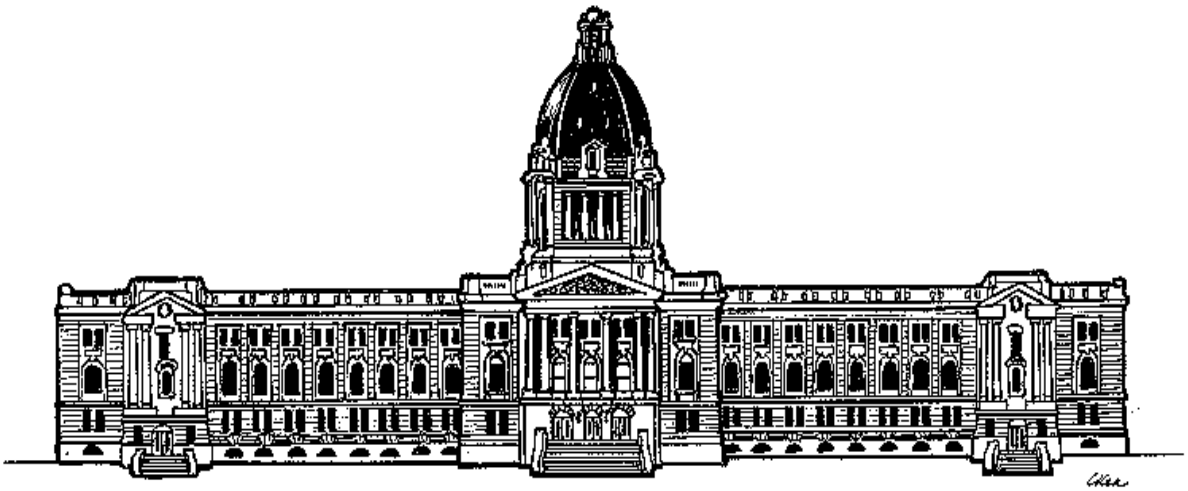
Standing Committee on Health Care

Hansard Verbatim Report

No. 12– July 25, 2001



Legislative Assembly of Saskatchewan

Twenty-fourth Legislature

STANDING COMMITTEE ON HEALTH CARE
2001

Judy Junor, Chair
Saskatoon Eastview

Hon. Jim Melenchuk, Vice-Chair
Saskatoon Northwest

Brenda Bakken
Weyburn-Big Muddy

Hon. Buckley Belanger
Athabasca

Bill Boyd
Kindersley

Rod Gantefoer
Melfort-Tisdale

Warren McCall
Regina Elphinstone

Andrew Thomson
Regina South

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

The committee met at 09:02.

The Chair: — Good morning, and welcome to the Standing Committee on Health Care. It's a legislative committee and it has been charged with receiving responses to the Fyke Commission or the Commission on Medicare. And we will report back what we've heard to the Legislative Assembly by August 30. This committee won't be making recommendations. It will be just submitting back what we've heard.

And we've given half an hour to presenters. Hopefully during that time you'll have your presentation and then we'll have some time for questions.

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

We have your submission, so give us your name and who you represent and then you can begin your presentation.

Mr. Dufresne: — Okay. First of all, good morning, Madam Chair, and hon. members. We certainly appreciate the opportunity to be here and present our views on the Fyke report this morning.

My name is Ron Dufresne. I'm the president of the Saskatchewan Emergency Medical Services Association — better known as SEMSA, and also takes a lot less breath to get that out — as well as the president and general manager of Moose Jaw and District EMS (emergency medical services) in the Moose Jaw-Thunder Creek Health District.

To my right is Mr. Gerry Schriemer. He's the operations manager for M D Ambulance in Saskatoon, as well as the vice-president of SEMSA.

To my left is Mr. Larry Kendel. He is a district health board member in the Twin Rivers Health District and our secretary treasurer of SEMSA.

So we're all delighted to be here this morning. Thank you.

What we've done this morning is we've taken the liberty of providing you two copies . . . or two different, I guess, written reports, the first being the one that we'll present this morning. It looks like a PowerPoint presentation. The second being our response to the EMS development project which was commissioned by Saskatchewan Health last year and completed last fall by Dr. Jim Cross and Mr. Rick Keller.

Mr. Fyke pulled out a few specifics out of the EMS development project so we'll speak to those today. But additionally we thought it would be beneficial to provide the entire response to the EMS development project for your review.

So this morning we would like to . . . We have a short presentation. We'd like to spend a little bit of time I guess doing a couple of things. One is to provide some information education to you on SEMSA, what EMS is about, and as well provide our views on some key issues.

The vision of SEMSA is to provide leadership in EMS through accreditation and standards of excellence. Our mission is to provide guidance, support, and a common voice on behalf of EMS members in Saskatchewan.

Our SEMSA membership consists presently of 90 services out of 112 in the province. Membership consists of 50 per cent public operated . . . owned and operated services, as well as 50 per cent contracted services. So we have a nice mix within the province and on our board of directors.

SEMSA is representative of 95 per cent of the total call volume performed in Saskatchewan. So when we look at membership of number of services, we run 80 per cent, but when we look at the total call volume performed, we represent 95 per cent — over 95 per cent of total calls.

Currently in Saskatchewan we have 112 ambulance services; 14 of those services operate what we call a 24/7 operation, which only means that those services operate with staff at a station 24 hours a day, seven days a week.

However, it's important to point out that out of the remaining services, all services do provide responses 24 hours, seven days a week. Albeit that those staff in some of those services are not on task at a station somewhere. They could be on call from home, so they could be woken up in the middle of the night, that sort of thing. But it's clear to . . . it's important to notify everyone, or to clarify with everyone that all services do operate in the province 24/7.

Services in Saskatchewan respond to over 76,000 calls a year, and again we must indicate that our system presently in Saskatchewan is not broken. That has been somewhat of a view out there. It's not. We don't believe it is. We do agree that it needs a little bit of a push, some resources, perhaps some proper alignment, but it's certainly not broken. The job is getting done.

The citizens of Saskatchewan can count on the emergency services in place, whether it's a full-time service or not. They are being serviced to the best of the service's ability with the resources available. And we do congratulate the services within our province for providing the service they do within existing resources.

Centralized dispatch is one of the key areas that Mr. Fyke pulled out of the EMS development project. This is kind of a tender subject, I guess.

We believe, SEMSA's position is that we should support the existing dispatch centres. Ninety-three per cent of all calls in Saskatchewan are being dispatched by a wide area or professional dispatch centre at present. The remaining 7 per cent can be absorbed quite easily.

It makes more sense to support the existing infrastructure and the existing staff and locations rather than shift 93 per cent or rather 100 per cent all into a new centre with new procedures.

We believe that regional rather than one central dispatch centre

is the best idea for our province. It will keep people employed on a regional basis rather than going to one central location.

Regional rather than central is becoming the best practice on a national basis as well. And there's evidence out there in Canada already, where they have looked at centralized dispatch, have actually done it, and are backing that off now.

The opportunity for communication enhancements regarding regional services or some type of Telehealth on a regionalized basis would provide better support to specific regions or health districts, whatever they may look like in the end.

It would also provide redundancy for calls should something happen to one specific dispatch centre. This redundancy would also be provided within our borders. We wouldn't have to look outside Saskatchewan to provide this service.

Much of the infrastructure is in place and significant investment has been made by the individual dispatch centres in the province, as well as a significant number of staff are employed in the various places.

The guidelines for dispatch centres in the province have already been jointly developed between the existing dispatch centres and Saskatchewan Health. So that document is already out there. They are just guidelines at this point however.

Next we'd like to take you through the training levels and some of the names, I guess, or the definitions of the training that we have in emergency medical services. The first would be EMD, which is emergency medical dispatcher. They're the people that our citizens talk to in time of emergency. Those are the people that dispatch the ambulances and provide pre-arrival instructions to people and help over the phone.

Then we have EMR, which is emergency medical responder. Primarily these people operate in the smaller rural locations and they have first aid and CPR (cardiopulmonary resuscitation) training and primarily function as an emergency vehicle operator but as well as attend to patients.

Next is first responder. First responders are very, very important and an integral part in the delivery of EMS in rural Saskatchewan. And that is a 40-hour-training program.

Next we have the EMT, emergency medical technician, which is approximately a 500-hour-training program as well as street experience with an experienced individual for a practicum.

Next is the EMTA, which is the emergency medical technician advanced. Access to this program generally looks . . . or generally consists of two years as an EMT in the field with experience and then an additional 600 hours of training.

Next is the EMTP, which is the emergency medical technician paramedic, which is an additional 13 months of training.

Then there's the critical care provider, which primarily has been piloted in Saskatoon and is used primarily for emergency air ambulance through Saskatchewan air ambulance program.

We believe that staffing level . . . In response to the staffing levels of personnel in Saskatchewan, we believe that we should promote and support the role of the first responders in rural Saskatchewan. Currently there's 98.05 per cent of all calls responded to with at least one EMT minimum basic on every call. So we don't have a big gap to go to close that up to a minimum basic.

The goal is to have one EMT basic on every call in the immediate future. We believe that we should increase the minimum standard to the EMT advanced level over four years. In order to do that, we believe that the programs delivered . . . the program should be delivered on a local or regionalized basis to provide access to the existing EMTs or people practitioners in those areas so that they can actually get the program completed without relocating for a specific period of time to come to the major urban centre.

By enhancing the level of training to the EMT level over time in the rural areas, we believe that it will definitely result in increased . . . in enhanced patient care in rural Saskatchewan.

We'd like to take you through just the anatomy of a call just for clarification more than anything. First of all there's the event or incident. Early recognition is paramount in this case. We believe that we can play a very, very important role in the education, safety prevention aspect within the province. And we'll speak a little bit more to that when we get to the integration stage.

Early identification of an emergency is someone who activates the EMS system and makes the telephone call.

Then you have the response of the emergency medical dispatcher who screens the call appropriately and forwards the appropriate resources. The EMD, emergency medical dispatcher, also delivers pre-arrival instructions to the caller. So essentially there is . . . care is initiated at the time of the call because the emergency medical dispatcher provides telephone support and telephone advice as to what to do in the case of the emergency. They do stay on the phone with the caller if required.

First responders are then activated, specifically in rural areas, which again reduces the time or shortens the time to when somebody arrives. The first responders in a rural area, if we can get them there as early as possible, there is somebody there who takes control of the scene and provides initial stabilization and initial treatment.

EMS then arrives and brings the necessary medical equipment to the patient's side. We assess and treat the patient at scene, so the time of treatment doesn't begin when the patient hits the emergency room. The time of treatment actually begins when the call is received by the dispatcher and then the continuum of care continues through the process.

Through all this with the information gathered by the dispatcher, the first responder and then the EMS providers when they arrive on scene in an ambulance can really absorb a lot of information about mechanism of injury, lifestyle situation that the person was in. So when we talk about gathering data for wellness or the future of health, we really have access to a lot of information right out there in the field.

After the patient is assessed and treated on scene, then of course the patient is transported to the most appropriate location. The patient is then received by the emergency department staff, report is given from the EMS operation, from the EMS operators to the emergency room staff and physicians, and of course the continuum of care continues on.

Next is our integration strategy. We do believe that there is opportunity for integration of EMS providers into health, you know, in a greater way. Integration should ensure quicker access 24 hours a day and of course add value to our clients and patients.

We believe that we have an excellent opportunity with the knowledge that we have of our communities and the knowledge that we have of specific scenes and histories to promote health, wellness, safety, and emergency service activation, but also additional educational programs out in our communities.

We talk a lot about whether an individual working EMS can do a job and be able to drop it and carry on. Education and prevention, safety prevention is an excellent opportunity to do that.

We can utilize EMS personnel in value-added roles to augment existing services, not replace other positions. And probably the most important, we really need to be a part of the primary care team.

Next is ambulance fees. Ambulance fees must not impede access to services but must also determine its use. They should not be based on distance, so the rural residents should not be penalized for living in rural settings. They should be standardized throughout the province and inter-facility transfers should be in insured services.

In the area of response times, our response times provincially are very, very, very close to the recommendations in the EMS development project. And if you look at the response times on a provincial basis, we're probably there. What we're recommending is we look at response times on a city basis and a regionalized basis, but even in the cities, on a sectoral basis.

The idea there is if you lived on the outskirts of the city of Saskatoon you may be outside that 8 minute, 59 seconds on a regular basis. But yet if you look at the total average time, the city would look fine. We feel that citizens everywhere deserve the same type of service.

We believe that urban emergency ambulance calls in the 10 major cities be responded to within 8 minutes, 59 seconds 90 per cent of the time on a response sector basis, and rural emergency ambulance calls be 30 minutes 90 per cent of the time on a response region basis. Hence again a little bit of a push for our regionalized dispatch and regionalized approach to EMS.

A little bit on the ambulance fleet we thought we'd glean out of the EMS development project to talk to you about today. We believe that the front-line ambulance replacement should be 300,000 kilometres or five years; non-front-line ambulance replacement not to exceed 300,000 or 10 years.

Diesel transfer units can be maintained up to 500,000 kilometres or 10 years, and a strict progressive maintenance program for all emergency vehicles in Saskatchewan. We do not believe that we can eliminate 100 ambulances out of the Saskatchewan ambulance system.

We would like to see the establishment of a provincial ambulance advisory committee. This committee would be established to effectively deal with changes in policy, establish standards, and develop strategies to effect positive change in the current EMS system.

We would also like to be a part of the quality council as a member of the primary care team.

In conclusion, we believe that recent progress in EMS has been very, very positive in Saskatchewan. The levels of training and quality of care is continuously increasing even within the existing resources that we have available.

The opportunities for public education and prevention and safety are absolutely endless because we do have the mobility and the knowledge and the experience in our court. EMS is often the point of entry to the health system so we can glean out a lot of information from where we go, places we go, a lot of health indicators are available to us.

EMS can offer invaluable information to other health partners regarding these lifestyles and indicators that we see in the street. We believe that we should support the existing system, but demand quality and measurable results. To include appropriate partners in the health care decision-making and planning processes; SEMSA needs to be involved with any changes that would occur to the EMS system in the province and we feel we can contribute positively to that.

Enhancing EMS in Saskatchewan can provide the safety and security our citizens need and deserve, as identified by Mr. Fyke. Appropriate enhancements to EMS specifically in rural areas must be completed prior to changes in patient flows. We do really believe that if there's changes to patient flows, hospital changes, without a proper EMS system, infrastructure, it could have devastating effects specifically to our rural residents.

We are, and will continue to do the best we can within the resources we have. And we will adapt to the changes ahead but we believe that it must be an inclusionary process, and we would love to be a part of that. Thank you.

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

Mr. Gantefoer: — Thank you very much, Madam Chair. And thank you very much for your presentation, and I'm pleased to have another copy of a response to the EMS report.

On your anatomy of a call description, I wondered — and you didn't mention it specifically — but I wondered how the 911 system interfaces with your dispatch system. I assume in your anatomy of a call that the call comes into 911, and how is the relationship between the 911 system and your EMS dispatch system — how does that interface?

Mr. Dufresne: — Essentially the 911 PSAP (public service answering points) is a call-taking centre, call-sorting centre, so essentially a person dials 911; they sort the call whether it's police, fire, or ambulance, in the appropriate location or region; and the call is essentially transferred to the appropriate emergency medical dispatch centre.

Dispatch centre actually does the call interrogation as for resources required, patient condition, that sort of thing. So the 911 PSAPs are strictly a call-taking, sorting station.

Mr. Gantefoer: — Okay. So then the personnel who actually then do the online counselling, the online advice, once it's determined it's a medical emergency, are your EMS people rather than the 911 people per se. And in the instance of fire or police, the same thing applies. It's a routing service more than an actual dispatch. It sort of moves away from the image people have of 911 on television, if you like, where the call comes in and everything is done by that same operator, at least that's the impression that is given to people.

Currently — and I appreciate in your presentation you indicate that there are some enhancements that could be made to the regional dispatch system — one of the arguments for a more centralized dispatch, maybe it's greater efficiency and fewer personnel in order to operate it. Is there a relationship between the number of calls that are handled and the number of personnel you need?

What I'm getting at, if every one of the 76,000 calls or whatever that are tendered in the province come to one centre, you would need so many people. If they go to five regional centres, would you still need essentially the same number of people? Is there a cost efficiency by having one centralized dispatch system?

Mr. Dufresne: — In relation to the EMS Development Project Report, it does indicate that there would be some efficiencies. The only problem, the report was very, very silent on the existing cost of the existing system. So there may be some efficiencies as far as the number of staff go, but we don't believe that they would be that great.

And we also believe that there are, I guess, greater values in keeping the regionalized approach versus centralized, because in addition they are . . . The national best practice is to move away from centralized dispatch because it is too big of an animal to manage.

Mr. Gantefoer: — Is there an advantage in the regional approach to having operators that may have increased familiarity with the geography and with the territory and so there is less likelihood of dispatch errors, I guess, for lack of a better word, number one?

And number two, is there going to be the GPS (Global Positioning System) mapping systems available in the near future that will also help identify physical locations and things of that nature to minimize dispatch errors?

Mr. Dufresne: — Certainly there's two, I guess, trains of thought on the local version. Everybody believes or a lot of people believe that if you have the technology you can dispatch for anyone anywhere, and I guess that is a theory.

We do believe that the local familiarity is very important and it has worked for us. So of course, why change something that's working?

In addition to that, the GPS AVL, automated vehicle locaters . . . that technology is out there and in use in many services. So that is out there right now.

Mr. Gantefoer: — How far are we away from the actual mapping of locations so that in essence when the call comes to the dispatch centre, that that call can be identified with GPS coordinates I guess that would show up and so that you would be able to know physically where the call is originating from, at least from the telephone location it's originating from? And would that be a useful addition to the system?

Mr. Schriemer: — I believe right now in Saskatoon, NRIT (new revolution in information technologies) people are looking at and working with Sask mapping on that. So we have that in place in Saskatoon and we would like to extend it rurally. But it's a matter of resources and time for our IT (information technology) people to work on the AVL in the rural mapping and working with Sask mapping on getting that down to a science.

Mr. Gantefoer: — And one final quick question. On your training levels, your critical care provider, you indicated were a special designation used largely for air ambulance. You went through the enhancements as you went through the EMT program. Is the critical care provider a further enhancement or is it a separate training model?

Mr. Schriemer: — Actually it is a further enhancement. So you'll take your emergency medical technician paramedic and we're asking that they have anywhere from three- to five-years street experience before they go into the program. And it ran this year as a pilot project, and it was approximately four months of twice a week classes.

And it is strictly limited to air ambulance right now just basically because of the enhanced protocols they have. And those protocols haven't been changed by the regional medical advisers' committee or Saskatchewan Medical Association to allow us to use them on the street. So it's more invasive therapy, more drug monitoring, things of that nature. But we need protocol changes to allow us to do that on the street.

And our goal is to utilize the critical care paramedics for road inter-facility transfers so we can keep the resources in the hospital, and we know they're pushed to the limits now. So instead of taking a nurse out of ICU (intensive care unit), you use a critical care paramedic who's already on the street anyway and he'll do that inter-facility transfer.

Mr. Yates: — I have a number of questions regarding training of volunteers, and in particular in rural settings. A lot of the small ambulance companies in rural Saskatchewan are staffed by volunteers.

Have you put any thought to having an aggressive program where you believe within four years it should be up to the EMT

advanced level? How would that be possible in volunteer services in rural Saskatchewan? Have you taken the time to think . . .

Mr. Kendel: — I think that to do with some of the SIAST (Saskatchewan Institute of Applied Science and Technology) regulations, to be able to move those people forward, to say if they're an EMR at the moment to bring them up to an EMT is possible. But as it says in here we need to . . . the people who are working as volunteers often don't have the time to get away from the rural area to come into a major centre for training. So the training has to be taken back to the rural areas to make that work.

But there's tremendous potential in farm people to become part-time EMRs or EMTs in the communities. They're available. They often have good backgrounds in the area just from their familiarity of what they do on a daily basis. Like they would make very good EMT practitioners on a part-time basis when needed.

But we need to take the training to the rural area to make that happen. I think that's likely the largest drawback at the moment.

Mr. Yates: — My second question has to do with maintaining skills. Once you have . . . And I should tell you, I worked for RAMRAD (Regina Area Municipal Road Ambulance District)for a number of years so I'm very familiar with the skills required. But it takes a great deal of activity to maintain those skills at a proficient level, and particularly, advanced skills.

Have you thought of some program which would see the rotation of staff perhaps into larger centres to work with greater volumes of calls in order to use those skills on a regular basis in order to keep them up, or some program to maintain those skills? Because if they're not used on a regular basis, it's like anything else, it becomes difficult to keep proficiency up with them.

Mr. Kendel: — I believe part of their, part of their completion of their training is to have to come and do, like, 25 calls within a larger centre to begin with.

And then to do the ongoing training, sometimes they can do a lot with in-service, or they can be used — if they have a good relationship with their local hospital facility — they can often do some of their skills in there. They'll build a rapport with the department to be able to practice some of those skills. And in some cases, they will be called in and allowed to do practices in the department to maintain their skills.

Plus a good in-service program can make a big difference in the area where, like I say, they may included in the Moose Jaw training program or Swift Current or North Battleford or wherever. So they can come in, you know, to a regional area.

Mr. Schriemer: — Also I'd like to add that's, we feel, that's where the integration model comes into place. When you're looking at advancing staffing levels to the EMT or EMTA level and they may be only doing one or two calls on their shift, if we can integrate them into other primary care levels within their district, that enables them to thus use those skills on another basis. So by augmenting the existing staff, whether it's working in emerg, working in long-term care homes, by having patient contact — the patient contact is what they need to keep their skills up.

Mr. Yates: — Thank you.

The Chair: — Further questions?

Ms. Bakken: — Further on what Mr. Yates was questioning about. If you see volunteers being trained and working in the system, most of these volunteers are people that are from their local community. They're providing this service because they see it as a need. They're not interested in a job. So once we move to further training and they become paid employees, what is the cost going to be to the system? And are we going to be able to maintain those people in rural Saskatchewan as a paid employee? I just don't . . . I don't understand how this is going to work. These people are doing . . . are not . . . are doing this as a service not as a lifestyle and as a job.

Mr. Schriemer: — I think what you see a lot of times in rural Saskatchewan — and we have this with some of the rural services we're affiliated with — is that yes, people volunteer because that's all they want to do is they want to volunteer. You get some services and some people want to do it full time. Now I think when you're looking at recruitment, right now everybody pays for their own training. Okay when I went to paramedic school, I paid for my own tuition, I paid for my own living expenses in Regina, all that. And that's still done at this time.

Now if you're going to recruit people to work in rural Saskatchewan, the big thing is to recruit people who have a stake in that community. There's nothing worse than trying to take someone who's taken the training, move them to the rural area — they're not going to stay because they want to go to the big centre. They want to go back to Saskatoon or Regina if that's where they came from.

So I think a lot of it is in the recruitment and retention strategies that get put into place to ensure that the people you're training in the rural areas have roots there, and that's where they want to belong. And I don't think then you'll have a big cost turnover of constantly retraining people because they're leaving to go work in the major centres.

Ms. Bakken: — Of course we're going to have a cost of providing training and we're going to provide that training. And we're also going to have an ongoing cost to the system if we're going to now start paying these people instead of them being volunteers. So there definitely is going to be an increase in cost to the system.

Mr. Schriemer: — What's really sad right now is when we talk about recruitment and retention . . . and we see good quality paramedics, EMTs leaving EMS, not so much . . . they're not leaving EMS to go, say, to Alberta — some have, they've left to go to Alberta — but they're going to join the police forces. They're going to where they're getting a better wage and they're getting consistent scheduling.

So we have those strategies mapped out and where we need to go to retain our staff. But you know if you talk to Regina EMS today, they have full-time paramedic positions they can't fill. And the problem is, is people are comparing the wages for similar-like jobs — whether it's firefighting, policing, or EMS — and they're saying why am I going to put up with the hassles of EMS if I can go to policing or fire and get recognized for my work there and be paid appropriately. So that's the retention strategy that has to be worked on quite closely. So we can avoid the cost overruns of retraining people to fill vacancies when people leave to go to other emergency services.

Ms. Bakken: — I hear what you're saying. I guess what I'm . . . the problem here is that we're talking about volunteers and we're talking about paid employees. And what we have now in rural Saskatchewan are many people that are volunteers and do this. The same as we used to have with health boards; where people by and large did it as volunteers and we had an efficient system and people did it because they believed in what they were doing. We had the same thing in rural Saskatchewan with volunteers.

And now the proposal is to move away from that and have everyone paid to provide the service. So I guess . . .

Mr. Dufresne: — It's important to note that there's several services out there, the volunteer services that actually have people trained at the EMT and EMTA level in some of the rural communities. So to just say just because there's going to be an increase in training level and now we have to pay them, I don't think that's necessarily the case.

We believe in the regionalized basis, and those decisions for the type of service required in those specific geographies need to be, I guess, mapped out by those districts and by those communities. So in fact you can have a small rural service doing not a great call volume but still have people volunteer, but maybe provide the training. So you can have people trained to the EMT basic, EMTA level; they could still be in a volunteer capacity and still be trained at that level depending on what that specific community, that specific district requires based on call volume needs.

Ms. Bakken: — That's a good point. That's something we should remember that just because they have further training doesn't mean they have to be paid.

Mr. Kendel: — I believe that there's lots of health board members who do it because they want to, not because they're paid for it first of all. And secondly, I think that we have a volunteer fire service where you're a volunteer, but you're paid when you go out on the call. And I think that . . . there's some first responders who are dispatched through a fire service in fact even get $1,000 tax deduction because they're a volunteer in the fire service; where if you're a first responder, you may not get that tax deduction at the present time unless you're under that service.

So to say that somebody is a volunteer, like they're often volunteers but they're paid when they go on the call. And that's more common than not throughout the province. And the same with your search . . . your rescue squads within the district. They appear to be . . . they're a volunteer service, but they also bill SGI (Saskatchewan Government Insurance) when they go out on a call and they're paid for their call-out, but they're a volunteer service in the meantime.

The Chair: — Any further questions? Seeing none, then thank you very much for your presentation and for your written submissions that you've given us. Thanks.

Our next presenters can have a chair at the table. Good morning, and welcome to the Standing Committee on Health Care. This is an all-party committee of the Legislative Assembly and its first task from the Assembly was to hear and receive responses to the Fyke Commission, or the Commission on Medicare.

The committee won't be giving recommendations to the Legislative Assembly. We'll be responding with what we've heard from our presenters in hearings like this.

The committee, as I said, is an all-party committee. I'm Judy Junor, the Chair. Dr. Melenchuk, at the back here, is the Vice-Chair. Andrew Thomson, Kevin Yates, Deb Higgins, Brenda Bakken, Bill Boyd, and Rod Gantefoer are here with us this morning.

We have given presenters half an hour, and hopefully, we have time, in that half an hour, to ask a few questions. The committee members usually have some questions.

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

Ms. Anderson: — Thank you, Chairperson Junor. Good morning, members of the committee.

The North-East Health District certainly appreciates and welcomes the opportunity to make this presentation to you, the Standing Committee on Health Care.

We will begin with introductions. I am Margaret Anderson, chairperson of the North-East Health District.

Mr. Will: — I'm Andrew Will, the chief executive officer of the North-East Health District.

Mr. Nakonechny: — I'm Leonard Nakonechny, board member.

Mr. Karras: — And I'm Bruce Karras, a board member for the North-East Health District.

Ms. Anderson: — The purpose of our brief is to summarize the observations, the comments, and recommendations from the North-East Health District regarding the report submitted by Mr. Ken Fyke.

I will be presenting our brief this morning and then Andrew is prepared to discuss the possible impact of Mr. Fyke's recommendations on the North-East Health District.

I would like to mention that our board and management staff hosted an information meeting with the surrounding municipal councils and community leaders to discuss the serious

implications of the Fyke report. The brief that I am about to present to you was discussed at that meeting and we were encouraged to come and share these views with you today.

Following this report, Bruce and Leonard then will read several letters from the representative communities, and then, finally, I will make some concluding remarks and then we are willing to answer any questions.

The North-East Health District has prepared this submission to communicate our views about the final report of the Commission on Medicare. We are pleased to have the opportunity to submit our opinions to the Standing Committee on Health Care.

The North-East Health District recognizes that the recommendations in the Fyke report will have a major impact on the delivery of health services. We have considered specifically the impact of these recommendations for the delivery of health services in our district, the North-East Health District of Saskatchewan, and have prepared this submission to express our prime areas of concern, as well our areas of support.

The Fyke report, in our opinion, goes too far in the consideration of hospital closures in rural Saskatchewan. The recommended travel time of 60 to 80 minutes is simply unacceptable because it is unsafe. Access to emergency room services and 24-hour diagnostics within a reasonable time is critical particularly to all residents . . . the older residents of our area.

Mr. Fyke suggests that the hospitals would service a population of 30,000 to 50,000 people. This standard is too high for rural Saskatchewan. The proposed 10 to 14 regional hospitals are too few because of travel time to in-hospital emergency services.

The recommendation made in the Fyke report would result in the closure or conversion of hospitals that have indeed an adequate service volume to maintain effective services. These hospitals should continue to provide acute care services. Closing or converting hospitals that deliver efficient service volumes will only transfer costs.

The cost savings associated with the conversion of the hospitals we feel will not solve the problem of cost control. We need to examine the major contributors of expenditure growth such as drugs, such as specialty services, and other technological costs.

Acute care should continue to be provided in communities with adequate physician resources. Our ability to deliver acute care service is critical to meet patient needs and to sustain an adequate physician base.

Access to acute care, emergency, and diagnostic services is important in the recruitment and retention of physicians in rural areas. The recommendation made in the Fyke report would result in the closure or conversion of hospitals that have adequate physician resources. The loss of access to hospital services will affect the recruitment and retention of these physicians in rural Saskatchewan. We feel this is already happening.

Centralization of acute care beds would create human resource challenges. The acute care beds may be realigned to regional hospitals, but moving the staff that will be needed will be much more difficult. Many of the health professionals currently in the system have ties to the community they serve. They simply can't pick up and move.

Staff who are mobile have other options to consider, indeed including moving outside of Saskatchewan. Ladies and gentlemen of the committee, can we afford to lose more of our health professionals from Saskatchewan?

We are concerned that fewer acute care beds in rural Saskatchewan will result in added pressures to the tertiary centres, further decreasing access to acute and tertiary care. Tertiary centres currently depend on rural hospitals to accept transfers of acute care patients following the provision of the tertiary care. We must ensure that rural districts continue to have the capacity to provide both transfer follow-up and other acute care services.

Primary care services need to be in place prior to change in small rural hospitals.

We support team-based delivery of primary health services. We believe significant progress has been made, especially in smaller districts, towards a team-based approach to care. Physicians currently do participate as important members of care teams in rural Saskatchewan.

We support the establishment of the 24-hour health help line to enhance care options.

We agree that emergency services need to be improved and standardized. Emergency services are very inconsistent throughout the province. The current funding model needs to be improved to create incentives for operators to employ staff with enhanced training. I think those sort of things were just discussed here this morning. We strongly agree with the recommendation that ambulance fees should not be based on distance.

We agree that a provincial strategy for human resource planning is critical. It is important to maximize the scope of practice of health professionals. However at present we are concerned that the continued threat of restructuring is seriously affecting the stability and the morale of our workforce.

We support the emphasis on quality and agree that we need to continue to emphasize a quality approach to the delivery of health services. We support the continued development of performance indicators to measure this quality.

We need to invest further in information technology and our capacity to use information to make decisions. We support further implementation of SHIN (Saskatchewan Health Information Network), and the development of a portable, electronic health record.

A strategic plan needs to be developed to guide the development and maintenance of the health services in the North. We can't emphasize this need strongly enough. Northern services need attention first. It seems that acknowledgment is given to the need to improve services to the North but the

recommendations, we feel, simply fall short of action.

District structure should be determined after decisions regarding service delivery have been made. The number of health districts is not the real issue in Saskatchewan. Reducing the number of districts, we feel, will save very little, if any, in management costs.

We are also concerned that larger districts will result in a loss of community participation in decision making. It has taken eight years, ladies and gentlemen, to develop a sense of community at the district level and wouldn't it be unfortunate to seriously disrupt or upset the progress at this point.

We agree that there is a critical need to clarify the roles and responsibilities of health districts and Saskatchewan Health. Roles and responsibilities are a far larger issue than district size.

Intersectoral partnerships are most effective, we feel, at the local level with active involvement of individuals who have the authority to commit financial and human resources. Districts are now able to develop these intersectoral partnerships to meet community needs.

This concludes Part I of our formal brief. I'll now ask Andrew to deliver Part II.

Mr. Will: — Good morning. In order to put the recommendations into perspective, I'll present some information specific to the North-East Health District on two main issues, implementation of the primary care model and the closure of rural or conversion of rural hospitals.

Significant progress has been made towards a team-based approach to primary care. In discussions with staff and physicians in the North-East Health District, the message came through very clearly that we do operate in a team approach to primary care. The North-East Health District believes that investments into comprehensive and fully integrated primary health services should continue.

It is unclear in the Fyke report whether diagnostic services would be available outside of regional hospitals. We believe that diagnostic services are essential to primary health teams at the community level. Currently in the North-East Health District, basic diagnostic services are provided in Carrot River, Smeaton, and Arborfield health centres supported by more comprehensive diagnostic services in Nipawin Hospital.

The North-East Health District was successful in obtaining funding for a three-year primary care project. This project funds an advanced clinical nurse who facilitates primary health care in communities of Arborfield, Carrot River, and Zenon Park. This project has been very successful, and we are in discussions with the Department of Health regarding expansion of the program to meet client need.

Intersectoral partnerships are an important component to the delivery of primary care. The North-East Health District has been very successful in developing partnerships at the community level to address the health needs of the communities we serve. We believe that these intersectoral partnerships are most effective at the local level. An integrated services committee has been established which has resulted in programming to meet community need.

The North-East Health District has partnered with local organizations including the Nipawin School Division, Social Services, the Métis local, First Nations, Justice, and community groups. Some examples of programs developed through these partnerships include a preschool program for children at risk, a diabetes care program, a youth counsellor, an outreach program, a youth group, nutrition for kids, a homelessness project, an assisted living project, and we're currently working on implementation of the Kids First program and integration of health services at Cumberland House.

The North-East Health District believes that comprehensive and fully integrated primary health services should be the main focus in planning and delivery of health care in Saskatchewan. Decisions about where acute care facilities are viable should be separate and apart from the development of primary health care initiatives.

It is the position of the North-East Health District that the Fyke commission goes too far in the consideration of rural hospital closures. The Fyke report recommends a network of 10 to 14 regional hospitals to provide basic acute care and emergency services. The report recommends that regional hospitals should serve 10 to 14 communities with a minimum of three to five physicians serving a population of 30,000 to 50,000 people. He suggests that there be a maximum 60-minute travel time for 88 per cent of the population and 80-minute travel time for 98 per cent of the population.

Given these standards, the existence of even the larger rural hospitals is threatened. We're left guessing which hospitals will survive.

Nipawin Hospital, built in 1986, is a modern, well-equipped facility and delivers dietary and other support services to a connected 96-bed long-term care home. The facility was originally built with the capacity of 70 beds and currently is operating 38 acute care beds, with an average daily census of 25. Including respite and long-term care, this census would be 30, and that's an 80 per cent occupancy rate, so it is a fairly busy hospital.

Last year there were 17,600 outpatient visits to the Nipawin Hospital emergency room, which amounts to an average of 48 per day. The Nipawin physicians provide both first and second call coverage to our outpatient department. Also Nipawin Hospital, and we forgot to mention this in our brief, operates a very busy intensive care unit.

There are 12 general practitioners and a radiologist who have privileges at the Nipawin Hospital. Ten practise in Nipawin and two in Carrot River. Both of the Carrot River physicians participate in emergency coverage for the Nipawin Hospital.

The physician also provides satellite clinics in Smeaton, Choiceland, Cumberland House, Red Earth, Shoal Lake, and Arborfield. Recruitment and retention of physicians would be significantly affected if Nipawin Hospital lost acute care status.

The North-East Health District physicians have provided the

district with written and verbal feedback regarding the Fyke recommendations. They are very concerned about the recommendations in the report, and specifically the impact these recommendations may have on the Nipawin Hospital.

General surgery, anesthetics, and radiology services are provided by local physicians. There were 146 in-patient surgeries, and 563 day surgeries provided in the Nipawin Hospital last year.

Our physician resource plan has identified a need to expand to two surgeons and two anesthetists to meet patient needs.

Nipawin Hospital obstetrical services, supplemented with Caesarean section capability, and there were 152 births at the Nipawin Hospital last year.

Services provided at the Nipawin Hospital also include a chemotherapy outreach program, and a Telehealth program.

Nipawin Hospital has a complement of 15 visiting specialists who provide a broad range of specialty services close to home. Cardiology; internal medicine; dermatology; ear, nose, and throat; general surgery; allergy; obstetrics and gynecology; orthopedics; pediatrics; podiatry; respiratory medicine; rheumatology and immunology; urology; and psychiatry, are all provided in the Nipawin Hospital through visiting specialists.

There were approximately 4,200 visits to these specialists in the Nipawin Hospital last year.

Many community services have been incorporated into the facility including home care, physiotherapy, occupational therapy, dietitian services, home care services, and mental health services. The mental health services include an on-staff psychologist and a visiting psychiatrist.

Nipawin Hospital is the only acute care facility in the North-East Health District. It provides services to a population of 16,500 people in an area of 22,700 square kilometres. It is important to emphasize that there are no hospital services within the province either to the north or to the east of the Nipawin Hospital. There are many communities that already travel long distances to receive their services at the Nipawin Hospital. These include Cumberland House Cree Nation, 170 kilometres; Shoal Lake First Nation, 104 kilometres; and Red Earth Cree First Nation, 92 kilometres.

Travel time to the nearest hospital is a better measure than the actual distance. Factors such as weather and road conditions affect travel time. Also the response time of an ambulance and the waiting time in an emergency room needs to be considered.

For example, the average response time from Nipawin to Cumberland House and return with a patient to Nipawin Hospital is 5 hours and 21 minutes. That's average time.

If Nipawin Hospital were to be converted, we would be looking at an additional 60 to 90 minutes travel time. We believe that travel time to an emergency room should be within the golden hour and that additional travel time to a hospital would jeopardize the safety of patients.

Nipawin Hospital works closely with other major centres in managing acute care resources. Even with the current acute care resources in the province, there's a need for hospitals like Nipawin to admit patients following tertiary care.

