestimated and diminished the scope of acute care that is currently provided in many of the small urban and regional hospitals in our province. Many types of services such as reducing and setting fractures, administering thrombolytics to heart attack patients, treating accident victims, managing overdoses, providing obstetrical care which the commission was especially silent on, is acute care, and is currently being offered at a consistently high level in many of the communities that are targeted for conversion and redefinition.

In terms of emergency response and inter-facility transfer, we support the proposal to eliminate the current discrimination

against rural people as a result of these based on distance. The SMA also supports the work done in the previous summer by Dr. Cross and Mr. Keller which details the type of emergency response services that we should be seeing in our province.

The report also tended to overlook the use of GP (general practitioner) specialists which has traditionally been something of importance in our province. It has lost some of its impetus but is not possible to resume. There are GP surgeons, anesthetists, and obstetricians practising in this province, and utilizing enhanced skills of general practitioners in these areas may be more practical than expecting Saskatchewan to suddenly acquire the ability to recruit specialists to more regional centres at a time when we are having difficulties manning the ones that we already have.

Dr. Scharfstein: — I'll just make a couple of comments about quality as I am sure you are aware that the Fyke Commission emphasizes quality. And I would simply emphasize that certainly the SMA and physicians generally are absolutely supportive of the concept of emphasizing quality and having a system that's focused on quality and on evidence-based decision making.

So in that context, we would be highly supportive of the general principle of emphasizing the importance of quality and doing whatever we can to provide physicians and others with the tools to in fact assure quality.

Having said that, we do itemize in the brief here a number of specific concerns about the quality council per se. And it's more or less because in our estimation there's a fair lack of clarity as to exactly what the quality council would be — its scope, its authority, its accountability. And of course Mr. Fyke is recommending a very major and significant investment in time and money in a quality council. And we think it would require an awful lot of clarification to be certain.

We would also like to emphasize that simply establishing a quality council won't in any way assure that better quality care is provided, that there are an awful lot of other significant factors to provide the tools to the providers and others to assure that quality care. So we would be quite anxious to continue with some sort of dialogue as to how we could facilitate improvement in quality practice and in better use of evidence-based practice, but we would have a number of questions about the quality council per se.

In regard to the references about health districts, we're sure that you've had lots of presentations in regarding how many there should be and who should close and how many, etc. And we're really I don't think in a position to offer particularly astute observations about that.

What we would point out I think is that perhaps, at least in our estimation, more important than the number of districts and their location is clarification of the districts' roles and responsibilities, the issues of accountability and their authority. We think that's been a major impediment to perhaps having a smooth introduction to regionalization in the first instance. And that is still somewhat questionable as to whether it is sufficiently clear.

So we would think that before changes are made in terms of the boundaries or numbers of districts, that there should be more clarity as to exactly what their role is and what their authority is and what their accountability would be.

Dr. Karras: — One of the things, as president and last year as vice-president, is that we tour the province and we get information from our members and we talk to them as often as we can.

And over the last number of years there are some common themes that physicians will express to us with great dismay. And these include the inability to access necessary care for their patients and the insufficiency of resources, both human and fiscal which result in our inability to do our job. This results in poor workforce morale and a steady erosion of public confidence in the health care system.

Waiting lists, in spite of attempts to improve with more funding over the last few years, have continued to grow. Shortages of physicians and nurses has most definitely contributed to this problem. Regardless of the reason, people are suffering often with their conditions deteriorating while they wait. Problems other than emergencies are still important for us to address in our system. This problem must be addressed by the changes.

Dr. Scharfstein: —Finally I think just to sort of conclude with our remarks, we have put in the brief as well some observations in regards to issues that we think really aren't very well addressed through the Fyke Commission that really demand attention as well, perhaps even more so. And we've listed what we think might be the three most important, the first being workforce morale.

In our estimation it isn't any better today than it has been for some time, and it's very low. And our sense is that workforce morale is probably the number one factor that is important in determining how the system operates and the quality of care that's provided.

It's also reflected in the second dominant issue that isn't perhaps addressed very well which is public confidence, and we know that most of the polls continue to show that the public's confidence in the system has not improved. If anything, it's getting worse. And that links somewhat to morale as well.

So we think those are two are very significant issues that didn't get a lot of attention in the report but which remain to be answered, and we realize that there was the Bachman commission to look at that as well. But to date we think that probably hasn't been properly or well enough addressed. So we think those are two major issues that unfortunately haven't been covered very well.

And the final one we comment on in addition to some of the earlier observations is sustainability. In our estimation, the Fyke Commission's report, other than providing some opinion as to whether the changes suggested will provide an affordable and sustainable system, give no real evidence to support that statement.

Our sense is that sustainability is probably the predominant reason we had a Fyke Commission in the first place. The

concerns about will it remain affordable, how much more of the provincial budget can be put into health care without jeopardizing all the other things that have to be done as well, and we don't see a lot in the report that will address that.

We are aware that the Romanow commission and others are looking at those issues, and maybe they're broader, but we do think that's going to be a dominant issue for the government in the foreseeable future and for a long time. And the simple observation that investment in these changes now will result in a more affordable or sustainable system without other significant changes and discussion, and we're not so sure that's the case. And there really was very little in here in terms of exploring the options to make the system more publicly affordable and sustainable, so we think there's a lot of work left to be done there as well.

Dr. Karras: — We're ready for questions.

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

Ms. Draude: — Thank you very much for your report. I have a couple of questions. When you . . . earlier, we've heard many times today that attracting and retaining doctors in an area without a hospital would be a concern. I'm wondering if you have an opinion on that.

Dr. Karras: — I would think that that's quite a fair statement. If you look at some of the issues that physicians find difficult, practising in rural areas, they include the issues around feeling safe, being able to have the tools that they need to practise and do the job that they can do, and those tools include things that are commonly found in hospital settings for the emergencies and for the things that don't happen that often, but when they happen, we have to deal with them.

We have to deal with roads that we cannot necessarily travel on. We have to deal with air ambulances that can't sometimes come for hours or at all because of weather conditions or other needs, so the concept of providing more and more areas with less and less support for physicians and expecting them to be practising in those areas comfortably, it won't happen.

Dr. Scharfstein: — Also I think the experience of the 52 communities that have already been converted. We were doing some analysis on that recently, and many of those communities no longer have a physician, and they almost all had at least one resident physician. So it would appear that physicians are generally unlikely to practise in a community without an acute care centre. They'll provide itinerant services in satellite clinics, but are unlikely to remain resident of a community. They really require more than just a health centre for the full scope of practice that we're currently training.

Ms. Draude: — I also heard you say that you were in support of the EMS report that was put forward. We've heard a number of concerns in my constituency and across the province that there's concern with the distances that would have to be travelled and the likelihood that it's going to take over an hour or closer to two hours to get an ambulance to a victim . . . or to a patient, I guess would be a better way of putting it. And also the training that would be required for the EMTs, EMTAs, and the paramedics would have to be trained — not here, right now, we'd have to . . . it's going to take a while to get them through the system.

So although I can appreciate that you've probably looked into the report, I'm wondering if those two areas concern you with the report that was brought forward to Fyke.

Dr. Scharfstein: — Well they would, and we have a committee on health emergency services that actually did look fairly closely with that and actually talked and met and discussed that with Dr. Jim Cross as well.

I think the committee was aware that there would need to be a lot of enhanced training of ambulance personnel. They do recommend that, of course. It's a question I think more of how long would that take and how much investment is required to get an adequate training available so that your ambulance personnel are sufficiently trained. That would link of course as well to how many more centres will or won't have acute emergency services available.

And we certainly are also aware of the problem of distance. I mean the ambulances do have to be close to the patients and so there may need to be a fairly significant investment, we expect, in emergency services, ambulance and training. And we would concur with that. But we think that the report did sort of deal with that and did suggest that that would be required.

Ms. Draude: — I guess the report talks about basically cutting back the number of locations for ambulances and that has brought a lot of concern to people in rural areas because we do know it's going . . . Travelling on road conditions and taking into effect the weather, it could mean that there's a lot of people are going to be sitting a long time to get to wherever this hospital will be. So it's something that I'm hoping that it's been looked at well so that you are confident that people will have the coverage they need.

Dr. Scharfstein: — We share that concern. I mean we would definitely agree that you have to have sufficient numbers of ambulances close enough to the people that are going to need their services and it may be that more are required than is envisaged in that report. We would not be in any way opposed to expanding and providing more, and that's critical to those small rural communities. We certainly agree with that.

Ms. Draude: — The other area . . . you talked about some of the areas that were overlooked in the report, and one that we've heard about frequently is the whole area of mental health wasn't discussed in the report. And I was wondering if that's something that you've been looking at as well.

Dr. Scharfstein: — Well as we started out saying, it's hard to condense into a short brief all of the issues. Aboriginal health we thought was a critical issue that you could write a whole report on as well. There are major issues there. The College of Medicine, major issues with that. And mental health services, for sure that has been historically one of the neglected areas in terms of well integrated and it is a critical issue as well, we would agree.

Hon. Mr. Melenchuk: — Thank you very much, Madam Chair. I have several questions. I think you've really hit the nail

on the head when you itemized your key points as physician or health care worker morale, public confidence, and sustainability. I think that's something that's been identified for some time. And certainly the purpose of Fyke and this all-party committee and eventually an implementation strategy is to try and address those issues.

The point with regard to contracting physician services. This has been on the plate for probably six or seven years now at least. Are there any working groups that are currently meeting in terms of working out some of these areas?

Dr. Scharfstein: — Not at the moment, but I think there will be. You may be aware that in our last contract we also bargained, in addition to the fund we have to assist with recruitment and retention of rural physicians, we have a fund to assist in recruitment of regional and urban specialists. And part of that will link to developing contracts as well.

And there have been some preliminary discussions with the department about revisiting our framework agreement and sort of making it functional. And certainly I don't think you've had a presentation from SAHO yet, but they've identified to us, as have particularly several districts, that they see the need to have a proper bargaining process. So there's been some very preliminary discussion only.

But we've been quite frustrated that it's been several years, and all of the contracts currently are being negotiated on an individual basis with individual health districts because there isn't a central process for bargaining. So that isn't currently in place, other than in preliminary discussions. Not much else is being done.

Hon. Mr. Melenchuk: — Yes, the point with regard to having a central table. I can remember having this discussion quite a few years ago about bi-level bargaining along the lines of how education with teachers is bargained in the province of Saskatchewan where there was a central table with a clear mandate and then local . . . or link agreements with local groups as well, which in this case would be health districts.

So you believe that there's a necessary central process that needs to be implemented?

Dr. Scharfstein: — Yes. Yes, we do.

Hon. Mr. Melenchuk: — The recruitment and retention issue of course is one that's been highlighted by a number of groups that have presented. There have been a number of initiatives that have been negotiated to assist recruitment and retention of physicians in rural Saskatchewan and obviously in regional centres now as well.

The question arises in terms of physician supply and manpower supply. Again this is something that's been debated for some time but it's certainly the opinion of the medical association that there is a physician shortage in rural and urban Saskatchewan.

Dr. Karras: — Yes, I think that that would fairly reflect the position. I think there have been concerns that because the number, total number of bodies has been the same for a number of years and the population hasn't increased, that that means we must have enough physicians. The problem with that, you know, divide the doctors by the population approach is that doctors are doing quite a different job now than we used to do and probably are not willing, with the newer physicians coming out and the older workforce population, to work 80-hour weeks any longer.

So part of it is that there will be more people needed to do the work if we're looking at a healthier physician population who are able to continue the work. Both the younger and the older physicians are probably not going to be wanting to work 80-hour weeks on average. This is not a sustainable way to run health care. So there would be a need for more physicians based on that.

Then if you look at some of the technology and some of the labour-intensive types of things that we're doing, things like angioplasties which are making a major difference to health care, there are many examples of fairly labour-intensive technical things that physicians are doing now that we previously didn't in other times past. And so that again increases the need for physicians to be able to provide those sorts of services. And I guess those would be sort of two, but there are many others.

There was actually quite a good article in the last *Canadian Family Physician*; just looking at it from a family physician perspective on some of the reasons why the numbers will need to increase over the next while in the way our work has changed and will continue to change over time.

Hon. Mr. Melenchuk: — The next question that I have is with regard to primary reform, primary care reform. Now in your brief you clearly differentiated between the definition of primary medical care and what you would consider primary health care. And primary medical care would indicate first contact as well as comprehensive. What is your definition of primary health care?

Dr. Scharfstein: — I guess what you have here I guess, and you've pointed that out, is that we sort of confined ourselves a bit to discussing to some extent medical care, which is what physicians provide. And that's our area of sort of expertise.

Primary health care, I guess I would have to turn the question back because we are not sure. We've heard an awful lot of definitions. And when we hear the message, primary care reform, which has been talked about federally, provincially, in every province, at every level, it seems to mean different things to different people.

So what we've tried to do in the brief is define what we understand primary medical care to be, which is what we know.

Primary health care, which involves a whole lot of other issues, can be as broad as including housing and poverty and a whole lot of things, social services; or it could be narrower in terms of simply incorporating other providers of first contact care, of a health nature. It can be any of those things and I guess we understand that those are important. And we understand that physicians have to be closely linked, and I think Bev mentioned that in a lot of communities physicians are very plugged in to

teams and interact daily with all sorts of other providers.

Our comments are more specifically focused on medical care.

Hon. Mr. Melenchuk: — I think in Fyke that this was one area where there was a lack of clarity even though primary health care reform is considered the base of his model, that the whole system evolves from that primary health care reform. He really doesn't get into defining the roles of the various providers. And certainly this is the first time we've seen a clear definition of what the role of the family physician as[CORRECT] the primary care provider, providing primary medical care.

Other examples of health care providers as illustrated would be a chiropractor or perhaps a nurse practitioner in northern Saskatchewan or an optometrist or whatever. But how they co-ordinate into a team concept, I think needs to be clarified and obviously there needs to be ongoing dialogue on how this model would work. So that was one point of clarification.

I found interesting your comments with regard to the ability to recruit specialists to regional centres and the concept which has been in existence in Saskatchewan for some time about GP specialists. And are there any initiatives at this point in time in terms of expanding some of the entry positions where GPs could take additional training with regard to enhanced surgical or anesthetic skills or whatever?

Dr. Karras: — Yes, there actually are some programs in the province, especially with anesthesia, obstetrics, and gynecology. And I think that there is certainly is room for discussion with the College of Medicine and the post-graduate programs for those sorts of things.

Some of the CORRP (Committee on Rural and Regional Practice) programs allow for some further training options with support, either shorter term or longer term. So some of those sorts of initiatives have been there.

I think that that is a direction that hasn't been fully explored, and whether in a province as small as ours is with a medical force as small as ours is, we need specialists, we need subspecialists, but we may also need to have generalists with special skills.

Dr. Scharfstein: — Another point, I think, is that we in fact historically have had far fewer specialists in Saskatchewan than any other province as a ratio of the population. And I think the reason we've managed to maintain reasonable care is that general practitioners in Saskatchewan historically do a lot more than general practitioners in many other provinces. Obstetrics is a good example and probably psychiatry would be two prime examples where we have general practitioners providing a level of obstetrical and psychiatric care that is quite a lot beyond the average that's provided in many other provinces.

So we think that there's a lot that could still be done to enhance that; and with our sparse population and geography, the reality is I think we're going to have to rely on general practitioners to provide a lot of those secondary levels of care we commented on, on our sense that perhaps Mr. Fyke underestimated the extent to which general practitioners today are providing a fairly significant level of acute care, both primary and secondary.

Hon. Mr. Melenchuk: — Just to follow up to that point, the College of Physicians and Surgeons made a presentation earlier and I asked the question with regard to itinerant surgical services. Do you see a role at some point in time for day surgical procedures to be done in regional hospitals by itinerant surgeons and the post-op care provided by perhaps GP specialists that may have had additional surgical training?

Dr. Karras: — I think those sorts of options should all be looked at in detail. Certainly there would be a need to focus on quality and to look at ensuring that these skills are adequate to deal with the post-op situations.

But in fact, if you look at the rapidity with which many people are being discharged post-operatively, a lot of them are going home to rural communities where there may be their family doc with no additional training who in fact may be dealing with the later complications at any rate.

So the concept that we may need to just identify those areas and ensure that there's an adequate education and support process to allow that reality to be properly addressed and properly looked after, I think that is part of the direction we should be going.

Hon. Mr. Melenchuk: — But I hope I didn't say day surgical because what I meant to say was patients who would be admitted for more than several days from a surgical procedure.

Dr. Karras: — Well I guess we see a lot of . . . in rural Saskatchewan we see a lot of people discharged from major centres, two and three days post-op hip surgery, and where we are really doing the follow-up care in our rural communities already.

Hon. Mr. Melenchuk: — And that brings me to . . . the next point is that in terms of rural acute care, it seems to me that prior to health care reform that oftentimes surgical patients who would come from outlying communities were transferred back to those facilities on day four or five for the final phases of the recuperative care.