We can only speculate whether Nipawin Hospital would continue to provide the current level of services, lose services, or be enhanced to provide a larger regional function. We believe that the criteria for decisions around which hospitals will continue to provide acute care are unclear in the Fyke report.

We believe that hospitals like Nipawin, which clearly maintain a viable level of service, are able to attract and retain a good supply of physicians and provide quality services, should continue to operate as an acute care facility. The uncertainty with respect to which services will survive is already having a negative impact on the recruitment and retention of health professionals in the North-East Health District.

In summary, the implementation of comprehensive and fully integrated primary health care services must be the primary focus as we strive to improve the health of Saskatchewan residents. Decisions with respect to acute care infrastructure should be considered separate and apart from the implementation of primary care.

Mr. Karras: — I would like to read to you the letter of support from the town of Carrot River.

> Dear Committee Members:
>
> (The) Town of Nipawin Council fully supports the information presented by the North-East Health District to the Standing Committee on Health Care.
>
> As a growing community, Nipawin holds a population of more than 5,000, with an additional 1,500 persons living within 10 km of the town. Twelve general practitioners have privileges at the Nipawin Hospital, Nipawin, including a GP Surgeon and a GP Anaesthetist. Nipawin has three fully staffed clinics with ten doctors. Carrot River provides an additional two doctors. In order to maintain our current physician base it is crucial acute services are provided.
>
> The service area for both Nipawin and the Nipawin Hospital spans across northeastern Saskatchewan from the Smeaton area through to the Manitoba Border. Distance and safety must be considered.
>
> Agriculture, forestry and tourism are the three primary industries in the area. Current exploration and future diamond mining development in the Fort a la Corne Forest solidifies the importance of full service health care at the Nipawin Hospital.
>
> Thank you for your attention. We look forward to making a full presentation to the commission.
>
> Glen Day
> Mayor, Town of Nipawin

Mr. Nakonechny: — I have a letter here from the town of Carrot River and it's a submission to the Standing Committee on Health Care.

> Dear Committee Members:
>
> The Council of the Town of Carrot River wishes to confirm that it fully endorses the information brief prepared by the North-East Health District and submitted to the Standing Committee on Health Care.
>
> Carrot River has two Physicians working from two fully staffed clinics in our community. There is no longer a hospital here, but laboratory, x-ray and other diagnostic facilities remain intact in the Health Centre now being constructed in Carrot River. The Provincial Government must not alter or remove this infrastructure as a result of this review. Removing these services would most certainly result in immediate departure of our Physicians. Further, our Physicians and community require a hospital nearby for residents requiring acute care services.
>
> Ambulance services require both expansion and improvement in rural Saskatchewan. More ambulance vehicles, and more staff that can reside in base communities are a necessity. Too often, base communities are left without immediate ambulance response services for long periods of time because existing ambulances are engaged in transporting patients to city hospitals 300 kilometres away. Carrot River and district, with its large industrial base and its vast agribusiness, and for many more reasons, deserves the provision of the core essential health services identified in this document.
>
> Thank you for the opportunity to bring these issues to your attention. I cannot emphasize enough the importance of the above issues to Carrot River, the North-East Health District, and rural Saskatchewan. I trust that these comments will receive your most favourable consideration.

And this is sincerely, Jim Doherty, mayor, town of Carrot River.

I also have a letter here from the resort village of Tobin Lake. I will not read it entirely but I'll read the last paragraph:

> The commitment of the North-East health district to provide quality health services to the residents of the northeast is vital to the economic growth of this area. It seems to me that the Fyke report writes off rural Saskatchewan too easily and it is time eyes are opened to see exactly where this province can grow. Thank you.

And this is submitted by Robert J. Taylor, mayor, resort village of Tobin Lake.

Ms. Anderson: — Thank you. This concludes the brief that we wish to submit this morning. The North-East Health District is committed to providing quality health services to the residents of our district.

It is essential that the Government of Saskatchewan have a plan for the delivery of health services. In consideration of this plan, we request that appropriate services be maintained.

In some cases the Fyke report recommends taking too much away from rural Saskatchewan, and this may result in increased pressures on the urban services.

We believe that health districts, the Government of Saskatchewan, and indeed the Government of Canada, need to work together to ensure a quality, efficient health care system. The roles and responsibilities of health districts need to be clarified in order to allow for effective planning.

We must identify the major contributors of expenditure growths and develop a plan to provide the services that are needed.

Closing or converting efficient rural hospitals will not solve the problem. The North-East Health District board concludes that without concrete plans and commitments, health services could well be decimated in rural Saskatchewan.

If this were to occur, the health status of Saskatchewan people would certainly be affected. And, ladies and gentlemen of this committee, we firmly believe that if health care is affected, it will not be in the positive direction that the commission had hoped for.

Thank you, and we are open to questions.

Hon. Mr. Melenchuk: — Thank you, Madam Chair. Just a few questions, and thank you for your presentation. And I want to comment on the clarity of the presentation in terms of itemizing your concerns with the Fyke recommendations.

On page 1 of your brief, you key in on a very important point. Acute care should continue to be provided in communities with adequate physician resources. But I think there's a little bit of . . . It's unclear to me what would you think as adequate physician resources — a stable practising group, a stable single practitioner? What is adequate physician resources?

Mr. Will: — Well I'm not sure that we're the best people to make a judgment on that. But I do know that it seems that on-call is a major issue with physicians and it seems like physicians tend to work better in groups of three to five on call. And I know that is the standard that was mentioned in the Fyke report.

But I think if you were to look at the number of hospitals, 10 to 14 that he suggests, that it would be quite a few more hospitals in the province that would meet that minimum requirement as far as a physician base. And for example, Nipawin Hospital operates with 12 physicians who provide both first and second call coverage to Nipawin Hospital.

Given the standards in the report, it leaves us with questions in our mind. We'd like to believe that Nipawin Hospital would continue, and have been quite comfortable to this point that it would. But it leaves questions in our minds.

Hon. Mr. Melenchuk: — And I think that's the comment we've been hearing from many presentations and presenters that have come forward, is the lack of clarity on some of the recommendations.

And certainly you reference the fact that even when we're talking about everyday services and acute care provision, that there really wasn't any documentation about lab and X-ray services and where they would be provided. And of course that's crucial to rural Saskatchewan and of course to local communities.

The other question that I have with regard to your presentation, we had the College of Physicians and Surgeons in earlier, I think last week. They talked about sustainable group practices as being in that three-to-five range and also recommended that they need to have access to a base modicum of acute care services, diagnostic services, and so forth.

So just on the recommendations that we've been hearing, it would seem that the Fyke report, that would mean . . . you know, the closure or conversion of 52 hospitals just doesn't make sense. And in fact, the comment from the registrar of the College of Physicians and Surgeons was that it's highly unlikely that that program would be successful and it seems far too aggressive.

So in terms of what is the base requirement for having acute care services, I think you've itemized clearly that in terms of essential physician practices or stable practices.

But in terms of location, what would be ideal in terms of travel time to acute care services. I don't think you agree with the 80-minute or 60-minute thing, so what would you see as ideal?

Mr. Will: — I guess a few comments on that. And that is a tough one to actually . . . We know that 60 to 80 minutes isn't acceptable. Now what is is a harder question. We do know that in the past there was some work done around physician response time to rural hospitals and that at that time, in order to allow some flexibility, they came up with a response time of 30 to 45 minutes to a rural hospital.

And I think that there was some work done in that in as far as the golden hour. Sort of they looked at safety issues and came up with that standard. And I think that seems more reasonable, in my opinion.

Building on that, we've also had discussions even with our ambulance operation, which is staffed at a paramedic level in our district, and sort of said what do you feel comfortable with? And sort of the response that I received was, well I'm not sure. I said how about 80 minutes? No way. How about an hour? I'm not sure. And, how about 45 minutes? That's getting reasonable as far as the time to get someone back into the hospital. So I think that's a few ideas around the response time.

Ms. Anderson: — And I think one point we'd like to further stress is already in our area, as we mentioned, the people from Cumberland House. If an ambulance has to sent from Nipawin to pick up a person — an acute care situation or an emergent care situation in Cumberland House — to get that person back to the Nipawin Hospital is already five and a half hours, and that's under good travel conditions.

So beyond that point, if Nipawin Hospital were to close and if Melfort or Prince Albert or some other hospital was the next closest, what would be the purpose of sending an ambulance? So I guess these are the questions that we pose for the committee and indeed for the Government of Saskatchewan.

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

Mr. Gantefoer: — Thank you, Madam Chair, and thank you very much for coming. I don't want to ask too many questions because I'm quite familiar with the area.

One of the things that I'd like to ask you though, in addition to all the services you've outlined and they are very comprehensive and complete, I would like you to outline some of the programs that are being initiated on a tri-district basis in the northeast. North-East, Pasquia, and North Central have a number of initiatives that they do together. And I think it's important to also indicate the enhanced services as well that are as a result of tri-district co-operation.

Mr. Will: — I'm glad you asked that question. I think we should have built that into our submission.

We have a very good working relationship on the tri-district area and have been very successful in supporting each other in the implementation of programs. And there's three that come to my mind quickly.

The dialysis satellite unit in Tisdale was a tri-district initiative and has been very successful in meeting patient need, and delivering a service that really needs to be delivered close to home.

A second initiative that the tri-district area has worked together on is the implementation of a medical health officer. We have identified the need for that in our area and have aggressively went out and sought after one and have been successful in getting a medical health officer for our area.

Another program that we received support on within the tri-district area is the implementation of a Telehealth project in Nipawin, which we're working on getting the full benefit out of.

So those are three that come to the top of my mind quickly.

Ms. Anderson: — I think another area where we do work together is the chief of staff and the chairperson and the CEO (chief executive officer) of the three districts meet on a quarterly basis and try to go over the different successes and problems and shared services that we can work on.

Mr. Gantefoer: — Last week the town of Tisdale made a presentation to us, and Mr. Taylor, who I think you're all familiar with in terms of his input into the health services in the northeast, was asked the question: would the success of the tri-district programs lend itself in a fairly non-disruptive way towards ultimately one regional health district that would encompass roughly speaking the tri-district that's now there. And he seemed to indicate that that may be a logical kind of move somewhere down the road.

What would your response be to that kind of a suggestion?

Mr. Will: — I guess some of our discussions have been and I guess our point at this stage is we really need to see what the plan for health care delivery is and have some idea what direction will be taken, and then I think we need to take a look at it.

In my mind, there are some issues that need to be addressed. First of all, if we get into a reorganization stage, it's going slow down some progress, I believe, in the implementation of primary care. It's going to take some time to bring even three organizations together.

There's other issues to address. Currently if I even look at the support workers in the three districts, there's three different unions there. And I think there's some major labour relations issues that would need to be addressed.

As far as the spirit of partnership, etc. — yes, I think that those three districts are already working together very closely and have a very common, I guess, population need that they're looking at. So I see both some pros and cons. But I firmly believe that isn't the main issue that's in front of us.

Mr. Gantefoer: — Thank you, Madam Chair.

Mr. Thomson: — Thank you, Madam Chair. And I want to thank the presenters today for a well-thought-out and a concise brief.

I want to start by highlighting the fact that there were many things today that I think you agreed with in the Fyke report. All too often in these hearings we have simply focused on the negative. And I hate for us to see those pieces lost.

I'm pleased to see you support the primary health care service. I'm pleased to see you support the emergency response service, the human resource planning, the quality council, and the northern health strategy.

I think that all too often we are so caught up in protecting our own turf — be that the size of our districts, be that our own community hospitals. Representing a Regina seat, I can tell you I fiercely try and protect my health services here. So your comment that the changes Mr. Fyke recommends would be very bad for Regina, certainly I think strike home.

As I've listened to the presentations over the last — I guess this is our 10th or 11th day of hearings — it has become clear to me that what you say in your very first line is very true, that the Fyke report goes too far in consideration of hospital closures. And indeed I think that in the model that Mr. Fyke proposes of regional hospitals and community care centres, there is a group missing in between that — a group that clearly Nipawin falls into.

I can tell you the government has made no decisions whatsoever as to what if anything out of Mr. Fyke's report should be implemented. I'm not the Minister of Health. Fortunately Mr. Fyke's not the Minister of Health. And we are, I think, very much aware of the situation in the districts, particularly in the larger urban communities like Nipawin, and the good quality of service that's provided.

I don't have a particular question today because I think that your report has covered off a lot of that, but I did want to assure you that your message has certainly been heard by government and has certainly been heard by and repeated by other communities.

So I want to thank you very much for the presentation today.

The Chair: — Seeing no further questions, then thank you very much for your presentation, as Andrew said. Thank you on behalf of the whole committee.

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

Good morning. We decided to forgo the technology, so we'll get into our presentation right away.

Welcome to the Standing Committee on Health Care. It's an all-party committee of the Legislative Assembly and its first order of business is to receive and report back to the legislature on responses to the Fyke Commission, or the Commission on Medicare. We have to report back to the Legislative Assembly on what we heard by August 30. So our hearings are progressing, as you see today.

We've given 30 minutes to most presenters. You have an hour. And hopefully you'll have some time at the end of your presentation to answer questions from the committee since we do seem to have several questions.

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

You can introduce yourself and where you're from. We have some written material, I think . . . Oh yes, we do. It's been passed out already. And you can begin your presentation.

Mr. Leys: — Good morning. My name is Lyle Leys, and I am Chair of the SAHO (Saskatchewan Association of Health Organizations) board of directors. With me today is Louise Simard, president and chief executive of SAHO, William Dumias, SAHO board member, and John Yarske, chief executive officer of the Battlefords Health District.

Madam Chair, before we begin our presentation this morning, I'd like to thank the standing committee for the opportunity to present SAHO's views on health services within Saskatchewan. If there's one point that we'd like to leave with you today it is that a comprehensive and integrated primary health care services must be implemented immediately. These services are critical to the sustainability of the health care system.

Prior to outlining SAHO's response to the Commission on Medicare's final report, I'd like to give you a brief overview of SAHO's membership and the role we play in the health system. I would then like to describe that this process . . . what this process was used to develop the document that we have presented to you today.

In spite of the constant criticism of the health care system by

media throughout North America, Canada, and Saskatchewan, we would like to state that we do have a quality health care system in Saskatchewan. And most importantly, the most efficient and equitable health system is one that is administrated publicly, not privately, and funded through general taxation. This principle must be preserved. We welcome changes to the health care system that improve quality care and deliver services close to home.

SAHO is a provincial body of 32 health districts, 50 affiliated agencies that provide acute and long-term care, 51 allied organizations that provide a range of community-based services, and 40 associate members including professional licensing bodies, educational programs, and other health-related representative groups.

SAHO provides leadership and a common voice for our membership. We also provide many day-to-day services including a provincial payroll system, management and administration of pension and benefit plans, communication and policy support, as well as education and training.

SAHO plays a large role in labour relations for the health sector in Saskatchewan as a representative of employers' organizations or health districts and designated affiliated agencies. While we have a diverse membership — some of our members have varying views on issues — however, the position we are representing to you today represents a general consensus from our health district board and affiliate members.

The process of preparing SAHO's position contained in our brief has been ongoing since the Commission on Medicare released its first report, *Caring for Medicare: The Challenges Ahead* in October of 2000. In response to this report, SAHO prepared a comprehensive brief in consultation with our membership responding to the questions raised by the commission. The brief was submitted to the commission in December 2000 and has been provided to you for further detail and information.

Over the last year SAHO has worked with a committee that is representative of our membership to develop our position on quality health care for presentation to government. The document that we present to you today was discussed with health district board and affiliate members at the end of June 2001. This report represents a general consensus of our district health boards and affiliate members.

So on to the question. How does Saskatchewan create a system that is sustainable and based on quality? SAHO believes an important and first component in achieving a sustainable, quality health system is immediate implementation of primary health care services delivered close to home. Primary health care is a comprehensive, democratic, and socially responsible approach to improving the health and well-being of people. It is a philosophy, strategy, a set of activities, and a level of care that is based on the holistic approach to health.

Acute care is an important component of primary health care, but community-based services, population health, and the broad determinants of health are also important components. Once primary health care teams and networks are operational, the health care provider at the first point of contact will have an array of resources and expertise that they can make available to the client. This will result in quality and service improvements. Access to integrated primary care services is the first point of entry . . . at the first point of entry will ensure that the service received by the client is linked to the most appropriate health professional or service.

Through the establishment of multi-disciplinary primary health care teams who collaborate to address the needs of individual families and communities, we can better ensure that appropriate services are being provided on the clients' needs. This will ultimately lower the risk of ill health and, in many cases, lessen the need for acute care.

Primary health care services should be funded and structured in a way that encourages and provides a balance of treatment, rehabilitation, health promotion, and disease prevention.

Attached to our document in appendix A is a more detailed paper on primary health care. It was presented to the Commission on Medicare and we believe that you will find it useful.

Another aspect of primary health care that enhances the quality delivery of health care services, the encouragement of individuals, families, and communities to seek out information about their health and to participate in health promotion initiatives and health education. People are encouraged to inform themselves and so make better decisions about their health.

Through the collaboration of the primary health care teams and involvement of individual, families, and communities, the health of the citizens of Saskatchewan will improve. In turn, this should reduce the need to access acute care.

This means that community involvement and decision making are essential to foster health and well being. Community involvement and decision making at the local level facilitates people and communities taking ownership of their own health and the health of their communities. It also facilitates problem solving at the local level, as well as the collaboration on intersectoral partnerships on a district basis. These are necessary components of quality primary health care services delivered close to home.

SAHO welcomes changes to the health care system that improve client care. SAHO sees primary health care teams with local community involvement as improving client care. Therefore this government's first priority before it considers any changes to restructure should be to have those primary care teams in place and functional.

Primary health care teams must have access to local diagnostic services, emergency services, long-term care, information service, and acute care within a realistic travel time. Not only are these services necessary for health care purpose but they also aid in recruiting and retaining health care workers.

There is grave concern by our membership that Fyke's proposal to convert 50 hospitals to primary care and community care centres will result in the loss of diagnostic services in local communities and unrealistic travel times to emergency and

acute care facilities. This would negatively affect the delivery of health care. There is also concern that this would further complicate recruitment and retention initiatives.

With respect to specialized care, like everyday services, our primary health care must be provided in the context of a provincial implementation plan. And any decisions that would result in change should be made within the context of this provincial plan.

The provincial plan can include clearly identifying criteria to determine which services can be provided throughout the province, and where and what services can be provided on a prairie regional basis.

A type and location of medical specialty services in Saskatchewan must be first and foremost a matter of public safety and medical viability and should be carefully planned to ensure high quality and sustainability over time.

SAHO believes there must be a closer medical relationship between tertiary hospitals in Regina and Saskatoon, and the regional hospitals.

SAHO further believes that the concept of health districts contracting physicians has merit, but further work and discussions with physicians in this area are required.

SAHO believes that quality must be at the forefront of Saskatchewan's health system. The health system must look and think beyond the traditional delivery model for a sustainable system that is based on quality. This process must support health care providers and health service delivery model, and it must address the entire spectrum of health services, not simply focused on acute and specialty care.

Prior to the health reform of the 1990s, we had a health care system that was largely focused on acute care, doctors, and hospitals. There was very little focus on other health services such as community-based services, therapies, population health initiatives, and so on. It was a system where we had over 400 boards and very little, if any, coordination and integration of health services.

The challenge was to integrate and coordinate services more effectively, while at the same time retaining community involvement, enhancing the role of community-based services, and emphasizing population health and well-being. Significant progress has been made in these areas and these goals are still valid as pointed out by the Commission on Medicare.

Therefore our quality process should include not only acute care and specialized services, but also the full spectrum of health services. In other words, if we are going to improve health and well-being through the delivery of primary health care services at the community level, we must have processes that focus on quality of those services too.

Establishing and implementing processes that support quality throughout the health service delivery model will be challenging, however it is important and necessary. Our members overwhelmingly support the development of a process while not necessarily endorsing a quality council, but to move that quality agenda forward.

This process should be based on supporting and moving the vision, values, and goals of the health system forward, and enhancing the outcomes. Discussions with government, SAHO, and district health boards, and professional organizations are required to define this process.

Considerations in these discussions should include a clearly defined mandate that includes primary care and all other health services; a clearly defined accountability framework; a process that does not duplicate existing mandate or services; and a clearly defined decision-making criteria of performance indicators and research initiatives.

Clients will be entering the health care system through primary health care point of entry. The quality of analysis received at that point and the quality of the services received at that point can prevent or reduce the likelihood of that person needing access to acute care. In other words, an ounce of prevention is worth a pound of cure.

Therefore once again, it is imperative that a quality process focus not only on acute care and specialized service, but also on primary care services.

Health districts and Saskatchewan Health need to develop funding approaches that stabilize district budgets and provide funding predictability on a multi-year basis. This will require changes to the current funding structure. If a quality-orientated funding system were to be implemented, the processes that link funding to incentives would need to be well defined. A prerequisite to such a system would be a well-established process for measuring quality.

National coordination of the quality agenda is required; this coordination to be focused on developing a national system that evaluates and monitors the health system.

On the issue of district health boundaries, although SAHO is not opposed to changing boundaries, governance at this point is not the issue, and any decision about the number or size of health districts should await a decision on what, where, and how health services will be provided in the province in the future, as well as the implementation of primary health care services throughout Saskatchewan.

Once again, although SAHO is not opposed to changing boundaries, SAHO does not support either the nine or eleven district model proposed by the Commission on Medicare.

Changes to health district boundaries should be based on clearly defined criteria that include: the support of the service delivery model; actual services being provided; geographic distance; community involvement and local decision making; referral and service patterns; trading patterns; human health resource issues; recruitment and retention; intersectoral partnerships; and union jurisdiction issues. The models proposed by the commission do not reflect these principles adequately.

Also the initial process for establishing district boundaries was a public process with public involvement. Therefore any changes to health district boundaries must be done in

consultation with district health boards, affiliates, communities, and other stakeholders with the goal of assuring that appropriate boundaries are developed that will improve the delivery of health care services including quality care at the local level.

Any changes to the boundaries should not lose the principle of community involvement and ownership in the planning, developing, and delivering of health care services because this is essential to achieving primary health care and population health goals.

As pointed out earlier, involvement of individuals, families, and communities is essential to primary health care in the population health. If individual families and communities are too far removed from their local health district board, their public participation and planning and delivering of health services will be lost. This public participation is a significant and important aspect of primary health care.

Further, within a health district, communities need to be able to work together and communities that are used to working together will collaborate more effectively in the delivery of health services. And therefore, trading patterns are important and should be considered if district boundaries are to be redrawn.

Some of our members are concerned that if district boundaries are geographically too far from one point to another and if control is centralized too far from a small community, that small community and the individuals and families living there will not get the care they need.

Intersectoral partnerships are important, and health district boards have been carving out relationships with municipalities and school districts. Some have been collaborating and planning in delivery of health care services. Some school districts have told us that working with a centralized district health board too far removed will create barriers to continued intersectoral work.

SAHO was also concerned about the need for stability in the health care system. This is essential for public confidence and for retention and recruitment purposes. We have come through a decade of change, and although SAHO recognizes that some change is necessary and desirable, unless it can be demonstrated that further changes improve patient care, we cannot agree to this change. This becomes even more critical when change will inevitably cause more instability in health care and make it even more difficult to recruit and retain health professionals and workers.

In other words, in the final analysis it needs to be a proper balance between many factors including: quality health care services, integration and coordinational services, local control of health services and community involvement, the ability to foster intersectoral partnerships locally, respect for referral and service patterns, trading patterns, the need for recruiting and retaining health professionals.

The roles and responsibility and accountability of the provincial government and district health boards needs to be clarified. Framework of accountability that was prepared in the early ’90s is still valid but needs to be refined using the knowledge of our experience over the last 10 years. Until the issue of roles, responsibility, and accountability are completely clarified, we will continue to have confusion and uncertainty as to the responsibilities and accountabilities. This needs to be our priority if we are going to create a more stable health care system.

Progress has been made in the primary health care and population health outcomes of the residents of the North. This progress should be continue to be built on. The development of a strategic plan for health services in the North will assist in this goal.

Although health service in the North is a priority, we cannot lose sight of the fact that the people . . . the population of the people of Aboriginal ancestry is growing as well as their associated health needs, and therefore we need an improved health delivery model to meet their needs. It is critical that we move health services for Aboriginal people throughout Saskatchewan to the top of the agenda.

A long-term human resource plan needs to be developed to clarify human resource needs and strategies, as well as to enable employers to plan for future service provision. This strategy should include a labour adjustment strategy, a strategy for fostering healthy workplaces, a communicated plan for managing change, and using all staff to their fullest potential.

Because of SAHO’s role as a representative employer’s organization for health districts and designated affiliate agencies, it is important that SAHO is a full partner in any human resource strategy.

Part of any long-term human resource plan is achieving stability in the health system. A stable work environment contributes to the success of recruitment and retention initiatives. Therefore at a time when we already have significant challenges with respect to recruitment and retention of health care workers, any changes to be made to the health care system must improve patient/client care and assist in the retention and recruitment of health care workers.

Much needs to be done to improve the quality and the delivery of health care services in Saskatchewan and to improve and promote the health of individuals, families, and communities throughout the province. To keep these goals at the forefront of the health service delivery system will require a commitment by stakeholders to the renewal of primary health care and population health philosophy and a comprehensive approach to producing and maintaining health and well being, while delivering quality acute care services.

SAHO urges the government to begin immediately to implement quality primary health care services close to home.

Investment and change is important, but money alone will not resolve the issues facing the health system. We need more focus on primary health care, more focus on prevention, and more collaboration amongst all sectors.

The first step in the change process is a commitment from the Government of Saskatchewan to work in partnership with stakeholders to develop and implement province-wide primary health care. This step cannot be overlooked, as it is critical to

the sustainability of the health system and to the assurance of quality service as close to home as possible. Health care stakeholders need to be given the opportunity collectively to develop, understand, and accept a new health delivery system.

It's imperative the government consult with our members during the development and implementation of any changes. We are integral to the planning and delivery of health service in Saskatchewan and our input is important. At the end of this process, our members want quality health service delivered close to home.

Thank you for your time, for your attention.

SAHO board member William Dumias will now speak to you about the need to address the health issues impacting Aboriginal people throughout the province, and then we will be happy to respond to any questions you may have at this time. Thank you.

Mr. Dumias: — Thank you, Lyle.

First of all, I want to thank the standing committee to make room for the people of northern Saskatchewan who I represent. I represent the zone 10, which includes the Keewatin Yatthé Health District, the Mamawetan Churchill River Health District, and also the Athabasca Health Authority.

As Lyle said, my name is William Dumias. I come from the community of Southend Reindeer, which is one of the reserves of the Peter Ballantyne Cree Nation.

And a little bit about the Mamawetan Churchill River Health District representation. We have three First Nations on that board. One is the Hatchet Lake Band, the Peter Ballantyne Cree Nation, and also the Lac la Ronge Indian Band. Also we have one person representing the Prince Albert Grand Council. And the other members are from some of the communities within the districts.

And I just wanted to say zone 10 wants to let the standing committee know that they wholeheartedly support SAHO's brief and on the comments made by our chairperson, Mr. Leys, in particular support SAHO's position on making things fair and its comments respecting the people of Aboriginal ancestries.

SAHO has stated that much more needs to be done to improve and promote the health of individuals, families, and communities in the province. And this is best achieved through holistic programming on the population health and to be evaluated over the long term.

SAHO recognizes that in order to have a sustainable health system and to improve the health of families and communities, a proactive, broad, determined approach to health programming needs to be reflected in the health service delivery model. And this speaks to a primary health care model with a population health approach.

It is interesting that "The Government of Saskatchewan is . . . (also) promoting prosperity throughout the province and a high quality of life for all Saskatchewan people". And this is a quote from your budget of 2001-2002, *Connecting to the Future*.

With respect to health issues, SAHO has also taken the position that, because of the growing populations of people of Aboriginal ancestries, the high health needs, and the need for an improved service delivery model to meet their needs, and it is critical that we move health service for Aboriginal people to the top of the agenda. And we wholeheartedly support this position.

What is needed is a province-wide health service that addresses services for people living on reserve, people living off reserves, and in the North, southern, and also central Saskatchewan.

Partnerships between districts and First Nation health services are vital. Efforts at building these partnerships and developing contractual service agreement should not be . . . (inaudible) . . . by intergovernmental contentions and jurisdictions.

You know, for nearly 15 years the federal government has invested money into reserves to develop First Nations holistic self-government health plans and delivery systems. Where these plans and systems have come into place, a major benefit for the people has been the ability of local service managers to collapse the stovepipe resourcing and programming of the federal government into a single fund, and use these resources according to the needs assessment of each reserve.

Staff has been trained to deal with the whole condition of the presenting person, his or her family, community, especially with respect to mental and emotional health. Some of the best examples are found within the Meadow Lake Tribal Council area with its nine bands.

District health boards have been given a mandate to encourage such programming, and they are close enough to the community to realize successes from their efforts and their initiatives.

Aboriginal residents throughout the province may have some of the same unique health issues as northern residents. Similar growth and composition issues. Similar disease and health problems. Similar historic health service challenges.

Culture of Aboriginal people is holistic, and Aboriginal health strategy must be holistic. It must place the individual within the appropriate family and community context. It must emphasize prevention, not just treatment. It must recognize the complex jurisdictional issues and the Aboriginal communities between the First Nations, the Métis Nations, the health district, the federal and the provincial governments.

And it must recognize that the health of Aboriginal people requires co-operation and support from other government departments and agencies, and must include participation in Saskatchewan's economy.

Another quote from *Connecting to the Future*:

> All Saskatchewan people must enjoy prosperity and a high quality of life — we seize the future with confidence and a spirit of innovation.
>
> Companion strategies for rural revitalization, northern development, and working with Métis and First Nations people.

> Economic growth is a prerequisite to a high quality of life for Saskatchewan . . .

These are quotes from *Connecting to the Future*.

The same desires that Saskatchewan have, the Aboriginal people have those same desires — prosperity and a high quality of life. We're certainly on the same direction. Maybe we're not on the same track. Maybe we're running parallel to each other on some of the things that we desire to do. But connecting to the future should be our same goal.

One of the challenges: we will have to find opportunities for partnerships and collaborations between the Aboriginal and non-Aboriginal groups; learning how to continue to deliver effective health services to a rapidly growing population; and the development of partnership agreements with the governments and health districts — co-management is possibly the favourite approach rather than the host approach.

The challenge again is to determine just how to structure the partnership relationship; to base it on evaluation of what each partner is providing and managing; to develop a mutual agreement to help make the best use of each partner's existing resources; and to be secure and to be comfortable with these partnerships.

On our health status reports. They provide an eye-opening review on how the determinants of health such as employment, education, recreation, housing, and childhood development influence our health. The reports include some very unsettling statistics. But it is timely to have this information available for us because this will aid us in setting priorities and planning action for the future.

Under SAHO's Aboriginal development program — this is what I would like to speak on, which is important because it affects the economic situation of Aboriginal people and is therefore a determinant of health and a very positive program — employment and therefore economic factors such as income is considered a determinant of health. To address this issue, SAHO has begun an Aboriginal development program with the objective to increase the participation of the Aboriginal people in the workforce.

In order to achieve our goal of increasing Aboriginal participation in the health sector workplace and to achieve a representative workforce, our first major stress and mandate must be to prepare the workplace through education.

More than a decade ago, 1989, Dr. James Irvine, director of northern medical service division within Saskatchewan's College of Medicine wrote:

> There is an urgent need for more Native people in Saskatchewan's health profession.

However, by 1995 still less than 1 per cent of Aboriginal people work in the health sector, Saskatchewan's third-largest workforce with approximately 41,500 employees.

Now more than ever, it is urgent that we make significant progress to employ Aboriginal people. Each year the employment gap between Aboriginal and non-Aboriginal people in Saskatchewan increases by 1 per cent. In the next five years, 46,000 new Aboriginal people will enter the workforce and will be seeking jobs in Saskatchewan.

Governments, employers, and unions need to commit to prepare the workplace through public education. This strategy will help stop the continuing escalation of this employment disparity and avoid the development of a large Aboriginal underclass, which would have significant social implications and add more costs to the already overburdened health care system.

Positive steps for change need to be taken. These positive steps require a cultural change through a comprehensive education strategy. Within the highest Aboriginal population across Canada, Saskatchewan needs to and is playing a leadership role in this area. And no other province has any initiative of this scope and scale for Aboriginal employment.

There have been significant inroads in the recruitment of Aboriginal people in the health sector, from less than 1 per cent to 3 per cent. But retention of Aboriginal employees remain a problem. Low retention is strongly related to misunderstandings about the partnerships and the current Aboriginal issues in the work environment. This in turn creates backlash and employees' resentment.

Breaking down the barriers and addressing misconceptions about Aboriginal people in the workplace is a key to success for the partnerships over the long term.

Education of health care workers on the need for partnership. A representative workforce, the economic benefits of hiring Aboriginal people, and on-current Aboriginal issues is essential in achieving our goal for a representative workforce.

There's others that I would like to leave with you. But in closing, and I think the message is very clear, in closing, we can work together in wellness and we can make a difference. But we have to pull down some barriers such as jurisdiction, such as responsibilities, such as representation, off-reserve, on-reserve, prejudice, equity, willingness. These are some of the barriers that we have to pull down.

And I really want to thank you for this opportunity to speak, and especially to speak in these Chambers. I thank you again, Madam Chairperson.

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

Mr. Gantefoer: — Thank you very much, Madam Chair, and thank you, members of the presenting group from SAHO this morning.

Your brief certainly covers all of the main areas in the Fyke report and I certainly very much appreciate the well-organized presentation you make.

A great deal of your presentation talked about that we cannot ignore the fact that we shouldn't focus everything on acute care and specialty services; that we've got to keep in mind and keep our eye on the ball in terms of the primary health issues, the determinants of health, and all of those issues. And I don't think

there are many people that will philosophically disagree with you at all.

However I think that we also have to face a pragmatic challenge. And that challenge is that somehow we've got to engage our people, our citizens, in that process. Few would argue that many of us do not eat properly, eat too much of the wrong foods, do not get enough sleep, have too much stress, smoke — all kinds of issues that negatively impact our outcome.

How do we build a bridge between that reality? And the other reality is is that at the other side of the equation when our health suffers because of our decisions that we make, very often poor ones, that there is no relationship. If I need health care, I simply go and get it. And so irrespective of my level of responsibility throughout my life, there is no linkage for my need for services at the other end.

When we talk about accountability, we sometimes talk in a quality council about accountability of the system. What about accountability of ourselves as individuals? How do we make that connection?

Mr. Leys: — Well I think one of the things — and we've emphasized that in our submission — is the need to have primary health care teams out in the communities. And those teams are very integral to the education, the health information that's out there.

One of the things that we believe will happen and we certainly have some health care problems. Just recently on TV they talked about Canadians being obese and that brings on the onset of diabetes and those things. Early detection is very important in that, and primary health care teams in the communities will be able to do that.

But more important than that I believe they'll be able to provide health information and educate the people as to why they shouldn't eat those things and why it's detrimental to their health and why they should exercise. In the communities . . . and then that's where, I believe that's where we will have an impact when we can get people, communities involved, get the local people involved in those initiatives. That's where we'll make a difference.

Mr. Gantefoer: — I think . . . you know it's a great theory. Few would argue that there are many people left in our society that do not understand that smoking tobacco is bad for your health in a very, very dramatic way. And yet significant numbers of our young people and significant number of people not only continue to smoke, but begin to smoke.

And so there are some of these realities, and I don't think anybody would argue that people don't understand or haven't been educated to the dangers of that decision.

So a philosophical approach of saying we've got to educate people may not make the connection. In some instances, like tobacco, it has made some progress. But few would argue that it's made as much progress as we would want.

The second reality is, in that whole process — and I don't know the exact number — but a very significant part of the health care dollars that are going to be spent on each and every one of us, likely, is going to be on a final catastrophic battle that we're going to lose at the end of our lives. And any of these preventative programs, any of the educational programs are not going to change that reality as well.

So how do we shift enough dollars from the acute care system and the delivery of health care services to fight that catastrophic battle for each of us? How do we shift significant of those scarce dollars to really make the impact on the primary end work, given the fact that some of the learnings we've had on smoking and those issues have not borne the kind of results that we'd like?

Mr. Leys: — Well certainly, we haven't the impact in some areas we thought and hoped we would. The other thing and part of that whole equation is that we don't know how bad it would have been if we hadn't had the smoking initiatives and some of those. So those are some of the issues.

How do we get people to understand that, and that's difficult for us to do. How do you shift the dollars? One thing that the Commission on Medicare has said that if we're going to have those initiatives of primary care that it's going to take an investment of dollars. It's going to take extra dollars to do that. The commission says that in its report. And so that's an important thing to remember. Investment in the future is going to cost some dollars, there's no question about that. But it will pay a long-term dividend, I'm still convinced.

We may not be . . . haven't maybe made the progress that we hoped to have made, but we have made progress and we will continue to make progress as long as we continue to work at that level. I think we've made significant progress in the education of people, in understanding that they need to become accountable themselves. And I believe that that will begin to snowball as we go into the next series of reform and change in the health care system.

And I brought some people of expertise along with me. I'm going to invite some of them if they have comments to make at this time. That's why they're here, to help out in this area.

Ms. Simard: — SAHO have taken the position that we need high quality acute care in the province. And in our earlier brief of which I think you've received a copy this morning, we pointed out and made the statement that we did not feel acute care dollars could be reduced any further in the province.

And if you do an analysis from 1990 to 1997, you will see that we did reduce on a per capita basis quite significantly, acute care dollars, and commensurately community-based services increased. We took the position therefore that reducing acute care dollars at this time, because if you compare us to the rest of the country, would not be advisable. So if we are going to implement a primary health care system in the manner that it should be implemented, it will require an investment.

Mr. Thomson: — Thank you, Madam Chair. I have two questions I want to ask today. To start with, I am interested in what the future role of SAHO may be in the health care system, particularly as we move to a more evidence-based model. We

have certainly heard from citizens, constituents of ours, who talk about the, in polite terms, about the perceived expansion of the bureaucracies.

We've heard concerns that we have expanded the management too much. There are concerns that we have not focused enough on ensuring efficiencies between the department and SAHO and the districts. And now the suggestion is that we create an evidence-based quality council.

Do you see the quality council rolling in with SAHO, being part of SAHO, replacing SAHO, or simply being another arm, with additional staff, additional resources to help evaluate the system?

Mr. Leys: — If you take the model that the commission talks about, certainly it's an arm certainly removed from SAHO. It's a separate body altogether.

We don't necessarily endorse the idea of a quality council. While it may have value, it may have merit, it certainly raises some questions on . . . at our level. Will it be effective? Will it have ability to effect change? Will it become too bureaucratic, as you may have suggested? What will it cost? Where will the funding come from?

We don't envision it as being part of SAHO. No, the membership has never talked about that. We believe that quality needs to be built into the system, and that can be done through the establishment of standards and regulations. And then those standards and regulations need to be monitored, and that will give us an indication.

And as you build quality, we believe, into the system at the very basic level, and if you want to take a pyramid effect, you build it into the bottom, it permeates up through this system and into all of the aspects, especially care and acute care along with that. But we need quality at the bottom and we need quality at the community level.

Ms. Simard: — If I can just add to that. SAHO has not endorsed the council. It hasn't opposed it, but it doesn't endorse it. It speaks to the need for a process.

SAHO does not do evaluation of health care services. It doesn't do quality evaluation amongst the districts. That has never been a role of ours and we don't do that. That is a role of the Department of Health.

The Department of Health's budget, as I understand, is 7 or 8 million. And just going back to one of your earlier questions, what's being proposed for the quality council I think is 20 million, and then another 20 million for research. So it is a significant investment.

We have indicated that quality needs to be at the forefront. We do believe there needs to be a process to deal with quality, but not just focused on acute care and specialized care, which is very important, but not just. Because some people seem to be suggesting it should only be for acute care and specialized care. And so we are making the point that the process needs to be all-encompassing and needs to include primary health care as well in order to deal with quality at the first point of entry as well.

However, some of our concerns are raised in the brief on the quality council. Our concern is will the quality council have the ability to make anything happen? And if it does have the ability to make something happen, what is its accountability to the public?

Generally we feel one reporting to the legislature isn't sufficient accountability, depending on what its mandate is and what it can make happen. Because if it has the ability to say these services won't be performed here, or you will only get certain procedures under certain conditions, that's a very public responsibility, and therefore there needs to be accountability to the legislature. So what's the framework for accountability on a quality council?

I had referred to the Department of Health's budget, and in that regard I want to say that the Department of Health now takes the responsibility with respect to quality. Is there going to be an overlap between the council and the Department of Health? Those roles will need to be very clearly defined so that there isn't any duplication.

So we've raised a number of concerns, but the most important point is, yes to quality; yes to including primary health care in the quality process.

Mr. Thomson: — We've heard a great deal from — I guess, staying with the question of integration and how the bodies work together — we've heard a great deal from districts who appear before us, saying that certainly we need to maintain basically the number of districts, we need to maintain the election of reps. Indeed your brief speaks to that as well.

But I find that there is a disconnect between what ordinary citizens tell me. Certainly Mr. Fyke makes the point that the participation rate in the last health board elections was only 10 per cent. Nine out of 10 voters stayed home. I know that when citizens phone me and I suggest they may want to talk to Dr. Bachynski, who is their rep on the Regina Health Board, they tell me quite bluntly that as far as they're concerned that's why they elect members to the legislature; that the health board reps are something else and really don't provide that kind of direct accountability. They feel the members are accountable.

I'm interested in knowing what the rationale is for maintaining the number of districts, for maintaining the elections, running elections that certainly are expensive. We know that by postponing them this year we saved $400,000. And frankly, I haven't heard from any citizens any great desire that we should be continuing on with this process.

Is there an ability for us to further streamline the process, to better integrate the way the Department of Health, SAHO, and the districts work together?

Mr. Leys: — We support the concept of elected boards and appointed boards, that's our position — as they are now, they should remain.

And if you want to engage the public and if you want to have community involvement, I think it's necessary that that process

be maintained.

I know that the turnout at elections is low, but also turnout at some municipal elections is not any better. So do you do away with that system too? No. I think the system has worked. I think it provides local input. It brings the issues to bear to the health board that need to be brought there.

I think that the appointed members bring a balance to that. The appointed members can represent specialty groups or whatever the government sees as a reason to do that and has worked . . . My experience is that it worked very well.

You know, you want to comment . . . John, do you want to make comment on that, a word from your perspective?

Mr. Yarske: — Well I think that, generally speaking, although we acknowledge at times there may appear to be a relative indifference, I can assure you when the issues are serious and/or of a controversial nature or that substantial change is considered or that issues of funding or conflict arise or services, the utilization and the communications with elected and appointed board members is really quite extensive and quite thorough, as we witness in the SAHO district dialogue that we have regularly — at least a couple of times a year — and on an as-required basis.

I think, witness the reaction to this particular committee, this process and the number of public meetings that have been held in the various districts, facilitated by the existing boards.

I think the general feeling of the membership is, as Mr. Leys indicated, although at times the response during elections may peak and wane, some of that may have to do with the timing and the frequency of the elections. Some of the recommendations that we have made in our brief would be to arrange for elections in a more timely and concurrent fashion with municipal processes and things of that nature.

So I think rather than dispensing with it, we're looking at ways and means of actually improving the process and that there may be further dialogue in that regard that would see some further public support and commitment in the overall process.

Ms. Simard: — If I might just add as well, on the issue of elected boards. Initially, when elected boards were put in, it was as a result of a consultation process and the public called for fully elected boards.

We decided to put in partially elected/partially appointed for reasons that were stated in our earlier brief.

I think that if you were to do polling, and I believe the Department of Health's most recent polling on this issue will illustrate that the public still supports fully elected boards. There may not be a hue and cry for it, but I believe the public still supports the principle of a democratic process of selecting the people who are going to run your health care system, through a district system.

So I would say that there is support for election to district health boards. Now on the question of whether or not you have a health board and instead use MLAs (Member of the Legislative Assembly) in the Department of Health, the reason that the province went to health boards initially was further integration and coordination because it's virtually impossible to do it centrally out of Regina, to do that kind of coordination and integration that's necessary to achieve a seamless health system.

So the way one accomplishes that is through regional boards or district boards. And I think that that goal is still important to move to even more integration and coordination than we have today. And we're always working in that general direction.

Also in order to actualize a population health approach to your health care. To have . . . to incorporate broad determinants into your thinking and to move to a primary health care system, you need involvement from communities, families, and individuals. And that's generally recognized by the World Health Organization.

So how do you achieve that? How do you get that involvement? Well hopefully, we can get it through district boards that are elected, partially elected, and that encourage meetings in the public and encourage community involvement by the local level.

I think that SARM (Saskatchewan Association of Rural Municipalities) and SUMA (Saskatchewan Urban Municipalities Association) have recognized that that input is important into the delivery of health care services. They represent a large portion of the public in their local communities as well. I think there's general recognition that community involvement in the delivery and planning of health care services is essential for a quality health care system.

And then of course the question is how do we accomplish that. Well the model that we have attempts to do that. And it's true that we might be able to strengthen it and even do more in that area. But it is an attempt to get that involvement.

Mr. Leys: — I think one of the things also is that this is a fairly new process. You know we had, I think, two calls for health board elections, and so I think it's again a public awareness and education that needs to take place.

It's also interesting to note that Alberta has now moved to partially elected boards in their jurisdictions too.

The Chair: — Excuse me, Mr. Thomson, before you continue. We have two presenters left before we recess for lunch so I just ask that we move along with our questions and answers so we could be done with this presentation in five minutes. Thank you.

Mr. Thomson: — Madam Chair, I will quickly conclude then. I was going to ask about waiting lists. I'll leave that alone and I'll stay on the question of expenditures.

I'm interested in page 29 on your brief. You say that the health system's budgetary problem is not mainly on the expenditure side of the equation but on the revenue side. And the revenue solutions rest with the political choices of the provincial government.

Should I be reading something more into that other than raise

taxes to pay for health care?

Mr. Leys: — The question is often asked: what is enough money to spend on health care? And certainly we don't have the answer to that.

We believe, again if we go back to the primary health care model that we need to make an investment in that; that that will pay long-term dividends. But in the short term it's going to cost some money. We need to work collaboratively together. We need to develop intersectoral relationships that will help to minimize costs of programs. We need those partnerships, and we continue to work on them.

But to say that we need less money or more money, that's a difficult question. But we need to make investment in people at a relatively young age. We need to educate them. We need to inform them. And I think that that will begin to pay dividends in the long term.

Mr. Thomson: — . . . understand what that means. As I read the paragraph, and it says that the problem is on the revenue side, not the expenditure side.

Ms. Simard: — See, I think the point that is largely being made there is that we hear a lot about how health care costs are escalating out of control. But if you do an analysis from 1990 to '97, you will see that in constant dollars we actually have been spending less per capita than we did in 1990 — that's based on CIHI (Canadian Institute of Health Information) statistics — if you do an analysis and take inflation into effect.

And so as health care stakeholders we're somewhat concerned when we see costs are escalating out of control. We say: is that a complete analysis of the system? Let's look at the expenditures in '90, the expenditures in '97. And we only had statistics up until '97, so it doesn't include what's happened in the last three to four years.

So when we did that analysis and we found that in constant dollars we're probably spending less per capita than we did in 1990, then we have to ask ourselves the question: well why is it becoming a larger percentage of the provincial budget?

That may have something to do with revenues that are being brought in or not brought in. It may have something to do with the fact that there may have been further reductions in some of the other areas.

And so the point we're trying to make is it isn't necessarily an expenditure problem. It's more of a revenue problem and we need to do an analysis of what the revenues are and how it compares to the other jurisdictions, the other areas of the provincial pie. And it may be a question of looking at taxation as well and how that's accomplished.

But it's . . . we're trying to make the point, it isn't necessarily health care costs are out of control which is what we hear so much in the press and other places; that we think it's important for us to take a close analysis at that.

Mr. Thomson: — I'm pleased that SAHO continues to support public financing but I think we do need to look for efficiencies regardless of where the percentage of budget . . . I don't know what the Health budget was when you left politics in '95 and I came in, but I know that today it's 2.2 billion. I know it was considerably less than that when I was first elected in 1995, and I know that that money only comes from one set of pockets. So to hear that the problem is on the revenue side concerns me a bit.

Nevertheless I hope that SAHO and the department continue to work together to look for efficiencies, and I appreciate the presentation today.

The Chair: — Thank you. Dr. Melenchuk, remembering the cautions I previously mentioned.

Hon. Mr. Melenchuk: — I had about a dozen questions but I'll try and get them into yes/no formats here.

Prior to 1992 Saskatchewan had one of the most decentralized health delivery systems in the country, in fact in North America. We are moving a little bit more to some centralization, but is it the opinion of SAHO that the proper model for Saskatchewan is a regional model?

Mr. Leys: — I guess we would need to have a definition of what a regional model . . . your definition of what a regional model is.

Hon. Mr. Melenchuk: — A regional model would be similar to what we have in terms of a district, where you have your province broken down into various jurisdictions that would provide primary, secondary, and have relationships in terms of provision of tertiary care. So in essence what we have today is a regional model.

Mr. Leys: — Certainly we support the model that's there today. We also recognize that there could very well be some advantage to change at some point.

We don't think that, again, that the 11-district model or the 9-district model is acceptable. We think travel distances and health boards will be too far removed from communities to have local input.

But there certainly is a place at some point for rationalization of some sort. But again, it needs to demonstrate that it will improve services.

Hon. Mr. Melenchuk: — Yes, the reason I was asking the question is we've had several comments with regard to greater integration and coordination of services which requires more regional envelopes and comments on greater local control of decision making.

And we obviously have a situation where Mr. Fyke didn't believe that we had the proper mix in the current model that we have in existence, and you don't agree with his recommendations that 9 to 11, or the current boundaries.

What you have said in your brief is that you believe that some rationalization should occur, but there needs to be input — stakeholders, communities — and that they should be based on things like trading patterns and natural flows and things like

that.

So that's basically your position then.

Mr. Leys: — Certainly, I guess, in that whole mix our position is that primary care needs to be a priority of this government or the department before any other changes are made.

Hon. Mr. Melenchuk: — I think we've heard that from quite a few other presentations as well.

Some of the stakeholder groups that represent health care workers have identified the three big issues to them, in terms of broader definitions, as low health care worker morale, decreased public confidence, and the need for a sustainable health care system.

And certainly the reason that I'm just making that point is I wanted to ask SAHO's position with regard to some of the comments on casualization of the health care workforce and what initiatives could be entertained to diminish this trend or in fact reverse the trend so that we see more full-time work in our health care system.

Mr. Leys: — I'll ask Mr. Yarske to speak that, as a CEO.

Mr. Yarske: — Well I think we recognize those are indeed . . . you know, we acknowledge those are major concerns. And on that basis we have supported the various initiatives undertaken to look at issues like increased ability, improved planning of recruitment and retention procedures, ways and means of creating more permanent positions.

Unfortunately it's a very, very complex situation and merely making a commitment to do that, although that's the essence of it, takes a long time to accomplish. Process of retention, recruitment, stabilization of the workforce then would result presumably in increased morale and commitment.

One of the main things, I think, we focused on in our brief is the creation of stability in the system. The uncertainty, the anxiety, the enormous change that we've gone through in the past decade has contributed substantially to all of the factors we face today. And so therefore we feel that any further change in the system has to be very thoughtful, very planned, and implemented in an incremental, systematic way.

But it's not just a simple solution. It's a combination of all of those things, and I think that by and large we have begun to address many of these issues through changes in collective agreements, in the way we go about this process, and in our initiatives on recruitment and retention. But it will take time. It's something that didn't happen overnight; it can't be changed overnight frankly.

Hon. Mr. Melenchuk: — Of the follow-up to that question then is comparing Saskatchewan to other jurisdictions in terms of their mix of casual, permanent, part-time, and full-time employers, what would be considered the appropriate per cent of full-time employment? Would it be 60 per cent? And have you done the research in terms of interjurisdictional comparisons?

Mr. Yarske: — Well I think there has been some basic research done on this and certainly there are plenty of research papers available. I think if I . . . I can't recall exactly, but in an approximate sense I think that is a target. I think what we've seen, however, is a move from when that used to be in place historically to the opposite where we have probably 60 per cent casualization and 40 per cent permanent workforce and we have to somehow reverse that trend. So I think that's a very close target.

Hon. Mr. Melenchuk: — The final question I have is with regard to the recommendation that of course primary care reform, as recommended by Fyke, is the base of his model and you would agree with that. And you would also stipulate that no changes should occur until we have that primary care envelope well established and in place.

And it begs the question, because we've had many, many presentations about the accessibility of acute care beds especially in rural Saskatchewan and we know that we've had a fairly substantial decrease in the number of acute care beds offered in the province of Saskatchewan over the past decade. The current number of acute care beds as identified by Mr. Fyke in his report, would you agree that that's maybe the right number or should there be more acute care beds, and how does Saskatchewan compare to other provinces and other jurisdictions and the number of acute care beds per 1,000 population?

Mr. Leys: — Certainly we make a very emphatic point in our brief that the primary health care service teams need to be in place before any changes are made. As to the proper number of acute care beds, we don't have a position on that.

We think that certainly closure of 50 hospitals would be a disaster for rural Saskatchewan, and in Saskatchewan particularly because where do people go to get the . . . access acute care services when some of our numbers indicate that if 50 hospitals were to be closed, we could take as . . . up as much as 800 beds out of the system. There just isn't that capacity in the rest of the system to absorb that.

Ms. Simard: — I think the important thing is to get the primary health care in before you do any sort of analysis as to what services are needed. You need to make sure there's emergency, diagnostic, and services in these communities if you decide . . . if the government decides to convert hospitals.

But primary health care will have certain demands on services. Plus it will reduce certain demands on services. And until that's up and working, I don't believe that this kind of analysis can be made, and I don't believe that . . . And so SAHO has not taken a position other than to say we're very concerned that 10 to 14 regional hospitals are way too few in the province.

We talk about travel distances, and we talk about our concerns for physicians and communities if they lose emergency and diagnostic services out of their communities. Recruitment and retention is an issue. You heard a lot of this from the brief that was presented earlier.

Mr. Leys: — One of the things that seems to have been linked together is the closure of hospitals and . . . or the establishment

of primary health care team and the closure of hospitals. At SAHO we don't believe that that's necessarily the case.

Primary health care teams may very well function in a community where there is an acute care facility, and that needs to be a point that we would like to make at this point — that just because we have primary care health teams in place doesn't necessarily mean that we accept the closure of a hospital.

Hon. Mr. Melenchuk: — That's all the questions that I have. And thank you for a very comprehensive presentation today.

The Chair: — Well, SAHO, as we can see there's probably a lot more time we could spend with you, and thank you so much for your presentation. And we did have your previous . . . your brief to the commission, we did have distributed to the committee before we sat. But thank you for bringing it again, and thank you again for coming.

If we could ask the next group of presenters to take their seats at the table. I'd like to welcome you this morning to the Standing Committee on Health Care. And I apologize for being late, but that's been sort of our MO (modus operandi) for the whole time we've been sitting.

This is an all-party committee, and a Standing Committee of the Legislative Assembly, and our first order of business is to receive responses from organizations and individuals to the Fyke Commission, or the Commission on Medicare.

The committee is charged from the Legislative Assembly to report back to the Assembly what we've heard. We'll not be making recommendations; we'll be reporting back what we've heard. And that report is due August 30.

Our presentations are half an hour and within that presentation time we hope you'll have a few minutes left for questions from the committee.

If you want to . . . oh, I'll introduce ourselves first. I'm Judy Junor, the Chair. Dr. Melenchuk is the Vice-Chair. Andrew Thomson, Kevin Yates, Deb Higgins, Brenda Bakken, Bill Boyd, and Rod Gantefoer are here with us today.

And you can introduce yourself and then proceed with your presentation.

Ms. Kowalski: — Madam Chairperson, and members of the committee, my name is Gwen Kowalski, and I have the pleasure of being the chairperson of the South Country District Health Board. Accompanying me today is Mr. Norman Poirier, our chief executive officer.

In order to give context to the brief, I will speak very briefly on South Country District Health and my own background. South Country District Health is located in the south central portion of the province, and covers 13,064 square kilometres. The district includes Shamrock in the northwest portion of the district, Mossbank and Crane Valley in the northeast, Willow Bunch and Viceroy in the southeast, Rockglen in the south, and Kincaid and Hazenmore in the west. Currently there are approximately 12,000 residents living in the district.

I am a nurse by profession and presently work in the emergency unit of the Moose Jaw Union Hospital. During the course of my career I have worked in home care and long-term care. I speak to you not only as a board member but a health care professional, intimately familiar with both the provision and receiving of health care services.

South Country District Health, in preparation of this brief, has consulted with many stakeholders and has read numerous reports regarding the Fyke report on medicare. It is our opinion that the issue revolves around the fact that Mr. Fyke's report is an exercise in theory.

The numerous reports and briefs submitted for your consideration represent the realities of implementation. Mr. Fyke's report has many good points. The most notable is that it stretches the imagination. It makes us revisit everything we do and questions the rationale, the benefits, and the need to improve.

The difficulty with conceptual plans is that they are, in many respects, nebulous. It would be impossible and dangerous to implement such a plan without first analyzing the feasibility of implementation and the consequences. We strongly recommend in-depth consultations with all stakeholders and analysis of any changes being considered prior to implementation.

The report on medicare reads like a theorem whereby if all the basic truths are in place, then the result follows. This is not the case. Mr. Fyke makes many assumptions in respect to physician participation, district number, and size — all of which need a great deal of study prior to implementation.

Specifically, our physicians have advised that the loss of our hospitals will result in a mass exodus of physicians to larger centres. Rural health services, which are subpar now, will be dramatically reduced. Physicians are not interested in working without access to hospitals.

The number and size of proposed super-districts does not take into account historical trading patterns, referral patterns, geography, or road systems. They are cumbersome and unmanageable. Large districts and the expanded role of EMS will result in response times of hours, not minutes. Rural residents will not have ready access to services but be required to travel great distances. Longer response and travel time will result in poor outcomes in many cases.

This, in turn, increases cost and need for services. Families will have to travel long distances to visit or follow up with ill family members. Large districts will erode the volunteer and community support presently in place around existing institutions. The result will be a less friendly, desensitized, impersonal health care service.

Large districts will make it more difficult to raise funds for capital projects and equipment. Lack of trust by communities. Large districts may or may not achieve additional administration efficiencies. What result will be a restructuring of the bureaucracy with positions shifting from one area to another?

Large districts will be limited in their ability to cope with labour

unrest strikes because of the area they cover and the reduced out-of-scope mix. The recent CUPE (Canadian Union of Public Employees) strike is a good example. Large districts had less volunteers and found it harder to manage. The end result was a loss of public trust and lower staff morale.

Larger districts will result in another Dorsey commission. They will increase the power base of the unions and throw the health system into confusion and turmoil for years. Tinkering with district size is more a cosmetic benefit for public perception, high visibility, low returns.

The loss of rural hospitals will accelerate rural depopulation and severely impede any initiative for rural revitalization. Relocation of retirees to the city due lack of confidence in future health care being available is a prime example. This causes loss of family and community support and the need for more health services when clients are ill.

We question the ability of the tertiary regional hospitals to cope with the massive transfer of clients to already overworked facilities. Long waiting lists will simply get exceedingly longer.

We question the role and location of the 14 regional hospitals. Again, distances, geography, and road network will mean one to two hours of response time by EMS to transport a client from southwest rural Saskatchewan to a regional hospital even in good weather.

Large districts will not improve turnout for health board elections. People are usually content to leave the board in place unless they are unhappy with an incumbent. They will then contest the position. Apathy may occur when stakeholders feel the board is too far away to listen to local needs. Longer distances may make it more difficult to obtain qualified candidates due to extended travel time.

Efficiencies can be obtained within the system by developing criteria for care in response to treatment models aimed at quality of life, not quantity. Doctors can then deny treatment if a patient does not meet criteria. Examples are prosthesis replacements, cataract surgeries. In diseases such as Alzheimer's, when the natural disease processes lead to not eating, then stomach tubes would not be an alternative. In resuscitation when quality of life is already poor, in strokes when antithrombolitics or surgery are not an option, CT (computerized tomography) scans would not be done. And so on and so on.

The developing of integrated care pathways, which would direct care, would ensure that all stakeholders are treated in the same manner, no matter where they live.

The quality council is made responsible for a great many issues but given no authority to correct. A similar concept was attempted in Alberta and even dismantled. To achieve desired outcome, they need to have power. They could be given the authority to develop and integrate the above-mentioned criteria and care pathways.

Retention of management and health professionals is not necessarily tied to the size of district. Creating an environment that is consistent with opportunities for quality of life at home and work is. We should be putting forth the positives of living in Saskatchewan: clean air, clear skies, friendly people, good quality of life, and safe communities. Money isn't everything.

On the positive side of the equation, we support Mr. Fyke's recommendations with respect to technology, research, and health indicators.

We are pleased to advise that South Country District Health has been working towards many of the commission's recommendations for years. We have two acute facilities. One is already an integrated facility and plans are in place to convert the other.

We have strong primary care teams in place with existing physicians and other professionals. We have created a network of clinics, health centres, and integrated facilities, which balance the needs of communities with available resources.

We are continuing to work on improving partnerships with the affiliate and other districts to achieve better health care for the communities and operational efficiencies.

In short, we are putting in place quietly but surely many of the commission's recommendations. We are doing so at a sustainable, achievable pace. We would continue the list but the above are representative of key concerns regarding the Fyke Commission on Medicare.

As stated earlier, Mr. Fyke's report is an exercise in theory. Implementation is a totally different matter. We urge caution and restraint in implementing any of the recommendations. All changes considered should be thoroughly discussed with the stakeholders. To quote one of the stakeholders in our district:

> We already have a two-tier health system — rural and urban.

We urge you to ensure this does not become true.

Finally, we thank this committee for the opportunity of presenting this brief on behalf of the Board of South Country District Health and its residents. We trust our comments will benefit your deliberations and final recommendation. Thank you.

The Chair: — Thank you. Just before we move on to questions, your final comment about our final recommendations. We're not making recommendations. We're just going to report to the Legislative Assembly what we've heard.

So we'll move to questions from the committee.

Hon. Mr. Melenchuk: — Just have one question in terms of your opposition to having less number of districts in the province of Saskatchewan. We look at Alberta with three times the population and 17 regional health authorities, and we look at New Brunswick with, you know, roughly a similar population and six regional health authorities.

How is it that there's acceptance in terms of the need for integration, coordination of services on a more regional basis

and also maintaining local input in decision making? There seems to be some fears that perhaps with a larger district that we lose some of that local input and local decision making, but other jurisdictions seem to have gotten over that. Is there specific concerns with regard to your district that you could maybe sort of extend a little bit for us?

Ms. Kowalski: — We don't have a problem with fewer districts. We just don't think it's appropriate to have too few. That the districts become too large and too unwieldy. We want to take into consideration the natural trading paths and the referral patterns and the road network.

And I believe it was Nova Scotia who had five regional hospitals and have gone to eleven because they felt that the bigger ones were a little bit too difficult to manage. So I think we just have to be very cautious and work slowly towards this.

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

Ms. Bakken: — Thank you very much for your presentation. And I think it's becoming very clear to all of us on the panel that we're hearing the same message over and over again that the health districts in rural Saskatchewan have taken it upon themselves to provide adequate, efficient, and effective care for all residents in their area, and that you've been working on that on your own and making that available to your citizens.

And I just would like to comment that I think we're also here beginning to see that many of the recommendations that Mr. Fyke has are backwards, that we should be enhancing the role that hospitals can play in rural Saskatchewan in order to make health care better for all citizens of Saskatchewan because we take the heat off of Regina and Saskatoon by doing what we can already do, and provide good services to rural Saskatchewan.

So I thank you for coming. I know that the members on this side are certainly listening and hear what you're saying, and I hope all members will come to the conclusion that we have to enhance the role that you play in the health delivery system, not make it less. So thank you very much.

The Chair: — Thank you. I'd like to just thank you on behalf of the whole committee and assure you that the whole committee is listening to all the presentations that we have, and we will report back to our Legislative Assembly what we do hear. And thank you very much for coming.

Thank you. I'd like to welcome our next presenter. As you've heard, I think, sitting through a couple of presentations, we're the Standing Committee on Health Care and it's an all-party committee of the Legislative Assembly. Its task is to receive responses to the Fyke Commission, or the Commission on Medicare, and report back to the Legislative Assembly what we've heard. We'll not be making recommendations.

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

If you want to give your . . . we have half an hour, and hopefully, you'll leave us a little time for questions. And give your name and where you're representing . . . or who you're representing, and proceed with your presentation.

Ms. Elston: — Thank you very much, Madam Chair. First of all, my name is Murray Elston. I'm with Canada's Research-Based Pharmaceutical Companies. We are the national organization representing the innovative pharmaceutical companies in Canada, includes not only the transnational companies, about which many will know — Merck, GlaxoSmithKline, for instance — but also a large number of bio-pharmaceutical companies that are Canadian-based, ones which are known, I suspect, like QLT from BC (British Columbia) and Biomira among others.

Let me say two things. One, you've got a volume of paper here. The one piece is a written presentation which has a little bit more detail, and then I copied my speaking notes just for the ease of following, so you don't have to take notes. I was once in the legislature in Ontario, so having sort of gone through some of this stuff, it's helpful just to scribble a couple of words at the side as opposed to having to figure out what the witness is really perhaps wanting to say.

May I say firstly, Madam Chair, that I appreciate the opportunity of being here and the arrangements made to permit me to address the committee. We think the work is extremely important. I will be as brief as I can. In fact I will probably even précis some of the speaking notes.

I will refer you to the fact that we do believe very strongly in the power of research. The Fyke report, while not spending a lot of time on that, highlighted that as an important element in their paper in two or three places. And we would join with him to indicate that we think there are tremendous opportunities in Saskatchewan for the development of further research activities.

We have a huge activity Canada-wide, about $960 million, but a very limited amount of activities in Saskatchewan. You'll see by the notes, about eight and a half million dollars worth. But we see the building that is going on in terms of infrastructure, which would support a continued expansion as being a preferential series of steps, which we think, will be beneficial to an increasing role in that place.

I would also like to say that we have taken a look at the Fyke report, and I have enumerated several places at which we see major areas of agreement. We like the idea of quality. Obviously we like the idea of integration. But we would like to note, I think — or at least I would like to note — two or three things.

Just one from a personal point of view, prior to moving to Ottawa last July, my previous home was Walkerton, Ontario. And while there is a brief mention of the importance of public health, might I underscore for the purposes of good health status, the very strong and important role that public health and the provision of those communal services and the quality of those communal services have to the health status of the populations.

Unsuspecting people, my neighbours, are now dead as a result of perhaps people straying from the types of aggressive public

health initiatives which brought in communal, potable water, communal disposal of sewage, and other things. So I can't help but perhaps deliver that personal message to you — that while we tend often to think that we've licked a number of problems, if I can put it in the vernacular, those problems exist and ought to have attention paid to them in a real way.

That will take me on to a listing. I think I've listed seven areas in relation to places where we support an integrated system. For instance in the Fyke Report . . . recognized appropriate management of chronic conditions such as cardiovascular disease, diabetes, psychiatric conditions, all of those things are important. But for the purposes of saving time, I will let you sort of quickly browse through those and if you'd like ask me some questions.

We think, with respect to proposed solutions, Rx&D supports these other elements: incentives to adopt best practices. We think that that is an important role, particularly in prescribing, and that there should be disincentives set in place to deal with ineffective practices.

We like enhanced basic and continuing medical education for physicians on evidence-based prescribing. We like an enhanced role for pharmacists as a part of the primary health teams. And again I might underline the point that it would be part of the primary health teams. We like the idea of an integrated approach of service providers at all levels which are not always easily found.

Improved real time information systems equally are as important, and I think during the course of reading the Fyke report it was interesting where the comparison was made between shopping for a car and shopping for other commodities, including health care. And where the most information was available was if you were really looking at the commercial transaction for a consumable, which was, I think, in most cases relatively speaking, less important than finding the right information to consume for health care purposes — very important information that was laid out there. The installation use of software that utilizes current drug knowledge about contraindications, drug interactions and therapeutic options — obviously something that we would support. Practice guidelines based on solid research evidence, feedback to prescribers, health districts and primary health teams on how well they are performing with respect to prescribing and compliance with accepted guidelines, public education on the importance of compliance and prudent use.

And might I just here digress just one moment to indicate that there has been work done in other provinces, and at the end of my speaking notes there are a couple of examples of this where it has been determined that the education not only of the professionals but also of the patient and the patient support — whether that be a spouse, a parent, or a child — is equally important in making sure that not only his compliance is carried out by an understanding of when certain activities can reduce the stress that perhaps will alleviate having to visit other expensive parts of our health care system, a very important lesson that has come out of some of the partnered activities in other provinces.

And then finally a clear, defensible and transparent criteria for determining which experimental drugs and populations warrant special status for coverage, an important element.

Although I would just like to highlight for you the fact that if we are in some cases dealing with experimental drugs, we really do talk about the issues there where perhaps clinical trials are still ongoing and coverage of some of those experimental drugs are sort of captured inside the activities of a clinical trial.

And so there would have to be in addition to a decision I suppose here, also an additional decision taken by Health Canada if there was an extension prior to approval for market of these drugs, of a special authorization to allow these pre-NOC or notice of compliance products to be made available generally to the public.

So we would like to make sure that we don't get into, in some way, some kind of extra layer of decision making where there are patients being sort of caught while approvals are having to be taken.

And finally, if I might before going into the issues about which I'd like to speak with a little more detail, I think . . . It was interesting to me in my former role as a public official, and for about two years I was the Health minister in Ontario in the '80s, which seems like a long time ago. But I would have expected, I guess, when I first read the report that ultimately what was being defined here was an incentive to drive towards the best health outcomes for patients.

I think perhaps it is implicit in some of the statements that are made and some of the paragraphs which are repeated in the text of the report — and I wouldn't indicate that Mr. Fyke is not interested in good patient outcomes — but I think for some of us who have been in the other world and now are on the outside of that other world of administering public health activities, that one must make sure that you don't compromise the drive towards good patient outcomes by measuring your response first on the basis of budget. I think you have to understand exactly what it is you are at in terms of delivering a program.

Why is there medicare at all? In the first place, it wasn't to ensure . . . it was to ensure that barriers which presented themselves to people receiving appropriate care were eliminated. And to the extent possible, we decided in the early days, much before there was a lot of sophistication around the application of drugs and other things, that that should cover physician and hospital services.

One now has seen the evolution of our system to a point where hospitals, physicians, and others in those areas have been joined by a huge number of other support people, not just nurses in hospitals. Now there are people who provide physiotherapy or audiology, people who are now sophisticated in delivering psychiatric services and new medications which did not even exist in those days. And to be quite frank, we are now intervening in ways which save people who would not have survived in the days when medicare was first introduced in this country. So we have to be very careful to make sure that we still look to improving the health outcomes as a first priority and that we measure ourselves in the . . . in relation to that priority as a health care system.

Ultimately, we have to be careful that sustainability . . . and in a couple places, there are examples of one from the United States where they were talking about the implementation of quality standards. And in fact there is an excerpt on quality which goes quite a long distance to excerpting piece by a US (United States) person, and in one of the — are they green? — paragraphs — I think they are — that are quoted, the black paragraph at the bottom of one of the pages actually goes on to say, high quality is what you get by using the resources available.

I'm not sure that everybody would agree with that. I think you have to be very careful at having a throw-away line like that because in many cases the difficulty which a lot of public policy people have is to wrestle with is trying to find ways of achieving a higher quality with the dollars you can. In other words, stretching them. In some cases, you cannot stretch a dollar further than it can go and you have to make decisions or take decisions as difficult as those may be to, in my day, adding six new CT scanners in Ontario — it sounds like a long time ago we had to worry about that — or adding new MRIs (magnetic resonance imaging), as the issues are now, or in fact adding new products to the formulary.

Those discussions and decisions taken in the past 20 years or so, about which I know a little, have always been difficult to take because it means that you have a current budget level which has to provide or develop for you some flexibility in delivering the decision to move on to the next level.

My view is that our health care system, and in spite of a lot of people who tend to think badly of it — and I think even some people who tend to exaggerate the difficulties of our health care system to promote an agenda which would drive change to the detriment, in my view, in some cases of outcomes ought to be very, very strongly urged to take a look at how the health care system has evolved.

The fact that new technologies, in spite of the very difficult questions of funding, are responsible for a system which was designed several decades ago, being able to go further to serve more people in a more efficacious and more meaningful way and having people live longer than any of the designers of the system would have thought possible. I'd love to make a speech about that but the time probably won't permit. But the thesis I think is very verifiable.

I can you one example. In 1985-86 when I first into the Health ministry in Ontario, we were dealing with the issue of surgery for ulcers. Now it was costing tens of thousands of dollars to have people in hospitals to deal with that. The advent of then Zantac, ultimately Cimetidine as the generic, took away the tens of thousands of dollars we spent doing the operations and the hospitalization and the recovery time, and you managed with a product that cost perhaps 2 or 3 or $400 a year — the same type of process — and ended up with a good result. And as a result of that we ended up being able to move on to the next series of problems.

So our health care system is solving a whole series of problems we never even contemplated being able to deal with in those days. So look to technology as an opportunity. Don't be as afraid of it as I think we generally have tended to be because it does offer us some solutions, and it offers and develops for us the type of flexibility which permits us to do the types of things which is public officials and public trustees of funds, which I think we would all want to happen.

One example, just because I visited these people last week, an interesting thing where the people operate for aneurysms, generally these things are hidden from a surgeon. He/she will have to go in and kind of look around and find out what's going on. New technology now permits people to identify through some software programming a three-dimensional image of the aneurysm as it is, even though it's hidden, and the surgeon can with some surety decide whether or not it looks appropriate to go in the way he or she first thought they would. And ultimately they can shorten the operation; in fact they can even take decisions that perhaps they didn't have to do the types of things that they would otherwise.

So just as an example, I want this body not to buy into the theory that technology and the expense of new technology, sophisticated and as expensive as it might be, is going to be a compromising element for a health care system.

Secondly, let me now go onto a couple of things. Some of the work . . . a couple of areas of which there were very brief discussions about drugs and, of course, that attracted my attention in relation to my companies, my member companies — I don't mean to be so possessive. But our association obviously wants to ensure that there is proper consideration of the advantages associated with using drug therapies; obviously associated as well with using proper therapies, and obviously we don't want to see unnecessary barriers raised against the prescription of appropriate therapies at appropriate times.

And a couple of the items which were slipped into the report in two locations, but particularly on pages 48, 49, dealt with quality and the issue of drugs. And there were two items which were raised. One was reference-based pricing which is purported to ensure that lowest-cost product of equivalent therapeutic value or benefit is used. And then secondly, there were formulative policies and templates for making formulary decisions and "fair price" calculations based on therapeutic effectiveness rather than the cost of production of price in effect in other jurisdictions.

The short form with which those discussions were initiated, I think, would require an extended period of time taken specifically on those in terms of understanding exactly what was being proposed. I think it's much too short a discussion for people to move into those areas, and I know they weren't singled out as exact recommendations, but they sit in the text of the report as though that was the way that Mr. Fyke wanted people to go.

And we would like to just advise that there are several problems, particularly with reference-based pricing. One is that the claim that this will be sort of the solution to costs associated with drug applications is at best perhaps a temporary respite, that the evidence from many jurisdictions that have practised reference-based pricing have found that there has been a return to increases in the drug benefit costs associated with each of the jurisdictions after a short respite.

It also has been shown . . . and I have to be very candid with you that I don't think that the evidence yet in terms of really strong studies is fully developed. But the initial evidence is that there are unnecessary barriers being built against the prescription of appropriate therapies. And it's certainly has been shown that there is extra administrative time taken by both physicians and by pharmacists as they deal with implementation of reference-based pricing.

So we think if you end up having barriers against the proper therapy being prescribed that you will end up with — and there are some evidence anecdotally — people being put in to hospital as a result of having had to return to the results of reference-based pricing. So I would love to come back at some point and engage in a much more detailed discussion on that than I think that we would have now. But only to say, could you pull it beside this as a report to the legislature, the sense that it has to be much more strongly discussed. It has to be more fully developed in terms of what it can actually deliver to the people of this province.

The other thing with respect to the pricing. I'm not absolutely sure what the report means to say by fair price and the one line that is basically there. Needless to say I wanted to remind people here that there is a Patented Medicines Prices Review Board in Ottawa which provides the test that is a non-excessive price test which permits our companies to sell in the market in Canada. We cannot have a patented product that is marketed without having the PMPRB (Patented Medicines Prices Review Board) give us a check mark that says we are non-excessive.