And we've lost some of those options now that we've decreased the number of rural acute care beds and perhaps compromised some of the problems in urban Saskatchewan with regard to waiting lists. Not having available beds is certainly a contributing factor to waiting lists and certainly can affect the surgical slate.

Do you believe that having those acute care beds in those smaller facilities in rural Saskatchewan are necessary, not only for recruitment and retention but also for discharge planning?

Dr. Karras: — I mean it's happening already. I mean we spend a fair amount of time actually providing rehabilitative types of care for which you need active management by your physiotherapy, your OT (occupational therapist). You have to have a large enough volume in order to be able to do those sorts of services. And if you're providing that type of care on a regular basis, I think you can provide it with good quality and in a very cost-efficient way.

So we certainly try very hard to accept back in rural areas in the beds that we have, people, as soon as we are comfortable to deal with them with the resources that we have. If those resources decrease, the ability to be able to provide that service that we presently do will be also diminished.

Hon. Mr. Melenchuk: — The final question that I have is with regard to the quality council. There have been some suggestions that this quality council should be an independent body accountable to the Legislative Assembly, such as the Provincial Auditor, reporting yearly to the Legislative Assembly and also directly to the public in terms of a report card on the system.

And I'm just wondering if you have any thoughts, preliminary or otherwise, in terms of what the makeup of this quality council should be.

Dr. Scharfstein: — A couple of just maybe, perhaps preliminary . . . because we did mention it's a bit unclear exactly what this council would be. But one thing we know it has to be — or two things.

One is it must have credibility and support by providers. If the providers don't have faith and trust that the council is completely independent and focused and motivated on enhanced quality and not other agendas, whatever they might be — political, economic, or otherwise — it will really have a very limited ability to affect the quality of care that's provided.

So the number one criteria — and I would suggest and I think that our association supports — is a quality council that is completely independent and focused on quality and then works with the providers, all of them, to develop those protocols and to give them the tools. We don't think you can mandate quality. Quality has to be something that is sort of built into the system.

We also think though that the providers — nurses, physicians, pharmacists, and otherwise — are all properly motivated to provide the best quality they can. What they need is the tools to do it.

So we would strongly encourage a completely independent council, if that's the way that this is to be done, that has that focus and is able to get buy-in and credibility with the providers, which we think would be critical. Simply reporting and monitoring won't result, we don't think, in enhanced quality.

Hon. Mr. Melenchuk: — So you would see one of the roles of the quality council, once you had achieved or recognized its independence, is that it would make recommendations to system improvements on an ongoing basis?

Dr. Scharfstein: — I think it would need a fair degree of authority to be able to be effective. And once again though, the authority has to come with that sort of co-operative relationship with the people you're trying to enhance the quality . . . that you want to enhance quality. So there needs to be that culture.

We agree completely with Fyke's point about creating a culture for quality. We would just caution that that can't be mandated. So that if you're going to invest in a council, it needs to have some authority and independence. But it also has to have that relationship with the providers.

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

Hon. Mr. Belanger: — Just very briefly, more of an observation of which I'd ask for your, for your counter-observation I guess.

One of the things that you've pointed out here is that 40 per cent of our budget as a province is being spent on health care. And Saskatchewan is not immune to some of the health challenges that people believe that we are, like as you look across the country and across the world. There's problems right around the world in terms of health care.

So Saskatchewan is not immune to some of these challenges and I would suggest or point out that one of the reasons why we're struggling with this Fyke Commission is that we need to begin to address some of these challenges.

So my observation — and I would like you to comment on that — is despite us spending the amount of money in health care and despite the fact that we're trying to address it, the question we often ask people is how much money is needed in health care.

And you've pointed out in your brief that shortages of physicians and nurses have most definitively contributed to this problem; definitely contributed to this problem. Now obviously it's in reference to the wait lists, and people say well now we have three months or six months or nine months on this wait list. So adding more money to the system is not going to reduce those waiting lists.

So I guess I'm just trying to rationalize here how much of these shortage of physicians and nurses are actually contributing to our health woes as a province, first of all, and as a country. And it's anybody's guess, but would you care to elaborate on those observations?

Dr. Scharfstein: — Of course you're touching on a subject that warrants an awful lot of discussion. I guess just two or three brief comments. First of all, in terms of shortages in the workforce, to some extent they're somewhat self-inflicted. I mean we downsize medical schools, downsize nursing schools. We did for a number of years work on the premise that Barer-Stoddard and others emphasized that there were enough health care workers in the system and we may not need more, particularly as we shifted to population health focus, etc. — the reality being in fact that we've now realized that we require a lot more providers, not just physicians but nurses and others, than we currently have.

So I mean it's not surprising, I think, that we're at that point, and yes, they will cost more money. In terms of how much is enough, I don't . . . we certainly can't answer that question and I don't know that there is an answer. I think it's important to point out that the governments collectively only pay 70 per cent of health care costs in this country. Thirty per cent of the costs of health care are borne by the citizens privately. And that includes much of the home care, long-term care, drugs, dental care, optometrists — a whole variety of I guess what we would

say are very important health care services. Health care service is much more than physician and hospital care.

So despite 40 per cent of the provincial budget and the massive amount that is currently being spent by government, an additional 30 per cent, and increasing every year, is being spent by citizens privately. And they are saying they are not getting the health care access they want.

There's a disconnect between the expectations of the public and what we are able to provide. And I guess our observation is simply one of, that issue is not addressed in the commission's report. And it has to be. And we hear Mr. Romanow talking about it and saying, well he's got to deal with that, and he's looking at Sweden and wherever else. And I think that's a fair comment. Everybody's got problems.

But there's very little in this report that talks about that fundamental problem. What is government going to pay for, what are the people going to pay for themselves, will there be public participation greater than there currently exists — those kinds of issues. We don't presume to know the answer and I think the public should have more to say about that than the doctors or the SMA. But we certainly think that dialogue has to happen and it isn't . . . and it isn't part of this discussion.

We don't think primary care reform is going to solve that problem for the government. And we don't believe that simply implementing the recommendations in the commission report will mean that you don't have to worry about the health care budget next year or five years from now. We don't see any evidence that says that's the case. So we think that you'll be back looking at those very issues again — fairly soon perhaps — because of course as Mr. Fyke points out, if there are going to be positive results from this they'll take some time to show, and if they're going to be.

So very difficult questions. I think we'd agree with you that those problems exist elsewhere. But we also I think would point out that that is what the public's really concerned about — will the care be there when they need it; are they going to wait longer than they currently do. And they don't appear to be as concerned about how we configure the system and how we deliver the services as long as the services are available. We think it's a critical issue.

Hon. Mr. Belanger: — Thank you.

Mr. Boyd: — Thank you, Madam Chair. And I wanted to just touch on the fact that the Department of Health we understand has put in place what is being called a parallel process to look at the Fyke report. And at least one of the presentations that we've heard earlier was of the view that it was to start to move towards the implementation of the process . . . or implementation of the Fyke report. That was the view of at least one presentation that we have had.

And I'm wondering whether the SMA has been invited to participate in any way in that parallel process.

Dr. Scharfstein: — Yes, we have. I've been asked to serve on one of the working groups, the health reform working group. There are several. Our past president, Martin Vogel, is on one of the committees that is looking at rural care. And there are other physicians.

I don't think we can answer the question as to what's the Health department thinking or planning. We know that we've been invited to participate in discussions. We're participating in the discussions on the assumption that no one's made any decision as to what they're planning to do and that's why we're being asked to participate. And until it's proven otherwise, that would be our assumption.

To this point we're not aware that anything has been done, so we have been invited to participate by the department. They have advised us that they will be working on implementation strategies, but as to when and how those will eventually be developed, we don't know.

So I don't think that we can answer the question any more accurately than that probably. And of course we're not aware of what the mechanics are, the relationship between this committee and what it might do or recommend, and the department and its working groups.

Our assumption is the working groups are dealing with nuts and bolts. But again our assumption is that if this committee was to make some fairly broad recommendations that were contrary to the Fyke recommendations, that that would be . . . presumably affect what they're doing.

And as we point out I think more than enough in our paper, there's a lot of areas that require a high degree of interaction, consultation, for a very long time, not only at this level but at the department level. So our assumption is that there will be a lot of interaction over the next several months and perhaps years working on some of these issues.

Mr. Boyd: — Well this committee will not be making recommendations to the government; it'll just be simply reporting what they have heard from the various groups. And so we're very interested indeed in what the goal and the mandate of the parallel process is, and I'm interested in what your thoughts are in terms of what their goals and their mandate is.

One would assume that they have — beyond just simply inviting you to participate — have given at least some degree of direction as to what their . . . what the process is and what their strategy is.

Dr. Scharfstein: — All I could comment on is our expectation. And our expectation is that as the representative of physicians in the province, we will be allowed and invited to participate actively in developing a response and in implementing any changes.

We reflect in this document, more than once, our disappointment at not being involved enough. And I guess I'd simply suggest that if it turns out that the department has in fact developed or is developing implementation strategies that we're not involved with, we would be equally disappointed. To this point in time, we haven't been aware that that's the case. So we've taken the department at their word that they want our input; they want us to be part of the working groups that will look at developing strategies.

It's fair to say that there have been examples where we think we haven't had that opportunity and decisions have been made without our input. We're hoping that this is perhaps a beginning of a different approach. So we're optimistic and hopeful that that will be the case.

Mr. Thomson: — Madam Chair, I'll pass.

The Chair: — Well, thank you very much. Seeing no . . . oh, Dr. Melenchuk.

Hon. Mr. Melenchuk: — Just one comment. About a month ago during health care estimates, the Minister of Health indicated there were eight working groups. These working groups would be going out and having a dialogue with stakeholders in the province of Saskatchewan and community groups.

I don't think there's any hidden agenda. There's been no implementation plan. There's been nothing presented to ourselves or anyone else. And these sorts of dialogues between the Department of Health and stakeholder groups have gone on since we've had a Department of Health.

We've had a committee with the Medical Association, the Medical Council. We've had committees that meet with the Department of Health to talk about alternate payment plans. There's been committees that met with the Department of Health to talk about primary care initiatives. And these committees and these working groups have been meeting for a long, long time. But there's no hidden agenda in terms of implementation. A dialogue is occurring, and the thrust of the dialogue is to maintain that concerns are addressed. Everyone knows the report; it's been filed. But in terms of implementation or how this is going to work, there have been no decisions made.

The Chair: — Thank you, Dr. Melenchuk, for that clarification. And thank you very much for your presentation tonight. Just continue . . . (inaudible interjection) . . . you have something to say?

Dr. Karras: — We would like to acknowledge the work that has been done by Commissioner Fyke and his staff. Not surprisingly, the report is about change. The physicians of Saskatchewan and the SMA are certainly prepared to be part of that culture of change as long as the changes result in improvement of health care outcomes and services to our patients.

We look forward to further consultation and dialogue to reach our common goals of a sustainable and quality system.

The Chair: — Thank you very much, again on behalf of the whole committee, for coming and presenting your views and your written submission also. Thank you.

If our next presenters want to come and take a seat at the table.

I'd like to welcome you tonight to the Standing Committee on Health Care. It's an all-party committee of the Legislative Assembly and our first task is to receive responses to the Fyke Commission or the Commission on Medicare. The committee will not be making recommendations to the Legislative Assembly. We will be reporting what we've heard from the hearings that we're doing like this one tonight and that report back to the Legislative Assembly will be by the end of August.

The committee is comprised of myself, Judy Junor, the Chair. Dr. Melenchuk is the Vice-Chair. Andrew Thomson, Kevin Yates, Buckley Belanger, June Draude, Bill Boyd, and Donna Harpauer are the MLAs here tonight.

And if you . . . We have half an hour set aside for presentations. If you would introduce yourselves and where you're from and then begin your presentation.

Mr. Anderson: — I'm Richard Anderson from the town of Kerrobert.

Mr. Poggemiller: — I'm Erhard Poggemiller, the mayor of the town of Kerrobert.

Mr. Anderson: — I'll start. I'm going to make the presentation.

Good evening, Madam Chairman, and standing committee. I'd like to thank you for allowing our presentation on behalf of the town of Kerrobert and the surrounding communities: Major, Luseland, Coleville, Dodsland, and our neighbouring rural municipalities.

Kerrobert is situated in a vibrant oil-producing and agriculture area of west central Saskatchewan. We are 40 miles east of the Alberta border and the majority of our oil activity takes place between Kerrobert and that Alberta border. Mixed farming makes up the other main industry around our town.

And many people have expressed grave concerns and worry about the Fyke report and whether it will be implemented, and all the citizens of this area feel very strongly that the Kerrobert Hospital should remain open as is or at an enhanced level.

We know that Saskatchewan residents are taxed equally and yet we feel that there is already a two-tiered health system in place because of the travel and distance to visit specialists and receive some treatments or procedures that are not available in our area. Rural people already incur extra expenses on fuel, food, lodging, and loss of income to visit these specialists that city or urban residents have easier access to and for minimal or no expense. Any further erosion of our health care in rural Saskatchewan would contribute more to this two-tiered system. It is simply not acceptable.

We also feel that the closure of a hospital in a rural community takes away that community's ability to progress. Area residents will not retire there. Aging people will move away. Qualified workers will not locate there. Industry will not be attracted and existing businesses will relocate. Our young people just will not stay. This will not only hurt rural communities but the entire province.

Most people when faced with relocation or options for employment are choosing Alberta because of our close proximity to that province. This scenario can also be proven from the communities that experienced hospital closures in the

early 1990s. The human and financial loses were detrimental to all of Saskatchewan.

Since those closures, health care budgets have increased steadily, yet we now have less doctors, less nurses, longer waiting lists, with less people in this province. Since the Fyke report has been released, it has produced non-confidence in our health care system in rural Saskatchewan.

We have had members of our communities sell their homes and move to Alberta, even prior to implementation of such, in hopes of obtaining a reasonable price for their property. We can expect more of this depopulation if this report is implemented.

Interesting to note, on the way down I was thinking of the people that have moved out of Kerrobert this summer and of the seven families that I can think of, six of them relocated to Alberta; one of them to a larger centre in Saskatchewan — all above-average wage earners, taxpayers from the province that . . . six of them we've lost, probably for good.

This province was built from a rural base and each time that base erodes it hurts the province as a whole. We must work together for the betterment of all of Saskatchewan and not just the urban centres. Our health care system does require changes. But before changes are made in rural areas, there must be more consultation with rural people.

We believe that Mr. Fyke's credentials are impressive as the report shows, however, we do not feel that he has experience with the low density and somewhat isolated population that is seen in rural Saskatchewan. The time required to get from a hospital to a certain location cannot be determined by looking at a map. Problems such as adverse road conditions and weather conditions have not been taken into consideration.

Our residents do not want to see a repetition of mistakes that happen in the past. We are dealing with people's lives. We saw, first-hand, elderly residents being moved around this province against their will, as their care homes were being closed. Many of them experienced undo stress, loneliness, or worry which can contribute to poor health or even loss of lives. The traumatic experience of moving from your home of many years to a care home is sometimes too much, let alone being uprooted and shuffled around a second or third time. Much suffering and hurt was also caused to relatives and family members.

Our elderly have paid their dues through hard work in building this province and our communities and through their spirit of volunteerism and generosity as well as being taxpaying contributors. We feel our seniors have earned the right to live out their lives close to home and to have access to health care close to that home. It is our responsibility to ensure this for them and that means an open and viable hospital.

All Saskatchewan residents have a right to reasonable access to health care, and we owe it to our children and future generations to maintain the health standards and facilities that were built and given to us by former generations.

We ask that you please consult with us to explore our needs and expectations as well as allowing us to contribute ideas on financial or funding alternatives. Maybe we need to examine implementing health care premiums again and there are many other possibilities that we are willing to work with you in good faith and openness. Please ask any questions regarding this submission and I will try to answer them. And I have a few questions for you as well if I could ask them at your convenience.

The Chair: — Thank you. The questions will come from the committee. We haven't really had the mandate to have a dialogue or discussion with communities so we haven't had the two-way conversation with questions, but we have had an opportunity for committee members to ask presenters questions and now I'd entertain any of those.

Mr. Yates: — Madam Chair, I have a number of questions. I'd like to get a greater feel for the service delivery in your community as it presently is. How many physicians would you have living and working in your community?

Mr. Anderson: — We have two physicians in Kerrobert.

Mr. Yates: — And how many beds would you have in your, at the hospital currently, acute care beds?

Mr. Anderson: — We have six funded hospital beds for medical, respite, convalescent, and palliative care patients. We have 42 long-term care beds.

Mr. Yates: — And would the majority of the utilization . . . or could you give me some idea of the utilization of those six funded acute care beds? Are they used primarily for acute care services or are they used for dealing with patients that should perhaps waiting to get into long-term care facilities? Could you give me some idea how they're utilized within your community or do you have any . . .

Mr. Poggemiller: — They're utilized in a flex manner. That means they're not only utilized for acute care but they're also utilized for people, elderly people waiting for a particular reason, or they're utilized for the doctors to observe for one or two days. They're utilized in a variety of ways.

Mr. Yates: — Would they also be utilized for patients being returned from tertiary care centres after . . . for post-operative care and those types of . . .

Mr. Poggemiller: — To some degree they are, yes.

Mr. Yates: — Thank you very much, Madam Chair.

Mr. Thomson: — Mr. Yates has asked the line of questioning I was interested in.

The Chair: — Any further questions?

Mr. Boyd: — Thank you. You outline in your brief that a number of residents, upon hearing of the Fyke report and its recommendations, have clearly made it their position that rather than be faced with the loss of services that they will relocate. And do you anticipate — I understand that's happened in numerous circumstances — do you anticipate that continuing to happen with the loss of services if the Fyke report is implemented.

Mr. Anderson: — I really feel that would continue to happen. I believe what's happened to date is we have a fairly, I'll say, a viable community. There's very good paying jobs around Kerrobert and our housing is doing well.

So a lot of people, I think, when they saw the Fyke report — and I've been told this — while real estate prices were strong, they thought they'd sell and get out while they still could. Since the Fyke report has come out, I know that real estate prices have dropped. There's some retired people that are leaving, going to Medicine Hat, and they are just constantly dropping the price of their house in order to sell it.

I see a vast depopulation of rural communities with hospitals; if they lose their hospitals, I truly believe that'll happen. And I think it happened to the communities that lost their hospitals the last time, and if you want to check, I'm certain that there would be statistics on that.

Retired people generally would . . . farm people would retire from an area and move into the town with a hospital and live out their lives there. And the last time they just took their money out of the bank and moved, and most of them moved to Alberta.

Mr. Boyd: — In addition to that, what other sort of downward spiral do you see as a result of that? Do you anticipate the loss of, perhaps the pharmacy, any other services that may be lost as a result of that as well?

Mr. Anderson: — I think with the loss of the hospital we would have . . . there would be a good chance that the pharmacy would go. And the pharmacy on our main street would be like your anchor tenant in a mall, I suppose. There's the, you know, the pharmacy, the grocery store; if they go, then the other smaller stores would follow. So I do see a downward spiral to that effect.

And I think that some of the oil companies will relocate to Provost or Consort. A lot of the activity is between Kerrobert and the border. We have trucking firms there that haul the oil. They basically dispatch the trucks. They have offices in Kerrobert. I would assume that if they find it more attractive to relocate where there is a hospital or a better opportunity to attract employees, they would possibly move.

They've actually . . . the Oilman's Association has written us a letter and in that letter they stated that it would affect their future decisions regarding locating in the area.

Mr. Boyd: — So Kerrobert obviously being in the heart of a very rich, oil-producing area, the oil companies have made it clear — through their letter, I assume — that if there is the loss of health care services in the area, that will indeed affect their decisions about investment in further oilfield development and gas development in the area.

Mr. Anderson: — Yes, and I have a copy of that letter with me if you'd like to hear it. It says, basically says that, I believe.

Mr. Boyd: — I think, Madam Chair, that that would be an excellent idea for the committee members to have a copy of that, and if you would please leave that, we would appreciate it.

We have been told by a few people who have presented to the committee that the Fyke report represents progress and that whether we like it or not, things move along and that we have to just simply accept it and move on. And that they have gone through a process of . . . Mr. Fyke has, has gone through a process of gathering information, proper consultation, and arrived at good decisions. Would you agree with that thesis?

Mr. Anderson: — I totally disagree with that thesis and I believe that if that's progress, we'll be progressing without an awful lot of rural Saskatchewan because it will be depopulated if that report is implemented. I've read it. I think it's totally discriminating against rural Saskatchewan, and I don't see very much in there that would progress in a smaller community or a rural area at all.

Hon. Mr. Belanger: — I guess just before you made your presentation to the committee, you heard the SMA brief somewhat. I just wanted to echo some of the comments that they made and comment to the effect that the shortage of doctors and the necessary skilled personnel in the health field is the primary problem with everything from the long waiting lists to making sure that the service is there.

And so the challenges are certainly mounting in terms of providing health care to the people of Saskatchewan. And as I've mentioned, Saskatchewan is not immune to some of the other challenges in other jurisdictions as well.

So that being said, do you believe that we have to re-examine the manner in which health care is being delivered in the province of Saskatchewan? Because clearly, we have been told time and time again that the system is not sustainable. Going down the same path is simply, primarily, going to alleviate the problem for a few months, but eventually we're going to have to face up to the challenge.

So I guess my question is do you believe that everything in the health care system is fine, that we should leave it as it is? Or do you think that change is necessary and that we have to look at health care as a whole to try and grapple with those global forces that make us trying to adapt to some of the pressures within the health care system?

Mr. Anderson: — I believe that there is changes necessary. I think it's important that we have — as a rural person — that we have input into some of those changes. I mention in my little brief that maybe we have to look at health care premiums.

I think another good idea would be to educate our public a little more on what it does cost to run our medical system and educate us about healthier lifestyles and everything else. I don't think that costs a lot and maybe we could . . . You read about the antibiotics that have been prescribed and over-prescribed and, you know, people should be aware of that and maybe they wouldn't be quite so eager to, to take them.

I know in rural Saskatchewan we're starting to get to be . . . we're afraid to get sick because it's going to take a long time for people to get to us. So maybe we'll all try and lead healthier lifestyles. I think that would be a good start.

Hon. Mr. Belanger: — I guess the, I guess the question I have

. . . and you've touched on it. I think it's very, very important that this is not an issue of the province wanting to put rural Saskatchewan even further. We all appreciate the agricultural crisis facing the province.

I think you touched the . . . or you hit the nail on the head, when you talked about premiums. I guess my question on the premiums you talked about as extra revenue for the health care field — where do those premiums go? Would they go to some of the salary costs? Would they go to the capital, the technology, the new medicines, some of the salaries of the specialists? Like the cost of health care is just absolutely tremendous. It's staggering.

So when you talk about premiums as additional revenues for the health care field, where would you see the premiums going? And what kind of range of price would you see premiums at?

Mr. Anderson: — I would like to see money directed more to the care workers. I think that we do need more doctors and more nurses. And I would rather be sending people out of the province for certain . . . like maybe for MRIs or something than flying them out for surgeries. I think it would be cheaper.

And I think maybe we have to forgo some of the new equipment in the city hospitals possibly — hold back on that a little bit and see, wait till the prices come down or till there's more need for them. It might be cheaper to pay for that outside the province than flying all of our children to Edmonton or Vancouver for heart surgery because we don't have a heart surgeon in this province that can operate on them.

Ms. Draude: — Thank you, Madam Chairman. I think, I believe, I know a lot of my colleagues believe that there is a big future here in Saskatchewan and that we have to believe in the province and the people. And it can happen.

And I also know that changes are going to happen. They've always happened. They happened in 1992 when the government decided to close 50 hospitals. The changes that happened in rural Saskatchewan at that time were not good. They were one of the nails in the coffin in rural Saskatchewan.

So now we're looking at changes again and the changes again are closing more hospitals. And I think we all know the saying, insanity is doing the same thing over and over again and expecting different results. I don't think that any area that had hospitals closed in 1992 can tell you that they benefited at all from it.

So when we have a van or a bus coming out in rural Saskatchewan talking about rural revitalization in the next little while, have you got any proposal or recommendations for this group of people that are going to talk about revitalizing rural Saskatchewan?

Mr. Poggemiller: — I can speak to that a little bit as mayor of our community. It was mentioned at a meeting I was at where Mr. Fyke himself was asking questions.

And apparently the economics that are created with the health system have no bearing on the economics of that community. Well I greatly disagree with that. In our community alone, it would take about $2.6 million out of our rural economy . . . like our local economy right there, within that area.

The other thing that happens is our young people and those that get the higher paying jobs and want to raise young families are not interested in locating . . . They'll work there. And the oil companies have told me that they will move the people in to do the work and they'll station them at Consort, Oyen, Provost, where there are health facilities. And that's where they'll build their house. That's where they'll deposit their cheque. That's where they'll buy their groceries and all those kinds of things. The economic spinoffs on that are horrendous.

Now when you go around further closing acute or closing health centres or health facilities, you're going to further depopulate. And this rural revitalization as it's called . . . On the one hand you're trying to create incentive to develop more activity in rural Saskatchewan, while at the other hand you're just cutting off both arms and there's no way that they can do anything. It has absolutely taken the feet out from underneath us.

Ms. Draude: — Many of the . . . Go ahead.

Mr. Anderson: — On that same . . . I've struggled with how we could have a rural revitalization program and talk about closing rural hospitals. Like, I agree exactly with what Erhard said. And I'm . . . I think it might be a little bit of an urban revitalization though, because if we close the number of hospitals that the Fyke report recommends closing, there's going to be an overload on the hospitals that are remaining, mostly in urban centres.

And I'm wondering: has the government considered the cost of expanding or rebuilding those city hospitals or urban hospitals in order to handle that overflow?

The other thing, the increased ambulance system that's going to be needed to bring these patients to hospital, and I guess the road building that we should have to do that, would maybe be a little bit of a rural boost. And airport upgrades or helicopter pads that they have to build.

But can this province afford that? I don't think we can afford the capital expenditures that it would take to implement this report.

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

Mr. Anderson: — Could I add one thing?

The Chair: — Certainly.

Mr. Anderson: — I thought I was going to get to ask questions, and I will make this just as a comment. Because I'd like it to be aware it's in here that it could be 80 minutes, up to 80 minutes from a health centre. And I want to make sure that everybody's aware — and I think we are, but I hope it wasn't missed in the report — that 80 minutes does not necessarily mean you will get to a hospital in 80 minutes.

You've got to become sick or injured in an accident and 911

has to be called. You then have to dispatch an ambulance and an emergency team, which takes some time. There'll be some time for them to get to you, and then they've got to assess you and load you and transport you that 80 minutes to the hospital.

And in the wintertime or due to road conditions, that 80 minutes can be extended to . . . I think the figures there that say 80 minutes, those people are two or three hours from a hospital. And I want to know if this committee or if this government thinks that that is acceptable for rural residents to be two or three hours from a hospital.

I could take a written answer to that if they don't want to answer me. But that's a grave concern of mine. And I've just seen that firsthand, where you don't realize that you call an ambulance and you think they're going to be right there. And they had to assemble a team and send them. It takes a long time.

The Chair: — Thank you. If you do have questions, you'd probably be best advised to submit them to the Minister of Health to get your answer. Okay. And thank you very much for your presentation tonight again.

Mr. Anderson: — Thanks a lot.

The Chair: — While we're passing out your report, I just want to welcome you tonight to the Standing Committee on Health Care. I think you heard my introduction before to the last presenters.

This is an all-party committee of the Legislative Assembly. Its mandate is to hear responses to the Fyke Commission and to report those responses back to the Legislative Assembly. We will not be making recommendations. We'll be reporting back what we've heard, and we'll be doing that by the end of August.

The committee, as I said, is an all-party committee. I'm Judy Junor, the Chair. Dr. Melenchuk is the Vice-Chair. Andrew Thomson, Kevin Yates, Buckley Belanger, June Draude, Bill Boyd, and Donna Harpauer are the MLAs here tonight.

We have half an hour set aside, and hopefully in that half an hour we have some time for questions from the committee. And if you want to introduce yourself and where you're from and who you represent, then you can begin your presentation.

Mr. Poggemiller: — Thank you, Madam Chairperson. And I'm the chairperson for the Prairie West Health District, Erhard Poggemiller.

Mr. Stevenson: — Rick Stevenson, CEO of Prairie West Health District.

Ms. Babiuk: — Fran Babiuk from Dodsland, Prairie West board.

Mr. Fetterly: — Jim Fetterly, Prairie West board, Luseland.

Mr. Poggemiller: — Madam Chairperson, and hon. members, I'm pleased to be here this evening and make this presentation. You all have a report in front of you. We spent a fair bit of time on it and it's fairly detailed. I'm not going to go through all the details. I'm going to highlight certain areas and then I would like to encourage some dialogue, some questions from you people as we go through this.

Just a quick highlight. The Prairie West Health District is some 12,500 square kilometres, includes eleven and a half rural municipalities. In the year 2000, we had a population around fourteen and a half thousand people.

We had a public meeting in our particular health district a few weeks ago. We had a good attendance. Some 300 people plus attended that particular meeting, and we gleaned certain comments that came from the meeting which are outlined in the report.

We also encouraged at that time for people to make submissions to us, give us letters, and so forth. And a letter that was mentioned previously from the oil company and so on, a copy of that is enclosed within this report towards the second half of this report.

I will glean some of the comments made out of those letters just to highlight them and maybe to spur questions from you people regarding some of our comments.

Some of the highlights that came out of that particular meeting was a motion was made from the floor of that meeting which reads as follows:

> That the residents and taxpayers of the Prairie West Health District convey to the provincial government our extreme objections to the discrimination towards rural residents by the Fyke report and that said report not be implemented without changes made through rural participation.

That was carried unanimously at that particular meeting.

Some of the highlights that were gleaned from the letters . . . and these letters here represent some 450 people. There's a couple of letters here that have been signed by numerous people and others have been from individuals.

Basically some of the comments made:

> "The hardship and the expense of travel is a reality, but quality cannot be sacrificed for the sake of proximity . . .
>
> The government speaks of rural revitalization and probably plans on spending mega dollars on hair-brained schemes like the "potato fiasco." If the government persists in . . . (implementing) the Fyke report by closing both the Kindersley and Kerrobert Hospitals it can only lead to further depopulation of the area to the demise of a small town like Kerrobert. Funeral directors will make a good living for a time . . .
>
> We in western Sask. need to belong to Alberta, not only to save our lives but our communities. I'm sure Alberta would welcome the rich oil reserves beneath our soil. It seems that the Sask. government cares only for the revenues from the oil fields but nothing for the well being of the oil workers. Perhaps Mr. Fyke is unaware that farming and the oil industry are touted as being dangerous employments with high accident rates.

And that came from the citizens of the area right around our particular health district.

Regarding some acute services, the comment was made, leave us with some feeling of belonging to the province. We are, after all, taxpayers and are entitled to the standard of health care people in larger centres receive at a much lower cost to them. These were comments that were made at our particular public meeting.

A letter from an individual way out in west central Saskatchewan about 10 miles from the Alberta border says:

> I would like to say that Mr. Fyke does not know much about rural Saskatchewan. In his report he wishes to close acute care in many small town(s) . . . I would like to see how he would react if his family lived in . . . rural areas and had a serious car accident. The distance to acute care is critical for us.

An oil company with 70 employees in our, in our particular communities wrote:

> The undersigned are employed by a large pipeline company in the Kerrobert area. Together with our immediate families, we total 70 people that utilize the health care facilities of Kerrobert. We view the proposal to downgrade the Kerrobert Hospital as a very serious threat to our families' health, spouses' employment, and current property values. Our decisions to work and reside in the area have been based on family health and spousal employment.
>
> In our opinion, more emphasis should be placed on promoting the rural-based economies and essential services that make up a large portion of the province's economy. Less emphasis should be placed on supporting the unsustainable growth of Saskatoon and Regina.

A comment was made by a personal friend of mine who wrote a letter to the CEO of our district stating about an ambulance:

> They arrived at Kerrobert at 10:40 p.m., over three and one-half hours since Dr. Wentzel's dispatch call came at 7:00 p.m.

They had to get a special unit out from the city.

The rural hospitals must be more than community care centres as stated in the Fyke report. They must be able to treat and stabilize emergency patients. If the existing services in rural health care further erode, more well-trained professionals will leave rural communities.

We believe in the worst cases, these health care providers may decide to relocate in other provinces and Saskatchewan as a whole will suffer.

Those are some of the gleanings from some of the letters that were written. In our public meeting, some of the comments that were made is the Fyke report promotes the depopulation of rural Saskatchewan. And some of the points are listed there on page 4.

The impact of hospital closure. Closing the hospital is synonymous with the reduction of acute care services. Physicians lose the ability to admit patients and diagnostic services are reduced.

A big one with our doctors — and I had phone calls from three doctors personally on this — the physicians lose the fruit of their work, the rewards that come from doing what they are trained to do — for example, diagnose, treat, and discharge the patient home.

A reduction of acute care services makes it difficult to recruit and retain physicians and other health care professionals. Decreased health care equals no care professionals which equals no health care services.

A reduction of diagnostic services impedes health care professionals such as home care nurses to do their jobs. A reduction of diagnostic services is seen as a major inconvenience to our elderly or to those who are unable to travel independently. Health care services are considered a staple community service.

A reduction of acute care services makes the future of the community uncertain and has the following spinoff: decreased ability to attract young families; decreased ability to retain those of retirement age. An unstable population or stagnant growth does not attract industry. Fewer hospitals necessitate longer driving times, translates to an increased cost to rural residents. In addition, we have no control on weather conditions. Inclement weather can inhibit or prevent travel during a critical time.