We would think that there would be perhaps suggested by the one line here a duplication or a process of some nature which would cause a duplication of activity and you should know that there are a number of provincial representatives on the working group of PMPRB, of which I also am a member, that have exerted their interests in relation to having the price tests applied fairly.

And then finally if I could just touch on this because I think generally speaking it complies with where you are. Health management is really the nature of I think where the benefits can best be described. It's in some ways a new iteration of perhaps a system in development over a series of years. It requires integration; it requires evidence-based information. It requires people to take conscious decisions about generating the best result from the investments that are given.

The health management approach is based on three principles.

Partnership. The program that we propose involve all the players in the health system namely patients, health professionals, the government, and the private sector including our companies. Every program is supervised by a coordinating authority in which all of these sectors are represented.

Scientific rigour. Every health management program is based on appropriate clinical, epidemiological, economic, and statistical data gathered at the beginning of the program to produce a base line and then referenced against performance.

And then finally integration of effort and communication which I won't go into because it is in some ways a little bit self-explanatory.

Two examples which I have extracted from the more detailed piece: ICONS which is Improving Cardiovascular Outcomes in Nova Scotia was a project jointly done between the government there, Merck Frosst, and some other members of our organizations talking about how we could increase the positive results from dealing with cardiovascular disease; a five-year project with a cohort of approximately 50,000 patients. The goal was to improve life expectancy and quality of life, and I think most of us could accept those as being the basis upon which we should move forward. So we ended up with that program identifying that in some cases there were under-prescription, under-diagnosis of cardiovascular problems and that at the end of the day the use of treatments identified as the most productive actually were increased, but the results were much, much improved as a result.

But the second issue which I have identified is PRIISM (PRogramme Intégré d'Information, de Suivi Médical et d'Enseignement/Integrated Program of Information, Medical Monitoring, and Education). It's a French acronym for a program undertaken in Quebec with respect to asthma, and it involved developing a coordinated response right through the health system to the patient and the support group. And following the implementation of that, or the activities around that program, there was a noted increase in the benefits to the patients.

So we recommend that consideration be given to enhancing collaborative methodologies and programs, such as health management programs that focus on improving patient health outcomes and ensuring the optimal utilization of pharmaceuticals, health services, and advice of health care professionals, physicians, pharmacists, nurses, the home care providers.

And we recommend that the innovative pharmaceutical industry be invited to participate in the detailed planning of quality improvements as they pertain in a health system and in particular as they pertain to pharmaceuticals.

Thank you, Madam Chair.

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

Hon. Mr. Melenchuk: — I just have one question for you with regard to your comments on reference-based pricing. Could you give some examples of jurisdictions that currently use reference-based pricing? And what does that actually mean in terms of the approach?

Mr. Elston: — Well the approach is basically to reference against a product in a category of treatments that are available. Oftentimes they would be existing treatments with a particular cost, and so the program, particularly in BC for instance, will reimburse on the basis of the cost of that product, not necessarily against the other products which are in the category.

Sometimes penalizes the introduction of new medications, which would perhaps . . . or for instance develop the method of reducing the number of dosages from three times a day to a single day dosage, or one single dosage per day. That having

been the case, it sort of goes against the idea that the improvements which go with one product, one pill a day for instance, as with respect to improving compliance. It also gets in the way of whether or not there has been improvements with respect to side effects, which may have been created by older products.

Particularly that's a very interesting feature of the new products as we become more precise in understanding what receptors deal with the types of medications which are consumed by various people.

Now we are much more precise about the types of effects which can be taken. But if you only reimburse on the basis of an existing older treatment which has less or, yes, less precision, then you're not going to perhaps end up with the best result for the patient. It may, one, take longer; two, may end up with complications; and three, you may end up with some hospitalization.

Other jurisdictions dealt with it. Norway — I think actually some of it have been laid out for you — Germany, and there are some others which we could give a little more detail on if you wish.

Hon. Mr. Melenchuk: — The point that I was trying to make, of course, is that the... your opposition to that particular methodology is based on quality aspects and also choice, I think, for providers of health care delivery.

Mr. Elston: — Pardon me, it's in that . . . in those two areas, but also in the area of having an efficient system. Because one of the things that happens with the analysis of reference-based pricing is that it tends to discount the types of administrative costs that are associated with having physicians and pharmacists and others having to go through a process by which they can put a patient on to the product which they think is more appropriate.

And also we think that there is . . . this is, I think, is the expression I use, because I don't think yet there has been yet enough definition yet around the research with respect to reference-based problem. But we feel that the full costs associated with dealing with the program inside government is fully acknowledged because, in some cases, we believe there's efforts taken to ensure that it looks perhaps better than it really is.

Hon. Mr. Melenchuk: — That's the only question I had and thank you for your presentation.

Mr. Gantefoer: — Madam Chair, Mr. Elston, thank you very much for your time in coming and your thoughtful brief.

I'm interested in touching on the research component of your presentation. Currently, the provincial government expends, through the Department of Health, for medical research something in the magnitude of a quarter of 1 per cent of the health budget on research. Mr. Fyke recommended an increase to between 1 and 2 per cent of the health budget.

In looking at the statistics that you give us for the nation, the $8.4 million, while it is an increase, also would be somewhere in that quarter of 1 per cent or similar to matching what the provincial government's investment is. And on a per capita basis, we might expect something in the magnitude of $30 million of the national research budget.

Are the two linked? Is there a connection or a synergy between research that is initiated by a province within a province and its ability to attract similar dollars from firms such as what you represent?

Mr. Elston: — I think the short answer is yes, but let me give you a couple of other riders to that.

One is that there has to be in place the type of infrastructure which permits the principle investigators or others here to be involved in the research field with a critical mass of people who are able to provide the supports, which really now are necessary if you're going to compete for an increasingly global research activity.

Let me say that generally speaking, in terms of research, both at the federal and provincial levels, throughout the country that our industry has seen, we actually support the improvements. The difficulty which we are always faced with is the fact that there are improvements around the world in trying to attract the dollars from our industry in terms of investments.

There are right now, for instance, studies going on in the UK (United Kingdom) and the European Union as to how they can better increase their research or improve their research climate to attract more money. And while the Canadian experience has been one of improvement, and in fact I think considerable improvement over our condition, it doesn't yet approach the scale of investments which are made in the United States, Germany, the UK, or Japan.

And the other thing which is something which compromises, I think, the Canadian world — has nothing to do with the tremendous resources here because we've got wonderful men and women in the research community who are internationally renowned — we haven't got a track record of the public investment in research and development over a long series of years.

Japan and Germany, for instance, when they went through their very difficult dislocations economically, maintained — and in a couple of cases, in other countries as well, there was an increase in the research investment — because they decided in previous years that what was necessary for their economies was to bite on right away to the development of a knowledge-based economy over some of their more traditional areas of activity.

I think that's a place where most of the jurisdictions in Canada — in fact I think I can say all jurisdictions in Canada would like to be. The issue is going to be the measurement of the stamina of the investments that are required to get into that global research game — my word, not perhaps the right one — because there is such a huge competition to be in that business now.

So anything that can be done in one magnitude I think will be important. But more important even than the magnitude is to make sure that it is a long-term commitment which is not

reversible because there is a wee bit of an issue fiscally. And I understand . . . I don't mean to downplay the issues of fiscal problems, but if you're going to be in research and development you must be in it year in and year out, year in and year out, decade in and decade out.

You can't turn the switch on as the Canadian government and the provincial governments have with the infusion of some more money for research now and then turn it off after three years and say, that's enough, and then try to start it again and be back to where you were before you shut it off. You lose the stamina. So magnitude is important, but I would say staying power is probably even more important than that. The maintenance of the resource base which is being developed is hugely, hugely important.

Saskatoon with the activity around the synchrotron is an important adventure because for me it is a demonstration that there is a long-term commitment with some vision, for instance. And I think we need to see that type of long-term activity played out so that if it's a quarter per cent now — and while I would agree let's go to two — if it's a quarter now, let's not slip to an eighth or let's not even shut it down so that you end up at maintaining a quarter forever.

Because the one thing that's interesting about research is that as you answer questions it expands the field of questions that you have to answer to be sure that you've got the types of crucial knowledge that permit you to then go on and deliver in our world new products for health care relief, or in any other world the next invention to assist in the development of a new agricultural product or the next invention that helps to develop new software to do analysis. And so those are my comments there. Magnitude is one which I think has to be really balanced on the long-term implications and sustenance.

The Chair: — Seeing no more questions, then thank you very much on behalf of the committee for appearing today and leaving with us your materials. Thanks.

The committee will be recessed until ten after one.

The committee recessed for a period of time.

The Chair: — Great. We'll get started. Welcome to the Standing Committee on Health Care. It's a legislative committee and it's an all-party committee, standing committee of the Legislative Assembly.

Its first order of business is to receive responses to the Fyke Commission and report back to the Legislative Assembly on what we've heard. We won't be making recommendations; we'll be just reporting back what we've heard. And that report's due to the Assembly on August 30.

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

If you'll just introduce yourself, where you're from. We have your submission and you can begin your presentation.

Ms. Harris: — Madam Chair, members of the committee, and members of the public. On behalf of the Assiniboine Valley Health District, we'd like to thank you for the opportunity to speak with you today about the Commission on Medicare report.

I'd like to introduce the chairman of the board, Mr. Ivan Peterson, and myself, Debra Harris, chief executive officer.

We'd presented you with copies of our submission to the Standing Committee on Health Care and are here today to present the information received from the people in Assiniboine Valley. And I believe you have the copies.

Rural health service needs are real, and we find among the recommendations in the report some that are positive, some that require further explanation, and some that cause us concern. At the April 23, 2000 meeting, the health district board analyzed the report and decided that dialogue with internal constituents was not only important but essential.

We developed communications plans to ensure the Commission on Medicare report was thoroughly reviewed with targeted stakeholders, and the issues and concerns raised were forwarded to the responsible agencies. An analysis of the strengths, weaknesses, opportunities, and threats shaped our review and helped to identify the impact on Assiniboine Valley Health District.

AVHD (Assiniboine Valley Health District) has a history of strong community involvement and commitment to stakeholder dialogue with any changes in health reform. Ten consultation sessions were held during the month of May to a variety of audiences: municipal and school leaders, First Nations leaders, health care unions, staff, physicians, ambulance and contract services, volunteers, auxiliaries, and the general public. Sessions were informative and well attended.

The presentation, discussion and dialogue of each session lasted approximately two hours. Over 200 people met to discuss the report. Information and workbooks were distributed in advance of the meetings to help participants prepare for the discussion. Notes were taken on the feedback and comments received. People in attendance vocalized their compliments of and their concerns with the report. All comments are included in this report in the back pages and they are unabridged.

This is the presentation of the summary of the initial communication with people living and working in our communities. Through this dialogue, eight themes emerged as either concerns or issues requiring action by the district. These themes assist in the understanding . . . in understanding the context of the environment, the information in the chapters of the report, and the public's interpretations of those recommendations. They are as follows.

The first theme: "Report complexity and clarity." They asked us: will it be cheaper or better than what we have now?

Most people expressed concern over the complexity of the report. It was easy to read but it discussed concepts that most people were not familiar with. This added to the confusion around what the new world would look like.

Some people had difficulty understanding what would be different from what they had now, thus they could not envision how this would be cheaper or whether there would be any efficiency created.

Theme number two: "Understanding the Change." They asked us: who will do the work? Will physicians and other health care professionals leave or be difficult to recruit?

Participants were unsure of the models of care in the Fyke report. They did not have clear understanding of who would provide care. There was concern that the uncertainty of the new system would create an environment of instability and this fear factor resulted in many comments regarding who would do the work.

Participants believed that rural health care is a speciality requiring practitioners with skills and expertise in the management of a broad range of health needs. They wanted qualified professionals who were able to work in safe, healthy workplaces where quality was promoted.

Theme number three: "Service provision." They asked us: where will we go when we need health care or have emergencies?

People were very concerned that they would not have services when they needed them most. People understood the need to travel for specialized care, but also the need to strengthen the health care services at the local level. They were concerned that travel to acute care centres would be beyond the resources of seniors and, as a result, their health care would deteriorate. There were concerns that diagnostic services such as lab and X-ray would not be available and would compromise their care. People wanted emergency service in their own communities and they wanted basic acute care at home. People in rural areas know only too well how difficult hospital care at distance was to access.

Theme number four: "Illness Care versus Health (Wellness) Care." They asked us: will there be enough of what I need today, tomorrow, and next year?

Generally the comments about health promotion and prevention indicated that people understood the issues but were concerned that they would be giving up service they need now for initiatives that may not benefit them in later years. With the high senior population in AVHD, the reality for most people is illness care . . . is that illness care is what they will require in the next few years, and the trade-off for them is unattractive at this time.

Theme number five: "Accessibility." They asked us: how will we get there? When I get there, will I get in or have access to what I need?

People living in rural communities are used to travelling long distances. They are aware of the cost of distance travel and of the wear and tear on their resources. Accessibility to health care services is an additional burden. Rural people want their needs recognized as well. They want others to understand and respect their lifestyle. Basic health care services in their own communities are very important to all people including those living outside larger cities.

Theme number six: "Fairness." They asked us: what about the elderly? Will services in regional and tertiary centres be available for them or for us?

People talked about fairness but not in the same way as was written in the Fyke report. In the meetings people spoke on behalf of the elderly. They were concerned that elderly people would go without health care. They were concerned about the lack of understanding others have about the relationship of rural hospitals and about community sustainability.

Theme number seven: "Accountability." They asked us: who will have control? Will there be local input into the new larger districts?

People were unsure as to who would decide their future and where they would go to ensure results. They thought the quality council was a good idea but wanted the roles and responsibilities clearly outlined. They wanted to have quality defined and measured and they did not want to pay for another level of administration in order to ensure that it was.

In terms of amalgamation, there was concern that the new structure would be too large to manage, and people would lose control at the local level. It was unclear to them whether large boards would listen to the needs of the smaller, more marginalized . . . (inaudible) . . . of people.

And the last theme, number eight: "Vision and timing." They asked us: when will this happen? Will we have input into the changes or are they already planned?

Memories of the last health reform remain clear in people's minds. They are cautious of new changes and not anxious to accept them without fully understanding a plan, the timelines, and the product they can expect at the end of the day.

It was through this consultation with our stakeholders we were able to put a face to the Commission on Medicare report. It helped us to understand the issues and the concerns of our customers, our clients, and our communities. It was enlightening for us to listen to the comments and views of others. We invite you to read them and to listen to the things people in Assiniboine Valley are saying. We invite you to read between the lines for what is not said.

In general, the comments produce the following five recommendations.

First, provide enough services at the local level to meet basic health care needs. Develop health care programs and facilities based on needs. Diagnostic and emergency services must remain in our community. Support community sustainability. Needs should support a structure that looks at today, tomorrow, and the future.

Second, recognize and develop rural health care as a specialty. Support the development of magnet environments in rural health care facilities and services. Support the enhancement and integration of best practices research in health care . . . in rural health care delivery. Recruitment and retention of health care

professionals for rural Saskatchewan is essential. Magnet environments will help build capacities.

Third, the location of service should not impose additional barriers. Recognize the additional pressure with travel distance to service, weather conditions, and aging populations. Understand our limitations.

Four, phase in the change with rural people as active participants. Ensure rural representation shapes the analysis, discussion, and implementation. Work with us to help us create our future.

And five, include the social aspects of health and recognize the quality and lifestyle of rural people. Accept our diversity and shift away from marginalization through respect and acceptance. Recognize our unique contributions.

At the meetings, we explained to participants that each health district was consulting with communities in a different way. Some were holding large public meetings; others were consulting in small groups, and others were dialoguing with health care professionals and employees. People understood that we would bring their concerns forward through the consultation process, as we are today.

This presentation brings to you the voices of the people living and working in our communities. It is no way meant to be all-inclusive. Many participants believe change is good. They want a voice in the type of change. They want to know that change would be for the better. We would like to say thank you to our citizens for so thoughtfully and articulately expressing their views.

We would also like to thank the committee. We are confident that this important body of information will be influential as the committee makes their decision.

And now I would like to invite Ivan Peterson to present his message on behalf of the board. Thank you.

Mr. Peterson: — Thank you, Debra. I think at the outset I'd like to say that we fully support the presentation that SAHO made to this body this morning.

I'd also like to talk about four things, maybe a little more specifically. One is the establishing the need to change the delivery of health care, secondly a little bit about acute care, governance, and maybe touch on some unique issues surrounding health care.

I think it's very, very important for us to establish that there is indeed a need to change the delivery of health care. I say that because I sincerely believe we have a very good health care system. It's been identified in a variety of ways. Even nationally, the accreditation, particularly in our district, was . . . the team felt that we were doing excellent work, and services were being delivered in a very appropriate manner. So I think it's extremely important, before we embark on anything, that we clearly establish that there is indeed a need to change.

If there is a need to change, then what are those reasons? And certainly we could identify some perhaps. Like, is it because there's a population shift in Saskatchewan? Or is it because we can't recruit staff? Is it because of changing medical practices throughout Saskatchewan and Canada? Is it because of technology? Is it because of sustainability? Or is it to improve the system? Or is it a combination of all of those things?

I think it's very, very important for us to establish that.

So first then I think we need to make the case. We need to communicate it, and we must have the courage to communicate it in a . . . fairly and honestly. For example, I don't think it's easy for any of us to say, that although these are good positions that we can't recruit workers. It may not be easy for us to admit that we can't afford it. Or getting closer to our home I suppose maybe . . . you know the one thing that is constant over the years is that Saskatchewan has about a million people from 1930 to 2001. And it's clear that they're not all in the same places that they were so there's that effect on how we deliver services. But in any case it seems to me that we very clearly need to establish the need.

I said I wanted to speak a little bit about acute care because it seems to me that this is the one that we are grappling with most in this report. So what do the people of Assiniboine Valley want? To my mind they want it clear that there is a flow of services, that it's clear what they receive where. And it's also clear that this system is without glitches, that they're not going to be told that there's a problem with obtaining services from point A to B to C.

And then on a different level they certainly want local primary health services. And I think legitimately so, because we definitely have needs. Certainly we are good at some things that we do and we are pretty cost effective as well both to the system and to clients.

Now one could say how would you design the system. I think acute care is very relatively easy to provide if you have a large population within a small area. It flows very nicely. However, that is not the case in Saskatchewan so it becomes more difficult.

So it seems to us at least that the problem is how do you develop a system that can attract necessary staff to locations that will be dispersed in such a way that response time will be within reasonable limits and distance covered by patients for service will be minimized and not cost prohibitive.

To my mind, we needed to adopt a system that was first outlined by Christopher Wren where you go from a few services to all, in a systematic way largely determined by geography.

I could talk about ambulance services but I think you've heard that many, many times. They do have certain limits as to what you can do in an ambulance and they certainly have certain time constraints as well.

So I think that we need to work on a solution that would strategically place certain centres where you can receive a variety of services in rural Saskatchewan that would certainly include emergency services, long-term care also has needs, home care needs, daily office type services, necessary locations

where you can convalesce, receive respite, etc. So I think the implication is clear that we need a very well-coordinated system that has some direction.

Governance is the third thing I wanted to just mention. I don't believe it's a big stumbling block. However I do believe that it has two components. It seems to me that it has a local component where some decisions are best made locally, and it has a more central component that requires some direction, and again I refer to acute care; remember I talked about flowing of services.

And one of our members puts it very clearly, to me at least. He says that if you compared it to the municipal situation and building of grid roads, it is true that there is some autonomy within a municipal system where you build the grid roads, or when you build them. But somebody outlined the plan so that they lined up, and you had continuous roads. And I think that we need some of that in the system as well.

Just to quickly move to some unique features that I think will have to be dealt with . . . Health care is unique in a system that there's an expanding health care. There never seems to be a void. Like, if you talk about education, you know if you only have four kids, well then I guess you have to make some adjustments. But in health care there is always some very, very goods needs. You can always expand it. And some of that we may need to look at. What we are going to cover and what are some basic needs.

It is my belief that waiting lists have to be addressed. I believe that they are a constant reminder to people that the system isn't working as well as it could. I believe that they erode the confidence in people that the system will be there when they need it.

Two-tiered is also a comment, and I don't believe it's something that is very well understood. It seems to me that two-tier is basic. That we don't have a two-tiered system for providing basic health care services is a very admirable part of the Canadian psyche and should be maintained.

So I think, to sum up, I think we need to make the case for change, if indeed there is one, have the courage to set the path, and let's get on with it. I believe that indecision is very costly to the system. Thank you.

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

Hon. Mr. Melenchuk: — Thank you very much for your presentation. At the outset you indicated that you obviously support the SAHO presentation that we heard earlier today. And of course one of the key . . . in fact there were two key ingredients to the SAHO presentation: one, the establishment of primary care; so the necessity for primary care reform prior to any other major changes.

And I guess those are the two points, is that they do . . . or there is an expectation for change. They believe primary care reform, as Mr. Fyke has indicated, is essential to having that integrated, coordinated system. But also to make sure that when you have the plan for change outlined, that you can provide the security, especially for the people of rural Saskatchewan, that their services will be maintained until they can see, or perhaps at some point, recognize that maybe there is a better way in some ways of delivering services.

Would you agree with those two key points from SAHO?

Mr. Peterson: — Yes.

Hon. Mr. Melenchuk: — The second question that I have is with regard to your recommendation with regard to the local level, that any changes must be based on need. And obviously I think every one of the presenters that we've had would agree that a need is access to diagnostic and everyday services at the local level, and there shouldn't be any tinkering or tampering with that basic service component.

Ms. Harris: — And we would agree with that. And we heard that strongly from our constituents as well.

Hon. Mr. Melenchuk: — Thank you.

Mr. Yates: — My questions have to do with services delivered currently in your health district. I noticed that there are a number of facilities within the health district.

I'd just like to have some sense of, in the three hospital facilities within the district, what type of services are delivered? As an example, are minor surgical procedures done? What type of diagnostic services are done? Are beds used for acute care purposes or more for convalescent care? Some sense of how services are delivered within your district?

Ms. Harris: — We do not have surgical services at all in our district. We have acute care, 46 acute care beds over three facilities. We have a range of diagnostics, including ultrasound on . . . it was on an itinerant basis, but it's now being centralized in one location.

And we have long-term care services, community care. We do have some obstetrics in one of our facilities, obstetrical services, but that is a limited amount as well. Does that answer your question?

Mr. Yates: — Yes, it does. I have one further question regarding the number of physicians that would be available in each of those hospital settings. Like in Preeceville, do we have two physicians, three physicians, and somewhere in Kamsack, and . . .

Ms. Harris: — We have three physicians. In Canora we have five. In Preeceville we have provisions for two physicians, but right now we are recruiting. And in Norquay we have one physician.

Mr. Yates: — Thank you very much, Madam Chair.

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

Our next presenters can take a seat at the table. 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. The mandate of the committee is to receive responses to the Fyke report and report back what we've heard to the Legislative Assembly. We won't be making recommendations. We'll be reporting back what we've heard, and that will be by the end of August.

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

We've given people half an hour. Hopefully within that half an hour you have your presentation and leave a little time for some questions from the committee members. If you want to introduce yourself, then begin your presentation.

Ms. Jurgens: — I'm Victoria Jurgens. I'm currently working as a community and district dietitian in the Parkland Health District. I just finished serving a term as board of director on Dietitians of Canada, and prior to that I was both vice-president and president of the Saskatchewan Dietetic Association.

Ms. Cook: — Hello, my is Stephanie Cook. I am the associate director of clinic nutrition services for the Regina Health District.

Ms. Dahl: — And hi, I'm Wendy Dahl. I am currently a doctoral student at the College of Pharmacy and Nutrition, and I'll be telling a bit more about my background in my presentation. I'll be doing the speaking this afternoon.

Okay. Thank you to the committee for the invitation to present feedback on the Commission on Medicare. I will be speaking on behalf of the Saskatchewan members of Dietitians of Canada and Saskatchewan Dietetic Association. Dietitians of Canada is a nation-wide voice of dietitians with about 5,000 members who meet our academic and experience standards. It is the only national organization of dietitians in Canada. The Saskatchewan Dietetic Association is the registering body of dietitians in this province.

I am also a registered dietitian, currently pursuing my doctoral program. Prior to this undertaking, I practised as a community dietitian in a rural health district. I have seen first-hand the evolution of health districts and more recently the many crises of staff turnover, low morale, lack of coordination, and inefficiencies.

I was fortunate to have been a member of a primary health service team and have seen the quality, effective, and efficient care that can be delivered by a salaried physician, primary health care nurse, and dietitian working closely with mental health, physiotherapy, podiatry, and public health. Unfortunately I have also seen the costly physician-dominated care where fee-for-service billing concerns have overridden the needs of the patient.

The dietitians — in reply to primary health teams — the dietitians in this province, particularly community dietitians, are in full agreement with the plan of establishing primary health service teams. Research indicates that dietitians are crucial members of such teams.

For example, dietitians are uniquely qualified to be key players in both the prevention and treatment of diabetes. Data collected by the diabetes educator sector of the Canadian Diabetes Association, which is the national diabetes educator certification body, indicates that dietitians passed their qualifying examination at a rate more than twice that of other professionals.

Counselling for cholesterol management is another example of how essential dietitian counselling is to the team. Non-specific, dietary advice indicating a lower fat diet will likely result in no effect on blood cholesterol levels. The dietary guidance of an experienced dietitian may assist the same individual to achieve effects near that achieved by some drug therapy. Combining this guidance within the structure of a primary health service team with all members supporting the effort of other team members will result in dramatic health outcomes.

Evidence for this comes from the dietitian-directed lipid clinic established in Regina in 1998. This clinic has achieved statistically significant improvements in cholesterol through the combined efforts of appropriate and timely nutrition and pharmacy services.

The concern we have relating to primary health service teams is the present staffing levels of dietitians, particularly in rural districts and in outpatient and community of urban districts. At present most rural health districts have only one dietitian. Often this dietitian is responsible for community nutrition education, outpatient counselling, in-patient consultation, long-term care consultation, staff education, and health promotion activities. It is not possible for a single individual to accomplish all these tasks, and much necessary and health promoting activities go undone.

A recent study completed of dietetic services in long-term care facilities in rural Saskatchewan and the results will be presented at the rural health conference in Saskatoon in October of this year, indicates that residents of long-term care received close to no dietetic services although research indicates that they are great nutritional risk and that admissions to acute care facilities and premature deaths are closely linked to nutritional status.

Research has indicated that long-term care residents that receive 45 to 60 minutes of dietitian consultation each month have significant health benefits. This equates to at least one full-time equivalent long-term care dietitian in each rural health district and many in urban centres.

Another area of great concern is that dietitians are for the more part absent as key members of home care, although research again indicates that nutritional status of home care clients is perhaps the greatest threat to their independence.

No rural health district employs a home care dietitian. And Saskatoon District, with a clientele of between 4 and 5,000 home care recipients, employs one part-time dietitian. The Regina Health District does not at present provide funding for a home care dietitian, despite the fact that screening of these clients repeatedly identifies that a significant portion of this population is at nutritional risk.

The Fyke report states that in rural areas where the population is

very dispersed, professionals would likely be members of more than one team in the network.

Will we continue to expect health service providers to provide services to 5 to 10 communities? If primary care service teams are to become the norm, a significant increase in registered dietitians will be required. Current funding procedures must change to reflect this need as many of the current community positions are covered by soft money only and offer little long-term security.

While we agree that it may be necessary to convert small, existing hospitals into primary health centres to use existing bricks and mortar, we believe that the teams need to be highly visible and out in the community, in schools, and in senior centres, as community members coming to a centre may perpetuate the hospital mentality.

A quote from Fyke's report states:

> Most groups indicated that their members were not utilized to the full extent of their scopes of competencies and that the full use of their skills could result in better patient outcomes and savings to the health system.

This is particularly true of dietitians. In a model using adequately staffed primary health service teams, dietitians may be able to make full use of their knowledge and skills. Team members will need time to learn about the strengths and abilities of other team members and communication will be vital to this process.

We support the proposal to implement a centrally located 24 hour a day, 7 day a week telephone access to information and services. However, we would definitely advocate access to nutrition services as part of the service.

Saskatchewan residents frequently have nutrition related questions as evidenced by the popularity of the previously available dial nutrition service provided by dietitians throughout the province. And I should add that actually was a volunteer service. Recently this service has ceased due to funding constraints, however, it is our opinion that the ability to have questions answered in a timely fashion by competent professionals is instrumental in potentially circumventing unnecessary medical appointments.

In reference to specialized care, clinical dietitians are an essential component of the specialized medical teams, which deliver a wide range of services. Just as medical specialists benefit from a critical mass of patients, so do dietitians.

The commission's recommendation to eliminate smaller hospitals and instead concentrate resources into the 10 to 14 regional hospitals will be beneficial to the practice of dietetics, as this would allow the increased specialization of dietetics in these regions, leading to expertise. Dietitians support the concept of a province-wide plan for specialized care and tertiary centres while ensuring follow-up and support services close to home, as long as these services are sufficient and timely.

Reduced hospital stays have disrupted the traditional dietitian's approach to nutrition education of acute care patients. We see the evolution from acute care nutrition education to outpatient and community-based educational programs as a step towards effectiveness that is much needed in the dietetic profession. Again we see the strength of the primary health service teams. We foresee dietitians as an integral part of discharge teams.

In regards to "Making Things Fair," to improve the health status of the people of Saskatchewan, the Commission on Medicare recommends the continuation and/or development of public health, health promotion, and disease and injury prevention strategies. These strategies should be developed by a team of health professionals with a similar professional make-up as primary health service teams, but also with individuals with knowledge and skills in health promotion and research.

Strategies need to be well-developed and the primary health service teams need to be involved in the implementation and evaluation. Data collection will need to be clearly defined and measurable, and reporting will need to be in a usable format.

Dietitians have a pivotal role in strategies to address the broader determinants of health, as nutrition is a key factor in the determinants such as personal health practices, healthy child development, and physical environment. Dietitians already take part in multi-sectoral collaboration and action such as the good food box programs, but much more support in these areas is needed. Dietitians' skills in the areas of safe food handling, the purchase and preparation of low-cost, nutritious food and appropriate nutrition for all stages of the life cycle are at present underutilized.

In regards to quality, dietitians support the concept of a quality council with Dietitians of Canada and the Saskatchewan Dietetics Association providing input on matters related to the nutrition profession. Representation from all health professionals will be integral in maintaining an effective council, thus we would also advocate for a dietitian as a member of this council to provide advice and input on matters related to the delivery of nutrition services.

Although we have not underestimated the importance of such a council, we would question if this would impact the role of the present accreditation process and caution against duplication of function of these groups. The concept of a council providing a template for the districts to report standard information to the Saskatchewan public would be very beneficial.

In support of change. As with other professions, attracting and keeping nutrition professionals in this province is a mounting problem. Positions posted in rural health districts are now going unfilled. One step to rectify this shortage has been undertaken by the College of Pharmacy and Nutrition with their newly-established integrated Bachelor of Science and professional internship. In this upcoming year, there will be eight more individuals meeting the requirements to practise dietetics. Also dietetic interns are increasingly being exposed to rural community dietitian practices, and it is our hope that these same individuals will remain in the province.

In the last three years Regina Health District has retained 16 of 27 graduating interns with Saskatoon Health District retaining 9 of 27. Reasons often cited for leaving include wages and benefits offered in other provinces. The average wage of

dietitians in this province is amongst the lowest in the country. Districts may benefit from joint planning and recruitment initiatives for nutrition professionals as current practices are not successful.

Fyke states that "the health care system runs on fumes of tradition and opinion," and I would add that so does professional practice. For dietitians this will soon be something of the past as we are becoming dedicated to research-based practice. The establishment of the Canadian Foundation for Dietetic Research 10 years ago has supported this initiative with a funding of small practice-based projects. Now multi-centre projects are being funded by CFDR (Canadian Foundation for Dietetic Research). However this funding is small in comparison to the dietetic research needs in this country. The Dietitians of Canada have recently partnered with the American Dietetic Association and produced the first comprehensive evidence-based manual of clinical dietetics.

More locally, Regina Health District employs a full-time research dietitian, and the University of Saskatchewan's integrated education incorporates research projects as a significant part of professional training. To date, few research dollars have been allocated to facilitate nutrition research in this province. The dietitians of this province look favourably on the recommendations to increase health research funding, and we encourage the government to accept this recommendation.

We have the skills and abilities within Saskatchewan to conduct research to measure the impact of our service, and we would suggest that research dollars be specifically earmarked to investigate the importance and effectiveness of nutrition as it relates to primary health care.

As a final comment, we support the proposed organization of the province's health care system with the province providing central planning and leadership and health districts to organize and deliver services. Advocacy efforts and evidence-based practice recommendations will be much more effective if approached centrally than trying to influence the policies of 32 health districts.

Throughout the Fyke report, reference is made to the importance of lifestyle and nutrition as a cornerstone to disease prevention and overall health and well-being. Dietitians need to be in key positions to affect improvements in nutrition, which in turn impact the rates of chronic and debilitating diseases. The contribution of dietitians to primary health service teams must not be overlooked.

As our health care system moves towards integration, ensuring adequate dietitian representation is of paramount importance and will be instrumental in improving the health and well-being of Saskatchewan residents. Thank you.

The Chair: — Thank you very much.

Hon. Mr. Melenchuk: — Thank you very much for your presentation. The question that I have is in terms of human resource planning. If we were to incorporate a primary care reform model where we had group practices and team practices, and a dietitian was a member of a primary care team, are there the human resources available in the province of Saskatchewan to man these primary care teams in rural Saskatchewan today?

Ms. Dahl: — I would imagine, at the present time, there's not. One of the problems in the past with actually getting young individuals to take dietetics is that there's always been a limited number of jobs available. And right now with the food industry the way it is, a lot of dietitians end up working for corporations and they're . . . there's a big demand right now so they're easily, they're easily . . .

Ms. Cook: — If I could add, our province does graduate and will be graduating this year 22 qualified registered dietitians, so 22's a fairly significant number. The problem in the past has been, of course, keeping them in Saskatchewan because of wage discrepancies amongst the provinces. That has been our number one challenge.

Hon. Mr. Melenchuk: — The second question that I have is do you see the move with regard to dietitians and their scope of practice becoming more community based as opposed to institutional based?

Ms. Dahl: — Definitely. And the education that they're receiving, at the College of Pharmacy and Nutrition, is definitely training them for community-based practices.

Hon. Mr. Melenchuk: — The third and final question that I have is with regard to payment models for team members of these primary care teams. I think you had mentioned very early on in your comments that the team that you had worked with had a salaried physician. And do you see that as the preferred method in terms of a primary care team?

Ms. Dahl: — Definitely.

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

Okay, if the next presenters would like to take a seat at the table.

We welcome you today to the Standing Committee on Health Care. It's a committee of the Legislative Assembly, and it's made up of all-party members. The mandate of the committee is to receive responses to the Fyke Commission or the Commission on Medicare, and to report back what we heard — not make recommendations but to report back what we heard to the Legislative Assembly on August 30.

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

We have half an hour set aside for your presentation, and hopefully in that time there'll be a little time for questions from the committee members.

If you'd introduce yourself, and where you're from, and then present your . . . go ahead with your presentation.

Mr. Molnar: — My name is Elmer Molnar. I'm mayor of the village of Kennedy, and this is my wife Jeanne, who's come

along to give me moral support.

I'll sort of read this and make comments as I go along, so you can sort of follow along with it. I apologize for two typos on the page at the bottom; I'll point them out as I get there. But time and budget restrictions didn't allow us to get them corrected.

Madam Chairperson and members of the Standing Committee on Health Care, I am Elmer Molnar representing the village of Kennedy. And I thank you for the opportunity to express our concerns about the proposed health care delivery system.

Kennedy is a small, peaceful community in southeast Saskatchewan. Our claim to fame is the prairie lily that grows in abundance, the large number of fireflies, and of course the professional Moose Mountain Rodeo. Kennedy, like many small villages in Saskatchewan, is located at the centre of everything. We are approximately 110 minutes from centres like Yorkton, Weyburn, Estevan, Brandon, and Regina, and suppose you could throw Minot in; it's a little farther than that.

The Moose Mountain Health District presently provides health care for the Kennedy residents in the Kipling Hospital which is approximately 25 minutes' distance. On the roads we have now, if they improve, that maybe cut down by about five or six minutes. Many of the village residents are senior citizens and therefore have to find some sort of transportation to the town of Kipling, usually a friend or a relative. Last week there were two presentations expressing the importance of keeping the Kipling Hospital, and I only wish to add that the removal of the hospital from Kipling will leave a major geographic void in the area. If you take a look at the map of Saskatchewan and lift Kipling out of there, you suddenly find lots of empty spaces and hills and valleys and things like that that sort of make us quite a long way from Broadview and other places.

Our population, as I have mentioned, has a very high percentage of senior citizens who have retired in the village — that includes myself — because of close proximity of the Kipling Hospital. There is reassurance in knowing that they can get to Kipling much more simply and quickly than to some other far away place.

I was compelled to come and speak to this committee as mayor of Kennedy because of all the concerns that were voiced by the people. Statements such as "The government doesn't really care about rural citizens." Now I don't believe that, but a lot of people do. And "once you can't drive yourself, this is not the place to live. We pay the same taxes so why are we given severely reduced care as rural people? Maybe if we get less service, we should have to pay less tax." A novel idea but probably the only fair thing to do.

I wonder why Mr. Fyke did not suggest that the hospitals in Regina, Saskatoon, and Prince Albert be relocated to geographical locations that would provide equal access to both urban and rural residents. This change may increase the driving for city residents to 50 minutes, but that would still be less than the 80 minutes suggested by Mr. Fyke. It probably won't happen, but it was a thought.

The report does not provide any time or distance data for 2 per cent of the population. While 2 per cent seems to be a small number, it represents 20,000 people; there's one typo there if I didn't put a zero in you should put one after it. 20,000 people in real terms. Ladies and gentlemen, this is a population of a major city in Saskatchewan. Are these people to be totally abandoned in the name of progress and cost saving? A lot of people but, you know, they are widely disseminated, they can't speak with one voice, so I hope that, you know, they will not be forgotten.