The oil and gas industry is a driving force for economic development in the west central area of the province. As an employer, this industry is concerned about the safety and overall health of its employees.

The closing of a hospital and our long-term care facility will result in the closing of businesses and loss of families in those communities. As well, people move away to be closer to critical health services.

As mayor of a community, I get that lots. Every time we have a meeting and we have people do petitions and they want certain breaks from taxation and so on, one of the key questions asked is what kind of health care service do you have in your community. And there's other . . . I'm sure other mayors of towns have the similar thing.

Rural Saskatchewan pays its fair share of taxes and at the same assessment rate as urban areas. Therefore government must treat rural Saskatchewan more equitably when making decisions on health care.

The oil industry stated quite clearly that the closing of acute care facilities will result in industry relocating their employees out of the province.

Benefits of a local hospital provide an opportunity to be close to family and friends during a time of acute, chronic, or terminal illness. Associated costs with being far away from home and family are eliminated.

And I had many people, before we had this public meeting, come to me that couldn't make the meeting in Kindersley and said, you know it cost me $800 last month because my wife had certain illnesses and she had to go and see a specialist. We went to see a specialist and there was no phone call, no communication from the specialist back to the local facility to tell them that they couldn't get in. He drove in, stayed overnight, paid the hotel bill, paid the meals, paid the travel costs coming back out, all for no avail. He had to go back in again. It happened three or four times to an individual.

Those kind of things, if we maintain . . . increase services in our rural centres . . . And yes, we need some changes to our health system. I fully agree with that. However, by diminishing the amount of services available in rural areas, I fail to see the reasoning as to how that would increase efficiencies and reduce costs. It may reduce costs to government but it's going to unload the cost back to us. And somehow we have to get these people and look after our people.

There's other things listed here as benefits of our local hospital. Life-threatening situations, we've had several in the last while. On page 6 you see some statistics regarding the Kindersley integrated facility which I was able to obtain rather quickly: 88 births; total surgery patients, 464. And then surgical days include orthopedics, general surgery, obstetrics, EMT, dental, pre-assessment clinical days, dermatology. And you see the numbers there.

Shared community services. Some community-based services and programs such as physiotherapy, drug and alcohol treatment programs, dietitian programs, public health officer, etc., can transcend district boundaries.

There's a need to develop acceptable standards across the province, and what services should be provided in health care facilities.

Only after logical, sensible consultation and justification would Prairie West Health District citizens in west central Saskatchewan look at the facility closures that are . . . that were forecast within a three- to five-year plan. Time and time again people have told us that, before you do anything, let's see what you're going to put in place and let's see what that's going to function like. Then we're prepared to take a look at doing some changes. Don't do changes without knowing what's going to happen.

With the proposed closing of smaller facilities under the Fyke plan, regional facilities have to pick up demand for surgery. We had a conversation with our local doctors and they made these comments: need to enhance cardiac programs, services, and beds in Kindersley; doctors agree with a Kindersley/Rosetown sharing specialty services unique to each centre.

And what we mean by that, would be as an example, if Rosetown hospital would have fluoroscopy and Kindersley would have ultrasound. If you needed fluoroscopy, you would go to Rosetown. If Rosetown resident would need ultrasound, they would go to Kindersley. We would eliminate the wait in the big centres for those kind of things. And we could utilize the smaller centres to do that. And the physicians have agreed that they would work together with that.

When we done this, we done it in consultation with a larger body called West Central Government, who are also going to make a presentation here. And we are prepared to work together, but it has to be sensible and reasonable, and it has to make sense to our local people.

Doctors also said: need to step up day and short-stay surgery with capability for one- to five-day short hospital stays for recovery/observation; need to establish a program of recruitment and retention of physicians and other medical professions. With proposed closing of smaller facilities under the Fyke plan, regional and service . . . regional and services facilities, such as Kindersley, Rosetown would have to pick up the demand for surgery. Government should look to strengthen districts such as Prairie West that have a strong infrastructure so they can handle expanded services; important to enhance EMS services which should parallel normal area trading and travel patterns.

Some of the board's concerns about the doctors were district doctors are concerned that primary care, travelling team concept will not work. And it's not quite clear what exactly was meant by that in the Fyke report. However, when we ran that by our physicians, they kind of chuckled and said, I'm not going to be part of a roving show, a road show; that's not in my plan. He said, I have made a practice in my particular community and I don't intend on travelling around the district to fulfill my work. Some doctors have indicated that they may relocate out of the province or out of our area if facilities close and they don't have access to put people in acute care. Availabilities of doctors to meet the community needs for acute services is a critical component of a proper continuum of health care services in Prairie West.

When a doctor leaves a community, the physician practice and/or the district is placed under human financial resource strain to replace the lost doctor and to provide, or to provide advanced clinical nurse. Accessibility to doctors and basic acute care services saves lives. Heart attack victims and victims of illness or misfortune and infants were saved by prompt access to integrated facilities. The responses involve the EMS services, trauma response, and acute care, all based out of Prairie West integrated health care facilities. And these happened in both Kindersley and Kerrobert in the just recent past.

If you look on the next couple of pages, you'll see a couple of maps there and what we've done is we actually drew circles around. The Fyke report mentions 80 minutes of travel time so we just took a compass and we took out, took the major centres such as Lloydminster, North Battleford, Saskatoon, Swift Current, and Maple Creek and we drew what we call 80-minute circles. Those 80-minute circles are the dotted black ones. You see there is a huge area left unattended. If we have no major facility within Kindersley or thereabouts, we have no services. According to the Fyke report taken to the letter and from some of the meetings I've been at, that could end up being the result, that there is no major centre of service within our whole district. Where does that leave our residents?

The next map is that of the west central government showing a part of that community that we belong to out there. It's made of numerous municipalities, towns, and villages, a lot of which had input into our submission here.

Travel and geographic factors. Time and distance travel to acute services of 80 minutes outlined in the Fyke report is too great and will place lives of our residents in danger and, as the previous speaker said, 80 minutes is not 80 minutes. It could add up to being a lot more. As suggested in the Fyke report, you may see that nearly 80 per cent of the Prairie West Health District is left out of that service area. In order to have those services within the 80 minutes, it would only be logical to have a major centre located at Kindersley. Through the huge oil field development, it would benefit all involved to maintain the services that are presently being offered at Kerrobert, thus covering the total area.

EMS medical services, the golden hour to save lives can be used up simply by the fact that it now takes 30 minutes or more to reach an accident scene because of great distances over rural roads. A further time to treat the victim and 30 minutes to transport to the nearest local acute care facility, further stretching out the golden hour which will cost lives.

This EMS response time can be compared to the urban areas where the response time is measured in minutes, leading to comments such as: is my life less valuable than a life in urban areas?

Taxation is a big issue. If the government's not willing to supply rural Saskatchewan acute care services, let's go back to community hospitals. Rural residents pay the same tax as urban residents. We should expect same or similar services.

Accountability. We need to be more aware of what the costs of health care are. Perhaps everyone should receive a statement when we receive services. Residents should be better educated on how they deal with simple health care issues.

The provincial government should be held accountable through the court system for lives lost because of reduction of acute care services.

The next few pages outlines the vision that our particular district has, and taking the map into account, in some of the facilities I mentioned — Kindersley, Kerrobert, Eston, Eatonia. EMS, looking into the future, we have talked about doing things such as maybe there's some effort should be made with partnership with Alberta STARS Air Ambulance Program, continue to pursue service enhancements.

This would have Prairie West explore the possibility of local delivery services which at present are difficult for residents to obtain in a timely manner. Possibilities could include dialysis, ultrasound, MRI, portable mammography, CAT scan, innovative diabetic program, cardiac rehabilitation, residential rehabilitation.

In conclusion, just to quickly sum up. Change is inevitable but should be driven from the bottom up, not the top down. Amalgamation of health districts is not out of the question, however the boundaries should be coterminous with other government boundaries.

The Fyke report has strengths and weaknesses. Enhanced EMS services, a 24-hour advice line, and a quality council are seen as good ideas, but it's unclear how these would be set up. Some comments made around the quality council was who would be on that and how would they be appointed. The report fails to explain primary health services.

In conclusion, Prairie West is prepared to work closely with Saskatchewan Health, the West Central Government Committee, stakeholders, and professional organizations. The common goal is to ensure the development of a sustainable model of health care services that meet the needs of the citizens of Prairie West Health District.

The people of Prairie West Health District and west central Saskatchewan request that they be given the freedom and the support to pursue the health vision that they have collectively developed.

And I think I'll stop there and entertain some questions.

Mr. Thomson: — Thank you, Madam Chair. I want to thank the district officials who have attended tonight for their brief and their presentation.

I have a few questions tonight that I'm interested in hearing your opinion on. I'm interested in knowing what it is in the Fyke report that would lead you to believe that Kindersley would be anything other than a regional hospital.

Mr. Poggemiller: — Where that came from initially was at a conference call that happened through the provincial organization, SAHO. And if you take the average daily census, I believe is the term, Kindersley does not make the cut that was established for developing a regional centre.

Mr. Thomson: — What was the, what was the cut, and who established it, I guess is the question.

Mr. Poggemiller: — I can't answer you as far as the number goes. I forget what the number was. All I do know is that it was a big conversation from the provincial Chairs and CEOs around a conference call. And Kindersley did not make that cut.

Mr. Thomson: — As I read Fyke, Fyke says that there'd be 14 regional centres. If Kindersley weren't one or at least weren't shared with Rosetown, what would the 14 be then?

Mr. Poggemiller: — I didn't put that proposed list in the report, but it would be all the major centres being Moose Jaw, Weyburn, Estevan, Melville, Yorkton, Melfort, North Battleford, Lloydminster, Swift Current — did I say Weyburn? Meadow Lake, Yorkton, I said. Tisdale, I believe, was another one that was mentioned. And I don't remember what some of the other names were.

Humboldt was another one. I think that's 13 — 12? Moose Jaw I did. Maple Creek. I think the report says something like 10 to 14 too.

Mr. Thomson: — Interesting, you know. Obviously Kindersley is located more than two hours to Saskatoon. I don't think that there's another major hospital . . . I don't know what's in Oyen. I don't think there's a particularly large facility there. Kindersley would seem to me to be a natural for either, on some basis, shared or otherwise, some kind of expanded service.

So I find it interesting that there would be a sense that Kindersley would lose its hospital. I read the letters that have been sent in; you've appended some of them. I just wonder about the type of information that's being provided, or how people come to some of these conclusions.

I have a letter here from a Ms. Amos of Kindersley who says that she understands from this meeting on July 5 in the Kindersley district that there would only be . . . that we'll probably lose our Kindersley hospital.

Another woman writes me, a Mrs. Schlosser and says with only three hospitals slated for acute care . . . this is based on her attendance at the meeting on July 5, and it goes on. I wonder why these people are being led to the conclusion that Kindersley won't have a hospital.

Mr. Poggemiller: — One of the reasons is because of the information that we have gleaned from the meetings we've been at, as board members, through the various provincial meetings that we've had, and we've had no indication that we will retain our status.

Mr. Thomson: — How many physicians are there in the town of Kindersley?

Mr. Poggemiller: — Five.

Mr. Thomson: — And surgeries are currently performed in the hospital.

Mr. Poggemiller: — There are.

Mr. Thomson: — Well I'm just at a loss to see why there would be this fear that Kindersley would lose its hospital. I guess I'd be interested in knowing what you can do as a health district board, and what else can be done to allay some of these concerns that we're going to have, as one woman is obviously concerned. Only three hospitals with acute care. It's clearly not represented by anything I've read in Fyke, and it defies logic.

Mr. Poggemiller: — I have no idea where that number comes from.

Mr. Thomson: — So what are the things that you as a district board can do then to allay some of what I would say is obvious fear among citizens that there will not be a hospital, potentially within two and a half hours of the border, that Saskatoon would be probably the nearest one.

Mr. Poggemiller: — One of the things we need is a definite answer from government. We have no problem . . . like our vision shows exactly, if you read what we've got there, as to what we're trying to do in enhancing services and so on.

Once the Fyke report came out, once we heard what some of the comments were around our particular position as far as in the scheme of things, we decided as a board to be proactive and start going after seeing what other services we could provide to prove to government that, yes, we are a viable centre to be a regional centre.

We have let the public know some of these things that we're doing. However, when it comes around to the board table, the board itself — even though it raises its own funding and goes to communities for funding and so on — we still have to answer to governments and ask them for permission to do certain things, even though we can see how we can budget this and put that financial plan in place. Maybe that protocol has to be there to some degree.

But we find it rather frustrating that we're always hamstrung by . . . you know, the Almighty down here, if I can put it that way.

Mr. Thomson: — How many people live in the district?

Mr. Poggemiller: — Fourteen and a half thousand.

Mr. Thomson: — You work co-operatively, as I understand from your presentation, with . . . I forget the name of the neighbouring district that Rosetown is in.

Mr. Poggemiller: — Midwest.

Mr. Thomson: — Right.

Mr. Poggemiller: — Midwest and Greenhead are the other two districts we work with.

Mr. Thomson: — So I take it from your presentation then that you see there to be an opportunity either alone, Kindersley alone as the larger centre in that area, or co-operatively with another large community like Rosetown, to be able to share services say perhaps as Swift Current and Moose Jaw do. Or to better coordinate physician services and surgeries.

Mr. Poggemiller: — That's right.

Mr. Thomson: — Well I'm not the Minister of Health, and I, you know, don't make these decisions but from what I can see, knowing what I do about the town of Kindersley — somewhat partial to it because I was born in Kindersley — I think that it is . . . the fears that these people have are obviously of great concern to them. I think, clearly, we should both work actively and quickly to allay those fears that there will not be hospital services in the town of Kindersley.

Hon. Mr. Belanger: — I just want to point out as well that as a member of the government, certainly as a member of this commission, we haven't . . . we've been hearing folks come out, come forward and explain the value of their hospital and figuring there's going to be this huge fight on some of these things. And I want to assure you that we have not been privy nor instructed to make any comments about the Fyke, but to hear what people have to say.

In one of the letters in your brief — and I want to commend you on your brief; it is very well done, a lot of good information, and certainly it's always important to see that the fight coming from the people of Saskatchewan to protect health care — one of the letters that was presented here was from Helen Murphy and Diane Kohlman, and the last part of their letter they wrote they . . . I just highlighted five points. And these are some of the things that is in everybody's mind. This is not necessarily talking about closure of hospitals. They go on to say no. 1 — not numbering them but pointing out:

— educate residents about the cost of abusing the system.

The second point they make was:

— consider attacking pharmaceutical companies to decrease the cost of medications.

No. 3:

— monitor the physician and surgeons — are they abusing the system??

The fourth point they make is:

— have doctors be required to do a certain length of time as general practitioners in rural areas if there is a problem.

The fifth point they make:

— there must be many other ways to cut the cost of health care without totally destroying our health care in the rural areas.

These are some of the questions that the Fyke Commission has posed to people. And it's not in the privy of government to begin at random picking hospitals out of the air and closing them. We are trying to rationalize our health care system so we're able to keep it intact, and the province is the only one doing that — Saskatchewan is. And across the country, as you turn on the news — Nova Scotia, Ontario, BC (British Columbia) — we have all those problems with health care. You just turn on the news and any jurisdiction, news coverage is on health care crisis and so on and so forth.

So we're trying to grapple with that and given all the challenges we have with health care, we can appreciate the services that many rural physicians and hospitals and health care centres provide to the people of Saskatchewan.

And coming from a small community in northern Saskatchewan, I appreciate the fact that accessibility is very, very important to small community people. So I guess my question to you is that, first of all, I think it's very, very important that we understand the challenge with health care and that there's a very important role for rural, urban, and northern Saskatchewan people to play in preserving and protecting our health care system.

That being said, what are some of the ideas that you would have to really begin to make the system work well despite the fact that you know — and we know — that the costs are escalating on a constant basis?

Right now we spend 40 per cent of the provincial budget on health care. Is there a way of reducing their costs? Is there answers to these ladies' questions in their letters? And this is the reason why we're having these hearings is to hear the stakeholders' response to Fyke. We are not making any recommendations. We have not been privy to any document saying these are the hospitals that are being closed. We really want to grapple with this health care challenge and the cost associated with it. And that's, pure and simple, the purpose of these hearings. So I think that's one of the things that I wanted to make very clear.

And I would ask, based on some of your presentation, how would we rationalize the health care system. How much do we need in health care? Is 40 per cent enough? Is 45 per cent enough?

Like we're talking 2 billion, 2.2 billion and those costs can begin to escalate. So the question the ladies have here are some of the points that I think we want to hear about it as well. So I would ask for your opinion on that.

Mr. Poggemiller: — Okay. I would ask Rick to respond to that.

Mr. Stevenson: — On your question, sir, about making the system work better and directions, we tried to address some of that in our report by talking about the day surgeries and short stay surgeries. By increasing that in Prairie West would not only help our own residents of the district in west central, but would also be able to help the cities in their long waiting lists by bringing people out to Kindersley and other communities to do those surgeries. And we think there'd be a real benefit.

And some of the other things that our Chairman outlined would help to relieve the pressures from the cities and reduce the waiting lists. Waiting period for some surgeries in the city is several years. And in Kindersley and other communities, it can be very short, in a matter of a few short months. And then we improve people's quality of life. We get them back to work. We get them on their feet, living a better life. And the whole situation is better. Forestalling any more serious surgeries may be done by correcting the little problems.

Mr. Poggemiller: — I also think that the cost per day to operate a hospital bed in rural Saskatchewan is considerably less than it is in the large centres.

And you know, it's always the country people drive to the city. I think there's specialty surgeries or small surgeries that could be done in outlying areas to alleviate the cities greatly. And let's have some of the city folk drive out to the country. It wouldn't hurt them to see what it looks like out there once in a while. And you know, I really think that that would be co-operation all the way around, if they did a little bit of the driving as well.

Mr. Belanger: — And that's exactly my point is that these are some of the ideas and the options we need to examine. And I thank you for that and I also commend you for some of the points that you're making. And all these comments will be, of course, put together in a document going to the government and certainly trying to see how we can alleviate the stresses facing our health care system.

Because like you, we have people that travel from my constituency six, seven, eight, nine hours. And they've got to pay for a motel, gas. And it gets very expensive when you centralize health care services.

So northern Saskatchewan, like rural Saskatchewan, we have to appreciate the constraints that the health care system has — the shortage of physicians and nurses and other health care professionals. That's a very real challenge.

So I think it's a matter of us putting our heads together, saying that $2.2 billion we have now, how could we make best use of it so the health care system is fair, it's equitable, and it's accessible by all people? And that I think is a very important point.

And we musn't get off on the wrong track of saying this hospital's closing or that hospital's closing. I would just encourage us to look at the happy medium, the common ground that we can build and protect the health care system of Saskatchewan. Thank you.

The Chair: — Any questions?

Mr. Boyd: — Thank you, Madam Chair. Would you say that the reason why there is considerable concern about the loss of facilities in rural Saskatchewan, and in dealing with Kindersley in this situation, is because when you read Mr. Fyke's report on page 31 he is recommending 10 to 14 communities, even though he doesn't identify those communities and even though the government seems very defensive about the fact that that is what indeed he said, and hasn't identified those communities, one doesn't have to go very far in an exercise of putting the pins in the map to determine what they are and what they won't be.

And when you . . . Would you say that that is the reason why people have made those determinations on their own when they look at it, and they look at the recommendations, and they look at what the government is saying, that it's a pretty simple step of logic to arrive at the conclusions that they have?

Mr. Poggemiller: — I would say so.

Mr. Boyd: — And in addition to that, that they feel that when they look at the report and they're talking about emergency response times and they look at their location within the province and they see themselves considerably further than 80 minutes from a facility, that it calls into question that assumption as well.

Mr. Poggemiller: — That's true.

Mr. Boyd: — And that when they look at their community and they see people basing their decisions about where they want to live and remain in that community, or whether they even indeed want to remain in that community, they're making their decisions in large measure based on what is available in that community in terms of health care services.

Mr. Poggemiller: — That's true.

Mr. Boyd: — Thank you, Madam Chair.

The Chair: — Any further comments? Seeing none, then thank you very much for your presentation tonight.

Welcome this evening to the Standing Committee on Health Care. This is an all-party committee of the Legislative Assembly and its first task is to receive responses to the Fyke Commission or the Commission on Medicare, and report back what we've heard as a committee to the Legislative Assembly by the end of August. The committee will not be making recommendations. It will be reporting what we've heard.

As I've said, it's an all-party committee. I'm Judy Junor, the Chair of the committee. Dr. Melenchuk is the Vice-Chair. Andrew Thomson, Kevin Yates, Buckley Belanger, June Draude, Bill Boyd, and Donna Harpauer are with us tonight.

We have 30 minutes. If you want to begin your presentation by introducing yourselves and who you represent.

Mr. Holmberg: — Good evening. I'm Dale Holmberg and my colleague is Don Mitchell. And I want to thank the standing committee for the opportunity to make a presentation on behalf of the Moose Jaw branch of the Saskatchewan Health Coalition. We are an organization that is dedicated to the preservation of a universal, publicly funded health care system.

I will get right into my presentation. Quite obviously I'm not going to be able to cover everything and Don will end up by making a summary and recommendations.

At the outset I want to say that I'm alarmed by the impression that I believe is being created that we will soon not be able to afford our publicly funded health care system unless we quickly make some drastic changes.

In chapter 6 of his report, Paying the Bills, Kenneth Fyke says the province spends 40 per cent of government revenues on health care. This is clearly not true and it seriously undermines his assumptions. If we look at the Public Accounts for 1999-2000, we see that the government spent 1,955,736,000 on Health for the year ended March 31, 2000. At the same time its total revenue was 5,856,932,000. The proportion of health spending to revenue is 33.39 per cent, not 40 per cent. If we include revenue from Crown corporations as the Provincial Auditor does in his 2000 Fall Report, the total revenue increases to $9.229 billion; using the same figure for health spending as before, the proportion of health spending to revenue falls to 21.19 per cent, almost half of Mr. Fyke's figure.

A better way of looking at health care is as a percentage of GDP (gross domestic product). Using Statistics Canada figures for '99-2000, Saskatchewan Health spending is not out of line with the rest of Canada. The results of provincial health care spending as a percentage of GDP are as follows: Newfoundland, 7.7 per cent; Prince Edward Island, 7.4 per cent; Nova Scotia, 8.1 per cent; Saskatchewan, 5.5 per cent; Alberta, 4.6 per cent; Nunavut, 16.1 per cent, etc.

Even if you use the health expenditure figure from the public accounts of $1.955 billion instead of Statistics Canada's $1.649 billion, Saskatchewan is still comfortably situated in the middle amongst the provinces, at 6.5 per cent of GDP.

That brings us to the burning question of hospital closures. Will the closing of 50 hospitals save us bundles of money and make the health care system more sustainable? The answer is probably not.

The reality is that even before 1990 hospitals were playing a decreasingly important role in the health care system. In 1975, expenditures on hospitals represented 43.2 per cent of total health expenditures. By 1990, that figure had dropped to 33.6 per cent.

While expenditures on hospitals increased at an average annual rate of 9.6 per cent from 1975 to 1990, the other factors that made up health care expenditures were increasing at a rate of 12.6 per cent. Not surprisingly, the fastest increasing expenditure were on drugs at an astronomical 14.3 per cent annually.

While spending on health care was slowed by the cutbacks across the country in the early 1990s, it did not stop. Even with spending on hospitals at a standstill, total health expenditures in Saskatchewan still increased 24.5 per cent between 1990 and 1998.

While money may have been saved on hospitals, it appears that much of it went into the other health-spending category, which continued to increase at an annual rate of 8.2 per cent between 1990 and 1998, so that by 1998 it occupied 19.4 per cent of total spending as opposed to 11.6 per cent in 1975.

In fact between 1991 and 1995, while expenditures on hospitals decreased by $130.5 million or 16.5 per cent, other health spending increased by 155.2 million — a hefty 49.4 per cent increase.

By 1998, at 545.2 million, other health spending had increased nearly elevenfold since 1975. That compares with a fourfold increase in hospital spending — the lowest of any of the categories.

Drugs had also continued to increase between 1990 and 1998, although at a more sedate 4.8 per cent annually. Since 1975, drug expenditures had also increased nearly elevenfold, reaching 365 million by 1998.

Between them, the two categories now represented more than the money being spent on hospitals, whereas in 1975 the two combined had been less than half of hospital expenditures.

By 1998, spending on hospitals in Saskatchewan had dropped to 27.1 per cent of total health expenditures, below the national average of 32.2 per cent. Saskatchewan's per capita operating expenses for public hospitals, at $654, were markedly lower than the Canadian average of $759 in 1994-95. At the same time, Manitoba was spending $870 and Newfoundland was spending $927 per capita.

Those figures would suggest that Saskatchewan's spending on hospitals was hardly out of control.

More importantly, as Patricia Tully and Etienne Saint-Pierre so astutely observed in the 1997 Statistics Canada report, "Downsizing Canada's hospitals," quote:

> The costs of health care do not necessarily disappear when they are not incurred by hospitals. "The process of shifting the costs and the care from hospitals can serve to increase long-term costs for the system." Comparable amounts may have to be incurred by other sectors such as residential care facilities and home care, and by individual patients and their families. The costs of nursing care, drugs, medical supplies, specimen collection by laboratories, food, laundry, utilities and cleaning that are provided by hospitals have to be covered by these other institutions or by patients themselves, either out-of-pocket or by private insurance, once they go home after early discharge, day surgery or outpatient care.

In her book, *Operating in the Dark: The Accountability Crisis in Canada's Health Care System*, award-winning journalist Lisa Priest says:

> What figures may seem to show at first blush — that hospitals are doing more with less, and Canadians need not worry — looks very different when one goes deeper into the data.

She goes on to say, quote:

> As drastic as cuts to hospital inpatient care have been, there have been huge increases in other areas. Day and night care — defined as care for outpatients, those on geriatric day care, those receiving renal dialysis, and substance abuse day or night programs — has jumped forty-six per cent; surgical day care has increased to thirty-seven percent; the use of clinics has increased by twenty-four per cent; and emergency visits have crept up a tiny one per cent over a seven-year period . . .

According to Priest, that is only part of the story however. She cites a University of Toronto study by Dr. Geoffrey Anderson that tracked downsizing in Ontario hospitals. It "suggests the poor are bearing the brunt of the cuts." One example:

> The rich saw an increase of twenty-six per cent in day surgery, but those living in the poorest areas saw a three per cent decrease during the same time period.

She cites a number of other examples and concludes:

> The long and short of it is this: It appears the poor are shouldering most of the cuts to the health care system.

My own union, the SGEU (Saskatchewan Government and General Employees' Union), has first-hand experience of the impact of privatization on extended health benefits plans. Facing spiralling drug costs, the provincial government raised the deductible in 1992 from $125 to $380 per year and eventually to $850 every six months. Driven mostly by the increased burden of drug costs, our extended health benefits premiums for single coverage have risen a whopping 537 per cent and family coverage 420 per cent since 1992.

Meanwhile, we have seen anecdotal evidence of the uneven impact of cuts on different income groups. The Health and Welfare Trust, which handles the extended health and dental benefits plans for a number of smaller bargaining units, has noticed . . . has noted that well-paid units are heavier users of the benefits plans than low-income units.

Given what we know about the determinants of health, it is doubtful that the lower-paid members are healthier. Therefore, it is likely safe to assume that they are deterred from availing themselves of benefits by deductibles and upfront payments that are beyond their means.

That impact of health cuts is something that does not show up

in the expenditure figures. Something else that doesn't show up is the cost of accessing institutional health care when it becomes increasingly removed from a patient's place of residence. There are financial costs to the individual, the family, and the community.

We have all heard of the high-profile cases where people have to travel to Toronto or the Mayo Clinic in the US. We are familiar with the fundraisers to provide the substantial financial support that family members require to accompany them.

Unnoticed, every day in Saskatchewan many families are incurring the cost of travel, food, and accommodation to be with members who are receiving medical treatment in Saskatoon, Regina, etc. That is not taken into account. That phenomena will increase as more facilities close and Saskatchewan residents have to travel greater distances.

In the case of rural communities, money that may have been spent locally ends up getting spent in Regina or Saskatoon. It isn't just those dollars that are lost to the local economy. It is the multiplier effect that elementary economics tells us would have resulted as that money circulated through the economy. That is also lost.

Communities that actually lose health facilities are hit with a double whammy because they also lose the incomes of well-paid health care workers and the potential economic activity the lost income would have generated as it filtered through the local economy. This is not considered in downsizing decisions.

Mr. Fyke says achieving a health care system that delivers high quality at lower cost can in time allow for public funding to expand into more parts of the system. In other words, at some time in the future there may be some kind of health cuts dividend.

Canada's experience with downsizing would suggest that isn't likely to happen. At any rate it is putting the cart before the horse. We all know the health impact of social and economic conditions. In 1989 the federal political parties vowed to wipe out child poverty by year 2000. Instead we ended up with 50 per cent more children living in poverty.

Last year in the United Nations Children's Fund report on child poverty in 23 industrialized countries, Canada placed a dismal 17th with a rate of 15.5 per cent. The countries with the lowest rates of child poverty were Sweden, 2.6 per cent; Norway, 3.9 per cent; Finland, 4.3 per cent, etc.

These countries' low rates of poverty did not happen by accident. If you look at the graph for total tax revenue as a percentage of GDP, you will see that every one of those countries ranks high on the graph. It is pretty safe to assume that they have used their higher levels of taxes to implement policies and programs to reduce poverty and inequality.

In fact while public expenditures on income security in France, Finland, Norway, Luxemburg, Netherlands, Denmark, and Sweden ranged from 20.5 to 26.3 per cent of GDP, Canada's expenditures represented only 11.9 per cent of GDP in 1990. Thereafter in the face of growing poverty, Canada chose to cut taxes further.

Consider the revelation this spring of a $15 billion federal surplus. Did we hear anything about poverty reduction? Recently Canada lost its number one UNDP (United Nations Development Programme) ranking of the best country in the world in which to live largely because of its persistently high rate of poverty.

Since poverty and inequality tend to drive up health care costs, it should come as no surprise that all of the aforementioned OECD (Organization for Economic Co-operation and Development) countries except France spend less on health care as a percentage of GDP than Canada.

For those who believe that privatization is the way to lower health care costs, it should also be noted that every one of those countries also has a higher rate of public expenditures as a percentage of total expenditures on health than Canada. Some have considerably higher public expenditures. Whereas the public portion in Canada is 69.6 per cent; in Sweden it is 83.8; Belgium, 89.7; Czech Republic, 91.9; and Luxemburg, 92.3.

Change will come. It is inevitable. But steps will need to be taken to ensure that it is change for the better. It must not compromise access and shift the burden to families and individuals. It must not come at the expense of rural women, the sick, the poor, and the elderly.

In international terms, we are a wealthy nation so we have the wherewithal to spend more on health care than we do. Ultimately it depends on our priorities. Keep in mind that in 1998 Saskatchewan residents spent $385 per capita on gambling — second only to Manitobans who spent $445 per capita.

Also remember the Cuban example. After the Soviet Union collapsed, the Cuban economy contracted by 35 to 40 per cent, and some say up to 60 per cent. Exports and imports fell 70 to 75 per cent, yet they managed to keep every hospital and school open. In fact despite the economic difficulties, spending on public health increased by 17 per cent between 1989 and 1994.

Finally, greater privatization is not the answer as some would have us believe. We need only to look to the US (United States) to remind us of the follies of that system. In a 1999 survey, one-fourth of American adults, an estimated 40 million people, said they went without needed medical care when sick, due to costs.

Thank you.

Mr. Mitchell: — I'd like to thank the committee for the opportunity to be present. I'd just add, in terms of the Saskatchewan Health Coalition, it is a provincial organization with locals in Prince Albert, Saskatoon, and Moose Jaw, made up of individuals as well as organizations, including several trade unions. So it's fair to say it's largely an urban-based organization, but we also have rural members.

And Dale has highlighted some of the issues and assumptions that surround the Fyke report. And I just want to reiterate some of those in summary, and our major concerns and the direction

we see in terms of recommendations.

Our commentary will be seen as critical of the province's past record in addressing progressive health reforms, as well as in meeting current policy gaps. But we should emphasize that the biggest factor clearly in undermining medicare in the province was the abandonment and financial assault on social programs by federal governments since the 1980s.

So to reiterate the first point that stands out — as Dale outlined the numbers — and that is that the proportionate cost of publicly funded health care has actually fallen even as our collective wealth has expanded. And that the Fyke report is grounded in an exaggerated sense of crisis about health care costs relative to the rest of our economy. We think it's false to present health care expenditures as out of line and out of control, relatively speaking, and that the numbers have really been manipulated to reinforce cost-cutting measures such as hospital closures and conversions.

Our level of commitment to public health care is much lower than other countries of similar wealth and status, and even lower — as Dale mentioned — than Cuba, which has faced the issues of a US trade blockade and the collapse of industrial subsidies from the Soviet Union but is maintaining a free, universal, high-standard health care system and hasn't closed hospitals.

People in Canada want and within their means are willing to pay for a better health care system, and with some vision and political will we could do much better.

Second point is that corporate costs of for-profit health care are indeed out of control, and this is one of the serious omissions in the Fyke report.

For example, on the issue of drug costs. He recognizes that as an issue but fails to see the critical importance of expanding medicare to deal with drug costs because that's not sustainable. Well it's certainly not sustainable for individuals on low income.

We recognize there are these uncontrolled and wasteful cost factors affecting the system. Unfortunately the Fyke report doesn't give emphasis to expanding medicare to include prescription drug supplies which is the biggest cost offender as a publicly owned and operated branch of community health care.