At this point, I will talk about the costs of having fewer hospitals and larger districts from the perspective of a rural resident. Financial costs. The rural resident pays the same taxes as the urban. The rural resident must pay transportation costs. The rates for travel I think are around 40 cents a kilometre. So a lot of these people would probably have to expend if they were being paid mileage of $150 for travel costs. When they get to these distant places for hospital service, they have to have meals, lodging if there has to be an overnight stay, and there has to be arrangements made for children, you know, who have to stay at home. In a way this is almost like a second form of taxation, you know. It looks like well, you know, they have to lay this cash out but I'll be referring to that a little bit later.

Emotional costs. Many old people will die alone because family and friends cannot be present because of monetary, time, and distance factors. I mean, if you have come in 110 miles from the city, you're a senior citizen and you don't have family in the city, it's very difficult to stay overnight and be with someone who is in the process of leaving this world and you are never quite sure of when they do it. Okay? So you sort of have to be available at all times.

Ladies and gentlemen, try to imagine a mother with a seriously injured child waiting for an hour or more until an ambulance arrives. Time passes very slowly under these circumstances. I believe that the response time in the city of Regina is four minutes. I may be wrong. Abel Wagar told me that many years ago.

There will be feelings of insecurity and concern in the people because you know they are never sure how things are going to be. Like, if we take last November 1, it wouldn't have mattered much where you had to go if you had an emergency, but you certainly wouldn't have wanted to travel 110 miles.

Many people now in rural Saskatchewan will relocate or have to relocate to places where access to acute care will be better. The Government of Saskatchewan claims that it does not want a two-tier health care system. In other situations, a two-tier health system represents a publicly funded health care system as opposed to a privately funded system.

The underlying implications is that the private system will provide a better service at a greater cost than the public system. The government does not acknowledge the two-tier system in Saskatchewan but it obviously exists as an urban level and the rural level. And I will cite a few examples. Also I would like to say that I am not . . . if this tends to sound like I am against urbanization and whatever, I am not; I'm just trying to show there is sort of a polarization occurring here because of financial situations and certain human care situations that arise.

The rural and urban taxpayers pay the same taxes. Equal payments usually translate into equal services, within

reasonable limits. The availability of specialized services is much more accessible to the urban resident than the rural resident. The rural resident has to supplement his taxes with direct cash outlays in order to access to these specialized services. And I won't relate those, but I mean to go to the specialist, eye specialist, or whatever you have to go to see, that you cannot find locally at the present time.

I believe that this difference should be addressed at the taxation level. The rural resident should be able to deduct the extra health care expenses from his taxes. Another solution may be to use the tax money to buy the 20,000 rural residents a comprehensive medical plan and allow them to seek medical services where they see fit.

There is ample you could . . . you know, I think the cost per capita is $2,000. If we project Mr. Fyke's report by 2005, it will be $2,300. So if we were to take say $4,500 or $5,000 and go to Blue Cross and say well look, we can't look after these 2 per cent of our population a long ways off, maybe you can give us a group medical plan for them and then they could choose whether they want to go to Minot, Regina, Saskatoon, or you know wherever. And then they would at least have the benefit of being able to pick a place, where they want to go, rather than being sort of allocated to a particular location.

The next thing I have here is on the establishment of a quality council. And it's just a thought that I had. The establishment of a quality council appears to be a sound concept. Who would not want better quality service and reliable accountability?

The problem arises when you start looking at motivational factors. Are we going to reward the health care centres with high marks by giving them more money, or maybe some other perks, and punish those with low marks by reducing their funds so that they will get lower marks the next year? If we use this method we will get the best . . . we will help the best get better and the worst to become worse.

Much thought must be given to how judgment will be passed and how these judgments will enhance the system. For example, will doctors be prepared to get report cards? You understand what I'm saying.

And just how will we try to motivate a district or an area that is not say performing up to the quality council standards? How will we motivate them to do better? Will it be by some positive approach, and say look, if well maybe if we give you fellows more money you'll be able to do a better job? Or are we going to say well, you kind of mucked things up, and you're not going to get as much money this year?

Mr. Fyke I think alludes to the fact of monetary motivation by stating that probably their funds would be cut a little bit, which of course would be counterproductive I think in the long run.

All right, so when I was here a while ago, I sort of felt that the group was kind of looking for some financial solutions as well — the questions that were asked and people did not allude to them, so I'll let my imagination fly a little bit.

And our society operates with a perception that if government, insurance companies, and large corporations are paying for services, the price must be much higher than if an individual is paying. This attitude greatly inflates the costs of automobile repair, dental work, drug plans, and medical plans.

I'm certain that I don't have to dwell on this as I'm certain that you are all familiar with this dilemma. You go to a dentist and the first thing they ask you is, have you got a plan? I said no, and I said, you worked on my tooth last month. He said, I'll do it for half. Now this would never happen if this was being done under an insurance plan or whatever because people feel that if insurance is paying, we might as well take it for all it's worth. So maybe this is something that has to be looked at.

The provincial government must realize that there are other ways to finance health care services. Government is like a big vacuum cleaner that voraciously sucks up everything at one end and disseminates hot air and rhetoric at the other.

There is a major problem for governments to collect money as taxes and then to direct it in the required direction in an efficient manner. And I mean, I am not faulting government. I mean, that's basically what happens. You know, it comes in and then you have to sort of chop it up into little pieces and ship it out in different directions.

The money moves into the black hole of general revenue, from where it is directed to provide services. But the amount of money coming out is much reduced because of operating costs. The option of course is not to collect the taxes in the first place.

If I may allude to the great income tax refund south of the border, it's a fine political move but doesn't really make economic sense because the taxes were collected and now they're spending millions of dollars sending it back again. And of course the people, if they hadn't paid the tax in the first place, would have been much better off.

I have an example here — some people have told me they have difficulty understanding it, so you can ask me some questions about it later. As an example, let's take a hypothetical family of four. They will pay approximately at this time $8,000 tax for health care services if we assume the per capita cost in Saskatchewan at $2,000. The government will collect this tax, leaving after administration, for a better figure, $6,000 for the health care system.

Now I will admit that I was unable to find any information that when a dollar comes in through taxation, passes through the system to be given back, as to how much it's worth. So I really don't know, when we say that we spend $2 billion on health care, is that $2 billion taken in in taxation and run through the system, or is that $2 billion coming out of the system, going directly into health services? I don't know that, so I have been making some . . . I made my assumptions here, and any assumption can be made there that you wish, and if you have facts to fill that in and figures, it would probably be much better.

Let us assume that's roughly a 25 per cent cost, you know. I would say that if a dollar goes into government, only 75 cents comes out. Now I don't know if that's close or not. I would not even try to argue that point.

Let us assume that this family has a gross income of $50,000. If we were to take 10 per cent of this, or $5,000, to be paid directly by the family to the service providers in the health care system. In other words, this hypothetical family would pay directly to doctors, hospitals, or some other service provider. Once the $5,000 is used, the government system would kick in. The hypothetical family, in order for this system to work, the amount of money available for the health care system must not be reduced because if you need $2 billion, you need $2 billion regardless of where it comes from.

The hypothetical family would receive a tax credit for their costs up to $5,000 for the current year. Since this money did not pass through the taxation system, it would have a real value of 6,600 . . . actually 6,666, based on the 8,000/$6,000 ratio. The total amount paid by the family would still be $8,000, but to get the same value through taxation, the government would have to collect $9,600. So obviously this system would give you a much better bang for the buck.

In other words, if you don't collect the tax and pay directly — and I don't know, I'm not an expert in how these things would be done — an old age pensioner for example, whose income is $7,000 a year, would look after 10 per cent of that. Okay? And what would happen is they would get a tax credit for that, so they would have actually paid their taxes, but rather than going to the government and running it through the system, they would be able to pay it directly to the service provider and bypass the administration costs of taxation.

Now this is somewhat different than user fees. Other premiums . . . I feel that any premium that would go into the government, by the time you've paid $100, by the time it worked its way out would be considerably less. I understand when they had the habitat $11 fund, by the time it got through the system, there was only a dollar left for the farmer, and they charged the hunter $11. So I mean obviously this administration system does use a lot of that up.

And I think there are other things like, you know, probably overuse of emergency services and probably more visitations than are absolutely necessary. There may be solutions to this, and there may not be, but a lot of these old people sometimes have to have somebody to talk to so what do they do? They go see the doctor, and they, you know, it helps a little bit.

In conclusion, I thank you again for your attentive ears, and remember that most of us in this province have strong rural roots, so let us put our heads together and find creative solutions that are mutually acceptable by both groups without increasing polarization. Urban and rural are not equal but they are complementary. Thus we need solutions that will enhance the relationship to create a strong and functional society. Thank you very much.

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

Mr. Thomson: — Thank you, Madam Chair, and I want to thank the presenters for coming in today.

This is an interesting proposal that you make and it's not unlike work that has been done by the Fraser Institute. The Fraser Institute calls these things or this model a medical savings account. What they advocate that we do is we take the government's health budget, the money we collect in taxes, we buy health insurance to protect people against catastrophic injury, and we give back a certain amount of money for them to use on their own, be it for maintaining healthier lifestyles, buying gym memberships, these kind of things.

Part of the problem with it is that as soon as you move to an insurance based system, while the advantages to those of us that are younger, live healthier lifestyles, don't smoke, the advantages are also to people that live in the cities. Because if we were to set up each one of the health districts as an insurance company, you end up with many of the same problems that we've seen down in the States with the HMO (health maintenance organization) model.

Canada's model is complicated, but in many ways it provides a better coverage for people outside of the larger urban centres. And this is one of the things that I think we need to be mindful of. I know that rural residents — and we've certainly heard this a lot — believe that there's a two-tiered health care system — one for rural and one for urban. If we were to move away from a government-sponsored system you would see that very much in spades.

So I'm not sure that we are ready as a nation — I'm certainly convinced we're not ready as a province — to either go back to the hospitalization system that Douglas had in the '40s or to this new medical savings account model that Preston Manning and the boys have cooked up at the Fraser Institute.

But I think that it's certainly good that you've advanced the debate, because I think we need to be mindful that there are real costs and that those costs are added on whether you're in rural or urban areas, and that the kind of choices we make certainly do impact on the kind of health care we need.

As you probably know, Allan Rock yesterday made a comment saying he was responding to a question as to whether fat people should pay more taxes and pay it on things like snack foods and all the rest. This so-called Twinkie tax, you know. I for obvious reasons am opposed to that. But it is part of that ongoing debate that I think people need to understand is that there is a cost to choices of where we live, the choices of what we eat, the choice of the lifestyle we maintain and that although we may not have to pay it today, we're going to pay it down the road.

So for the time being, I am personally of the belief we have an imperfect system, but I just think it's the kind of system that we have right now that we are best working with. So I'd certainly appreciate your view. I thank you for advancing the debate though.

Mr. Molnar: — May I comment? I was not proposing, you know, a health insurance, except for those 20,000 people who are all over the place.

In my example, basically what I am suggesting is that if the user were able to pay directly to the service provider as opposed to going through the taxation system, and I mean it would be still tied to it because it would be tied to their gross annual income or whatever, and if they were to be able to pay directly to the service provider as opposed to paying as taxes and the service

provider being paid by the government that, you know, you might be able to have a savings of say 20 per cent which would add to the value of the system and you could probably get by with less taxes.

Mr. Thomson: — I think the problem with this is that folks like me that don't use the health care system much wouldn't pay much. I'm not sure anyone wants to get to the point . . . or I'm not sure how you would equalize that out that I should help pay for someone else's heart attack.

Mr. Molnar: — But if a family of four has to pay $8,000 and they only use 1,000 — 7,000 of that 8,000 has been paid as taxes and the 1,000 would be paid directly to the service provider. So if you wouldn't pay . . . you know, you wouldn't get any tax credits unless you used the system. So the taxes will still be there to keep it fair.

Mr. Thomson: — How does the system work for the person that needs a $60,000 heart operation?

Mr. Molnar: — That's why we have medicare in Saskatchewan. It kicks in at this point. Like they're not limited to that. I mean my idea is that because we take 10 per cent of their gross income and they would pay that directly to the provider, now basically they would get this back as a tax credit.

But if they need a $60,000 heart transplant, that's why we have a major medicare system and that's where the government kicks in. I think I mentioned after that, you know, the medicare system would take over at that point. Basically what I'm trying to do is, you know, where the nickel and diming that happens happens at the beginning of the health care system where a lot of this happens, that this would tend to take care of that.

But it is not intended to replace the major situations. Like even on my house insurance I keep $500 because I can handle 500 — a deductible that is — but I can't handle, you know, the catastrophe event, if you understand what I'm saying on that one. Like it really wouldn't change anything except, you know, the government wouldn't handle a certain amount of money. That's basically it. The service would be exactly the same.

The Chair: — Any further questions?

Ms. Bakken: — I'd like to thank you for you presentation and for taking the time to come and to showing your concern for health care in rural Saskatchewan.

And I find it interesting on page 2 where you talked about the financial and emotional costs to rural residents if we should go with the Fyke report. And I think this is something that we need to be very aware of, and it's something that is not addressed in the Fyke report.

And so I appreciate that. And I just think it's important that we as committee members realize that this is more than about straight dollars and cents. It is about emotional costs and how we're going to implement . . . if these recommendations were implemented, how it would impact on individuals and how they would cope with it. So I thank you for your presentation.

The Chair: — Thank you, and seeing no further questions, on behalf of the committee, I'd also like to thank you very much for taking the time to come to give us your opinion today — and for your support person.

I haven't been able to say this yet, but we're a little early so you can come and take your seats at the table.

I'd like to welcome you today to the Standing Committee on Health Care. It's a committee of the Legislative Assembly. It's an all-party committee. Our task is to receive responses to the Fyke report or the Commission on Medicare and report back what we heard to the Legislative Assembly by August 30.

We're not making recommendations as a committee. We're simply reporting back what we heard. Our presentations are set aside in blocks of 30 minutes, and hopefully, we'll have some time at the end of your presentation within that 30 minutes to have some questions from the committee.

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

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

Ms. Elliott: — Madam Chair, and committee members, my name is Sharon Elliott and I'm the president of the Saskatchewan Physiotherapy Association.

The Saskatchewan Physiotherapy Association is the provincial branch of the Canadian Physiotherapy Association and we represent over 300 physiotherapists in our province. The mission of the Saskatchewan Physiotherapy Association includes the promotion of high standards of health in Saskatchewan. Physical therapists specialize in movement of the body. We aim to improve movement, restore movement, maintain movement, prevent loss of movement. Our scope is very broad.

We work from ICU, intensive care unit, to outpatients. We work in hospitals, clients' homes, long-term care facilities, rehab centres, public and private clinics. Our scope includes respiratory, such as asthma, chronic bronchitis, emphysema; neurological conditions from strokes, multiple sclerosis, head injuries, spina bifida; orthopedics, soft tissue injuries such as sprains, strains, closed hip and knee surgeries, back pain. We cover it all. And we also cover all ages from the very young to the very old.

As an organization, we endorse the recommendations of the Fyke report on medicare. At this time, I would like to highlight just three areas of the report we believe are important.

The first area is primary health care providers. We support the concept of primary health teams. But we also recognize that primary health care can have different meanings. For example, primary health care is often linked to acute care in urban centres. In this setting — let's say it's the downtown acute care hospital — primary health care is traditionally associated with core services delivered by, traditionally, medicine and nursing.

But if the services are moving to the community as the Fyke report suggests, then primary services need to expand or broaden its focus. Primary services we feel are more than medicine or nursing. They can be a wide variety of health professionals serving a wide variety of functions — for example, assessment, treatment, screening programs, prevention. The list goes on.

The first task, however, is to define what core services are deemed essential in a community. As an example, a neurosurgeon would be an essential core service in an urban centre, but this speciality service would not be a primary service in a rural centre. However a rehabilitation therapist — this includes physical therapists or occupational therapists — a rehab therapist should be deemed a core service to the person who has returned home following a stroke or a head injury or a spinal cord injury or the person who has been diagnosed with Parkinson's or multiple sclerosis.

A therapist in the community — whether it's hospital based, clinic based, or associated with home care — this therapist in the community is a vital link to the person's rehabilitation and to their family. So we believe physiotherapy should be a core service, but unfortunately often it is not considered a core service.

At present, core services have not been clearly defined by the government. We urge that core services are defined and that they are appropriate for the community whether it is a rural community or an inner-city community.

An excellent example of core services in an inner-city area is the Al Ritchie Health Action Centre, and I'm very pleased to have one of our members, Diane Lemon, with me today, and Diane is the director of the Al Ritchie Health Action Centre here in Regina.

Let's say that the definition of core services does include physiotherapy across the province. But the person who receive physiotherapy, they will want to know, are the services covered for them? Well unfortunately it might not be covered.

Public funding of outpatient physiotherapy services is very limited, and the amount and level of service available varies greatly from one district to another in our province. Many services are paid for by third parties, and as a result physical therapists have been two-tiered for over 15 years.

I'd like to introduce Brenda Collocott who sits to my left, and she's the owner of Gold Square physiotherapy clinic here in Regina.

So once again, we encourage the government to define core services. Additionally, appropriate funding must occur, ideally with community partners and third-party payers at the table.

Returning to primary health care, physical therapists are trained to work as primary health care providers, and as a primary provider, we assess, we treat, and we refer clients to the appropriate service as deemed necessary. Examples include physical therapists who are involved in pediatric screening programs, physical therapy in orthopedic clinics and in home care settings with the high elderly population. And in this setting, the home care with seniors, we believe that primary health care can take the form of health promotion and prevention activity.

Health promotion is highlighted in the Fyke report, and this brings me to my second point: health promotion and prevention. Physical therapists are currently involved with health promotion and prevention activities particularly related to secondary prevention. The Saskatchewan Physiotherapy Association strongly advocates for an expansion of activities in these areas of health promotion and prevention.

When I worked as a community therapist, approximately 90 per cent of my caseload were older people. Most often they were housebound; many of them were sedentary and frail. Many of them were at risk of falls and losing their independence.

Promoting health to this population is the upstream activity, according to the Fyke report. So one of my activities as a community therapist in Weyburn, Saskatchewan, was I took the initiative, under the direction of the community, to develop a television program on the community channel. And the program was chair exercises for older adults. And this was aired, and still continues to be aired, on the community channel in Weyburn.

The program was actually developed four years ago, and older members of the community follow it to this day, much to my surprise. I am quite amazed. In fact this program is so important; it's the focus of my master's thesis at the moment. So my research of this television program indicates that this is a good example of community-based health promotion. And it probably should be extended to other communities in the province.

So speaking of research, our organization strongly supports the need for increased emphasis of linking evidence-based health research to everyday practice. We applaud the recommendation of allocation of 1 per cent of public health spending to research.

My final point relates to human resources and, of course, funding. We support the recommendation to integrate human resources planning for all disciplines with examination of the current enrolment levels of training programs. The number of physical therapists trained annually does not meet the human resource needs. Saskatchewan's capacity of trained physical therapists continues to fall behind provinces with similar demographics.

With the limited number of trained physiotherapists, some pockets of the province do not receive core rehabilitation services. One group is the Aboriginal population. Physiotherapy services are not available on reserves, for example. This is a huge barrier to those who require rehabilitation, for example, following amputation that often results as a complication of diabetes. Better still, physical therapists could be in a position to promote health and prevent disease, if the funding was available. To try and meet the needs of the Aboriginal population, the School of Physical Therapy at the University of Saskatchewan has developed initiatives to recruit Aboriginal students into the program and develop curricular content that will meet the needs of this population.

Another example of the impact of limited physiotherapy

services are those communities and settings that employ lower cost assistants, for example, therapy assistants. And this is appropriate in many cases, however, it must be recognized that effective use of such personnel, of these rehab therapy assistants, still requires sufficient professional staff. The physical therapist still has to be there. The physical therapist is the one that assesses patients, develops treatment plans, carries out specialized treatment, and monitors patients' progress.

So once again, the issue of training at the university level is one of our concerns. The School of Physical Therapy has a limited enrolment. When I graduated in the late '80s, we had 30 in our class and the number has since increased to . . . We had 20 in our class and the number has since increased to 30, but there it remains. We only graduate 30 physical therapists a year. Even if we could increase the number to 40 or more students, there's limited physical space on the U of S (University of Saskatchewan) campus for training. Resources in these areas is needed.

So to conclude, I've highlighted three areas of the Fyke report, with support for the recommendations that have been made in primary health services, health promotion and prevention, and human resources and funding. The Saskatchewan Physiotherapy Association wishes to be included in the next steps, which we hope will be implementation of many of the Fyke report's recommendations. Thank you.

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

Mr. Thomson: — Thank you, Madam Chair. I want to thank these three individuals for coming in and making an excellent presentation.

I am interested in how we can better incorporate physiotherapists into the primary health care teams, particularly in rural areas. One of the things that rural doctors have told me when I've met with them is that they have . . . they find often that they are ending up doing a lot of the physiotherapy aspects because they're not able to attract people out into the rural communities. How do you see us working to build that primary team at the very basic step, first of all being able to get physiotherapists out into the communities? Do you see it being on a contract basis with the districts? Do you see being possibly able to do it on a clinic basis where you would perhaps locate still in a larger centre and rotate out on a clinic basis, or how would you structure it?

Ms. Elliott: — Well certainly recruitment and retention to rural areas is a big problem and right now I think we cover all of those bases. Some therapists come from Regina to serve the rural communities on a day basis and some of the smaller centres have physiotherapists that are based there, but they're limited. And that's a great question. We're always struggling with how to incorporate them into that. Do you have anything?

Ms. Collocott: — Some of that too I think . . . You have to ensure that you've got a support mechanism in place for the physical therapists for any of the treatment team members in rural Saskatchewan. I know that with some of my associates, that tends to be one of their biggest concerns. Now with again the access to the Internet and computer, you can e-mail associates in other parts of the province to be able to ask for advice or to be able to look for different treatment options that others may be more familiar with.

But with that, I think, number one, I think each health districts have to ensure that they determine what is a core, what is essential service because that's one of the things that is not consistent across this province right now, that there are some areas of this province where yes you have access to physical therapists, and others you don't. And that has partly to do with accessibility to manpower, but also it has to do with whether or not it's been deemed a mandated service, and I think that's kind of where you start is the very core to deem it a mandated service and then to be able to see how we can end up keeping and attracting people out there.

There are I know, in the last ten years, there certainly has been an increase in the number of physical therapists that are actually working in rural Saskatchewan. But regrettably most of those are working there through private facilities, which, when we were talking about the two-tiered system that presently exists, that are how you're getting your physical therapist in rural Saskatchewan right now. That's aside from the community therapists that are presently working out there. But there needs to be access to both the home delivery service as well as a more hands-on approach as well.

Ms. Lemon: — I would maybe just add that contracting from other health districts might be the only way because that way you can rotate people for a certain length of time, and they don't feel that they have to stay out for more than one year or two years. I know that has worked in some instances and is probably the best solution at the moment.

Mr. Thomson: — I just have one quick follow up, Madam Chair. Your explanation of what physiotherapists do make it sound easy which of course it's not. It's an advanced discipline. But are there things that can be done, as part of a primary team, where you may feel more as a team leader approach, that you can work more closely with home care in some of these groups to make sure that people are remaining active at an earlier level? Do you see that as being a benefit of the primary model?

Ms. Collocott: — The prevention component I think is imperative because again dealing with other treatment team members and educating them in regards to what can be done so that there is some integration because there certainly is a crossover in many of the disciplines at a primary level, with that being able to be a member of that team. But again it comes back to mandating, you know, like is that service there. Very often . . . When you also commented in regards to the physicians not knowing, feeling that they have to provide the service because they don't have access, part of that too is the communication within the health districts, knowing what services are there.

I know many of the physicians that tend to come into our province or even just move into an area, they tend to learn it the tough way to be able to find out what services are available. There's no orientation program given to them to say that this is what's available.

So as a result they tend to hunt out the service whereas I think that there could be a more coordinated information provision that would be made available to new practitioners coming in so

that they would feel less like they have to do it rather . . . and they are more a member of a team.

Mr. Yates: — Thank you, Madam Chair. I just have a couple of questions around the human resource data to make sure that I understand what we actually had given to us.

When we look at number of new registrants in 2000, it says 44 and 28 of those were educated in Saskatchewan. So could I read from that that 28 of the 30 that graduated that year stayed in Saskatchewan?

Ms. Elliott: — Yes.

Mr. Yates: — So we're not in a situation of losing the majority of our graduates to other jurisdictions in this case?

Ms. Elliott: — No. This past year's graduating class was exceptional in that the majority stayed in the province. It hasn't always been like that.

Mr. Yates: — And I have a couple of questions around the registered physiotherapists that are working within the province — we have 461. And it says working outside the province, 39. Are those individuals that just keep registration within the province but have moved elsewhere and still pay the registration annually here? Okay.

Ms. Elliott: — That's right . . . (inaudible) . . . and move back.

Mr. Yates: — Is there any indication, by keeping registration, that that's likely to happen, they've gone away for a short period of time for education or something like that?

Ms. Elliott: — I don't have that information but it does happen.

Ms. Lemon: — Oh it certainly does. I know I had a physiotherapist that was working . . . had been working for me and then went to British Columbia. And I had heard by the grapevine he was going to go back to university. But I convinced him to come back and run the Plains Health Centre for a while. So people do . . . And he's still in the province, works for Sask Health now. So people do come back.

Mr. Yates: — Well I was just wondering why people keep registration here if they'd have to register in some other jurisdiction as well and pay two registrations unless there was some intent perhaps to come back.

Okay, thank you.

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

Okay let's take a 3-minute break while the next presenters come forward.

I'd like to welcome you this afternoon to the Standing Committee on Health Care. This is a committee of the Legislative Assembly. It's an all-party committee. The first task of the committee is to receive and report on responses to the Fyke Commission or the Commission on Medicare. The committee will be reporting back to the Legislative Assembly on what we heard by August 30. And we won't be making recommendations, we'll be reporting back on what we've heard during the hearing such as today.

The all-party committee, I'm the Chair, Judy Junor. Dr. Melenchuk is the Vice-Chair. Andrew Thomson, Kevin Yates, Deb Higgins, Brenda Bakken, Bill Boyd, and Rod Gantefoer are the MLAs today.

I would like to, as I said, welcome you today. If you want to introduce yourself and where you are from, we have your written presentation and you can begin.

Ms. Hayward: — Thank you very much. We represent the Pasquia Health District. My name is Carol Hayward. I am the board Chair. Rosalie Daisley is the Vice-Chair. Gord Denton, our chief executive officer; and Julie Cleaveley, director of community services.

And we certainly recognize that you people have had a busy month receiving and hearing submissions and we recognize that probably some of the things we have to say you probably will already have heard. Nevertheless, we do appreciate the opportunity to express our concerns.

The board and management of the Pasquia Health District have reviewed the report of Ken Fyke, Saskatchewan Commission on Medicare, Caring for Medicare, Sustaining a Quality System which was released in April, 2001. Meetings with physicians and staff throughout the district have been carried out to hear their views and feedback. In addition, health district board members have met with many community stakeholders such as municipal councils, health care auxiliaries, and seniors groups to name a few. Their response and feedback have been included in the board's deliberations and response.

While the board supports many recommendations made by Mr. Fyke, we have grave concerns about the provision of health care, particularly in rural Saskatchewan if all recommendations in the report are implemented.

Standards for access to acute and emergency room services as outlined in the report will not provide safe, effective care. Access to diagnostic services, laboratory, and X-ray as outlined in the report will impose barriers to timely, safe treatment. Qualifications for ambulance personnel are not acceptable if the other recommendations in the report are implemented. Reduction in the number of health districts as contemplated by the report are too soon, too few, and would result in a loss of community participation in health planning.

Access to acute and emergency room services. The report states on page 17:

> The realities of modern health care, however, have simply made small hospital obsolete.

The report contemplates replacing hospitals in 50 locations with primary health services. The Pasquia Health District Board does support the enhancement of primary services and primary health service teams, but they should be just that — an enhancement and support, not a replacement of acute care beds and diagnostic services or emergency services.

The report contemplates the need to further enhance home care and continue to make people independent. We strongly agree with keeping people independent, however, we believe that small hospitals play a vital role in providing the necessary support to allow this.

In the Pasquia Health District for instance, seniors over the age of 75 make up nearly 10 per cent of our population. Provincially that age group makes up a little over 7 per cent of the population. In many circumstances senior couples and singles are able to stay at home with the support of home care, however, when it is necessary to hospitalize, it can be very traumatic to have to leave the community and the support of family and friends.

Standards set for the distance to emergency room services are too great to provide safe emergency services. The report sets out a standard of a maximum of 60 minutes travel time to a hospital for 88 per cent of the population and a maximum of 80 minutes travel time for 98 per cent of the population. The distance would be too great for many emergency situations, which can and do arise in the rural areas even if a paramedic was the standard for provision of emergency service.

We believe the standard of 30 to 45 minutes, as presently set for physicians to respond to emergencies is more realistic. Rural residents should not be expected to accept less.

Recruitment and retention of health care professionals. We believe the closure of small hospitals will aggravate the already difficult issue of recruitment and retention of health care professionals. We believe it will be difficult to convince potential staff that they have access to better services when acute and emergency services are as far as 80 minutes away.

Many health care professionals have been sidelined since the beginning of health reform. They have moved on with their lives and in many cases chosen another career path. This province does not have a surplus of health care professionals and cannot afford to lose good quality people. We must learn from the past and not let this happen again.

If 50 of the existing 70 hospitals were closed, what would be the remaining bed ratios? It is our understanding that many of the existing larger hospitals are already congested and unable to meet the needs. Will rural residents even have access to acute services when they need them? Will the larger centres be able to staff more beds? We believe very few rural staff will be in a position to migrate to the larger centres to work.

The cost of operating larger hospitals will be greater. The more urban the setting, the more specialists will be utilized — obstetricians, pediatricians, gynecologists. This will result in higher costs than is presently enjoyed by seeing general practitioners.

Several small hospitals presently offer visiting specialist service programs. Specialists travel from the city and spend the mornings in the operating rooms performing a variety of surgeries, and then the afternoons are spent in outpatient consultation. These services are invaluable to the patients served. Patients return home, usually the same day as their surgery. Patients have been known to travel from the city to the rural to avoid the long waiting lists. This appears to be a health reform success story. We should focus on building on this success.

Contracting and payment of physicians by health districts. Having health districts responsible for organizing primary health services would certainly be a positive step in bringing all team players together. However, contracting and payment of physicians by health districts could be a very large step for some physician groups. To mandate this at the present time without a great deal of consultation could result in some major problems.

Economic viability of rural Saskatchewan. In addition to aggravating recruitment and retention issues for health care personnel, we believe the closure of 50 small hospitals will also have a detrimental effect on recruitment efforts of other industry and agencies such as school divisions, the forest industry, and other professional groups. This has serious implications for the economic viability of rural Saskatchewan and, indeed, the whole province.

Access to diagnostic services. Access to diagnostic services would again be a serious issue, especially for seniors, if they are only available in regional hospitals as indicated in the report. It could be said that many unnecessary tests would not be done if access was more difficult. It could also be said that many necessary tests would not be done, resulting in higher rates of hospitalization.

This will also create difficulties for young families and for working people. As well, physicians need access to diagnostic services in order for them to provide their services.

Qualifications of ambulance personnel. The qualifications of ambulance personnel contemplated by the report would be a reduction in standards for some of our services in the district. For example, we have at present within our ambulance operation one paramedic and a number of advanced EMTs.

As a minimum standard, an EMT on every trip would be an improvement overall as presently the standard is less and would be acceptable with the support of existing emergency rooms. However, if the closure of 50 hospitals occur this standard is not adequate.

Reduction in the number of health districts. We have come a long way in the last nine years. In 1992, steering committees were formed across the province with the mandate to establish health district boundaries. Guidelines were set, rules followed. By the fall of 1993, health districts were formed and spring of 1994 saw amalgamations taking place.

The early years of restructuring were traumatic, to put it mildly. Staff were feeling insecure and struggled with the change forced upon them.

By 1998 health districts were being accredited by the Canadian Council on Health Services Accreditation. Besides obtaining the knowledge and skills and development and use of performance indicators to monitor care and service delivery, one of the positive outcomes of the assessment process and preparation for accreditation was the bringing together of staff

from across the district.

Staff who used to be facility oriented were now working in teams with fellow staff members from other communities. This teamwork continued and, as districts are now being resurveyed, now there is a sense of district ownership by staff not witnessed even three years ago.

Maybe 32 is not the right number of health districts, but will there be substantial improvements to the delivery of health services with less? Will there be cost savings? We believe there is more to be lost than gained by the trauma caused by another round of restructuring.

I repeat: this province cannot afford to lose the professional people we have working in the health care industry.

If the province is really serious about boundary changes, restructuring must include social services and education. We are not suggesting boundary changes be forced upon social services and school divisions. Rather, common operating boundaries must be established. Some school divisions now receive health services from several health districts. Health districts are also providing services to parts of several school divisions. This causes intolerable inconsistency of services to youth, not to mention an administrative nightmare.

The Pasquia Health District does support many of the recommendations included in the report. The enhancement of primary services, development of primary health service teams, and the creation of a quality council whose mandate would be to improve the quality of health services in the province by drawing on expert advice and research to advise the government and health districts on standards for quality of health services are a few examples.

For the record we want to state that we support a quality process. For instance, development of performance indicators and improved annual reporting relating to health status such as outcomes versus the development of a council. The board recognizes the need for ongoing change and has worked very hard in co-operation with Saskatchewan Health to provide realistic services.

Since 1993 we have reduced institutional services throughout the district and terminated those services altogether in one community. Enhancements have been made in community services such as home care, physio and occupational therapy, mental health, social work and addiction services.

We have a youth initiative program we are very proud of and a medical health officer has been procured to serve Pasquia, North-East, and North Central health districts. Our participation in a primary health care project in Hudson Bay is further evidence of our willingness to do things differently and actively participate in health reform.

The board is open to continued change and our most recent health plan reflects that. However, the recommendations by the Fyke report are seen as too extreme. They will result in bringing about the demise of rural Saskatchewan and will undoubtedly have a negative effect on the overall viability of the province of Saskatchewan.

Saskatchewan is already a province having difficulty holding its own. Let us not be the cause of further deterioration. If medicare is in jeopardy, the closing of 50 small hospitals will not provide enough savings to pay for even one year's increase in health spending.

We thank you for this opportunity to express our concerns and look forward to dialogue with you.

Mr. Gantefoer: — Thank you very much, Madam Chair. And thank you very much for your presentation.

I have a couple of areas that I want to touch on this afternoon. You talked about the visiting specialist programs that are operating in your health district, I believe primarily in Tisdale, and the fact that there are outpatient services in addition to procedures, surgeries, etc., depending on the speciality. And your quote is an interesting one, when you say it appears to be a health care success story and it should be built upon that success.

Are there further opportunities that we have in rural Saskatchewan with these types of programs to actually increase services? Are we meeting demand now or the extra demand that isn't being met? Is this an opportunity to take pressure off, as you indicate, potentially some of the waiting times in the more urban centres?

Mr. Denton: — I believe that it is an opportunity to do just that. And I think that is borne out by discussions we've had with our physicians and with some of the specialists that come out. It certainly . . . it's beneficial in assisting large hospitals provide their services because we are able to take — although we certainly don't do any major surgery; the majority of what we do in our hospital is something that would be day surgery in the larger hospitals — but it certainly does take, help take some heat off of them.

Mr. Gantefoer: — And I know you would think that I'd be remiss if I didn't ask you to comment on the tri-district programs that are available. I know in your report you mentioned the tri-district hiring of a medical health officer, but certainly I think there are other programs like dialysis, programs of that nature, lab services that are shared, and things of that nature, that you may want to reflect on in terms of saying that the three districts in the northeast have found a way without necessarily looking at amalgamation to work together where those things made sense.

Ms. Hayward: — We have a very good working relationship with our neighbours and we also have listed several of the positives. And I guess we feel that the delivery of health services . . . we're always looking at ways to improve the way we do business and the way we deliver health services. And we've been able to do that without removing the boundaries.

Mr. Gantefoer: — The Pasquia District, from my recollection, has always operated in a balanced-budget position, And in doing that, I think it would be more than fair to say that the district has faced some very difficult decisions and challenges in the past. As they are now more behind us, are you satisfied that you've been able to make sure that the general health and the general service to the people in those communities that were

most effective have been properly looked after and that while it's been difficult, it's been successful?

Mr. Denton: — From our perspective, we believe that we have. And I think even in most cases, the community that was most affected — well I don't think they would ever say they were glad to have lost their facilities — I think have been able to move on, and we have provided services available, you know, in acute and long-term care.

For instance, we were careful when those services were reduced in Rose Valley, and that's where they were; that we did almost no reductions at Kelvington in acute and long-term care so that the slack could be taken up there. And it's, you know, within a reasonable time frame for access.

And a good portion of the people utilize the services in Kelvington. The Kelvington physicians are now providing clinic services in Rose Valley three afternoons a week. Some of the people from north of Rose Valley access services in Tisdale as well.

Mr. Gantefoer: — Is part of the rationale for your strong position in terms of saying that we cannot significantly further reduce acute care services in rural Saskatchewan the realization that you don't have the ability to cope with the closure of a Rose Valley by getting support from neighbouring communities as you did last time? The next round would eliminate all of those support communities virtually as well, and therefore the distances and the problems of what is contemplated in Fyke is not feasible in your opinion.

Mr. Denton: — The communities left in our district out . . . you'd have quite a long distance to go for emergency services, diagnostic services, and acute services. Took Porcupine out of the middle of it — well, they're right on the edge by being 45, roughly 45 minutes from Tisdale.

Kelvington, it's the same thing. Hudson Bay is over an hour from anybody and they have a forest industry that they're providing services to, so they have considerably more trauma and that kind of thing coming through their doors which I think you'll hear from the Hudson Bay people. I would certainly hate to see it thinned out any more.

Mr. Gantefoer: — Thank you very much.

Mr. Thomson: — Thank you, Madam Chair. I want to pick up where Mr. Gantefoer left off because this is really a central question to what we've been hearing.

Almost every board and every community that's appeared before us has said nothing more can be done to achieve efficiencies. No more facilities can be shut down. Are we now at a point where this is the absolute bare minimum of health care facilities and we must just commit all the money that we can find to sustain? Are we in a sustaining mode only?

Mr. Denton: — In our district, you know, we're not saying that there's no more efficiencies. We're suggesting there should be no more closures.