Saskatchewan, we feel, needs to take an aggressive lead in establishing this reform nationally. We could at least adopt the system of lowest drug cost preference such as has been brought in in British Columbia and Nova Scotia. And we also support the need for publicly operated home care, accessible as needed, as an essential expansion of medicare.

The third point is that the issue of urban and rural poverty, including the North in Saskatchewan, and the growing disparity of wealth between classes is the biggest determinant of poor health. High-cost health problems in our provincial population such as diabetes, heart disease, high-and low-birth weights, infant mortality, obesity, suicide, and depression all have a social and economic base and are disproportionate among urban and rural poor, especially Aboriginal peoples.

The province's failure to adequately address this poverty through income support, social housing, and minimum wage provisions, and its insistence on corporate and higher personal income tax cuts have added immeasurably to the costs of health care.

The desired shift emphasized in Fyke, from acute care in hospitals to primary prevention-based community health care, cannot happen in our view without redistribution of income and the enabling of healthier personal choices among the 20 per cent of families in poverty.

The fourth general point is overlapping with some of our rural colleagues that's been made earlier tonight. The population of rural Saskatchewan feels socially, economically, and politically abandoned by government at all levels. Rural communities have braced to Fyke, like earlier health reforms, as just more bad news.

The continuous pressures to depopulate over the past 20 years has come from a number of sources including the loss of national transportation subsidies and market-support subsidies that have systematically forced depopulation, the centralization of commercial services and government services, and then resulting school and hospital closures. Every wave of additional centralization has a negative multiplier effect as scarce and valuable local jobs are lost, adding further to the population decline and the inability to sustain services which define their community.

What Dale has argued in his analysis is that maintaining access to acute care may stabilize communities. And I would add that that stability can allow a more successful longer term transition, which is recommended by Fyke, with emphasis on primary care teams in rural areas to support and develop a healthier population.

Quick abandonment or conversions, on the other hand, will only further undermine and alienate communities which are already barely sustainable socially or economically. Hospitals, like schools, are a pillar of the local economy and some cost, quote, inefficiency in service delivery, at least over a short term, can be justifiable if the wholeness of a community and therefore, ultimately, the health of its citizens can be preserved or extended.

Only a serious commitment of additional resources, and a long and patient process of inclusion and nurturing could make a difference in rural Saskatchewan. The prevention-based services need to be in place first before local access to acute care is dramatically eroded or removed and left entirely to unpaid family volunteers.

Our recommendation would be proceed with extreme caution and develop a creative process for change in rural communities that respects local culture. And we don't underestimate the difficulty of that task.

But it's going to take a lot of energy and work and nurturing in rural communities to turn around the attitude that provincial and federal governments, in terms of the health care system, are the

enemy. And I think we need to recognize that the system was really built — originated — in smaller communities in rural Canada and that that kind of spirit and will could be rekindled on the basis of some creative partnerships.

Finally, I think we want to make the point that we recognize and resist the erosion which is currently happening of national, provincial, and community sovereignty over health care, as well as other areas of community service, which comes with recently developed international trade agreements. Again, a serious omission in the Fyke report that this trend and the risks involved are not identified.

We support the call that's been made by others, such as SGEU in their submission, for a moratorium on further international trade agreements which allow foreign for-profit service corporations to claim equal investment rights in areas of jurisdiction, which were protected, and . . . by and for the public sectors such as community health and education. The provisions in the draft General Agreement in Trade and Services, the GATS, could if implemented prevent any expansion of medicare into broader services such as home care or pharmaceuticals without equal treatment extended to for-profit competitors such as the pharmaceutical corporations, health insurance companies, and private home care providers.

Analysis of the current and impending impact of the trade deals is a serious omission in Fyke's report.

In conclusion again, I would remind you that the roots of community-based medicine and public health insurance are here in rural Saskatchewan. People organized door-to-door and farm-to-farm to create a system that was theirs.

In this current discussion of reform, the concept of direct democracy and local control which were the stated intention for elected district health boards should not be abandoned in the name of centralized administrative efficiency.

Thank you, and we'd be happy to consider any questions.

The Chair: — Questions from the committee?

Mr. Boyd: — Thank you, I'm interested in your argument that the government does indeed not spend 40 per cent . . . I'm not sure what the current figures are for the budget, but we have heard from the government and numerous members of the government that that is indeed the case. You seem to feel that argument does not . . . you don't accept Mr. Fyke's argument in that regard.

Mr. Holmberg: — He used the term revenue, and it certainly is not 40 per cent. All you have to do is look at the figures. But the other figure that is being used of course is program spending. But if you throw in the interest on the debt, it isn't 40 per cent.

Mr. Boyd: — Thank you; I'm interested in your comparisons to Cuba. Even myself, who have a great deal of concerns about where our health care system is going in Canada, have some difficulties drawing comparisons to Fidel Castro's workers' paradise of Cuba.

You seem to feel that there are some direct comparisons.

Mr. Mitchell: — I think there's not direct comparisons in many respects, obviously, including political comparisons. But the point is that under conditions of extreme economic stress, Cuba, which under more unfavourable circumstances had for a Third World economy built a very high standard of health training professionals and broadly based universal health care, free health care — unique really in Third World countries in the western hemisphere — found that under stress after 1989 when their foreign support from the Soviet Union collapsed and they had the continuing trade embargo from the US, was still able in spite of their decline in their economy by something like 40 per cent or more of their gross domestic product, still retain because of the priority on health care, a universal health care system and free universal public education.

So if it's just the sense of the priority and the commitment to that program and maintaining it under stress as compared to our stress which is there in terms of debt and deficit issues and all of that but nothing comparable to what Cuba went through, and yet they maintained that. So what we're saying by comparison is that surely with the expanded collective wealth we have in this country over the last decade, we can retain at least the same level of commitment that we had to health care in 1990, when in fact we're letting it slip. So that's the comparison, nothing more than that.

Mr. Holmberg: — Some of the comparisons for life expectancy, Cuba is actually very close to the United States. For Cuban males, 73.4 per cent; for females, 78.3 per cent. For the US, it's 72.95 for males; 79.67 for females. What you have to remember is that Cuba has done this on a GDP that is one-twentieth of that of the United States — 1,560 as compared to 31,500 for the US.

Mr. Mitchell: — In per capita GDP?

Mr. Holmberg: — Yes, per capita. I'm sorry. Yes.

Mr. Boyd: — It's an interesting argument. I'm not aware of what kind of services are available on Cuba. I haven't been there, and I hope I never have to go there.

Mr. Mitchell: — Well you won't get it from the national media. I mean one of the things about Cuba is the reporting on stories that happen there don't allow us to have easy measure of what really is happening.

Mr. Boyd: — They don't allow a lot of things in Cuba that we allow in free and democratic countries. And even though it's interesting for argument sake, I generally would be of the view that most people in Canada wouldn't want to trade much for what they have in Cuba.

Hon. Mr. Melenchuk: — Just a couple of points and a question. In Saskatchewan, the Finance department prepares two statements of its accounting policy, summary financial statements which is what we see in Public Accounts. And we're one of, I think, three or four provinces that prepare a General Revenue Fund or a consolidated fund of revenues and expenditures.

The 40 per cent figure refers to the GRF (General Revenue Fund) spending, as opposed to the summary financial

statements, which includes all the activities of government such as debt servicing and investment. So that's where that 40 per cent number comes from.

But I would agree with you that the better reflection, in terms of comparisons to other jurisdictions, is the percent of GDP.

And the question I have for you is what would be an appropriate per cent for Saskatchewan or do you have an idea of what that should be?

Mr. Holmberg: — No. I really have no idea. I just pointed out that we are in the range of the other provinces; in fact, some were in the mid-range. So no, I hadn't thought what might be an appropriate figure for that.

I just believe that with the importance of health care we can afford to spend more.

Hon. Mr. Melenchuk: — So a lot of the thrust of your presentation was basically to show that perhaps more funding could be provided and other services could be added in terms of our health care system. There has been a decline over the last 15 or 20 years with withdrawal of some federal responsibility.

When we originally looked at creating medicare in '62, of course, it was 50 cents on the dollar. When that was changed to establish program funding in 1977, there was a further decrease in transfers on health care. And with the CHST (Canada Health and Social Transfer) now, it's even less. So there has been erosion.

There has been, up to the point now, where the amount of dollars going into the health care industry or services is probably 69 cents as opposed to, you know, over 90 cents, you know, 20 years ago.

So the thrust of Fyke was that the sustainability, in terms of the demands for increases in the health care system in terms of funding demands was such that, at some point in time 10 or 15 years down the road, all of the revenues of government would be going to the Health department so there needed to . . . that financing issue needed to be addressed. And his proposal states that by creating the system efficiencies and the changes in the system over the next 4 or 5 years which he calls transition, which would require an additional 3 to $400 million, that you would then get to a sustainable curve where the revenue requirements for maintaining your health care system would match the revenues of government. But you don't agree with the Fyke analysis in terms of how that expenditure/revenue side works, then.

Mr. Holmberg: — The other thing that has happened is the percentage of government revenues as a percentage of the whole economy of course has fallen. The government revenues had been increasing at 3 per cent, whereas over the 10-year period between '90 and 2000 the economy itself was increasing at 3.68 per cent. So the capability was there. But I do agree with you that the federal government has to be assuming more of the responsibility than it is. And it can; I mean it has the money. Unfortunately, what it has done, of course, is rather than putting it into things such as health care, it has gone big time to cutting taxes.

Mr. Mitchell: — I think the other point we make is that the portions of health care costs — and it was referred to earlier in another presentation, I think — that are more out of control and rising rapidly are those that are in the marketplace in the for-profit health system, particularly drug costs. And so if the plan, the longer term plan for medical care doesn't address and expand to include those services, the cost to the system and the inequities for the population because those services are not universally available becomes more exaggerated. And clearly to do that, to address that expansion of services, it has to happen at the national level. So I mean Fyke basically sets that aside saying, we can't deal with that; it's not sustainable — when in fact if it were part of a national program and implemented across the country, it could be sustained and would actually reduce total health costs because those drug costs would be more under control.

Hon. Mr. Melenchuk: — The final question I have is with regard to GATS. Now the federal government has stated on a number of occasions that health care and education are not on the agenda with regard to international trade agreements. But you don't take a whole lot of comfort in those statements, I guess.

Mr. Mitchell: — Well reports that we have seen done on the listing of services in the GATS draft proposal include insurance services in health care, which . . . that's why I made the reference to pharmaceutical and home care as potential expansion. If those are services that are included in the agreement, then the capacity . . . and if those agreements are accepted under the WTO (World Trade Organization), the capacity of the federal government to move into that area is restricted because that becomes subject to equal treatment by foreign-based, for-profit corporations.

So it appears that it is listed in the draft statement from a report that was done by the Centre for Policy Alternatives, and the reassurances coming from the federal government sort of ignore that.

So, you know, there's clearly a basis for some concern there. And we would like the province to take some lead in ensuring that the commitment that has been made verbally is actually real, and that the draft agreement doesn't allow for discovery after the fact that we've lost our options.

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

The Chair: — No further questions? Seeing none, then thank you very much for your presentation and for your written material.

The next group of presenters could take their seats at the table. We welcome you tonight to the Standing Committee on Health Care. It's a legislative committee of the Assembly, an all-party committee. And I don't know how long you've been here; I know we're late so you've probably heard this maybe twice. But I just wanted to make sure everyone understands the mandate of the committee is to receive responses to the Fyke Commission, the Commission on Medicare, and we respond back to the Legislative Assembly with what we've heard. We won't be making any recommendations as a committee. We'll just be responding back or reporting back with what we've

heard.

I'm Judy Junor, and I'm the Chair. Dr. Melenchuk is the Vice-Chair. Andrew Thomson, Kevin Yates, Buckley Belanger, June Draude, Bill Boyd, and Donna Harpauer are here with us tonight.

We've tried to keep the presentations to half an hour and sometimes have been successful, others not. So if you could introduce yourself and begin your presentation.

Mr. Tynning: — I'm Ansgar Tynning, mayor for the town of Kyle, member of the West Central Health Subcommittee, and Co-Chair of West Central.

Mr. Lorenz: — Wally Lorenz, mayor of the town of Wilkie.

Mr. Poggemiller: — Erhard Poggemiller, mayor of the town of Kerrobert.

Mr. Tynning: — I'll start the presentation. I'll go through some of the points of what we have written down. Wally Lorenz may pick up on some of the items that I leave out, and then we would go into the questions.

Our presentation is based mainly on the direction of a consensus of our membership. The West Central Municipal Government Committee is an organization of over 70 rural and urban local governments from west central Saskatchewan who meet on a regular basis to discuss issues that impact the well-being of all municipalities. School divisions and health districts within our region also hold memberships in the organization and regularly attend meetings. At present, the West Central Municipal Government Committee membership is made up of two cities, 18 towns, 16 villages, 37 rural municipalities, and four school divisions.

The West Central Government encompasses a region of territory stretching eastward from Macklin and Lloydminster along the Alberta border to the Battlefords, and then south through Outlook to Kyle, and westward to Leader. Attached at the end of this document is a map detailing the region. And you may want to take a, just a brief look at the back page of our submission; the light part on that map indicates the area that we represent.

The West Central group functions within a structure that allows for the development of subcommittees to research issues that impact the quality of life in our communities. The final report of the Commission on Medicare, entitled *Caring for Medicare Sustaining a Quality System*, commonly referred to as the Fyke report, was identified by West Central as a document which warranted a response from our membership. In response to the Fyke report and on behalf of West Central Municipal Government Committee, we submit this brief to the Standing Committee on Health Care and to the Hon. Minister of Health.

I just want to add a note in addition to this as . . . also as to why we are here. We do know that the Fyke Commission was contracted by the Saskatchewan provincial government to do a proposal on the future of health care for our province. We also believe that the final report of the commission is probably very close to what the provincial government was expecting.

The responses to many of the recommendations of the final report by many groups and individuals was that more information was needed before responses could be made to many of the major recommendations.

With the commission having made its final report and the provincial government not having a part in writing the report, where will they get more information? We, the West Central Municipal Government Committee, felt that we should respond, based on the suggestions of the report, with what we believe are the minimum needs of health care for our area of the province.

We developed this response because of the many unanswered questions and concerns raised by the Fyke report. This brief represents the thoughts of the people from west central Saskatchewan on the type of health care services required for the citizens of west central Saskatchewan.

EMS services. An 80-minute ride to acute care services, as mentioned in the report, is far too great and will endanger the health and lives of residents. Travel on rural roads is dependent on weather, road conditions, the density of traffic en route to urban centres. These roads are often not conducive to fast travel.

Rapid EMS response times and services are critical to saving lives in rural Saskatchewan. The golden hour to save lives can be used up simply by the fact that it now takes 30 minutes or more to reach a person who has fallen seriously ill, or to arrive at an accident scene. Further time is required to treat and stabilize the victim. Then it takes 30 minutes to respond . . . or to transport the victim to the nearest acute care facility. Attempts to further stretch the golden hour will be disastrous for the provision of quality health care and will inevitably cost lives.

The 80-minute EMS response time cannot be compared to the larger urban areas where response time is measured in minutes, not hours, leading to comments such as, is my life less valuable than a life in a larger urban area?

Doctors and their support staff. Doctors have indicated they will likely move from their region or out of the province if existing acute care facilities are closed. Nurses and other support staff also hold similar views. The reduction of facilities and services does little to attract replacements to rural Saskatchewan. The loss of professional health care providers will have a negative domino effect on the economic well-being of all rural communities, both within the medical profession and in fields such as education, business, and construction.

Any economic downturn within a community that results from reducing health services must be viewed as having a potentially serious negative effect on efforts by public and private agencies to revitalize rural Saskatchewan. Ensuring high quality health care is maintained in rural Saskatchewan should be incorporated into the provincial mandate to revitalize rural Saskatchewan.

Enhanced health care facilities. Residents in rural communities cannot be expected to travel two or three hours to centres that provide acute care services. Such lengthy travel to obtain these services is unacceptable to the people of west central

Saskatchewan. These people must have reasonable access to necessary health care services.

Prompt accessibility to doctors and basic acute care services saves lives. For instance, from March to June of 2001 the lives of four heart attack victims, four other victims of illness, and one infant were saved due to prompt access to the Kerrobert acute care facility.

Providing of health care has a major impact on smaller communities. Consequently the government is seen as playing with people's lives when health care facilities are no longer available within a reasonable distance from their home.

A serious question has been raised. How can rural Saskatchewan survive without health care services? Providing health care services must be seen as a vital part of rural revitalization.

The issue of death with dignity is of immense concern. Residents who have lived their lives in rural areas are adamant that it is their right to die with dignity near their homes rather than in some facility far away from their homes and families.

Rural Saskatchewan pays an equitable share of taxes based on assessment similar to that of large urban areas. Therefore the provincial government must treat rural Saskatchewan with the same consideration given to large urban centres when making decisions on the delivery of health care services.

A provincial health care standard must be developed on what services should be provided in health care facilities. Standards and programs for the delivery of health care services must be in place before current health district boundaries are altered. Should the provincial government choose to reduce the number of health districts in a way that will affect west central, then we would ask to be consulted and participate in the decision.

There is an overriding need to develop an acceptable planning process to deal with changes to existing health facilities. Only after logical, sensible consultation and justification would the people of west central Saskatchewan look at any facility closures or changes. And also that there be a minimum of a five-year plan for the delivery of health care.

It is imperative that doctors be consulted to successfully develop and implement our vision of health care in west central Saskatchewan.

Since the beginning of health reform in 1993 there has been considerable reduction in health services and closures of health facilities in west central Saskatchewan. Just to give a brief example of the area where I live, part of Midwest Health District, in 1993 places like Elrose, Dinsmore, Lucky Lake, and Kyle were all downsized from integrated facilities to health centres. Milden and Beechy, for example, were closed totally. So there are six places, you know, in a very small area, and it's not uncommon throughout west central. So we've already gone through much of this.

We feel that it's important to retain services in surrounding existing health centres, develop flex beds in these centres for purposes of assessment, palliative, observation, trauma, and convalescent care, all of which could function with the minimum of an ACN (advanced clinical nurse) at each facility.

It is imperative that lab and X-ray and 24-hour emergency care also be retained in these facilities to provide necessary service to the community. Also to retain the services currently being provided in existing acute care facilities and develop flex acute beds to recognize and meet community requirements. These beds would be used in a flexible manner for acute, trauma, chronic care, assessments, palliative, observation, and convalescent purposes depending on community needs.

At the bottom, proper development and configuration of EMS services is vital. User fees should be set at a flat rate regardless of the distance travelled as recommended by the Fyke report.

I'll leave my part of the presentation at that for now.

Wally Lorenz, want to add to this or can we go into questions?

Mr. Lorenz: — I guess, just to make a comment in respect to, I guess, the situation within West Central, that we represent a body of some 70 municipalities plus the school division and health districts that are part of that membership in that sense.

We see that there's a real, I guess, opportunity of growth that can happen in that west central area. And I think we've heard about the oil industry and we've heard about some of the other ventures that have been going on in that whole area and that type of thing.

And I think there is a part of our submission that we talk about the fact that that oil industry wanting to just remove itself out of west central Saskatchewan and then locate itself into Alberta. It becomes a real concern for the communities within west central area, not just the Kindersleys and the Rosetowns and the Biggars. The smaller communities as well get affected with that whole situation.

Ourselves, we've got a project right now on the books. As far as the community of Wilkie is concerned, we got a $12 million project that we're sitting there looking at moving ahead on. And it's in front of the Securities Commission right now. But we're deathly afraid that we're not going to be able to attract people into our community to pick up these jobs in the sense of not having health care within our community and within our immediate region as well.

So as far as the economic concern is out there, I think it's very serious and I think it's very accurate in the sense of what will happen. It's not something that when it will happen or if it will happen. It's going to happen.

If something happens here with the removal of health care out of rural Saskatchewan and forcing it into the larger centres, you're going to lose the opportunity of rural revitalization completely, you know, what's out there right now.

The Chair: — Questions from the committee? Mr. Thomson.

Mr. Thomson: — Thank you, Madam Chair. I want to thank the three mayors for presenting this presentation on behalf of their group.

I want to turn our attention to the vision for health care outlined on page 5, section 5, and just ask, I guess, for them to elaborate a little bit on some of these ideas because I think in many ways they are very progressive and a positive step forward. How would you see these being delivered on a regional basis?

Mr. Lorenz: — Is there any point in particular that you're referring to?

Mr. Thomson: — Well I'm looking at expanded day and short-stay surgeries, the specialists floating back and forth.

Mr. Tynning: — I guess, to expand day surgery: some of these things are happening now in Rosetown and Kindersley, for example, out of Saskatoon. And that, we feel, is a great service to that area and we feel that they should be expanded on. This is what our people are telling us. More need to be able to take a place at home. The waiting list, for example, to get in for the surgeries that are provided in Rosetown and Kindersley is much, is much less than even going to the same physician in Saskatoon — for the waiting list. So we need to make better use of the facilities we have out in rural Saskatchewan. And even if some people had to travel the other way, if some people had to travel from the cities out to the rural part for some services, maybe that wouldn't be all that bad. Maybe they would understand.

Mr. Lorenz: — I think if I could just add to that as well. I think it's in the sense of retention of the doctors as well. Like if there's some other need for the doctors out in those rural centres that you're bringing these day surgeries out or you're bringing the patients back into the rural setting, that they can convalesce in the sense of surgery that they've had in the larger centres. There is another area of need for those doctors out there that you're going to be able to retain what you've got out there. And you're going to attract some doctors back out into that rural setting as well, in that respect.

And then it's the matter of cost. Like I think it was mentioned here earlier that the bed costs in the larger centres is much larger than the bed costs within the rural centres as well. And there's some pretty good efficiencies out there already. With the downsizing that's gone on of the 52 beds and . . . or 52 hospitals — and we're actually a hospital in Wilkie that was probably the 54th, that we were cut after the fact in a sense, to that sense — but I think the efficiencies are out there that you can build on those right now, and really utilize, you know, the system that you've got in place right now. And by bringing these day surgeries and these day programs back out there and the convalescent beds back into the rural sector, I think you can make, have some real benefits in the sense of providing an adequate service.

Mr. Poggemiller: — I guess another thing that is important is that utilization of the operating room space. Operating rooms are hard to come by in the city, and there are operating rooms dormant in rural areas and very well equipped.

Mr. Thomson: — I think I asked this question earlier concerning the relationship between Prairie West, Midwest, and Greenhead in terms of sharing services, but in the case that I didn't, I'll ask it again.

Mr. Poggemiller: — Well we do share certain services with all three health districts. And we also are — representation from all three health districts — we also attend West Central Government. So we work together with this whole region as such, as well as other health districts too. Like if you look at the map, it's larger than just the three health districts. There's about I think six altogether — six or seven — that it touches. And from time to time, various representation comes to our meetings.

Mr. Thomson: — I think it's a very positive approach that the west central governments have embarked on, to working together and trying to cross district boundary lines to try and build the services in for the citizens. And I think that the vision for health care that you've outlined is a progressive one.

I'll just close by saying that I think, at least from my perspective, I certainly agree with you that there's a real opportunity for growth in west central Saskatchewan. And the sooner that we can build back in stability, be it in medical care and then it will allow the rest of it to go from there, I think the better. That's something that the government and local . . . both the provincial and local level have to do co-operatively.

So thank you very much for an excellent presentation tonight.

Hon. Mr. Belanger: — Yes, I just wanted to again echo some of the sentiments of my colleague, Mr. Thomson, in terms of the collaboration that you've undertaken as a west central region.

And I like the phrase, the people speak. I think it's very, very important. And I guess my question I have for you today, in terms of collaboration and the whole process of going through Fyke: as you know by now, we're trying to find a way to rationalize as best we can providing the accessibility and affordability and eventually we hope the accountability of our health care system to meet the needs and demands of Saskatchewan people.

Have you undertaken any kind of exhaustive or intensive study of other jurisdictions, whether they're in Canada or whether they're in the States, of how a region could collaborate to meet the objectives that Fyke tried to do in his document? I guess other collaborative approaches by other regions in say, Nova Scotia, or some northern state in the US.

Mr. Lorenz: — As a committee, there is a west central association. We haven't got into that exercise of actually, you know, investigating what's happening in other jurisdictions as such, you know, in that respect.

I guess we've taken a look at what is the needs of west central Saskatchewan, is really what we've taken a look at. We haven't even taken a look at the Fyke report and said okay, we're to counter this, or we're going to, you know, we're going to fully support this and speak to it directly in that sense.

We took I guess a proactive look in the sense of what is the need out here in our area that we can sustain the services that are required here, and how can we drive economic development — which is a real, you know, which is a real need out there.

And I guess some of the discussion that we've had around the west central table in regards to the economics of this whole thing, and how can this thing really, you know, sustain itself, pay for itself, and what's the longevity of the whole thing down the road, you know, where's this thing going.

And you kind of wonder, you know, through some of our discussion that we hear is are we developing a type of elitist type of a health care system that everything is driven into the cities where the huge costs are in the cities in that respect to try and provide the services in there. And it's basically . . . this report in particular takes everything out of the country and focuses it on to the three major centres in the sense of how you are going to provide that service.

So at the end of the day when you keep escalating costs because you keep driving costs into the most expensive area of provision of service, then how do you keep up with that? You know, do you turn this thing around and actually send that cost back out to where it's a little cheaper to function and provide that service in that sense?

Maybe you need to turn this thing around a little bit and say, okay, we can do it in another way, we can do it more efficiently, we can do it more effectively in the sense of how this process can be delivered.

Hon. Mr. Belanger: — I just want to add to the premise that there is no question that the purpose of these hearings is to hear your response to Fyke. Fyke done the report, presented the report to the government, and he made his recommendations. And now we're in the process of hearing from the various groups and stakeholders out there as to what they think of Fyke. And that's why the recommendations from this committee aren't going to be made. We're going to report back to the government, as our chairperson has indicated.

But what I will say is that it's so very, very important that the message we have to rural Saskatchewan, and northern Saskatchewan for that fact, is that we mustn't squelch innovation. If there's an innovative way to provide good health care services to the people of the southwest, then so be it. And I think this whole exercise is exactly, as I mentioned before, opening up the doors to those opportunities and meeting that challenge. It's really about energy and it's also about courage.

So I just commend again the group for putting together the brief and also making the effort to work together. That's what this whole exercise is about. And thank you so much.

Mr. Boyd: — Thank you, Madam Chair. Would it be fair to say that your concerns are not surrounding co-operation between various districts, that you feel that where it makes sense that you are prepared to co-operate? Your concerns are more based on the fact that the Fyke committee is recommending that we go to 10 to 14 communities with regional health care facilities and that the rest find themselves with considerable less services than you do have today. Would that be fair to say that that is what your concerns are?

Mr. Tynning: — One point that needs to be made clear from our last meeting, which was held on Thursday in Luseland — and we had quite a discussion on this presentation — and the point that was made very clear by all of the membership there was that we're not opposed to regional hospitals, but not at the expense of taking away the services that our communities still have, to lose our health centres and the present acute care centres, but to enhance some facilities within the region to the level of regional services and retain what's in the communities. That was a message that was very strong to us.

Mr. Boyd: — So when you hear statements like we are trying to find a way to rationalize the health care system, what you take from that type of statement is that you will be served with less services today . . . or in the future, pardon me, then you currently are today?

Mr. Tynning: — I guess I might touch on one example of what's happened in my own community. We have a fellow who had just spent about two or three weeks in the Swift Current Hospital, a fellow in his 70s, where the family had been called in, you know, on more than one occasion. There wasn't much that could be done from there. He was sent home under the condition that he was to have a blood test done daily and the doctor would look at the blood test and determine what kind of medication he would have at the end of that day.

The problem that's happened is that two . . . or five out of the seven days of a week, the family would have to transport him from Kyle to the city of Swift Current for the blood test and then back again. And a person in his condition, that's not good. So that is what X-ray and lab facilities have gotten to in our area since . . . it's gone down. So we're hoping to restore some of that to allow these people to stay there and not have to go through that type of suffering.

Mr. Boyd: — Thank you.

Hon. Mr. Melenchuk: — Thank you very much for your presentation, and also for suggesting solutions in your vision for west central health care. The question I have in terms of specialist services in your district, the Saskatchewan Medical Association was here earlier this evening and they thought that it might be easier to recruit GPs who have had additional training in an area such as a GP anesthetist or a GP surgeon as opposed to specialists to smaller communities.

And I'm just wondering what you think about that concept. It's been in existence in Saskatchewan previously, but do you see that as filling a gap in your district as well?

Mr. Lorenz: — I think if we're going to utilize, if we're going to utilize, you know, the facilities and the services that we have out there, that we can enhance them by bringing these doctors in; that basically he can work in parallel with the services that can be provided out there. I think it's going to be a huge asset in that respect.

And I think also the fact of cost is going to be dramatically . . . you know, that's going to be some of your dramatic saving in that respect. That you don't have that specialist cost that gets tied into that type of a procedure, in that regards.

And the attraction of just a general practitioner out there is very difficult. You know, as a community ourselves, we lost one here when the first round of cuts went on. We had two doctors.

Then we lost our acute care facility. It was downgraded to an observation health centre. The one doctor being there 22 years left for Ontario just because of the fact there wasn't an acute care centre.

But if you had that kind of a service there that those doctors could enhance their practices, in that sense, I think it would be a tremendous bonus.

Hon. Mr. Melenchuk: — The final question I have is in one of your recommendations with regard to extension of Alberta's STARS air ambulance system into Saskatchewan, what component of that system are you thinking about for your district?

Mr. Lorenz: — Well I guess what we've investigated even a little bit to some extent, is the fact of implementing that type of a service into our area, as they're being provided in Alberta with. It's the full-blown air ambulance services; the helicopter service is basically what we're looking at in that respect.

And when you take a look at, I guess, at some of the areas that you're going to be stretched pretty thin on as far as ambulance service goes. And then the oil industry is another one that's very critical — when accidents happen out there, they're in a situation that they need attention immediately in that respect. Not saying that anybody else doesn't, but that's just a more volatile situation that we're dealing with out there in that respect as well.

Mr. Tynning: — I might just add that the three of us here spent a day at the STARS base in Calgary, and they indicated interest in helping develop something in this part of the country where the need was.

Hon. Mr. Melenchuk: — Thank you.

Mr. Yates: — Just one quick question, along the same lines with the STARS ambulance service. When you looked at perhaps envisioning that type of service in Saskatchewan, were you looking at a similar type of model that's used in Alberta, which is heavily subsidized by industry or by corporate dollars? And what role does that play in . . . would you say that play within the provincial system? Or are you simply looking at expansion of what's offered in Alberta into your sector of Saskatchewan? Are you talking about a larger vision for the whole province of that type of network?

Mr. Lorenz: — It would, you know, it would escalate into a provincial type of a system eventually, if that need was there and if we could structure it in that form. I guess we weren't looking at it just as a west central service, it would be a service that maybe could be piloted or started in that area, and then we could expand it into the entire province.

But we were looking at having it privately funded, you know, through donations through the majority extent. There is a portion in Alberta that is funded through the government as well. And that's an offsetting kind of from-the-ground ambulance cost that fits into their system in that respect. So there is, I think, about 20 per cent or something like that comes into their budget from the provincial governments in Alberta.

And I guess we were going to try and tailor it somewhat into that respect. They have looked at, I guess Saskatchewan in the sense of, is it possible even to do it in here. And the fundraiser actually that is working with STARS in Calgary, she's originally from Saskatchewan. She realizes exactly what some of the opportunities are in here in that respect as well.

Mr. Yates: — Thank you and I'd just like to comment. And I'm very impressed at the way that you have put forward some positive alternatives to look towards a better health care system in your part of the province. And that is the type of initiative we need and enjoy hearing in this committee. So thank you very much.

The Chair: — Seeing no further questions, thank you very much for your presentation tonight.

Our last group of presenters can come and take a seat at the table.

Welcome tonight to the Standing Committee on Health Care. I think you've heard all the little preamble probably twice so I'll just introduce myself, Judy Junor. I'm the Chair. Dr. Melenchuk is the Vice-Chair. Andrew Thomson, Kevin Yates, Buckley Belanger, June Draude, Bill Boyd, and Donna Harpauer are here with us tonight.

And we've got a half an hour set aside for the presentation. That would include some time for questioning. We've had Kindersley and Kerrobert so we might have exhausted our questions but who knows?

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

Mr. Hauta: — Thank you. Good evening, Madam Chairperson and members of the standing committee. My name is Kim Hauta. I'm the administrator for the town of Kindersley. And with me this evening are Mayor Ed Woloshyn and Alderman Cecil Campbell. And we're here tonight to make a presentation on behalf of the town of Kindersley. And I'd like to thank you for allowing us the opportunity to make this presentation to your committee.

A little background on our community. Kindersley is a town of about 5,000 people which expects to become Saskatchewan's next city. Located in the west central heart of the agricultural area, it contains a considerably large industrial sector which serves both the agricultural as well as the gas and oil industry.

Kindersley is located at the junction of Highways 21 and 7 on a direct travel route from Saskatoon to Calgary. It is 200 kilometres or two hours west of Saskatoon and about 60 kilometres or 40 minutes from the Alberta border. It has a main trading radius of about 100 kilometres or one hour to the north, west, and south, and a little less to the east — about 40 or 50 minutes.

Kindersley is a major educational centre in the west central region. It boasts the Prairie West Community College, Kindersley Composite high school with about 550 students, and two elementary schools with about 800 students. There is also a kindergarten to grade 12 school operated by the Christian

Fellowship/Alliance Church, and as well we are the seat of the Kindersley school district.