Our most recent health plan, which is now last year's health plan — as you know there was no health plan called for this year — called for some streamlining at Porcupine Plain in which we would try and bring acute and long-term care more under one roof than it is now and do some consolidating of staff. Now there isn't huge dollars to be saved there. And we were ready to move ahead and it was approved, but we kind of stopped it until the outcome of the deliberations on the Fyke Commission.

We felt if there was going to be wholesale closures of small hospitals, that to go through an exercise of streamlining — and that causes change which needs to be debated with the community and with the staff and so on — that it wouldn't make sense to do that and then have it turn around and be closed a year down the road if that's what was to occur. We certainly hope it isn't what will occur.

In addition, in Tisdale, we have just at the beginnings of a drawing board, plans for replacement of the older nursing home that's in the community. And when that is replaced, it would become part of the existing hospital nursing home complex that's there now, so that we'd have some further savings there as well in consolidation of the services.

So there is still some. It's not big compared to what has been done, that's for sure.

Mr. Thomson: — We have heard . . . this committee has heard the presentations now from three of the four . . . sorry, four of the five facilities in your district, or communities with facilities in your district. And it was interesting listening to differences in their approaches. Tisdale highlighting the inter-district co-operation that's happening, the way that they're working with Melfort and others. Porcupine Plain, obviously being a single physician, the facility is very nervous about how it will continue to offer its services. Rose Valley, as you have identified, not happy with the changes that happened in '93, and not looking at the process optimistically. And Kelvington very much of the belief that things should stay as are.

If there is a commonality among these groups within the district, I would say yes, certainly there's a sense of uncertainty to it. But it's interesting that they all look to different places in terms of what their next largest area would be. Tisdale seems much more interested in co-operating with the Melforts and the Nipawins, than Kelvington is in terms of co-operating with Wadena, which is just down the road from it.

How do we build those inter-community co-operations? Regardless if you're advocating we shouldn't change the district boundaries, how do we build co-operation between the communities to make them stronger?

Mr. Denton: — The health districts possibly could play some role in that. We probably, you know, what you're talking about with Wadena would mean some discussion with Central Plains Health District. We might facilitate some co-operation in that respect, with that . . . I'm not sure what all there could be shared either. They might share emergency on-call physicians, which might enhance that situation. Other than that, they're almost too far apart to, you know, contemplate one or the other not being there, I would say. But that's my opinion, anyway.

Mr. Thomson: — I don't know that we're talking about a case where it's one not being there, it's a question that when we do advanced services, they aren't going to be in every community. We can't afford to make sure that every single community has all the advanced services.

We're getting three main messages through these hearings — at least I believe we are. One, communities are telling us that health care has an important economic development component. And you've said that in your report. It opens up a debate whether we should be using the health budget for economic development, but nevertheless I think that's a reality, that it is there as an economic support.

We hear rural citizens tell us they want continued access to the facilities they have but we also hear that they want enhanced services or greater access to highly specialized services in the cities.

If we are talking about what we have plus, that means we've got to make strategic investments which means the communities have to co-operate. What I'm interested in is are there ways to have the communities co-operate to share advanced services, assuming that everything stays as is and we can find enough money to keep everything going as it is, plus enhance which at the 150 million more that we put in every single year. I don't know if that's realistic.

Mr. Denton: — When you're talking about enhanced services are you talking about the primary system now basically, or something else?

Mr. Thomson: — There's a great deal of talk about the need for enhanced diagnostics for better access to advanced surgeries even in the main tertiary centres that we need to have greater access to these things.

We heard a presentation last night from Kindersley and communities in the west central part who thought that perhaps there was an ability if we were going to enhance services and weren't able to designate say Kindersley as a regional centre, that perhaps they could work together with, it was Rosetown I believe.

We're at a point now where we need to start thinking about ourselves just outside of our community. Regina needs to start thinking about itself as part of a larger community with Moose Jaw and its surrounding neighbours. That same process has to happen in smaller towns also. How do we facilitate that?

Mr. Denton: — I agree and I think that . . . well you already indicated that Tisdale has shown that they want to co-operate. And when you're talking about Kelvington and Wadena I'm not sure, because they're not bringing too many of those extra kinds of services into those facilities. So I think a key area that could be explored is certainly the physician on call.

Ms. Daisley: — I think one of the things is though too, that Gordon had alluded to, the fact that health districts would help to facilitate that kind of process. And I mean I think that the Pasquia Health District has a record, a proven record, to show that we are willing to co-operate. I mean we do have our medical health officer, we have our dialysis. I mean it isn't a matter of fighting over where the dialysis is going to be located or that we would have it located in three of the larger sort of communities in each one of those districts.

I mean it was mutually agreed upon that, you know, Tisdale would be the best location for that and everybody seems to be co-operating in that area to make sure that that dialysis stays there. There's a great deal of fundraising from communities, from all those districts that, you know, funnel money into that to make sure that it stays there. And we also have a diabetic project that's a tri-district effort.

So there is a willingness. And it's hard for us to sit here and say, well this is what we would do. But I think that we've shown that we're capable of doing those things and we don't have any problem with working with other people and trying to come up with some creative thinking to make sure that happens. So if it means that we would look at other communities outside our district to try to work something out whereby services can be shared, we're willing to do that.

Mr. Thomson: — I think that's why we've chosen the Tisdale-Melfort example which I think is really a model in many ways of how we can share services. I think that's a very positive thing that's been done.

I just want to conclude, Madam Chair, by saying that I in many ways think that this recommendation on the bottom of page 3, talking about boundary changes, is a very positive one. In fact it's reminiscent of a conversation the Chair and I were having over lunch today about how there are other things that we need to think about in health in terms of how you deal with social services and the school divisions in terms of sharing without necessarily going into coterminous boundaries but how we work on that.

And again it was brought to mind the situation with the group we heard from last night, the midwest . . . the West Central Municipal Government Committee who have very much of a round table where they seem to involve municipal leaders and health districts even though they end up dealing with I think four or five health districts over there to look at co-operative planning. I think in many ways this suggestion is a very good one that we should be mindful of as we move forward with our report.

So I thank you very much for obviously all the work you've done both in presenting to us but also in terms of some of the innovative things you're doing in your communities. Thank you.

Mr. Yates: — I have just one question. It has to do with the issue of co-operation as well.

From your experiences . . . and we have some good examples within your health district and in your tri-district area of co-operation. And that same level of co-operation obviously doesn't exist in all parts of the province and to the same degree. And of course the districts are lines on a map and they may not reflect travel patterns or patterns of individuals in those areas. But from your experience is there anything centrally that can be done to enhance or help with the issue of co-operation between districts?

As we look to refining the health care system for tomorrow, co-operation is going to be a very, very key element in getting services to communities, if we're looking at enhancing services, much like your dialysis project in Tisdale. And are there things that you could see that would have helped the co-operation, anything that could be done centrally?

Mr. Denton: — It's an attitude I think with the boards that were in the northeastern part of the province. And I don't know what else to say about it. Maybe Carol . . .

Ms. Hayward: — Well other than to say if there's a will there's a way. And you know if there's a way you can do things better together, you sit down and work those out and work towards the positives and disregard the negatives.

And I guess . . .

Mr. Denton: — And I guess that would be the key thing that you could use to sell it, is everything that you have to gain by co-operation. And I think actually, in all honesty, Saskatchewan Health has promoted that idea.

You know when we went forward with the dialysis project, we were told that we were successful because there was three districts instead of one that was presenting it. There was a will by fundraisers in our part of the world to go out and raise the money, because that was part of the equation, that we would raise the capital money ourselves. And that I think would be the thing to promote, is that you have a lot to gain by working together, and cite some examples, I guess.

Ms. Hayward: — Another area that has been very successful for us, when I mentioned our youth initiative program, and that is one we worked in co-operation with Education. Well to put it simply, I guess we provide the people and they provide the space. And we have three school divisions that we work with and that has very positive outcomes for the youth in our district. So we've not only I guess co-operated with, you know, the community but with other professional groups as well.

Ms. Daisley: — I think one more thing that might be sort of something that's sort of in our favour is that, you know, when health reform started, people in their communities were fairly isolated. And you know, in what Carol presented, she talked about even the staff working in a district and first seeing themselves as being facility oriented. But as time has gone on, we've become more district oriented. Because when you get to meet somebody that works in another facility and you recognize that they may be doing something better than what you're doing, it's more efficient, and it actually produces better results, then you're more willing when you see everybody working together to continue that process.

And I think that in some ways the climate is right in Saskatchewan for more co-operation. Because we've already experienced some of that and we have positive examples and results, you know, from coming from that, then there will be the willingness to build on that.

And I think we are, I mean, we all recognize that we're at a point in the history of this province where things can't stay the same. Now which direction we are going to go into the future, it has to be determined yet. But I think that the whole spirit of working more closely with others is there. That's why we have partnerships with Education and Social Services and we have inter-facility or interagency groups that work well together in communities that we didn't see sitting at the table before.

But you know there is a spirit of co-operation not just from Health but from, you know, Justice and Social Services and Education because they are in much the same boat as what we are. That change is imminent. And you know, trying to determine what's going to be the best change for us is important to all of us and so there is a stronger spirit of being willing to co-operate and to have some give and take on both sides.

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

I invite the next presenters to take a seat at the table. Welcome to the Standing Committee on Health Care. Welcome back, Lyle.

This is a committee of the Legislative Assembly and its first order of business is to receive responses on the Fyke Commission, on the Commission on Medicare, and we will report back to the Assembly by August 30 on what we've heard. You probably heard me say we're not going to be making recommendations. We'll be reporting back what we've heard from various presenters.

You have half an hour and the committee is an all-party committee. I'm Judy Junor. I'm the Chair. Dr. Jim Melenchuk is the Vice-Chair. Andrew Thomson, Kevin Yates, Deb Higgins, Brenda Bakken, Bill Boyd, and Rod Gantefoer are here with us today. As I started to say, you have half an hour and hopefully within that 30 minutes we have time for some questions from the presenters. If you want to introduce yourself, where you are from, and begin your presentation.

Mr. Leys: — Thank you. They have recycled me and sent me back again this afternoon so . . . my name is Lyle Leys and I am Chair of the Midwest District Health Board. And with me today is Doug Ball, chief executive officer of the Midwest District Health.

Madam Chair, before we begin our presentation this afternoon, I'd like to thank the standing committee for this opportunity to present Midwest views on health services in Saskatchewan and how those services impact citizens within our district.

Prior to outlining our position and concerns about the Commission on Medicare, I'd like to make a few comments about our district. Midwest was the first rural district incorporated in the province and had actually pursued and established a number of partnerships within those boundaries several years prior to health reform being enacted.

Midwest has seen and been involved with numerous changes to delivery of health services in the district. The closure of 52 hospitals in the regional wave of health reform saw the conversion or closure of six hospitals in our boundaries as a district.

While we continue to manage a significant number of facilities, there has been a growing emphasis on community-based services. In our role as a host district to the tri-district service area of Greenhead, Prairie West, and Midwest, we continue to build valuable partnerships that enhance delivery of health care services.

In reviewing the Fyke report, the Midwest Board examined each recommendation and have responded to them in our submission which we presented to you today. We also consulted with the public and their ideas, concerns, and questions are part of our submission. Because of the time factor, I will respond to only a few of those recommendations in our presentation today but we encourage you to read and understand the concerns of citizens of rural Saskatchewan.

It is no accident that the Commission on Medicare's first recommendation is the establishment of primary health care service teams. Establishment of these teams is necessary if medicare is to be sustainable into the future. These teams will bring together a range of health care providers and services that will ensure that Saskatchewan residents receive the best care possible.

Critical to the provision of services and the retention and recruitment of health care professionals is that diagnostic services must be available to these teams. Access to long-term care, observation, stabilization, rehabilitation should be included as part of the range of services provided by primary health care teams.

Midwest has already recognized the importance of primary care service teams and some of the benefits for our residents. We pioneered the Beechy pilot project and have expanded it to the communities of Kyle and Lucky Lake.

The range of services . . . of health professionals involved and the range of services provided by primary health care teams needs to be expanded. It is vital to the success of this program that family physicians be an integral part of the team. Statistics provided in this submission reveal that the public support the services provided by local physicians and programs offered in the district.

The Commission on Medicare recommends that tertiary care be delivered in Saskatoon, Regina, and Prince Albert. While we understand the rationale for this, we feel there needs to be more dialogue with doctors to ensure that we make the best possible use of all resources. At the present time, Midwest provides limited specialty services and feel these services need to be continued. These services are an effective way of reducing waiting lists in tertiary centres. It is also a very. . . it is a way of providing services close to home for clients who find travelling difficult and time-consuming.

The Fyke report has stimulated increased awareness of these services and now some joint initiatives between Rosetown and Kindersley are being discussed. These initiatives will utilize existing staff and infrastructure. On the recommendation for making things fair, Midwest supports the development of goals with measurable outcomes. We also endorse the strategy to enhance health education and the other determinants of health such as education and income.

While Midwest supports the concept of quality, we have questions about the quality council — how will it be funded; how much will it cost; will it become another bureaucracy; will it have authority to make changes — are some of the questions that are being asked. To ensure quality in health care it must begin at the primary care level and extend on to acute care and specialized services.

We are not afraid of nor are we opposed to change. We have experienced lots of change and accept that as part of health care sustainability. The change must have a positive effect. Change needs to improve patient/client care. Change needs to enhance the ability to retain and recruit health care professionals. Change needs to improve public confidence, and change needs to bring stability for all health care workers.

At some point a change in district boundaries may be desirable, but the present time restructuring of health district boundaries would only disrupt the delivery of service, make retention and recruitment of health care workers almost impossible, and destroy public confidence in the health care system.

Midwest recently opened a new health centre at Davidson. This brought together in one location a number of health services including acute and long-term care, emergency services, diagnostic services, community and home-based services, and amalgamation of administrative and support services.

Plans are being developed to enhance the facilities at Rosetown and Outlook so we can provide this same level of services from one facility in those communities.

To sum up our comments on the Fyke report, it has raised a lot of issues. Some we support. Others we cannot. On many issues, it simply raises many questions rather than provide solutions to the challenges facing medicare. There needs to be broad consultation on many issues before we begin implementation of the report. We thank you for this opportunity to present our views today and we would be pleased to answer any questions you may have.

The Chair: — Questions from the committee?

Mr. Thomson: — Thank you, Madam Chair. I feel compelled now that we have the Midwest officials here to at least repeat briefly what I was saying earlier about the level of co-operation between Midwest, Prairie West, and to a certain extent Moose Jaw-Thunder Creek in terms of work that has gone on. We've heard a great deal from local communities about the work that is being done between communities outside of the districts, and I think this is a real positive and a real model that the rest of the province needs to look at.

The idea of shifting around boundaries I know always causes angst, whether it's constituency boundaries that directly affect us or municipal boundaries which we heard a lot about last year and now health district boundaries.

To me the issue of where the lines are drawn is not important so long as we have a degree of co-operation among the communities and that they make sense. And I think a great deal of what you have done, whether it is co-operation between Davidson and Craik or Rosetown and Kindersley, I think points

to that. And you are to be congratulated on it.

One of the questions I have is, having listened to several presentations and having read a good number of the public comments — and I appreciate that those are included in many of these submissions — one of them stands out at me in a presentation made today. And that is a comment from one of the citizens that says, if it's not broke, don't fix it.

I believe that — if it's not broke, don't fix it. But I have to say that that's a little different message than we got for 70 days during the normal legislative sitting when we were told almost constantly it was broken, that things were bad, that the status quo wasn't acceptable. Which is it? Are things broken? Or are things . . . is the status quo pretty good?

Mr. Leys: — I wouldn't say that things are broken but I don't believe that we could remain with the status quo. There needs to be, honestly be, some level of rationalization of change over a period of time. I think we need to be careful in how we do that. We need to have a plan and it all has to fit within the provincial plan. There are some things we need to do first before we really begin the rationalization and if our presentation from SAHO this morning — and it represents the districts across — is that the primary care health teams need to be put in place.

Again we are not opposed to change. I believe that change is part of what we do in health. I think when we saw such massive changes in 1992, when that happened was, because we hadn't changed the health care system for 35 years or more. We were continually doing the same thing over and over, and we don't want to fall into that again. We need to, we need to stay current with change, but change has to be positive. It has to instill public confidence. It has to provide patient/client care.

The Chair: — Any further questions? Thank you very much for your presentation.

We're so surprised that we're early. Thank you for being here and welcome to the Standing Committee on Health Care. It's a committee of the Legislative Assembly. It's an all-party committee. I'm Judy Junor, the Chair. Dr. Melenchuk is the Vice-Chair. Andrew Thomson, Kevin Yates, Deb Higgins, Brenda Bakken, Bill Boyd, and Rod Gantefoer are here today.

The committee's first task was to . . . is to receive responses to the Fyke Commission or the Commission on Medicare and report back to the Legislative Assembly on what we heard by August 30. And we're not going to be making recommendations; we're going to be responding back with what we've heard.

So you can begin your presentation by introducing yourself and then continue on.

Ms. Eberle: — I'm Darlene Eberle; I'm Chair of Central Plains Health District. On my left is Darcy Swinderski; she's Vice-Chair. And on my right is Kelvin Fisher, our CEO.

The Central Plains Health District is one of the larger rural health districts in the province with a district population of 20,789 and a medical referral catchment area in excess of 40,000 people. The district's boundaries encompass 7 to 8,000 square miles. The four major communities within our district boundary include Humboldt, Wadena, Watson, and Cudworth.

The Central Plains District Health Board welcomes the opportunity to speak to this committee concerning our thoughts, concerns, and vision for health care in this province. Throughout this presentation we ask committee members to consider five recurring themes. The need for a comprehensive plan for health care. The need for community involvement and participation. The importance of public confidence in the health care system. A greater reliance on community care centres, more so than was recommended by Fyke. And careful assessment of the impact of the change.

Concerning the establishment of primary health service teams, the Commission on Medicare has provided the people of Saskatchewan with a number of recommendations believed to be critical to maintain a sustainable health care system. The Central Plains District Health Board has reviewed the Fyke report and in our opinion the absolute key recommendation is the establishment of a team-based delivery model for primary health services.

We believe that many everyday health needs can be met by a multidisciplinary team of health professionals working together at the local level to provide care and support. Coordinated assessment and delivery of care will serve to eliminate gaps in service as well as minimize duplication of effort. Our board supports this recommendation wholeheartedly. However we do wish to raise some issues for the consideration of this committee.

Mr. Fyke suggests that primary health service teams work to provide continuity of service 24 hours a day, 7 days a week. He further suggests that many small hospitals may take on a new role as a primary health centre that would generally be open 8 to 12 hours per day. We share his belief that primary health services should be available 24 hours a day, 7 days a week. However we question how practical and affordable it would be to have a former hospital facility serve in this capacity.

We strongly urge government to exercise caution with respect to this idea. Overhead costs such as building maintenance, utilities, equipment costs, housekeeping, insurance, and other building-related costs are significant expenses for any building whether it be open 8 hours a day or 24 hours a day. We would like to recommend . . . to remind members of the committee that any expenses saved on overhead can be directly spent on client care.

We believe that the provision of primary health services by multidisciplinary teams is best accomplished in the context of integrated facilities. In small rural centres, wherever available, integrated facilities that are linked to long-term care services are ideal facilities from which to accomplish 24-hour, 7-day-a-week services as envisioned by Mr. Fyke. A critical mass of service, of staff, and services are already in existence 24 hours . . . on a 24-hour basis, and establishment of primary health service teams linked to these facilities can be accomplished very cost effectively.

There are many integrated facilities in rural centres throughout this province where infrastructure investments have already

been made by taxpayers. The Central Plains District Health Board encourages this committee to consider the potential efficiencies of a model of primary health services in conjunction with the existing network of integrated facilities across this province.

The conversion of small hospitals. Mr. Fyke recommends either the closure or conversion of existing small, rural hospitals. While we do not argue with Mr. Fyke's suggestion that the health system cannot sustain the number of small hospitals currently existing, we would like to address the issue of community care centres.

We have earlier stated our concerns with respect to the cost effectiveness of converting small hospitals into primary health centres that would be open 8 to 12 hours a day. Mr. Fyke proposes a system of 25 to 30 community care centres across the province. He suggests these centres be integrated with nursing homes and provide respite, convalescent, and palliative care services. We support this concept; however, we believe 25 to 30 community care centres is too few for this province.

We believe a greater reliance on community care centres than that recommended by Mr. Fyke should be considered by this committee. Rather than a reliance on a number of primary health centres only open 8 to 12 hours per day, we propose a larger network of community care centres across the province than that recommended by the commission.

Residents of rural Saskatchewan are willing to travel reasonable distances as long as the services they receive is comprehensive and meets their primary health care needs. We believe the most important consideration is that the service be comprehensive enough that such . . . that it builds confidence in the people that rely on it.

We would like to use the community of Cudworth as an example of the potential benefits of a community care centre.

Cudworth is a community of 829 people. Three years ago the Central Plains District Health Board made the difficult decision to close the hospital. Rather than simply closing the facility, the board in partnership with Saskatchewan Health and the community undertook to construct a health centre attached to the existing nursing home thereby creating an integrated facility.

The capital project included the addition of three multi-purpose beds in purpose of . . . pardon me, in support of palliative, convalescent, and respite care, as well as one short-term observation bed. It also included integrated space for use by home care, public health, mental health, community therapy, ambulance, physician, and addiction services. Further, the facility also provides laboratory, X-ray, and emergency services. Additional positions for a therapy aid and health promotions staff were introduced as part of the initiative.

The annualized cost saving is in excess of $600,000 annually. The capital cost of the project was 1.8 million. And given the annualized operational saving, this project, effective this month, has now paid back the initial capital investment. But more importantly, it has met and will continue to meet the communities' needs. The community is proud of this initiative despite some initial concerns regarding the impact of the hospital closure.

The commission's recommendation regarding the role of community care centres very closely matches our actual initiative in Cudworth. It has been a successful initiative. In short, our experience proves that it can work. Existing integrated facilities linked with nursing homes should be considered as the first choice for the location of community care centres.

Emergency services. The Central Plains District Health Board supports the EMS review report and Mr. Fyke in their recommendations that ambulance services must be enhanced and that improved standards for minimum staff qualifications be achieved. Accordingly, our board urges the government to significantly increase funding for ambulance services.

Further, we urge this committee to recommend that ambulance rates be standardized across the province. Rates are currently based largely on distance, and this is inherently unfair to rural residents whose emergency care needs are no less important than urban residents, who may only be 5 to 10 minutes away from an emergency care centre.

Acute care services. The Central Plains District Health Board agrees with Mr. Fyke that our province cannot continue to support the number of hospitals currently in existence. Three hospitals in our health district have been closed since 1993, and evidence shows that the health of the residents of our district has not been adversely affected.

However, that being said, it is our view that the government should cautiously consider Mr. Fyke's assertion that the acute care needs of rural Saskatchewan can be adequately met through a network of 10 to 14 regional hospitals. We as a board do not support such an assertion.

The Central Plains District Health Board supports the need for a province-wide plan for acute care services. Our board generally supports the recommendation that tertiary services are most appropriately located in Saskatoon, Regina, and to a limited degree in Prince Albert.

We agree with the plan for a strategic network of regional hospitals providing specialty services. However we have grave concerns with Fyke's recommendation suggesting 10 to 14 regional hospitals be established. It is our view that this may be too few to adequately address the health and safety needs of residents of rural Saskatchewan.

The commission suggests a model with 10 to 14 regional hospitals would ensure 88 per cent of the population would be located within 60 minutes travel time from a regional facility. We find this standard as presented to be unacceptable. This standard appears to be oversimplistic in nature, lacks rationale, and accordingly is impossible to support. It certainly raises more questions than answers.

For example, does it take into account road conditions in rural Saskatchewan? Winter travel? Additional information and very careful analysis is required with respect to this standard.

If a model for regional hospitals is adopted, it must be based on clear and objective criteria with respect to the number, location, and range of services to be provided. Factors such as existing services and professional resources, historic partnerships with neighbouring districts, potential for recruitment and retention of specialist staff all must be taken into account.

For example, there are currently nine family physicians in a group practice in Humboldt. Next month a general surgeon will begin a resident surgical practice. Three of the nine family physicians have speciality training in anesthesia and one has specialty training in obstetrics.

The Humboldt Medical Clinic presently serves the catchment area in excess of 40,000 people. In addition, a surgical group from Saskatoon conducts surgeries two days a week at St. Elizabeth's Hospital, thereby assisting with the waiting lists for elective surgery in Saskatoon Health District.

Specialists in cardiology, radiology, obstetrics and gynecology, internal medicine, orthopedics, ENT (ear, nose, and throat), and urology travel to St. Elizabeth's Hospital on a regular basis from Saskatoon to conduct clinics.

We currently have additional specialists requesting clinic space which we cannot accommodate.

These partnerships with specialists from Saskatoon have been in existence for many years and have proven to be successful in providing access for the public closer to home as well as ease of patient referral and valuable clinical support for family physicians.

In addition, St. Elizabeth's Hospital provides materials management and pharmacy services on a regional basis, as well as an outpatient chemotherapy.

We would also be remiss if we didn't mention the partnership with the College of Medicine in providing rural clinical placements for family medicine residents at St. Elizabeth's Hospital.

In essence St. Elizabeth's Hospital currently provides most of the services suggested by Fyke as those that should be delivered by a regional hospital — and in some cases more than Fyke recommends.

We are currently one of eight capital projects in the province in the planning stages. Planning to date has been carried out with the focus being one of not only sustaining, but also enhancing, the services presently offered at St. Elizabeth's Hospital in order to meet the needs of our clientele on a larger, regional basis.

However if one were to consider the standard of 88 per cent of the population having a maximum of 60 minutes travel time to a hospital, it leads one to question whether a regional hospital would be located in the city of Humboldt due to its proximity to Saskatoon. If this were to occur, it would clearly dismantle many of the services just described at St. Elizabeth's Hospital.

A further issue that must be carefully considered, if this were to occur, would be the pressure and negative impact that this would put on already limited acute care beds in Saskatoon.

The physician group in Humboldt has made it very clear that many of them would relocate to wherever specialty services were located. This is clearly not in the best interests of the residents of our health district.

We don't intend to belabour our point. However we cannot emphasize enough that the type and location of acute care specialty services should not simplistically be governed by geography, but rather by a comprehensive provincial plan which takes into account public safety, existing successful partnerships, recruitment and retention of specialty staff, trading patterns, and client access to services.

Ms. Swinderski: — Basic primary acute strategic alignments. We have indicated that the Central Plains District Health Board does not support the standard of acute care facility within 60 minutes travel of 88 per cent of the population. However we do appreciate that the province cannot afford to sustain the number of fully functioning acute care facilities currently in existence.

It is our position that the current situation is not sustainable, but also doesn't actually provide the required range of services required by residents of rural Saskatchewan. By attempting to maintain the status quo, we believe the result has actually been a weakened system of acute care.

We support Fyke's recommendation to strengthen acute care via a regional hospital system. However, as mentioned earlier, we have concerns that a provincial plan for acute care built on the foundation of seven tertiary hospitals and potentially 14 regional hospitals will not adequately meet the province's acute care needs.

Saskatchewan Health reports that there are presently 68 hospitals operating in the province. This represents a reduction of 47 acute care facilities to be replaced by 25 to 30 community care centres and an undetermined number of primary health centres. Despite our board's earlier comments that the province cannot sustain the current number of acute care facilities, a reduction of this magnitude is a monumental change that may shake the confidence of rural residents for years to come.

We propose that a reasonable alternative may be to target specific community care centres to provide basic primary acute care. These limited numbers of community care centres would be strategically located and aligned with regional hospitals. We would propose that these targeted community care centres be located in geographic areas where travel time to a regional hospital is a significant concern, and travel times are at the utmost limits of 60 to 80 minutes.

We would like to utilize the community of Wadena as an example where, in our opinion, travel times would be a significant concern. Further, we'd like to illustrate how a model for targeted, basic, primary acute care beds might effectively and efficiently address this concern.

Wadena is a progressive community of 1,500 people located at the junction of Highway 5 and 35. An integrated facility exists with 14 acute care beds and 52 long-term care beds. In addition public health, home care, community therapy, and mental health

services are located in the facility. Two resident physicians serve the community with extremely busy medical practices. Wadena's primary medical referral patterns are to Humboldt and Saskatoon. Its trading area is increasingly becoming primarily to Humboldt and Saskatoon.

Wadena is 60 minutes from Humboldt to the west, 35 minutes from Wynyard to the south, 65 minutes from Canora to the east, and 75 minutes from Tisdale to the north. It is unlikely Wynyard will be designated as a regional hospital so therefore Wadena is likely to be 60 minutes travel time, or perhaps more, from the nearest acute care facility. Our board has previously indicated that this standard is unacceptable.

However, a strategic alignment of a community such as Wadena with, for example, Wynyard with limited but targeted primary acute care beds in each facility would address the travel time concern. This limited acute care service would be of sufficient critical mass because it would be targeted so as to ensure safe quality care.

Physicians in aligned communities would work closely together in a collegial environment with the intent being to promote the sustainability of rural physician practice. For example, an alignment between Wadena and Wynyard would provide a critical mass of seven physicians working together in a strategic manner. This would significantly strengthen the care to surrounding residents of both communities through the coordination of the collective skills of seven physicians.

This alternative would be very efficient in that it takes advantage of economics of scale inherent in existing integrated facilities. In other words, staff are already in the building 24 hours a day providing long-term care, palliative, respite, and convalescent care.

A community care centre as recommended by Fyke is the logical site by which to strategically target limited numbers of acute care beds that would be utilized in the coordination with regional hospital beds. Further, as mentioned previously, these would most effectively . . . efficiently be operated as part of an existing integrated facility in order to take advantage of existing infrastructure investments already paid for by the taxpayers.

This alternative would address the following issues: provide limited but targeted primary acute services closer than 60 to 80 minutes from home; maintain the confidence and security of clients; cost-efficient delivery of care; sustained, stable physician services in a general geographic vicinity, at the same time allowing physicians to take advantage of their specific skills, abilities, and interests; district reorganization and meaningful community involvement.

The Central Plains District Health Board is not opposed to the reorganization of health districts, although clearly the question is how many are appropriate and in what configuration. While our board does not propose to have the answers to this question, we do firmly believe that nine to eleven districts as recommended by Fyke are too few for this province. This belief is based on two major challenges faced by larger health districts: first, the challenge for leadership and administrative support; and second, the challenge for meaningful community involvement and input.

Mr. Fyke suggested that the current system has too few managers. While we as a board agree with this suggestion, we do not want to focus our comments on the numbers of managers, but rather on the role of leadership in the management of health care. Leadership is a crucial component in any change process.

Health district residents, clients, and staff need to be knowledgeable of and have confidence in the vision, the values, and the service delivery system. This in our opinion involves more than just being aware of these issues, but more importantly participating in the discussion and development of these issues.

We are concerned that if districts become too large, board members and executive managers will not be available in order to develop and foster positive community relations, to listen and seek input, or to provide adequate administrative support to clinical managers and front-line staff.

Our experiences have clearly and succinctly shown that when executive management is a reasonable presence, communities feel their input is valued, thereby promoting a sense of ownership and confidence in the system.

Our CEO recently had the opportunity to speak with a clinical manager in a community in Manitoba. Manitoba currently has 12 regional health authorities. The clinical site manager expressed a great deal of frustration in her position. She reported that she received a visit to her site from an executive manager approximately every two months. She felt uninvolved, isolated, and unsupported.

This story poses two questions. What kind of confidence in the health system is this clinical manager portraying to the community, and can an executive manager and a board accurately understand the needs of the community given this scenario?

We would like to restate our board's position concerning the reconfiguration of health districts. We are not opposed to restructuring; however, our concerns just voiced with respect to the challenges for responsive leadership and fostering meaningful community involvement must be carefully considered.

That being said, we believe any district restructuring must take into account the following factors: travel distances; medical referral patterns; service and trading patterns; need to foster meaningful community involvement; impact on recruitment and retention of staff; plans that assure improved care and coordination of services. These factors should be carefully analyzed and considered prior to district restructuring.

Finally, the public must be involved in some manner in any discussion concerning changes to district boundaries.

In conclusion, we sincerely thank this committee and its members for allowing us this opportunity to speak to you today. If there were one final message that we would like to express today it is that rural Saskatchewan is not adverse to change. We continually hear that rural residents don't embrace change. This statement cannot be further from the truth.

The face of rural Saskatchewan has dramatically changed over the course of the last two decades. We have changed with it and will continue to change.

The challenge for this government and future governments will be to provide strong leadership in managing the change process by developing a comprehensive plan and implementing it such that the community involvement and public confidence is fostered.

Thank you very much.

The Chair: — Questions from the committee?

Ms. Higgins: — Thank you very much, Madam Chair. I'd just like to thank you very much for your presentation. It was very comprehensive, and it's nice to hear you relate the recommendations and how they would affect your district, and offer other suggestions.

One of the concerns that we've had . . . Just a short question. In the beginning of your presentation, you were talking about the community care centres and your feeling that there should be more and they should be relied on a little heavier than what the Fyke Commission recommended. One of the concerns we have heard from a number of people is that recruiting professionals in rural Saskatchewan is tough. It's hard to retain people and recruit them to areas.

Do you have this problem with your community care centre, because obviously the services that you offer you have a wide variety of professionals there, so has it been a problem?

Mr. Fisher: — Generally it depends on the community but generally we've been reasonably successful in most areas. Areas like therapies is always very difficult. But I think what we envision with the community care centres is that there doesn't necessarily have to be the whole core of the team there all the time. As long as the team is functioning, people can travel in and we can make use of the professionals that we do have.

Our concern expressed by our position is that if you invest a lot of money in overhead costs of health centres . . . hospitals converted to health centres can be very costly just to operate in terms of utilities, equipment costs, and those kinds of things.

Our view is that if you can centralize the services within a reasonable distance of many communities and many people, you can provide a more comprehensive plan for people and a more comprehensive service. And that may or may not necessarily mean that every single professional is available in every community care centre, but that they're working together and they're networking with others throughout the district. And that's really more important, I think at this point, is making sure that those services are available to people.

Insofar as we're concerned, primary health care teams don't need buildings. They need to work together, they need to communicate, they need to talk, they need to plan for people's needs. They can travel out to people and they don't necessarily need a building that's going to cost a lot of money. Our view is that we'd rather spend the money on care.

Mr. Thomson: — Thank you, Madam Chair. I want to thank the officials from the Central Plains District for a very thoughtful and very thought-provoking presentation today.

It is, in many ways I think, fleshes out much of what we've heard in this committee thus far without a lot of the emotion. It talks about some real successes within your local district and I think that speaks very highly of the confidence you have in the district and your ability to move forward.

I'm interested in the question of the approach presented by Fyke as he talks about his various levels and almost this cookie-cutter approach to facility planning, to district planning. You seem to be taking an approach that we should be looking more at what the communities already have and trying to build around that.

Am I correct in understanding that? And has that largely been what has been happening then within the Central Plains District?

Mr. Fisher: — I think so. One of the things that we feel very proud of is some of the work that we've done in Cudworth, for example. A very, very difficult decision and a bold decision by our board to close that hospital.

But what we've done there is we listened to the people in the community. And many of them passionately told us things like, we don't want our people to have to go to a neighbouring community to die; we need palliative care services. We want elderly people to come back from hospitals in Saskatoon, that we recognize are perhaps capable of providing the services, but we want them to be able to come back and convalesce close to people.

So we feel that we have tried to address some of those needs. It's always difficult to meet everyone's expectations. But I think what we've tried to do is provide a comprehensive network of services such that we can meet the majority of people's expectations as close to home as possible.

If I can comment perhaps on Mr. Thomson's couple of questions prior to our presentation, is he talked a little bit about partnerships between communities. And one of the things we would like to draw to your attention, that we would like this committee to consider, is the whole issue of the strategic alignments between some communities. And I noted last night in watching the presentation from the town of Kindersley, that they proposed a sharing of services perhaps between Rosetown and Kindersley. And I think that's really one of the things that we wanted to bring forth as a potential alternative solution.

We do believe in the concept of regional hospitals thoroughly. We believe that that is an excellent concept. But if you look at the map, there are going to be strategic areas where there is going to be large distances. And our board has made it very clear that 60 to 80 minutes is unacceptable.

But if you look at Wadena-Wynyard area, that is clearly an area that you're going to have a difficult time configuring and arranging for a regional hospital because quite frankly, because of the geography, you're not going to be able to retain and recruit and retain specialists. So you have to look at things

practically.

And I don't know as well the Kindersley area in terms of their ability to recruit. I think I noted that they had about four physicians in Kindersley for a population of 5,000. In Humboldt, I noted that we have nine . . . actually we're going to have a tenth, a general surgeon. And we obviously have a large catchment area. But geographically Kindersley, I can see on the map, will potentially be very, very far from anything.

And our proposal is very much in keeping with theirs in the sense that you may find there is real good, solid reasons to align certain communities with limited acute care services such that you can do it efficiently and you can do it competently.

And we actually have had some discussions with Living Sky Health District, albeit very preliminary, in terms of some discussions that we should put forth with regards to Wynyard and Wadena. And, you know, if you look geographically, it's an issue that we believe strongly in.

Mr. Thomson: — Thank you very much for the presentation. I think that there's a great deal of merit in what you say. Of course the government hasn't made a decision as to what to do yet with the report. Clearly Humboldt is well-positioned to become an enhanced regional centre.

I think a lot of what you've said regarding Wadena and Wynyard, I would say additionally it's something that I think Kelvington should probably look at as it's within that same basic area. It's unfortunate each of those larger communities falls within a different district. But obviously there's an ability to work together there, and I think that there's a willingness to work together.

I will certainly commend your report to the minister because I think it highlights a lot of very innovative ideas in a place where obviously the board has worked very hard to make sure the communities have bought in. So congratulations, and thank you very much.

Ms. Swinderski: — With Kelvington and Wadena, we have tried to work . . . like I'm from the Wadena area and we find the people in the Wadena area, as far as acute care and stuff, they don't want to move away from your Saskatoon and Regina. They feel they want to keep the movement going towards, you know, Humboldt or towards Regina, as opposed to going backwards.

The Chair: — Seeing no more questions. Thank you very much on behalf of the whole committee for your presentation and your appearance today.

Our next presenters can come and take a seat at the table. Welcome to the Standing Committee on Health Care. It's a committee of the Legislative Assembly and you've probably noticed we're a little out of order here, but Central Plains was here, and we were a bit early so we moved them in.