The town is a major provider of services of various kinds, including health services, a 16-bed acute care hospital with additional beds for surgery and maternity cases. There are two long-term care facilities housing some 100-plus residents. These require some 15 various nurses and support staff. There are two independent housing facilities for older folks, with managerial and maintenance staff. There is a well-established home care service for the town as well as other centres within the health district.

In the town of Kindersley there are four doctors and medical clinics. Kindersley Hospital is a large, well-maintained facility, well-equipped and staffed so it can provide full lab and X-ray services. There are several offices that provide community health programs located in the hospital building, and the area has excellent ambulance service to the surrounding communities.

The hospital presently provides vital acute care to the petroleum industry and the agricultural sector, treating accidents from these sectors as well as traffic accidents, burn victims, fractures, and electrocutions. Care to cardiac victims and other serious diseases is also provided, and the Prairie West Health District offices are located in the Kindersley Hospital as well. People in the oil field regard the availability of acute care services as essential to their presence in this area.

The town provides shopping services and a host of business services, recreational services, food services, accommodations, church, and consultation services to the residents of the town and surrounding community.

In the recreation field, there are two skating rinks, a curling rink, an indoor swimming pool, excellent ball diamonds, a regional park, several other parks, museum, golf course, bowling alley, a cultural centre, and a large public library — all which promote the health and well-being of the residents in our community and surrounding area as well.

The town also has a good-sized construction industry. The credit union and the co-op store are currently being expanded. Renovations are being carried out on a number of other commercial buildings and a considerable number of new houses have been built in the past two years. The town is policed by the RCMP detachment which is also located in Kindersley and indirectly the provision of police and fire services contribute to reducing health risks within our area.

When the Fyke report, *Caring for Medicare*, became available in April of 2001, it was discovered that while such ideas as fair and equal ambulance rates, the provision of better or quality health care, and greater efficiency of resources were quite easy to agree with, the report raised many questions and quite a few concerns, especially for folks in rural areas including the town of Kindersley.

The report is not specific about such things as how regional hospitals are to exist or what the criteria will be in establishing them, where they will be located, why the number of health districts should be reduced drastically from 32 to less than 12, and exactly what benefits are to be had from such change. What standards or criteria are to be applied as to whether smaller existing hospitals are to remain open or be closed.

With the uncertainty about location of regional hospitals, how can community health needs be assessed well? Without location of such hospitals being known, how can it be determined as to what hospitals existing today qualify as smaller ones or which 25 to 30 should remain in operation or which should close as hospitals and/or perhaps be used for some other purpose?

In the report there is no indication that the model Mr. Fyke suggests will save any money and in fact there is some indication that it could cost more money if we want to assume quality health care for Saskatchewan people. If no savings are to be realized today, as was the case when 52 of Saskatchewan's hospitals were closed several years ago, why would people today be anxious to accept Mr. Fyke's model of health care delivery when, to many in rural communities, the provision of health care quality is going to be lessened or reduced to zero?

Presently people are taken to Saskatoon from the Kindersley area for diagnosis and then returned because there are no beds available in Saskatoon hospitals. Where would they be returned to if their hospital near home were closed? If no money is to be saved by following Mr. Fyke's plan, why should we consider closing existing facilities that are providing service to their community? Because of the vagueness of some of the terminology and the recommendations made in the report, such as the numbers of regional hospitals, their location, the criteria to be used in making such decisions, etc., community needs become difficult to determine.

What will be the case with Moose Jaw with its 35,000 people and its location 30 to 40 minutes from Regina? What about Weyburn's 9,000 people and its location between Estevan and Regina, less than an hour's distance? What will be the future of Melville, 25 minutes from Yorkton, when its new hospital is complete? And there are other similar situations throughout the province.

Although the report gives no indication that North Battleford would have a regional hospital, it could be assumed that it would have one. The same could be assumed for Swift Current, and Saskatoon is designated as a tertiary centre.

A circle drawn using Saskatoon as centre in a radius of 60 minutes falls several minutes east of Rosetown. A circle drawn similarly from North Battleford falls north of Luseland, Kerrobert, and Biggar. A circle drawn similarly from Swift Current falls south of Sceptre, Eston, and Dinsmore. The area between Luseland and Leader, approximately a hundred miles, and between Eston and Biggar, about 80 miles, including Rosetown, which is 70 minutes from Saskatoon, would lie outside of proper coverage distances.

This would suggest strongly that a regional hospital is required in the Kindersley-Rosetown location. Some folks have suggested a shared Kindersley-Rosetown regional facility; and though the idea may have some merit, others fail to understand that logic.

If a choice of only one of these centres had to be made for a west central regional hospital, Kindersley would be the logical choice. It has twice the population of Rosetown; it is 50 minutes farther from Saskatoon than Rosetown; and Kindersley serves both an agricultural sector and an industrial sector, while Rosetown serves only an agricultural area. Kindersley has an average population of less than 40 years. Rosetown has a large elderly population.

A facility located in Kindersley would in 10 years still be servicing a population of mixed age. Presently in order to avoid city traffic, a good number of Rosetown's older population drive to Kindersley to shop and for other services. In 10 years, many of Rosetown's present population may not be there, and services established today may not be appropriate in 10 years time.

With the recreation, business, and cultural advantages listed earlier, Kindersley should stand a much better chance of recruiting the needed medical personnel.

Some of Kindersley's industrial sector is located 40 to 50 minutes from Kindersley. Rosetown would be too far away.

If a regional hospital at Kindersley-Rosetown or at Kindersley should become impossible when the appropriate criteria is applied, then it is an absolute must that services presently available from Kindersley Hospital be maintained or enhanced.

If Kindersley's hospital were to be downgraded from what it presently is, medical personnel including doctors, nurses, and support staff have indicated many of them would leave. The negative effect would not only be felt in the medical community but would have the same effect on schools, business, and residents. Such would be completely at odds with government and public/private attempts to revitalize rural communities. To try at this time, without proper consultation with the residents of communities to be affected by the recommendations of the Fyke report, to implement these recommendations, would be economically as well as politically disastrous in non-urban areas.

Government must talk to the rural people; listen to them, not the bureaucrats with their plans for revision. The bureaucrats will not be affected much in Regina or Saskatoon, nor will they be paying the price to set up the model.

At this time I would like to thank you for allowing us the opportunity to present our presentation, and we would be prepared to answer any questions.

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

Mr. Yates: — Thank you very much, Madam Chair. My question has to do with your perception or I guess your feelings about surrounding communities. If Kindersley was made a regional hospital and there was an enhancement of services obviously if it became a regional hospital, would surrounding communities, example Kerrobert . . . If some diagnostic services could be done more cheaply in a Kindersley hospital, would they have difficulty with that concept, do you believe? And it's probably a question I should have asked some of those communities when they were here, but as you expand . . . Obviously if you look at expanding and having a regional hospital in Kindersley, you would have probably more advanced diagnostic equipment, more enhanced services available that may not be as efficient in some smaller communities, or available. Would that cause difficulties in the region?

Mr. Campbell: — I'm not sure I understand the last part of your question. Could you . . .

Mr. Yates: — Well as an example, today there is a hospital in both Kerrobert and there's a hospital in Kindersley. If in putting . . . potentially putting a regional hospital, let's say in Kindersley, allowed the development of a new and more advanced laboratory services and then it was seen that it was perhaps more beneficial to ship blood samples from Kerrobert to Kindersley for analysis, would those types of changes in the local region, do you think, cause problems in the region, in the health service delivery in the region?

Mr. Campbell: — You're talking about the enhancement of services, which is a term that is used for communities as recommended by Mr. Fyke. Then those services would not necessarily have any negative effect on a Kerrobert or a Rosetown or any other community close by.

That is one of the parts with the report of the commission is that it doesn't really clearly address that particular type of thing. And so you're left to make assumptions or to guess what the situation might be. And it's with that having to guess or make assumptions that it becomes very difficult to respond to some parts of the report.

And though it was not our intention here or our vision to see essential health services in such communities as Kerrobert or Rosetown diminish, it does become necessary in an area that large to have some kind of enhancement. And if it were in the form of a regional hospital, which we have to assume again would be properly staffed and equipped to handle the kinds of cases that would be needing those services in that area.

Does that answer your question?

Mr. Yates: — Yes, and I'm not for a second suggesting that that would mean Kerrobert shutting down or anything because those decisions haven't been made or there's no preconceived assumptions. But if you put a regional hospital in and you're going to deliver new services to an area, you're likely going to have those new services in your largest, most up-to-date facility. And it may diminish to some degree expansion of new services to other communities that are within a close proximity.

Mr. Campbell: — I guess when we're suggesting a regional hospital here, we're suggesting enhancement for the communities around there as well as the town of Kindersley.

The Chair: — Further questions?

Mr. Boyd: — Thank you. Judging by the number of letters that the committee members and myself have received from Kindersley, the community of Kindersley and from the surrounding area, there certainly appears to be a great deal of concern and indeed uncertainty about the future of health care

services in that region.

And when we look at Mr. Fyke's report of calling for 10 to 14 communities to have a regional hospital system, primary health care services, I think the reason they are concerned is genuine. And when you have large public meetings like you had in Kindersley, I think it demonstrates and should demonstrate to us all the level of concern that there are about the loss of services.

So when we see that kind of concern out there, I'm sure you would agree that that kind of concern should be listened to.

Madam Chair, I want to take the opportunity to thank you very much and all other presenters from the west central area for their excellent presentations over the evening tonight. I think it speaks to your level of commitment to your community and to your region, and to the level of concern that your region has expressed with respect to the potential loss of services.

And I also want to thank you for taking the time out of your schedules to come down at considerable loss of time and expense to you and your communities and considerable travel time to Regina and we thank you very much.

The Chair: — And on behalf of the committee, I'd like to thank you also . . . oh, someone had a question.

Mr. Thomson: — I'm waving at you, Madam Chair, but you've been following the debate too closely, I guess.

I want to also thank the presenters tonight for coming from Kindersley and I want to thank them for the presentation that they made. I think that it is a compelling argument and an honest critique of some of the problems within the Fyke report; in particular, the vagueness. I understand that that has caused fear. I understand that fear has been certainly . . . the uncertainty has been used by some to advance their own causes.

I think it's important that the kind of logical presentation that you've presented and I think compelling arguments as to why Kindersley should maintain its services and is a good candidate for enhanced services, I think, really does speak well.

I have a question about how this idea of a shared regional facility might work between Kindersley and Rosetown. Obviously Kindersley is a larger centre. I would anticipate that it has more health services now. There's a reference to it perhaps being . . . to some people not seeing the logic in that. I just wonder if you could expand on that point.

Mr. Woloshyn: — Yes. That was kind of looked at, the overall, if the services were cutback on Kindersley area, Rosetown area, that I guess if we had certain services in Kindersley, certain ones in Rosetown, that would supply residents within the area more health care, more health services within the two communities rather than having to go to Saskatoon, North Battleford, or Swift Current.

I guess we're looking at the overall situation and the cost that I guess everybody else is looking at, and if that is the only alternative, then that's what we would look at. But it would still provide or not provide the services that would be required with say within the Kindersley area or west of Kindersley and then the regions on the western part of Kindersley. If they had to travel for some to Rosetown, it would not be the ideal situation but it would be better than losing all of the facilities.

So this is where we come up with the concept of looking at a sharing or amalgamation of services.

Mr. Thomson: — But that same model could be applied if you were enhancing services. That you could possibly share . . . for instance Moose Jaw and Swift Current share a CT scanner currently. That kind of a model could be employed within the region. Am I correct to understand that that's part of what you're advancing also?

Mr. Woloshyn: — Are you comparing us to Regina and Moose Jaw as an example?

Mr. Thomson: — I'm saying Moose Jaw and Swift Current . . . basic point clear enough, that what happens is there's a mobile CT scanner that's shared by the two communities — Moose Jaw and Swift Current. This is one of the cases where rather than having to designate one centre to have the CT scanner; you're able to share it between two facilities and two different communities. I was wondering if that was the kind of approach that you were thinking about in terms of shared enhanced services?

Mr. Campbell: — Yes that would be more or less what we had in mind. If that will work for them, perhaps the sharing of even a mobile service there that . . . well some have suggested an MRI. That might be a little ambitious, but certainly some of the Telehealth facilities could be that way.

The difficulty in trying to deal with that and answer a question like that is what appears to be a lack of standards set up so that we would ensure that the same type of services were going to be offered in each community across the province. At the moment, the report indicates that these would be determined by local boards and whether those local boards have the same vision or whether they haven't is anybody's guess right at this particular time. And we feel that those would be things that would have to be put in place before you could reasonably and sensibly discuss the merits of some parts of the recommendations that Mr. Fyke puts forward.

Mr. Thomson: — One of the concerns that's been expressed about the Fyke report is that it outlines a proposal which is really a cookie cutter approach; that it puts the compass down, draws a circle, and says everybody within that district has this exact same set of services as the next. And yet, we've heard from communities — for instance, we've heard from Tisdale and Melfort, and I guess also Nipawin — who share services among their facilities where they're able to; I think it's in Tisdale offers dialysis — am I correct? — on behalf of that area.

The difficulty with going with the cookie cutter is it very much puts into competition the Kindersleys and the Rosetowns, rather than a more collaborative approach, I think, that we're seeing in Melfort and Tisdale.

I'd be interested in knowing whether we would be better off

taking that approach on a case-by-case basis: where we take a look at the strength of the local communities and build the services around them, or should we do very much as Mr. Fyke is proposing and pick a compass point and draw the circles.

Mr. Woloshyn: — I would believe that we should look at it in realistic form. If you've want to pinpoint it and put your thumb down and say here's the centre, here's what it encircles, you're not basically looking at the realistic concept. I think using that as a guideline is probably all right. Nothing is carved is stone. Why can it not be moved in whatever direction required or enlarged, or does it have to be an actual circle?

I think the concern is here to provide the health care that's required in the area. We're all taxpayers. We all pay the same personal income tax. We all pay the same PST. We all pay the same GST. We should all be entitled to the same health service regardless of what part of the province we are in.

Mr. Thomson: — The only other question I have is just more for the record. In terms of the trade patterns and the flow between the communities, there's much more of an east-west connection than a north-south. You would look at much closer co-operation between, say, Kindersley and Rosetown, perhaps going up in to that Kerrobert area than you would, say, go further north or further south.

Is that generally accurate? You wouldn't consider Battleford your nearest regional centre or Swift Current, would you?

Mr. Campbell: — Yes. In doing some thinking on this — in constructing the paper that we have presented tonight — that was a point that was very much in our mind. Earlier tonight you heard from the west central group, which we are kind of a part of and certainly near the centre of. But if you think in terms of the eastern part of that, over in the Outlook area — west central group that I'm talking about, our area — Outlook lies over near the east side. It is close enough to the city of Saskatoon that it is logical to assume that rather than drive someplace to the west or way down to the south or to the north that they would prefer to get their services from the city of Saskatoon.

The same thing is . . . same thing is true if you think about the North Battleford and the communities west of there that are served by the city of North Battleford. Down in the southern part of our west central region, Swift Current serves those communities.

So that kind of leaves in the middle, this Kindersley/Rosetown area, and we felt that it is necessary to have some type of enhanced service in that area. And if it had to be shared in order to get it and make it work, so be it. If it has to be just one, then the argument presented in here applies.

Mr. Thomson: — I just want to conclude by saying one of the other things that we've certainly heard from communities is that they believe — many of them believe — that there is a category missing out of Mr. Fyke's report. And it's that group on that line between what he calls the community care centre and the regional health care centres. And we've heard that from many communities — I think in large part we're hearing that tonight from you as well — that there is a need for those larger communities to maintain the diagnostics, to maintain the lab services, to maintain obviously 24-hour care.

I'm a little distressed to read some of the newspaper clippings from the *Clarion* over the last little bit talking about Kindersley going down to an 8- to 12-hour centre. Obviously that's not going to happen. But I think that, you know that message has certainly been delivered by other communities that there are another level of community in there.

Mr. Campbell: — I would agree with you that throughout the report there are definitions that need to be given of some of the concepts presented there.

It becomes difficult to determine exactly what should be put there because you don't know exactly what the needs are. And you can't determine what those needs are until you have some idea of where the facilities are going to be located that provide for the needs in that area. And they are different. West central area lies between northwest and southwest, and all three are different.

The same is true across the southern part of the province. The oil patch in the Estevan-Weyburn area has different needs to what the ranching country does in the southwest part. So depending on how you look at it there and try to determine what the needs are, you have to have some fairly accurate way to measure it. And at the moment that doesn't seem to exist.

The Chair: — Do I dare say thank you now? On behalf of the committee then, thank you very much for taking your time to come here with your communities and present your views to us. Thank you again.

I'll entertain a motion to adjourn. Mr. Belanger. The committee's adjourned till 9 a.m. tomorrow morning.

The committee adjourned at 22:47.