This is an all-party committee of the Legislative Assembly. Its task . . . its first task was to hear responses to the Fyke Commission and report back what we heard to the Legislative Assembly by August 30. We're not going to be giving recommendations; we're going to be reporting back what we heard.

The all-party committee consists of myself, Judy Junor, the Chair. Dr. Melenchuk is the Vice-Chair. Andrew Thomson, Kevin Yates, Deb Higgins, Brenda Bakken, Bill Boyd, and Rod Gantefoer are here with us today.

The presentations are a half hour, and hopefully within that half hour we have some time after your presentation for a few questions from the committee.

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

Mr. Panio: — Thank you. Madam Chairperson, hon. members of the Legislative Assembly, and members of the standing committee. I'm John Panio, the Chair of the Pipestone Health District, and with me to my immediate left is George Pauliuk, our Vice-Chair; to my far left is Pat Connelley, he's one of the board members; and to my immediate right is Ed Sorsdahl, our chief executive officer.

So on behalf of the Pipestone Health District Board, we are pleased to be able to address you today, and we would like to give you our feedback to the report of the Commission on Medicare, the Fyke report.

Before we start we'd like to describe our district a little bit to you in case someone is not quite familiar with our territory. It's a very different configuration. The Pipestone Health District is long and narrow. It straddles the Trans-Canada Highway east of Regina. The district starts just west of McLean and stretches to the Manitoba boundary. The district is over 200 kilometres long but is only about 60 kilometres wide at the widest point. We jot into Rocanville at the far end, and at this end we jot into Montmartre and Carry The Kettle First Nations Reserve and Kendal.

The district has under 19,500 residents. The major communities in the district are McLean, Qu'Appelle, Indian Head, Montmartre, Sintaluta, Wolseley, Grenfell, Broadview, Whitewood, Wapella, Moosomin, and Rocanville. The largest community in the district has just under 2,500 residents. Over 2,500 First Nations people reside in the district in the communities of Carry The Kettle, Sakimay, Cowessess, Kahkewistahaw, Ochapowace. And there's a new First Nations reserve being formed.

As in the case in many areas of rural Saskatchewan, the population in the district is declining. But projections show it is not declining as rapidly as some other rural areas of the province. It has been projected that there will be just about 18,000 residents in the district by the year 2015, health . . . This is the Health Services Utilization and Research Commission figures.

There are seven long-term care facilities in the district located in: Moosomin, 68 beds and two buildings; Whitewood, 30 beds; Broadview, 36 beds; Grenfell, 34 beds; Wolseley, 80 beds; Montmartre, 16 beds; and Indian Head, 43 beds. The district has a total of 307 long-term care beds.

There are four acute care facilities in the district located in: Moosomin, 33 beds; Broadview, 16 beds; Wolseley, 18 beds; and Indian Head, 16 beds. The district has a total of 83 acute care beds.

There are three main health centres in the district located in Grenfell, Whitewood, and Montmartre. The district has . . . also provides community services including home care, mental health, alcohol/drug services, and EMS — two contracted services, two services operated by the district. The district has over 800 employees, filling 525 full-time equivalents or FTEs.

In responding to the Fyke report, we would first like to make some general comments and then comment on the report on a chapter-by-chapter basis. So it's kind of congruent to what other presentations.

General comments first. We believe that high-quality care services, including medical care, are provided in the Pipestone Health District. Well-qualified personnel, including physicians, nurses, and other health care workers deliver these services. Even though we believe the services in our district are of high quality, we recognize there is room for improvement. In fact, improvement and enhancement of these services should be one of our main goals.

We believe that in any change, process and health care is essential to develop a mechanism to involve physicians. Physician input and co-operation is essential to the success of any health reform initiatives. We hope this co-operation can be obtained as quickly as possible.

Our board believes that acute care services which includes acute care hospitals should be coordinated on a provincial basis to ensure there is an overview of the larger picture of acute care in the province. This may also have the benefit of ensuring that all residents of rural Saskatchewan have reasonable access to acute care services.

That brings us to chapter 1: the "Everyday Services." The Pipestone Health District endorses the concept of primary health services teams. We believe that to make such teams effective, involvement of family physicians is essential.

We strongly endorse the need to enhance community-based and emergency services. Our board also supports the concept that comprehensive services should be available 24 hours a day, 7 days a week. The telephone consultation service described in the report may be a worthwhile project. However to make such a service functional and cost effective, it would need to be promoted and managed on a provincial basis. We believe emergency response services and medical transportation should be enhanced. The board strongly endorses the concept that ambulance fees should not be based on distances travelled.

Our board is concerned about the potential conversion of small hospitals into primary health care centres or community care centres. Prior to any such conversions, it will be essential to have an overall plan for the allocation of acute services in rural Saskatchewan. Additionally, it is essential that primary health service teams be in place and operational before such conversions take place.

There must be a long-range provincial plan to implement conversions to ensure there is a continuity of service delivery. Conversions prior to the development of such a plan or the implementation of primary health service teams would be premature and would not be supported by this board.

Chapter 2: "Specialized Care." The Board agrees that tertiary services should be provided in Regina and Saskatoon. Because of the specialized nature of these services, it is important that careful consideration be given to the need for the placement of such services in Prince Albert, especially for the North.

Factors such as travel patterns should be reviewed to ensure locating such services in Prince Albert would accomplish the goal of alleviating some of the capacity pressures from Saskatoon.

The Pipestone Health District Board strongly suggests that the number and scope of acute care regional hospitals, as described in the report, needs to be re-examined. We believe the number recommended — 10 to 14 — is arbitrary. As stated earlier, we feel there should be provincial coordination for the planning and delivery of acute care services to ensure appropriate provincial coverage. The board feels that 10 to 14 acute care hospitals outside of Regina, Saskatoon, and P.A. (Prince Albert) will not allow reasonable access to acute care for citizens of rural Saskatchewan.

In rural Saskatchewan it is necessary to factor in driving distances when considering access to health care services. We do not need to remind you that in the winter driving conditions deteriorate and consequently travel time increases.

In rural Saskatchewan, hospitals are seen as symbols of health care. Any change to the number and location of the hospitals must be approached carefully, with a plan for how the services provided in these hospitals will be delivered in the future.

Chapter 3: "Making Things Fair." The Pipestone Health District Board strongly supports public health, health promotion, and disease and injury prevention strategies. Strategies to address the broader determinants of health must be developed on a provincial basis.

In the Pipestone District we have developed programs such as Parenting Plus, an early childhood development program for overburdened families; and the Defeat Diabetes Team to provide early education regarding diabetes; and partnership with Touchwood Qu'Appelle Health District, File Hills Tribal Council, and Carry the Kettle First Nations.

This is evidence of our commitment to health promotion. These programs, as well as our public health programs and other health promotion initiatives funded under the rural health initiatives, address health issues that are critical to the well-being and health of the residents of our district.

We believe that Saskatchewan Health should take a lead role in the development of measurable health goals for public health and health promotion programs. Such goals can be used to evaluate the effectiveness of health promotional programs.

Chapter 4: "Getting Results — Quality at the Centre of the

System." The Pipestone Health District Board strongly endorses the establishment of a quality council. The board feels the development of such a body is essential to continued progress within the health care system. We must move away from a system based on quantity to one based on quality. At this point we are able to provide much information on how much we do, but we can provide little information on how well we do it.

The board feels the development of quality council is a priority and that the government should act quickly on this recommendation. The development of performance indicators, the use of annual reports on the health system, and the paradigm shift to quality cannot be successful without some form of provincial guidance. We believe the quality council could provide this guidance.

Chapter 5: "In Support of Change." Health districts should be encouraged to work with each other to determine how services can be best delivered to the residents of rural Saskatchewan. Districts should also be encouraged to develop a district configuration set up based on service needs and patterns. The Pipestone Health District does not oppose a reduction in the number of districts, as long as any reconfiguration is based on service delivery needs.

The board also supports the need for a dialogue on the delivery of health services to Aboriginal people. Such a dialogue should involve all stakeholders and the lead role must be taken by Aboriginal peoples themselves.

The development of the electronic health records system would be of great assistance in rural Saskatchewan and should be pursued aggressively.

Health spending on research must be increased to allow the province to develop areas of expertise such as the delivery of rural health services.

Chapter 6: "Paying the Bills." In many ways, Saskatchewan is still feeling the effects of the health reform process that started almost 10 years ago. As further change occurs, it is important that the change process be managed so it unfolds in an organized and reasonable fashion. To accomplish this goal, a process of staff, community, and other stakeholder involvement must be developed.

In summary, ladies and gentlemen, the Pipestone Health District Board feels that many of the recommendations and the direction articulated by the report of the Commission on Medicare are positive. We do, however, have serious concerns regarding the conversion of existing rural hospitals and the development of only 10 to 14 regional hospitals to provide acute care.

The Trans-Canada Highway, one of the most heavily travelled routes in the province, bisects our district. Experience has shown us that medical services, especially emergency and acute care, are required to deal with accidents that occur on this stretch of highway.

The Pipestone Health District Board recognizes that change is inevitable. To sustain our health system, change is essential. However change must be managed and implemented in a rational, planned fashion. Change should not be made merely as a knee-jerk reaction to a problem. It must be made in a thoughtful manner, ensuring all stakeholders have input into the change process.

While there is much to support in the Fyke report, the critical issue becomes one of timing. In order for changes in the system to be effective and positive, they must be done in an atmosphere of co-operation. An overall implementation plan for change needs to be developed. If communities are to face conversions or closures, there must be a plan for delivery of services in that community and the plan must be operational prior to any conversions.

The Pipestone Health District Board endorses a consultation process with health districts, communities, staff, and other stakeholders to ensure that there is an opportunity to fully assess the potential impact of these recommendations, not only to the health care available to the citizens of the province but also the impact they may have on the viability and sustainability of life in rural Saskatchewan.

Ladies and gentlemen, thank you for your consideration of our comments and this opportunity to share these with you. And I am speaking on behalf of our board. Thank you very much.

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

Hon. Mr. Melenchuk: — Thank you very much for your presentation. The family physicians in your district in terms of setting up primary care teams, we heard from the Saskatchewan Medical Association that they're not opposed to looking at alternate methods of payments or even participating in primary care teams. But it's your belief as a board that there needs to be an important consultation and buy-in from the various groups before anything should be mandated along those lines. Is that correct?

Mr. Sorsdahl: — Very much so. I think we believe that in rural Saskatchewan the key player to health care in many ways is the rural physician, whether that physician be a part of a larger practice or a one- or two-physician practice. We believe that with the staff that we have it's quite possible to develop primary health care teams that may have itinerant members because we are in a rural area, clearly a rural area.

But we think that involvement of physicians in terms of how we structure that, in terms of alternatives for their payments, how they can have input into the design of that, is absolutely critical for the success of that endeavour.

We've had some success in areas, as Mr. Thomson is aware, in Moosomin, for example, because of their ability in that community to have a larger number of physicians. The critical mass is there. The willingness to look at ways that we can work with that physician component and with other parts of the community to deliver effective services, I think, is very healthy and is very positive. And we have that relationship in other areas. Unfortunately we don't have communities of that size that have that number of physicians throughout our district.

One of the factors that I think is important to point out to the

committee members with Pipestone is that the issues in our district are very difficult, because the issues . . . Due to the nature of the configuration, the issues in Indian Head are extremely different than the issues in Moosomin because of the location within the district.

So the way one configures could be very different at one end of the district as opposed to the other. That's why we're saying there needs to be reconfiguration of districts to look at service needs as opposed to existing district boundaries.

Hon. Mr. Melenchuk: — The other question that I had goes along with what we've heard from just about every presenter that's come forward, and that's the concept of maintaining reasonable access to acute care beds in locations throughout Saskatchewan. It is my understanding that in Pipestone, because of the nature of your district, long and narrow with multiple acute care facilities, that really none of them would really fit in as a regional hospital but they are providing needed acute care services. Perhaps most of these services would need to be maintained in the communities that probably have already been rationalized to a certain extent.

Mr. Sorsdahl: — No question. I think that's a very accurate assessment. There have been three facilities that were closed over the years in our district — in Whitewood, in Grenfell, and in Montmartre — and the four remaining facilities are spread out almost equidistant throughout the district.

I think if you look at a "regional acute care centre", depending on what one would want to offer in that centre, depending on whether you followed Mr. Fyke's recommendations or not, Moosomin certainly has a larger catchment area as well as significant distances from other regional areas such as Yorkton, Estevan, Brandon, Manitoba, or Regina. So Moosomin, given its catchment area, its physical location in the province, is different somewhat than Indian Head, which is a community of approximately 2,000 but given its proximity to Regina the needs and configuration of services there could be different.

Hon. Mr. Melenchuk: — I do have one more question, and that is co-operation with neighbouring districts in terms of some shared services. Are you co-operating with neighbouring districts in several areas?

Mr. Sorsdahl: — We're co-operating in some areas, that's right. We do provide services both for North Valley and for Moose Mountain, which are neighbours to the north and to the south. We hope that we can do more in terms of that kind of collaboration and co-operation down the line.

That happens again because district boundaries in Saskatchewan are not defined by clear geographical boundaries. And the boundary between Wawota and Moosomin is simply non-existent and therefore, if the services are not available in Wawota, people come to Moosomin. The physician left, so the Moosomin physicians now go down there.

So clearly we're working with other districts in a number of areas.

Hon. Mr. Melenchuk: — That's all the questions that I had. Thanks.

The Chair: — Seeing no further questions from the committee, then we thank you very much for coming today and presenting your views. Thanks again.

Okay. We'll stand recessed till 7 o'clock.

The committee recessed for a period of time.

The Chair: — If Living Sky wants to come and take a chair. Good evening, and welcome to the Standing Committee on Health Care, a legislative committee, and we're an all-party committee. Our first task is to receive responses to the Fyke Commission and report back to the Legislative Assembly on what we heard.

Our committee will not be making recommendations. We'll be reporting back what we've heard from our presenters and in the hearings that we've been having like this and in the written submissions, and we have to report back by August 30.

So we've given people half an hour and hopefully in that half an hour, there's still time for the committee members to ask a few questions.

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

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

Mr. Busch: — Okay. Thank you very much for the opportunity to be able to present to the standing committee this evening.

Let me introduce who we are here. I'm Wayne Busch from Nokomis. I'm the board Chair for Living Sky, an elected member to the system. And to my far right is Marg Berg from Cymric, Saskatchewan, a board member appointed. And beside her is Nona Longstaff from Wynyard, Saskatchewan, a board member elected. And to my left is Gordon MacMurchy from Semans, board member appointed.

What I'd like to do to start with — because perhaps our name, Living Sky Health District, doesn't have a particular connotation for a name of communities in it — just outline to you that our health district encompasses an area in central Saskatchewan much similar in size to many of the small health districts. But just to make you a bit more familiar with some of the area, it would range from Wynyard to the east and, in fact, even further east to a small community called Leslie, to the west to Lanigan and over to Watrous, and south on 20 Highway as far south as Strasbourg. So Nokomis, where I'm from, is kind of in the middle, just to give you a geographic sense of where we are.

We don't have a particularly long presentation, but we feel an important one for you today and I would like to just go through that and I think you may have copies of it there.

Anyway, it is the consensus of the Board of Directors for the Living Sky Health District that the work done by Mr. Ken Fyke and his colleagues, in preparing this report and the recommendations, is largely commendable.

We strongly agree that improved emergency response services in rural Saskatchewan are essential and that tertiary services need to be offered in two or perhaps three centres only. We believe that if those centres were used only for tertiary care, there would be adequate room for all those in need.

Further we would support the principle of quality improvement in general for Saskatchewan health care, whether through the auspices of a quality council or some other venue. We are strongly committed to the notion of primary health services and believe that rural Saskatchewan offers a variety of practice opportunities to physicians.

There is still room in fact for single-physician practice here in rural Saskatchewan, especially with the support of an advanced clinical nurse such as we see in our own district at Strasbourg and in other districts such as Beechy.

There are also opportunities for group practice or for physicians to group together in a community clinic setting which would be much similar to what exists in Wynyard.

The Nokomis health centre model with a single physician, long-term care beds, and all the community services under one roof is a good one and it works well for us.

There are issues however, specific to rural Saskatchewan and in particular our own district and its communities, on which we wish to comment further.

We believe that are two streams to Mr. Fyke's recommendations. The first of these is related to service delivery and the second to what we call running the ship or governance, and we have organized our comments loosely to accommodate this structure.

First on the matter of service or program delivery issues. In the Living Sky Health District our residents currently have local access to long-term care, home care, public health, mental health, physiotherapy, occupational therapy, palliative care, and pharmaceutical care, physician care, and emergency services. These work well and we are generally satisfied.

Generally for in-patient hospitalization our residents are sent to Saskatoon and to a lesser extent Regina as we maintain only 16 acute care beds on three sites throughout the district. These beds however are very valuable for convalescent care. And that would be instances where it's critical in order that the city hospitals are able to discharge as early as possible, then we would be able to look after them in a convalescent setting.

They're also important for palliative care, respite care, and observation. We have a great deal of discomfort with the notion of losing the ability entirely within our district for those features.

We are concerned that Mr. Fyke did not appropriately address long-term care services within his report. We believe strongly in an individual's need to live within his own community even when he can no longer adequately meet his own needs. Many of the elderly residents in our communities have lived their entire lives in one place, and have worked long and hard and have made many significant sacrifices for their community. To ask them to leave at the end of their days is not acceptable to us or to them. Long-term care is one thing that we do really well and we are proud of our service history.

While we take pride in our home care program, as well, and what we are able to accomplish on behalf of our clients in their homes, we concede that we cannot meet all needs, particularly in relation to respite, palliative, and observation. We need access to local beds in order to complement our home-based services.

While we have stated our position on enhanced ambulance response in the rural setting, we also believe that we must retain the ability to receive, stabilize, and dispose of casualties that do not necessarily require ambulance resources. We must retain the diagnostic services we currently enjoy including lab, X-ray, and ultrasound services in order to support good physician practice.

In the Living Sky Health District we are concerned about an area as large as that which exists between Yorkton and Saskatoon on the Yellowhead Highway having no staffed emergency centre. We would feel more comfortable knowing that Wynyard or Lanigan would retain some acute care capability, for this reason among others. This does not appear to be in keeping with Mr. Fyke's thinking.

We are convinced that some of the best things we do, we can do because we are small and because we are local. We believe that with adequate time and resources invested into our current system, we can make most things work for us. What does not work for the residents of the communities within the Living Sky Health District however, is long wait lists for surgical procedures and specialty appointments.

What does not work for those of us trying to deliver programs and services in rural Saskatchewan are some of the workplace conditions experienced by our employees. Nothing in Mr. Fyke's recommendation addresses our rural occupational health and safety concerns related to outdated equipment and insufficient staffing.

Secondly, on the matter of district structure and governance issues. There may be some problems with the existing district structure in Saskatchewan, but we are willing to agree that it is not perfect. We believe however that neither adequate time nor financial resources have been invested in this model to this date.

The board of the Living Sky Health District does not believe that any arbitrary configuration of districts or programs or services is likely to be any more successful than the current model if further study and discussion does not occur.

We believe that there may be some room for some rural board or district amalgamations and that where these make sense, mergers should be encouraged. And the way should be paved by the provincial government.

If and when districts are reconfigured, essential criteria such as geography, history, and established trade patterns must be considered. If and when districts are reconfigured, we must not confine ourselves to existing district boundaries. If we were to do that, we would miss opportunities to maximize natural linkages such as those that currently exist between areas like

Watrous, which is in our health district, and Imperial, which is in the Regina Health District, where all acute services for Imperial are currently being provided out of Watrous and the doctors share calls.

In the Wynyard, Wadena, and Foam Lake triangle, new ways to co-operate are being developed or discovered every day. A natural alliance exists between the communities of Lanigan in our district and Humboldt in Central Plains. It is our strong belief that these strategic alliances can and should be built up and in fact encouraged.

Mr. Fyke does not address the need for rural input and control in relation to health services planning and service delivery. Currently through our umbrella organization, SAHO, rural Saskatchewan has a strong voice. What happens to SAHO in Mr. Fyke's plan?

Recognition needs to be given to the fact that rural health care structure and delivery patterns positively influence the determinants of health in our communities through providing access to health services, local control, a voice for people, and employment opportunities.

It is important not to discount the fact that health care is almost the only thing left supporting the rural economy. We have seen our stores, our schools, our elevators close. Our health care facilities provide a huge economic benefit to rural communities, especially in the face of these other losses. What could possibly compensate for the loss to rural communities of this support to their viability and to their economy? The Living Sky Health District knows that the province can do no more than spend 40 per cent of its annual budget on health services for its people. We are well aware that funding from the federal government is a huge issue the provinces are attempting to address.

We must work together to encourage the federal government to increase its spending to an appropriate level and focus our energies rather than blaming each other for the ills of the system.

Finally, we assure you that we are not averse to change. However, we find very little substance of hope for rural Saskatchewan in Mr. Fyke's recommendations. Why then would we support them?

Once again, thank you for the opportunity to present our views to the standing committee. We would now make ourselves available for questions that you might have.

Mr. Gantefoer: — Thank you very much, Madam Chair, and thank you very much for coming this evening to make your presentation.

I would like to address a couple of issues. First of all, in your district, the community of a Wynyard has a very dynamic and vibrant community on the Yellowhead with a great deal of poultry development in that community. And I understand, with some connections to the industry, that there are potential plans for continued support and expansion in that facility.

Does the need to have acute care and emergency services play an integral part on the potential of that community's economic development to develop?

Ms. Longstaff: — I believe so. I believe that Lilydale certainly supports a good acute care and good physical care for . . . because they have numerous accidents. Because of — if you've ever been through the place — and there's a lot of, there's been fingers lost and limbs damaged and so there are some pretty, you know, a big requirement for immediate care.

Mr. Gantefoer: — Really in your health district you have three acute care centres — Wynyard, Lanigan, and Watrous, I believe. And each of them sort of have a unique, vibrant community with industrial or commercial or economic needs — Wynyard with the poultry plant, Lanigan with the potash mine, and Watrous with the whole lake development and things of that nature. And yet from your presentation, you have I believe 16 acute care beds in the three centres.

It seems like a relatively small number, but are they meeting your needs, and are your average daily census being able to work within that 16 beds, or what's your assessment of the 16 beds that are currently being designated as acute care?

Mr. Busch: — We've been . . . I think we've using them quite fairly. There are still occasions when in one or two of the communities some of those beds will remain empty, but that's just natural in the system that we operate.

But for . . . generally speaking, they are used quite quickly and used very well.

Mr. Gantefoer: — I would also suspect that the physician service base in the three communities rely very intricately on the fact that those acute care beds are available to them and the associated diagnostic and laboratory services.

It strikes me is that these are important areas. Would you outline in the three centres basically what services are offered, and what the physician base is for using those services?

Mr. Busch: — Well in Wynyard, for instance, we have a community care . . . a community setting . . . a community clinic setting and so the physicians that are operating . . . working in Wynyard operate out of that community clinic and have been in such a setting for quite a number of years. And they like that setting and work well, although it becomes a problem continually trying to place the ones that leave it. As it is a problem all across Saskatchewan and Canada.

In Watrous there is a setting of physicians . . . generally three physicians working there. And they work pretty much closely with the physician in Imperial and also in Nokomis. And Lanigan, there . . . we were down to one physician, but now have two physicians again working there.

And that basically, that's our complement in those three facilities. Yes, they do rely quite heavily on the ability to be able to have those beds . . . those acute care beds available to them.

Mr. Gantefoer: — Earlier today the Central Plains District talked about the need to recognize some of the geographic challenges that we have in developing acute care services, and

particularly, you know if we look at something above the community-based service or the community clinic. And that they suggested strategic alliances between communities and pointed to Wadena and Wynyard as a natural strategic alliance that should be developed and worked on.

And there was some suggestion that perhaps even Kelvington . . . and you suggest your three communities including Foam Lake. Those communities would be encompassed by, I think at least three health districts.

Are those realities an impediment in terms of these strategic alliances or are you able to overcome those impediments? And when you talk about a new potential look at a governance structure, are those the kinds of things that have to be considered?

Mr. Busch: — I don't think they've been an impediment at all. They've probably been an incentive to work together more closely actually.

Just to give you an idea beyond what the examples that you used of some of the collaboration and co-operation that is existing at the present time between ourselves and some of the health districts that are in our area. We have an ABI, or an acquired brain injury program or project, that we share with Central Plains. And it's working quite well. We wouldn't be able to do that on our own, neither would they, but between the two of us we can make it function and it works quite well.

We share a medical health officer. The pharmaceutical purchases, a lot of the pharmaceutical purchases for our health district we buy . . . or use the services of Central Plains because they have a larger pharmaceutical base to do the purchasing from.

The diagnostic services that we have . . . some of the diagnostic services that we have available to us out of the city of Saskatoon. Ultrasound would be an example — it comes out on a regular basis. Another something else that we share.

Physicians on call, the rostering of physicians on call. You mentioned the Wadena and Wynyard area. Certainly that happens there. It happens in Watrous, Imperial, and Nokomis. It happens and has happened to some extent over the last while, with Humboldt as well.

So these things are workable. They're not . . . it's not difficult to make them work under the present set-up that we have. They work quite well.

Mr. Gantefoer: — Thank you very much.

Mr. Thomson: — Thank you, Madam Chair. First, I'd like to welcome Mr. MacMurchy back to the floor of the Assembly. It's a pleasure to see him here tonight, and to have all of you joining us.

I have two questions. Actually I had several more but Mr. Gantefoer, being first on the list, got to ask most of the good ones. The two that I am interested in, though, that were not covered off . . . You make references to the single-physician practices in Nokomis and Strasbourg as well as Beechy. I'm very interested in how your . . . how these two communities differ in the way that you are dealing with one having the advanced clinical nurse support and the other still operating, as I understand it, largely on just a single physician then.

There are many communities out there in this situation. And I know for many rural residents it's a concern as to how you retain the physician in there without an interruption of service. So I'd be interested if you could elaborate a little bit on Strasbourg's situation, and Nokomis's.

Mr. Busch: — I'll get Marg to comment on Strasbourg because she's quite familiar with that area.

Ms. Berg: — The Strasbourg clinic is an affiliated organization with the Living Sky Health District, and we have a single-practice physician that's a salary position there, with the assistance of an advanced clinical nurse. And it's very well received in the area. I think the utilization statistics prove that. And the people are very happy with the situation there.

The clinic is open eight hours a day and besides the physician services and the advanced clinical nurse, they also have a chiropractor that comes in a couple of days a week, physiotherapy services are offered out of there, and a dentist's office as well. So it offers quite a range of services and it's working very well in the community.

It's open eight hours a day, but they do have a nurse on call 24 hours. She's not employed . . . or not on site 24 hours but there's a phone service for the remainder of the day and people can either, if there's a emergency in our area, we can either phone the ambulance or we can phone the clinic and the nurse will assess the situation and direct the client to the appropriate services, whether it is come into the clinic or call the ambulance or whatever it might be.

Mr. Busch: — In Nokomis, with the single-physician practice, the physician there is on fee for service, does not have an ACN (advanced clinical nurse) available, but has built up a very large clientele, very large program.

And services not only provide services to our own area within the district but also provide services to Touchwood Qu'Appelle at Raymore for instance, and does in fact go over on a clinic basis to the Kawacatoose Reserve once a week, and provides a lot of services for them. And we find a lot of those residents from that Kawacatoose Reserve returning to the community where our doctor resides.

Mr. Thomson: — Has consideration been given to adding an advanced clinical nurse into Nokomis?

Mr. Busch: — It hasn't at this time. But overall throughout the district, our district plan would be that we would like to be able to move to more sites where there are advanced clinical nurses. It will require a fair bit of work to be able to invite I suppose the physician into that kind of a setting. Not all physicians, I believe, are going to be able to work under those kind of . . . in that kind of a setting. And it would require, it would require some work, but nothing that couldn't be dealt with over a period of time.

Mr. MacMurchy: — I think on this issue, I've been around health for a fair little while and this issue of multi-practice clinics and single-practice physicians has been around. I would support — and we would support — a multi-practice but there are simply some physicians who want to work alone. They can only work alone so we should provide that opportunity for them.

Mr. Thomson: — I think that's a good point. I know several of the rural physicians I've talked to have talked about some of the difficulties that they have in . . . Some of the issues that they express in living in rural areas is the sense that they are on call constantly and they feel that they could often provide a better service if they were able to make use of an ACN.

Others I know quite like the more traditional style of practice and so it's interesting to hear how the two — since you have two within your district — how that's working. And it's encouraging to hear that in some cases you have been able to effectively use the ACN.

I think that's both my questions. Thank you, Madam Chair.

The Chair: — Any further questions? If not, then thank you very much for your presentation tonight.

I invite our next presenters to take a seat at the table. And welcome to the Standing Committee on Health Care. It's an all-party committee of the Legislative Assembly and we've been charged with receiving responses to the Fyke Commission. We'll report back to the Legislative Assembly by the end of August. on what we heard. We won't be making recommendations.

The party members are myself, Judy Junor, the Chair. Jim Melenchuk is the Vice-Chair. Andrew Thomson, Kevin Yates, Deb Higgins, Brenda Bakken, Bill Boyd, and Rod Gantefoer are here with us tonight.

You have 30 minutes and hopefully your presentation will allow in that 30 minutes time for questions if there are any. If you want to just say who you are and what you're representing or who you're representing and begin your presentation.

Ms. Pasztor: — I'll stand if that's okay. Is that all right?

The Chair: — Pardon?

Ms. Pasztor: — Is it all right if I stand?

The Chair: — Sure.

Ms. Pasztor: — Okay. I'm a little more comfortable standing.

The Chair: — As long as we can pick you up on the microphone.

Ms. Pasztor: — Sure. I'll move over if that's okay. My name is Sheri Pasztor. I'm a resident of Estevan, Saskatchewan and I'm currently doing a comprehensive human resource plan for the South East Health District as a component of my fourth year of my Bachelor of Health Administration degree.

I've spent the past two months in efforts towards the formulation of this plan and as such, I have some strong opinions with regard to the effect Fyke's suggestions would have on the South East Health District. Although I cannot speak on behalf of the South East Health District, and it's important that everyone understands I'm not trying to do that here, I certainly speak from their perspective.

Though I could spend all day speaking with regard to the future of health care in Saskatchewan, I have prepared approximately 20 minutes of a presentation in order to allow for questions or comments, at which time I will provide a copy of it for your use.

I will outline the aspects of health care in Saskatchewan that I feel are most crucial as the Fyke Commission comes under consideration.

With regard to Fyke's recommendations for everyday services, the implementation of a primary health service team operative will mean nothing more than increased quality of care. We have far too long allowed the medicare system to hold us hostage to the mistaken belief that physicians are the only professionals able to best serve Saskatchewan's patients. Physicians are penalized for choosing quality over quantity. By ensuring that patients receive the most appropriate care, duplication of physician and other professional services will be reduced.

In addition, the allowance of other health professionals to practise to the fullest extent of their scope will mean increased job fulfillment resulting in greater ease of recruitment and retention, in addition to increased quality of care. Physicians will provide those services only they are suitable to provide, thereby creating the potential for increased job satisfaction for doctors as well, with little to no effect on their income or autonomy.

Small hospitals that are simply no longer viable represent the ideal location for primary care centres, as they are currently positioned where a need has previously been determined. Such a conversion must be accompanied by an EMS system, an improved EMS system, to support this network of service provision however. This is an area which Fyke does not extensively address.

It must be ensured that access to essential services is not compromised in rural areas. It is necessary that rural residents be transported quickly to a facility that can best serve them in an emergency situation, a facility which will also be likely to provide a superior service to that now received due to its specialization in secondary or tertiary care.

Rural residents must be educated with the knowledge that service provision will be more appropriate and more timely and more likely to be locally provided despite tertiary and secondary care being provided at a more distant location. The EMS proposals outlined by Keller and Cross offer quality options to provide for such a service and would have the dual effect of allowing for the continuation of services with both small hospital closures and reducing the number of health districts.

Interestingly, a study done by the University of Calgary showed

improved cardiac outcomes with hospital closures and downsizing. And a Manitoba study has suggested the quality of care remains relatively stable with the loss of 700 beds in Winnipeg.

While broad conclusions obviously cannot be drawn from these studies, they certainly represent evidence in support of planned, selective centralization of service.

The effect hospital conversion will have on long-term care must be further investigated however. Perhaps by limiting facilities for long-term care, Fyke is encouraging more home-based care. This would likely be a positive move especially for the South East Health District. The South East Health District with its comparatively younger population, when compared to Saskatchewan as a whole, has a much higher number of long-term care beds.

Finally provision of services 24 hours a day should serve to prevent emergency rooms being substituted for clinics and will help to encourage patient responsibility in a certain level of their own care as true need may be confirmed or negated by a simple phone call. In addition, appropriateness of service will again be supported.

A network of primary care centres will best be served by a reduced number of secondary and tertiary service facilities as outlined in Fyke's recommendations for specialized care. The centralization of these resources will create a situation of specialization leading to more extensive equipment provision, increased quality of care, and improved recruitment and retention of those employed by these facilities.

Physicians whose expertise lies in these levels of care . . . lie in these levels of care will no longer be forced to compromise their training objectives by providing only the services that certain districts can manage to fund. In addition, the contracting of physician services will reduce duplication of services, inappropriate care, care that should be provided by an alternate professional, and case creation for monetary gain.

In my opinion, many physicians are not as opposed to alternate methods of providing remuneration as generally assumed. The fact is physicians are leaving the province anyway. Such a change may well cause further exodus, but so too will it improve recruitment successes.

Physicians will, and must, remain a fundamental component of health care provision through Fyke's plan; however, maintenance of the current level of physician autonomy cannot be reason enough to forego positive changes for the residents of this province.

I must suggest, however, that the concept of the quality council be further defined. While it certainly reads to have great potential, methods whereby this council would be created and wherein it would act must be explicit if success through it is to be witnessed.

It is the fair provision of health care that is now being questioned with moves such as the passing of Bill 11 in Alberta. Any quality health care system which works within the mandates of the Canada Health Act must include provisions for the fair distribution of those services deemed necessary in an evidence-based manner. This includes recognition of the disadvantaged position of those living in Saskatchewan's northern regions and of those of Aboriginal heritage, and taking planning measures to ensure they too receive quality health care.

It must be ensured, however, that measurable standards and goals go beyond ideals to specific accountability measures. It is refreshing to see the continued prioritization of public health, health promotion, disease and injury prevention, and the potential of non-traditional service methods.

The fact that the history of Canada's health care system is grounded in the scientific model of medicine does not mean it is at all times appropriate or the most successful method of service provision.

Investment in health education towards prevention and early intervention will not only reduce long-term costs associated with secondary and tertiary needs but it will also serve to empower the public to take responsibility for their own health status.

Accepting care from other professionals, those not currently considered within the realm of medical care such as the midwife and from oneself, will ultimately result in reduced medicare expenditures and improved health status.

Fyke's section regarding his recommendations for getting results is crucial to the establishment of a new and better health care system. By providing annual reports for the entire province based on performance indicators, true successes will be highlighted, as will areas where alteration or overall change is needed.

Continuous evaluation is necessary to maintain a quality centred system. Again, it seems that the quality council's role is somewhat ambiguous. My concern is with their lack of power to effect change and the extent to which it would achieve true community involvement.

The history of Saskatchewan health care is overflowing with examples of reports and opinions which may shed light on various situations but which have no bearing on the public and therefore unavoidably politicize provision of health care services.

In support of the positive changes outlined by the Fyke Commission, it has been suggested that the number of health districts be reduced to 9 or 11. This has been a controversial suggestion.

While there is little question among health care providers that 32 health districts does not provide an efficient foundation for health care provision, there appears to be, however, great concern regarding the method by which Fyke has divided the proposed regions included with his recommendations.

District determination based on population alone will not be successful, as ingrained flows such as referral and trading patterns, inter-area partnerships, and community involvement as well as resulting geographic distances would be near impossible

to change.

Rather, district division should be logical, making sense to residents involved, and honouring the community and cultural patterns that are important to them.

In addition, Fyke suggests investment in education, research, information systems, and coordinated human resource planning to further support the commission's initiatives. Increased research must be utilized however. In turn, more advanced use of information systems will facilitate the use of health related knowledge and services.

Coordinated human resource planning, however, is a matter that goes beyond good suggestion. It will be impossible to continue to provide quality care to the residents of Saskatchewan without it.

Regions currently compete between each other and within themselves for the same limited health human resource supply. Health care must be promoted as a fulfilling career, and educational opportunities must be made available and accessible.

In addition, educational opportunities must involve a monetary sacrifice that is conducive with wages earned subsequent to hiring. Coordinating these initiatives province-wide would mean a more equitable distribution of human resources available. The essence of the Fyke Commission report is coordination.

The implementation of components of Fyke alone cannot achieve the efficiencies possible with an integrated plan.

Beyond provincial planning Canada is very much in need of planning on a national level in an effort to remedy the vast discrepancies in health care funding and provision between provinces. I believe provinces are now exhibiting their willingness to encompass the necessary changes to accommodate viable solutions to the health care crisis.

Much concern is being expressed with regard to the fiscal effects of additional changes to the system. In order to determine how costs involved in health care provisions should be covered it must be decided what is desired.

While equal access to services is insured with 100 per cent public funding, government costs, ultimately our own costs, would decrease with an increase in private service provision. Currently however medicare in Canada is defined in the Canada Health Act to be universal and publicly administered, which remains the most efficient and least expensive way to pay for health care.

Fyke's proposals will not result in immediate fiscal benefits as certain amounts of funding will be necessary to effect these important changes. The solution is however to create a quality based system based on evidence of need. This will ultimately result in more appropriate care which will eventuate long-term efficiencies.

Costs will be saved in the methods of service provision rather than the amount spent on services or the quality of services provided.

How would the implementation of the Fyke report positively affect the South East Health District? A fully integrated system of health care provision would ensure sustainability in our district. Public responsibility for their own health status will be encouraged with an emphasis on proactive health care. Uniformity of quality of care will be established.

Improved EMS services would greatly advantage the district's rural population. Human resource competition within the district will be alleviated. Establishment of performance indicators will reduce confusion.

Fyke's focus on quality rather than money should be a reassurance to the district's population. The district's slightly younger population may be more ready to see health care change and I feel that the higher than average income found within the South East Health District may cause those of greater income to feel slightly more secure in the face of those changes.

In addition this district may perceive themselves to be less affected by the reduction of health districts as it is in a prime location to accommodate a new, larger district's regional hospital.

What concerns for the South East Health District would likely stem from the commission's implementation? Hospital conversion must be well planned and evolutionary. A definition of primary care and a primary care team must be established. For example, what would the points of entry be? Would residents of the district be able to select physicians of their choice? Primary care must be equally accessible throughout the district.

Clarification regarding how networking and communication will take place will be needed. True integration may be difficult to reconcile with the input of all stakeholders. There is a need for a closer relationship between the public and tertiary service centres. How will this be achieved?

Acceptable response and service times must be established.

Preventative care also needs to be evidence based. Division of districts must be aligned with factors beyond population alone. Multi-year funding would assist in effective planning.

The details for accomplishment of the Fyke plan will be the most significant obstacle to implementation. The role of district boards must be clearly defined and allow for significant public input. Implementing primary services before restructuring may not be possible due to a lack of both human and financial resources.

More attention must be paid to the future of long-term care.

I urge the government to take steps necessary to implement a system very much like the one proposed by the Fyke Commission. I hope that politics will not hamper a positive decision by allowing those who will always find reason to oppose health care change to prevent the alterations necessary in our medicare system needed to prevent the loss of public provision altogether.

This commission should not merely be another one of the reports to be included in health care planning for consideration and not for use. Saskatchewan had the courage to introduce hospitalization insurance and was the first province to implement medicare. Let us make another historic move towards ensuring the continued health of Saskatchewan residents.

The Chair: — Questions from the committee?

Hon. Mr. Melenchuk: — Thank you very much for your presentation. Certainly it sounds like you would be supportive of most of Fyke's recommendation. The question that I have with regard to the movement to the base of Fyke's recommendations, which is the primary care model, you would agree obviously that there needs to be a clear definition of primary care. But in terms of the different types of service provision that would be provided in various areas of rural Saskatchewan, for example, currently we've had a lot of presentations that talk about the need to have accessibility to some form of acute care services. They discuss the length, the travel times to potential regional hospitals and they basically are of one mind that there needs to be some acute care type facilities within a reasonable travelling distance to most of rural Saskatchewan. Would you agree with that part of their submissions?

Ms. Pasztor: — I feel that an improved EMS system would alleviate a lot of the problems they're seeing now even in their acute care services. When someone travels to even a short distance to a rural facility or hospital, say it primarily serves people with long-term care services, they're going to need an RN (registered nurse) who perhaps hasn't seen a heart attack in 10 years. If we have an improved EMS system, they're very likely going to get a trained individual who's dealing with these kind of crises on a more daily basis. I believe that the care would be better even if the travel distance is longer.

I'm not saying, however, that I don't feel a level of acute care couldn't be provided at a primary care centre. I'm not sure at what level that would need to end, but if physicians were available there and nursing staff, etc., I'm sure in some situations acute care services could be provided to a level anyway. I know there have been some examples of bee stings and things like that presented here and I think that situations like that could definitely be dealt with at a primary care centre. So I guess I'm in partial agreement.

Hon. Mr. Melenchuk: — Now the other argument that would be mounted by some of the presentations that we've heard, of course, is that the access to acute care beds is an important component to recruiting and retaining physicians in rural Saskatchewan. What would your argument be against that?

Ms. Pasztor: — Well, I guess what I have found with the time I've spent with the South East Health District is I've noticed so much physician frustration with regard to having to compromise their training goals and provide only the services the district can fund. And I feel that if we were able to recruit physicians for the purpose that we needed them for — so we're not recruiting them because they're a doctor, but we're recruiting them for a specific job at a certain location to give that kind of care — I feel the recruiting would be easier because the doctors, the physicians, that are specializing in secondary and tertiary care would have more people to serve in a bigger area at a bigger facility. And the other physicians that are more interested in GP (general practitioner) type services would be recruited to the primary care centres.

Hon. Mr. Melenchuk: — The Saskatchewan Medical Association made a presentation and gave a very clear definition of what they would call primary medical care as being a first point of contact in providing a comprehensive service, which differentiates them primarily from most other primary care health providers in terms of they are a point of entry, but they also provide a comprehensive service before there would be access to other services within the health care system.

The definition of primary health care talks a lot about various providers that would be points of entries or first contact. But again, the range of services provided by physicians in rural Saskatchewan is to such an extent that they are even talking about having a specialty of rural practice, where a primary care physician in rural Saskatchewan would provide a compendium of services much more extensive than an urban practitioner.

And there is a belief that it will be difficult to attract specialists or even the skill level required to service a broad-based rural population unless you have a rural practice specialty with enhanced training.

So the question arises is can you have a primary care team replace a well-trained physician in rural practice? And that's the question I'm asking you.

Ms. Pasztor: — Okay, so you're asking me could . . . would the primary . . . could the primary care team exist successfully without a physician's presence . . . physician being present that isn't trained extensively in rural service.

Hon. Mr. Melenchuk: — Well what I'm saying is that currently we have physicians in rural Saskatchewan working in group practices who are doing obstetrics, surgical procedures, who are providing psychiatric . . . in fact the majority of psychiatric services in terms of primary psychiatric care provided by family physicians in the province of Saskatchewan. And what we're talking about is, is it a model to have a well-trained generalist providing multiple services. Is that a more efficient model than having a primary care team where you have multiple care providers providing little niches of services?

Ms. Pasztor: — Well I guess it depends on the services provided. I think that . . . I hope it would lead to more effective and more appropriate care. I am not sure exactly in what areas the efficiencies would be realized. I don't have that kind of knowledge. But I would, I would hope that what it would do is increase quality of care. And I think that there are physicians offering a great deal of services right now that they're perhaps not most suited to be providing in any case.

Hon. Mr. Melenchuk: — It's a . . . let's just say that that was an extremely difficult question that teams of providers have not been able to answer. And I think you did a reasonable job in coming up with an answer.

The next question I have is with regard to funding models. And I agree with your point you made earlier that physicians in this day and age are not opposed to alternate methods of payment. And certainly a key component to these primary health teams would mean obviously paying a physician differently. Certainly physicians now who are fee-for-service basically have to see the whites of the eyes of the patient before they can bill, and subsequently it really diminishes their ability to provide telephone advice, counselling services, and other services outside of the examining room.

And I think that there are many physicians in the province of Saskatchewan, and certainly the Saskatchewan Medical Association is on record as not being opposed to alternate methods of payment, but they do say that this must be negotiated and there must be choice. They're opposed to mandated methodologies.

And I'm just wondering if you agree that this is something that is probably so important that we should achieve some semblance of buy in instead of trying to mandate a model?

Ms. Pasztor: — Okay. I guess sometimes my gut instinct would say nobody's going to like everything that comes out of this plan. And the residents of Saskatchewan aren't going to get to decide which little rules are followed and which aren't. And sometimes I question why the physicians have quite as much power as they do. And I know we need them and I want them to stay. Don't get me wrong there.

But I don't see why some amount of negotiation couldn't take place. I think there comes a point, however, where a decision has to be made. I question the fact that generally they're made by the physicians. I question that. I guess that's my view; and again, I represent no one in that view.

Hon. Mr. Melenchuk: — The final point that I . . . or the final question that I had for you was with regard to your comments on multi-year funding for health districts. And what are some of the advantages you would see to that?

Ms. Pasztor: — Well I've seen a great deal of frustration in the South East Health District with specifically human resource planning. I'm doing a human resource plan for them at the moment; there isn't a standing one in place right now. We're hoping that it can kind of be an evolving document that can be utilized from year to year.

But it's very, very difficult to plan any kind of service provision, especially human resources, without some idea of what's coming to you in the years to come. Often you don't know until the year's already started how much money you're going to receive and that makes things very difficult.

I know that the last submission that was sent to the ministry, that the district was very much for a curtailing of services and facility closures, things like that; they were very proactive in their approaches to providing services and everything was . . . they were told, just wait. And I can see now why. There's a lot going on right now, decisions that need to be made.

But when you take so much time, especially the board members, to make extensive plans and do the research and try to do the best you can for your district, and then boom it doesn't do any good anyway; I faced a great number of people who aren't even willing to help me or give me an opinion on the human resource planning situation because they feel that it's futile.

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

Mr. Yates: — Thank you, Madam Chair. I have two questions.

The first one being, your study was centred around South East Health District which, if you look at a map of the district, has a single hospital. I'm wondering if you would have found different results had you had multiple hospitals in the district with various levels of care being delivered today, and you would have had to look at it from a slightly different perspective in regards to human resource planning of say, multiple facilities, some of them perhaps being quite small. Because as Dr. Melenchuk has pointed out, we have heard a fairly consistent message on the closure of those facilities and the need for some acute care services in rural Saskatchewan.

So do you think you would have had different results or found different findings had you had multiple hospitals in your district?

Ms. Pasztor: — Well undoubtedly I guess some of my finding . . . well I mean the majority of my findings would likely have been different there. Some aspects of the South East Health District's demographic-wise are very different from a lot of the districts even surrounding it.

I guess in some ways the South East Health District is almost an argument for fewer acute care facilities because we do have one primary hospital that people travel to for acute care services. And it works fairly well.

There are improvements that need to be made in the EMS services, but I'm sure that it would largely depend on the district that I was looking at, what results I came up with. Given that I've only had two and a half, two and three-quarter months, I really can't comment on the other districts. I've kind of had to speak from the South East Health District perspective. But I think in a lot of ways it's almost an argument for centralization.

Mr. Yates: — Thank you. My second question has to do with the use of advanced EMTs and paramedics in rural Saskatchewan to deliver better EMS services.

How would you propose to maintain skills? You talked about these people being able to perform some things better than doctors or nurses who don't see them on a regular basis. But the same challenge that a doctor or nurse would have in rural Saskatchewan, maintaining skill levels, those paramedics would have as well.

So have you put any though in how . . . Because even in a city like Regina, you will see five, six, seven cardiacs perhaps in a week in a particular unit. And that's an awful lot. But that's in a city of the size of Regina.

And secondly, where do you see . . . In providing advanced

either cardiac care or dealing with a tension pneumothorax or any of the advanced medical procedures that paramedics are allowed to perform, it's still the doctor that makes the call. And I know this first-hand, having been involved. If somebody has a tension pneumothorax, it is the doctor that decides whether you're going to decompress in the field or in a hospital.

So how do you see the relationship there in order to keep . . . that if they don't have the skills, in your mind, in those rural facilities . . . The doctor's given permission for paramedics to use those same skills when the doctor ultimately takes responsibility for the call. There are medical protocols that allow the paramedic to do it, but the doctor makes the decision, which means he would . . . he has to know that those individuals have those skills and there has to be that interaction.

So how do you see those things working in rural Saskatchewan with very small call volumes?

Ms. Pasztor: — Okay. I guess the problem of maintaining skills is going to be a problem across Saskatchewan anyway. I feel that there would be a certain amount of skill-maintenance education, rotating employees that would have to take place.

With regard to the physician being responsible for the acts of an EMT or a paramedic or what have you, there would still be . . . there could still easily be contact with a physician without him actually being present. The thing is though is that maybe we need to look at accountability, and maybe it needs to be at that level that the accountability takes place and not at the physician level. Does that make any sense what I'm saying?

I hear you saying that the paramedics are making the call and the physician has to take responsibility for that call.

Mr. Yates: — The decision is made by the doctor in consultation with the paramedics in the field that are giving the information. But he still is determining, based on that information, whether you actually have . . . (inaudible) . . . pneumothorax or some other medical problem, and he has to know those people and have confidence in their diagnostic ability as well.

So in order to move . . .

Ms. Pasztor: — I guess the most that a physician would be able to do in a position like is know that if they're . . . the fact that they're employed and their training level suggests that they have a certain level of skill, you have to assume they do. And I think again the accountability has to lie there with the paramedic or the EMT.

Mr. Yates: — Thank you.

The Chair: — Seeing no further questions, thank you very much for your presentation, and we will pass it out now.

While we have a moment, we have some logistical things to discuss as a committee, and that is when do we meet to look at the draft report which could be August 21.

The committee is going to recess for 10 minutes.

The committee recessed for a period of time.

The Chair: — Welcome to the Standing Committee on Health Care. It's a legislative committee, and we're receiving responses to the Fyke Commission. And what we hear we're reporting back to the Legislative Assembly by the 30th of August. We're not making recommendations; we're reporting what we heard.

And it's an all-party committee of the Legislative Assembly. I'm Judy Junor, the Chair. Dr. Melenchuk is the Vice-Chair. Andrew Thomson, Kevin Yates, Deb Higgins, Brenda Bakken, Bill Boyd, and Rod Gantefoer are with us tonight.

We have a half an hour for your presentation. If we can have I think a few minutes at the end hopefully to ask a question or two if we've got them. Then if you want to introduce yourself and proceed.

Ms. Spence: — Thank you. Good evening, Madam Chairperson, honoured members, and thank you for this opportunity to discuss the Fyke Commission on Medicare.

My name is Caroll Spence. I reside in the community of Turtleford in the Twin Rivers Health District. But I'm also the facility manager in a nearby facility . . . sorry, integrated facility in the town of Edam, which is 30 kilometres away in the neighbouring health district. Ron.

Mr. Range: — My name is Ron Range. I am the chairman of the Turtleford Health Advisory Committee. I've been actively involved in health program for the past 14 years. I sat on as a board member when it was a local hospital until it was dissolved in 1993. And then we were formed as an advisory committee to Twin Rivers District on what to do with our facility or how it could be incorporated into the Twin Rivers District.

Mr. Blais: — Good evening. My name's Patrick Blais. I am the health services coordinator for the Turtleford care group. I've lived in that community for approximately 11 years.

First I'd like to extend a personal thank you to Andrew Thomson for taking time last Friday while he was in our area to tour our facility and for meeting with our physicians, mayor, and advisory council. Thank you very much.

Our presentation has two main objectives: to inform the committee members about our special area of rural Saskatchewan, and to respond to the Fyke commission and address our key areas of concern.

Turtleford has a population of over 500. It's situated an equal distance between North Battleford and Lloydminster — one hour each way. We're also one hour from the Spiritwood and Meadow Lake facilities.

Turtleford serves the communities of Spruce Lake, Mervin, Livelong, Glaslyn, St. Walburg, and Edam as well as the lake communities and our neighbours of the Thunderchild First Nation whose population is over a thousand. And we brought our big map to show you sort of our catchment area. This yields a population base of about 3,500 to 4,000 which swells to over

7,000 in the summer months with the busy resort communities of Brightsand and Turtle Lake. With more people choosing to retire at the lake, our permanent population base is ever increasing.

Although primarily an agricultural area, there has also been a marked increase in the oil industry and tourism. While striving to stay within the Twin Rivers Health District's mission and vision of Health for All, we provide services and programs as set forth by the needs assessment. These are included in the approved document for The Riverside Health Complex, our new integrated health facility. It is set to open in November.

Monies for the new complex have been raised by numerous modes of fundraising. A million dollars has been received from the trust fund of municipal governments, and a further 750,000 will be collected from the municipal governments. To date over 500,000 has been raised by numerous creative fundraising activities and cash donations, and the remainder of the funding has come from Sask Health.

We have a unique three-year Herd for Health — that should be h-e-r-d; it's to do with cattle — will have brought in over $200,000 by the time the project is complete. And the people of Turtleford and area have worked very hard in their fundraising efforts. We're very proud of the new facility.

Fortunately we have a well-rounded and active health team that includes pharmacist, stable two-physician practice, diagnostic lab and X-ray services. And the community service providers including a visiting addictions worker, dietitian, public health nurse, mental health workers, as well as visiting occupational and physiotherapies.

Community-based programs and support groups are ongoing with enhanced programming such as the diabetes Hands in Hands program which we've done with Thunderchild First Nations and Turtleford. It's a joint project.

As well we have a health liaison, first-responder services, home care, and wellness clinics in four communities, and a unique Adopt a Student program which we've incorporated.

Our staff members are trained in current OH&S (occupational health and safety) programs and the training is ongoing — such as TLR (transfer, lift and reposition) and disaster planning. Professional staff training includes ACLS (advanced cardiac life support), BTLS (basic trauma life support), ALS (advanced life support), with training in health communications such as MDS/RUGS (minimum data set/resource utilization groups) and SHIN (Saskatchewan Health Information Network).

We also have working staff working within guidelines for advanced scope of practice as well. All of this will be advanced and promoted with the move into our new facility, which integrates all of the above, including long-term care and daycare services.

Our team extends past our health district boundaries into the neighbouring community of Edam. Physicians from Turtleford and Edam share a scheduled on-call rotation. This has fostered and enhanced programs, and has brought about plans for further training of professional staff, particularly ACLS for the physicians and our registered nurses.

We've provided you with statistics from Turtleford and Edam — attached — from our facilities for you to review.

To elaborate on some of the points I have mentioned and to outline concerns regarding the Fyke report, I'll hand this presentation back to Caroll.

Ms. Spence: — Thanks, Pat. No doubt you've heard most of the same concerns repeatedly from other presenters and I'm sure you're growing weary by now; but we hope this report from Turtleford will serve to reinforce and emphasize to the standing committee the severe ramifications of Mr. Fyke's proposals.

Actually the Craik-Davidson presentation is remarkably comparable to that of Turtleford-Edam in the sense of being two nearby facilities in different districts working synergistically to provide health services to a large area.

In regards to emergency services, we want to emphasize that we feel it is imperative that emergency services are enhanced and well established in all the rural areas, and that sufficient training and education is provided before any of the proposed closures or major changes take place.

It is imperative also that early intervention provided within 30 minutes or less by EMTAs is available to assure maximal outcomes for the patients. We must consider not only the travelling time but also the long waiting room times in the regional centres — they're overcrowded now. Fyke's recommendation of one hour may be too long. We feel we're fighting for our very lives.

Just by doing the math it's clear that 10 to 14 regional hospitals will not be enough to offset acute care and emergency services for the whole province if numerous small facilities close down. In small rural hospitals or integrated facilities, the numbers and types of emergencies that are being dealt with in the outpatient departments are very significant.

For example, in Turtleford there are approximately 3,000 cases seen in the outpatient department annually. And in the 20-bed-integrated facility in Edam — only 30 kilometres away — there are up to 1,600 outpatients in a year; at least half are categorized as urgent or emergent.

It is a grave mistake to think that increased ambulance service will take the place of rural emergency departments. And please note that the EMS review, which was endorsed by Mr. Fyke, did not recommend an EMTA service in all areas of the province.

Recently a car accident victim was rushed to our facility. The accident had occurred some two hours before, but it took time to use the Jaws of Life and to transport the person to our facility. Fortunately Edam has an excellent doctor who, after inserting chest tubes, was able to stabilize the patient enough to send him on to a neurologist some further two hours away. Subsequently this patient was seen in Saskatoon some five to six hours after the accident occurs.

Turtleford and Edam can identify with the presenters from Redvers with comments like, this person would not have survived had there not been an emergency department and a doctor available in this town.

In various places of this report Mr. Fyke mentions utilizing volunteers. The greatest volunteers of all are the first responders who are on the scene immediately and provide life-saving measures to anyone awaiting an ambulance.

It is remarkable how well the Turtleford/Edam emergency departments complement each other. Our doctors, who incidentally have established their homes and are raising their children in our communities, collaborate effectively and share a call rotation. Nurses trained in ACLS are very proficient in handling emergencies. Our facilities are new and the emergency departments are well-equipped. A lab and X-ray technician is always on standby.

As well as emergency services, we have outreach programs in place such as COPS (chemotherapy outreach program of Saskatchewan), which is cancer outreach program, and Blood Services. Our centres provide follow-up care for post-surgical patients and new moms and babes. We care for the chronically ill, perform peritoneal dialysis, and monitor medical conditions that are sent to us from larger centres.

We are already a team and are able to provide first-class health and emergency care from Meota to St. Walburg. Now with technology such as SHIN and Telehealth and MDS/RUGS we can become even more efficient.

We in rural settings have so much potential. The government needs to recognize how vital our services really are.

Our vision is that in rural Saskatchewan we can become a leader in providing not only emergency but also general health care delivered on-site in rural communities.

When it comes to the chopping block, we trust that these viable facilities like Turtleford and Edam will be the very last to be eliminated, or perhaps not at all.

Fyke's report does not specify to what extent if any lab and X-ray services will be available to the primary health team. The fear is that people will have to travel for routine lab work such as fasting blood sugars which is fairly dangerous, INRs (international normalized ration), urinalysis, etc.

Also it's obvious that without diagnostic services we will lose even more doctors. What the commission states about quality of life is severely contraindicated by the theory that the sick, injured, elderly, or young family will have to travel considerable distances for these repeated routine services.

To practice family medicine physicians need a clinic, diagnostic services, and beds all in close proximity. Removing any of these components will serve to open the door for our doctors to seek a stable practice in another province or country.

You have seen this quotation from the College of Family Practitioners of Canada: "The success of health care reform will be realized with a strengthened rather than diminished role for Canadians family physicians," CFPC, 1996.

We hope there has been or will be extensive dialogue with rural physicians. Many, like in Turtleford, have enjoyed numerous years of successful practice in the rural communities. How can we ensure that they will not be scared away by the uncertainties of this Commission on Medicare?

A Twin Rivers physician is already departing just in anticipation of closures. So our major challenge then is to retain the physicians we already have and then make the Saskatchewan health care system so attractive that doctors will be proud to practice here.

Mr. Fyke suggests that primary health centres will be open for only 8 to 12 hours per day and will be supplemented by a 24-hour telephone advice line. It seems evident that Mr. Fyke does not fully understand rural living and the health issues in rural communities.

We wish Mr. Fyke had drawn a detailed picture of the primary health centres — where they will be located, how professionals will be incorporated, and if services will be provided on-site or be shared. How many of the primary teams members work hours will be travel time and what will this cost? What about the Saskatchewan winters and the current road conditions?

In describing the everyday services, Fyke states on page 15 that one or more members of a primary health team should be close at hand. Well we fear that one is not enough. And we ask which of the, quote: "unsung heroes of health care" will it be — the dietitian? A midwife? Both have their role, but can this one person cover for the whole health team?

Currently our nurses, pharmacists, physicians already provide a telephone advice service quite adequately. There are concerns of the advice-line operator making health care decisions based on the caller's perception of a situation and feel there may be a threat of lawsuits for inappropriate recommendations.

We have heard that some provinces use electronic answering devices for health advice. These are very intimidating for many people, especially the elderly. Many people who come to our centres do not even have a phone or are unable to use the phone.

Allow me to quote from page 15 and 16 of Fyke's report in regard to nursing home beds:

> . . . Saskatchewan must take into account the desire for local access . . . maximizing quality of life must be a priority. The best examples of current nursing home programs deserve to be adopted across the system.
>
> . . . more services are needed to support older persons and people living with disabilities, including the mentally ill, to help them avoid institutionalization.

And:

> For everyday services that are most commonly needed, access should be close to home.

We compliment Mr. Fyke on his awareness of the needs of the

elderly. He contradicts himself however by stating that the strong core of improvements includes community care centres in 25 to 30 locations to allow for overnight stays for convalescent, respite, and palliative care. We need him to clarify the phrase, overnight stays. And we need to understand how 25 to 30 centres could possibly be enough.

We don't feel that home care services and alternate housing can be increased enough to efficiently erase the need for numerous nursing homes.

Currently the respite beds plus numerous acute care beds are occupied with those awaiting long-term placement. Frequently, inappropriate placements result from the lack of housing alternatives.

Our communities feel strongly that long-term care residents need to stay in their home community. Surrounded by the warmth of family and friends, residents remain interactive with the community and family members perform much of the care that nurses might otherwise do. This personalized care would not occur on a regular basis if the family member were alienated in a nursing home elsewhere.

For example, St. Walburg has a beautiful, assisted-living complex and it's sitting nearly empty. This facility would be a perfect environment for numerous seniors in our communities but people refuse, understandably, to leave their home community.

In the event of a nursing home closures, it would be chaotic if alternate facilities, increased home care, and housing for seniors were not in place before the facilities are closed. The elderly would have to resort to private personal care homes which are too few, expensive, and do not have regulated standards.

Here's a quote:

> The realities of modern health care have simply made the small hospital obsolete.

A small hospital or integrated facility like those in Turtleford and Edam may seem obsolete to Mr. Fyke, but consider that in these small hospitals an amazing number of patients are accommodated. For example, in the outpatient department, serious injuries and illnesses are stabilized prior to transfer to larger centres, and many are treated and released or hospital in the centre for several days.

Acute observation beds are utilized to treat local patients and to receive convalescing patients from larger centres.

Community members with terminal illness receive the palliative care they require while surrounded by family and friends.

Elderly people in their own homes receive Meals on Wheels provided by the facility and also utilize the day program and a few weeks of respite care as needed.

Wellness clinics provide routine monitoring, foot care, teaching, and referrals. Meanwhile, the lab and X-ray department receives 2 to 3,000 visits per year while looking after the basic diagnostic needs of the community. In the same facility, each doctor may see 6 to 7,000 appointments annually.

The elderly of the community are able to live out their lives in their own community in a facility that they helped to build, and family and friends will visit often.

The small facilities are a hub of activity, all of which relieves the larger centre of thousands of hours of health care.

To close down viable hospitals or health care centres is simply systematic abandonment. We fear that if numerous small facilities are closed, larger centres and clinics will not be able to absorb these numbers. Already beds are full, waiting lists are long, and emergency departments are overcrowded in the larger centres.

Many rural nurses are farm wives and will not move or travel to larger centres to work, and so this could lead to an even further shortage of nurses.

Quote:

> Primary health networks can be instrumental in supporting municipal governments and voluntary service organizations in their efforts to address travel needs.

Are municipal governments prepared to address the horrendous travel needs that will result from Mr. Fyke's report?

People are already finding that travel for health care is overwhelming and expensive. Volunteer organizations are already at their maximum in small communities. And often the majority of volunteer groups are elderly because everyone else has a job.

Dr. Hutten-Czapski, the president of the Society of Rural Physicians of Canada states:

> Rural people should receive care close to their families and loved ones. Research has shown that even in high quality hospitals, patients don't do as well when they have to travel long distances to obtain care.

He also said that:

> Costs per case in rural hospitals are frequently much lower than in larger facilities.

Is it safe to have the elderly on the road frequently, whether they're volunteering or seeking health care? Many have restricted licenses or do not drive in the cities, or simply do not drive.

They will either be on the road a great deal, or may opt to ignore their health care needs because they have no way to get to their appointments. Public transportation does not meet these needs.

Quote:

> The health system must acknowledge the importance of family caregivers, and support family and friends by providing respite programs, day programs along with

information, education, respect and appreciation.

Information, education, respect, and appreciation will not pay for the days taken off work and the travel expenses it takes to drive children, neighbours, or elderly parents to centres an hour or more away.

Families and friends will bear an increasing burden of care and travel that will jeopardize their own health, family, and productive employment. Respect and appreciation will not minimize this.

With more day surgeries and shorter waiting lists there is bound to be even more burden on family caregivers.

In closing, we unanimously agree with Mr. Fyke that quality of health care is the top priority. Our new Riverside health care complex in Turtleford demonstrates our commitment and we have . . . we already have our own primary health team that works very well.

We wish to commend Mr. Fyke on his suggestions for health promotion, the quality council, human resource council, and research, and education. In regards to education, there are many organizations that are currently also promoting wellness.

We suggest that in preparing a new health care plan for Saskatchewan the government systematically look for the inefficiencies of the system we already have. In the accreditation process for example, the self-assessments completed by each health district might serve as an effective evaluation tool, and common threads can be identified across the districts.

Also, take a serious look at the statistics of the caseloads in rural centres, not only the outpatient department but also the acute/observation bed utilization and lab/X-ray services. Currently there is no reporting system for these numbers.

Find ways to decrease the inappropriate use of medical clinics and emergency rooms, both in the rural and urban centres. The government will then be more poised to build a new, solid provincial plan. We ask that the necessary changes are made a step at a time with constant re-evaluation.

We suggest beginning with tertiary centres and specialists, then decide on the number of regional centres. And once they are functioning smoothly and once SHIN and emergency services are in place, then consider closure of the least viable of the small centres. And finally, when the province has a solid infrastructure in place, it will be easy to determine the number of health districts that will be the most appropriate.

We welcome your questions.

The Chair: — Thank you.

Mr. Thomson: — Thank you, Madam Chair. And I'd like to thank all three of the presenters, in particular Pat and Ron who took time on Friday to help . . . tell me a little more about the community and how things work there.

I was hoping that you could perhaps share with the committee tonight some of the things that you are looking at incorporating into that new Riverside Centre, both in terms of the number of beds that you're looking at, how it's going to . . . some of the new services that you're looking at incorporating in, like the chemotherapy and those things — just for the knowledge of the committee.

Mr. Blais: — We've increased our long-term care bed capacity to 22 beds, including two respite beds. We have seven short-term stay beds, which include a chemotherapy room and a palliative care suite.

We have an outpatient department, and lab and X-ray, and the clinic's incorporated in the building as well with community services, public health. And we're bringing in a massage therapist, who's already coming in and doing in-patient things right now. We'll incorporate her in the community services area.

We'll have an active daycare program. We have one existing now but because of lack of space, we've had to limit the participants and there's a lot of people in our priority grouping in our home care program that would benefit from the daycare program. So we're looking to enhance that.

Meals on Wheels will be ongoing and that's increasing.

Emergency services — basically the same services we're providing now.

Ms. Spence: — The healing circle.

Mr. Blais: — The healing circle, yes. We've incorporated a ceremonial room. I just brought through a group of elders from Thunderchild on Monday to put the final touches on that after the gyprocing was done. They were very impressed. We've incorporated that program as well with Thunderchild First Nations.

So we're really excited about the facility and it's right on track.

Mr. Thomson: — It's always music to the ears of us down here to hear on track, on time, and on budget which . . .

A Member: — We are.

Mr. Thomson: — Which you tell me you are. Ron tells me we're still arguing about 163 or 168,000, but we can save that discussion for another night.

One of the things that I was particularly impressed with — and certainly comes through in your presentation tonight, but also was impressed upon me when I had the chance to visit — was the degree of intercommunity co-operation between: St. Walburg which I understand is where you get ambulance services out of; Edam where obviously there's a good relationship particularly in terms of sharing the resources of Turtleford's doctors; Turtleford obviously; Thunderchild.

This is something that I think speaks well to the strength of the way the communities have pulled together here. I'm wondering if maybe you can let us in a bit on the secret to how this happened.

Mr. Blais: — Caroll, is there a secret?

Ms. Spence: — Are you approaching me? The secret as to how this happened? I think the communities over the years, historically, have gotten their heads together in a lot of ways to do community events and things like that.

It's also out of necessity. The doctors in Turtleford wouldn't get a day off if they didn't have someone to share the call rotation, and the same with the doctors in Edam. One ambulance in St. Walburg and one in North Battleford serves both communities quite well. Those kinds of things.

The facility managers co-operate. Being I live in Turtleford and work in Edam, I'm interested in both facilities and more than interested in communicating. Our doctors have always got along.

I think it's just community life in rural Saskatchewan does things like that. That's how you manage.

Mr. Blais: — And I know . . . Sorry, Caroll, are you done?

Ms. Spence: — That's fine. I'm done.

Mr. Blais: — And I know the team approach is something that's engrained in my system. I worked as an advanced clinical nurse for 10 years in the North so I know what the value of teamwork is. And when we make mention too, the advanced role of practice we have, out of necessity over the years, have trained our LPNs (licensed practical nurse) to gain their medication tickets. And we're looking at ways of enhancing the nursing role as well. So that'll be promoted in our new facility. And those are things that are near and dear to my heart.

Mr. Thomson: — A final question. Actually you answered it. I was going to ask about the role for advanced clinical nurses and advanced, perhaps higher end of scope of practice for some of the non-doctors.

Mr. Blais: — I really feel advanced scope of practice, when you're looking at roles; you have to really remain within your guidelines. You have to know your limitations. It's an enhancement; I see it as enhancement. It can enhance the practice of in the one-physician communities.

And I know particularly in Loon Lake, where a friend of mine is an advanced clinical nurse with the physician there, they've enhanced a lot of their community programmes. And Joan is very proactive in diabetes education and does a lot in the clinic. And I consult with Joan a lot, and we've been friends for a long time. So I see it as an enhancement.

Mr. Thomson: — Thank you.

The Chair: — Any further questions? Seeing none, then thank you very much for coming tonight.

If our last presenter can take a chair at the table.

Welcome this evening to the Standing Committee on Health Care. The mandate of this committee is to receive responses to the Fyke Commission and report what we've heard back to the Legislative Assembly. We won't be making recommendations to the government or the Assembly; we'll be reporting back what we've heard in response to the Fyke Commission's report.

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, Deb Higgins, Brenda Bakken, Bill Boyd, and Rod Gantefoer are with us tonight.

We have 30 minutes for a presentation and in that time there you can leave some time for questions at the end hopefully. Just introduce yourself and where you're from and what you represent. You can begin your presentation.

Mr. Roberts: — Okay. My name is Grant Roberts. I'm from Saskatoon and I operate a fitness centre.

The title of my proposal this evening is "Occam's Razor Applied to Personal Health and Health Services in Saskatchewan." For those of you who are unfamiliar with the basic scientific precept Occam's razor, also known as the law of economy, this principle of logic simply put suggests that all things being considered the simplest solution generally tends to be the right one.

I emphasize the use of this axiom because of the urgent attention I believe this matter requires and the importance of drawing a straight line to its solution. If the very foundation of a theory is too complicated the chances of creating and successfully managing the model are improbable.

The problem. The physical condition of our population continues to contribute to the inevitable demise or collapse of the health care system. On July 23, 2001 a CTV/*Globe and Mail* poll demonstrated that 48 per cent of our nation is considered in medical standards obese. The city of Regina, unenviably, scored the second highest in the nation encompassing 56.5 per cent of the population, more than 8 per cent higher than the national average. Saskatoon did not fair much better placing seventh highest in the nation at 51.9 per cent. Logically these numbers correspond with the percentage of the population who remain physically active. Only 21.1 per cent in Saskatoon, followed by 20.2 per cent in Regina take part in regular exercise.

The purpose of my presentation today is to recommend a simple fiscal measure that not only will significantly improve the overall fitness levels of the Saskatchewan population, but will also unilaterally create longevity to the health care system by reducing both usage and the overwhelming financial burden.

While it is undisputed that leading a healthy lifestyle that includes an appropriately designed regular exercise regimen will have an overall positive influence, only a small percentage of Saskatchewan residents participate in regular physical activity.

As the owner of Pro Fit Athletic Club in Saskatoon, I can tell you that personal economic situations remain a leading cause for people abstaining from activity. Fitness facilities generally offer memberships at some of the lowest rates in the nation, yet people unfortunately continue to view this service as a luxury instead of a necessity.

People simply do not place enough value on their own health and well-being. This problem becomes twofold as this attitude inevitably leads to the premature and preventable illnesses, which ultimately puts unnecessary financial strain on an already weak medicare system.

Few would argue that it is difficult to perceive how this province, or nation for that matter, can continue to shoulder the burden of caring for a nation that does little to preserve itself on an individual basis.

Practitioners themselves predict the collapse of health services in as little as 10 to 15 years. It seems clear that something must be done. The solution I believe is simple.

In just the past week I have read diametrically opposing opinions on solutions. A recent study prepared by Dalhousie University suggests, in deliberately vague terms, that offering rewards in the form of tax cuts may be in order for individuals following healthy lifestyles, while those who choose to put themselves at risk cannot benefit or are potentially penalized. The report contains nothing specific, but does strongly suggest that individuals disclose usage of their portion of the $68 billion health services system. This declaration should be mandatorily reported via annual tax statements.

An opposing study of the Czech Republic prepared by tobacco giant Phillip Morris advises solutions to the contrary. This company blindly suggests, and I paraphrase, that the indirect positive effects of early death due to tobacco consumption provide government savings on health care, pensions, welfare, housing to the elderly. I think it is fair to assume that this particular solution will not meet favourably with the general populace. Nor would I suggest that one would want to be part of a society that places little or no value on the elderly, one that suggests premature death is good for the economy.

To demonstrate again the importance of simplicity, just last night, CTV (Canadian Television Network Limited) news reported another notion, devising the so-called Twinkie tax suggesting that unhealthy snacks and fast foods should be taxed additionally, making poor food choices less financially accessible, as an incentive for people to eat more nutritiously.

It is easy to see the importance of implementing the principle of Occam's razor. If the trend of clouding the issue was to continue, could we then expect a report from companies like McDonald's to follow Phillip Morris' lead in reporting in detail the social-economic value or benefits inherent with mass consumption of lethal levels of Chicken McNuggets? At what point do we stop and cry fowl?

Sorry, I couldn't resist the pun — Chicken McNuggets, cry fowl.

With all joking aside, there are no miracle products and no quick fixes. The answer, in my opinion, could not be simpler.

The answer. Once again relying on the elementary wisdom of simplicity, I submit that it is unanimously acknowledged that abstaining from smoking, eating nutritiously, and participating in regular exercise is the key to living longer, healthier, productive, and more active lives. Yet of the triad, exercise remains the least supported and mostly neglected component in Canada at large.

Governments do little to encourage the majority of the population to participate. It's time that the federal government and provincial governments pursue their mandate of reducing the tax burden for their citizens while keeping the nation's best interests in mind. It's time they grant a simple tax credit for persons who exercise on a regular basis in authorized establishments.

Reducing the social costs inherent in unhealthy lifestyles, promoting preventative measures and heightening the awareness of the benefits of fitness to the public at large is only economically feasible if supported by a substantial savings or incentive to participate. Simply put, talk is cheap and the sedentary majority of our citizens dominate public opinion. Participation will only be accomplished by a financial incentive making access to qualified fitness facilities and professionals affordable for all.

Doctors are prescribing exercise but frankly, doctors are not trained nor qualified to design personal fitness programs. The best health insurance possible is simply exercise, and the prescription is best left to fitness professionals available at qualified fitness centres.

In a national poll, 39 per cent of taxpayers agree that individuals making healthy lifestyle choices should be rewarded by the way of a tax break. The tax incentive I am proposing is limited to a 50 per cent of the amount paid by each participant enrolling in a sanctioned facility to a maximum of $250, whichever is less.

So how does giving money away preserve the health care system? Conclusively, studies show that exercise reduces the incidence of leading illnesses such as heart disease, obesity, diabetes, high blood pressure, osteoporosis, colon cancer, and even depression. Earlier I alluded to the CTV/*Globe and Mail* poll describing our nation as 48 per cent obese.

While obesity and diabetes have risen to epidemic proportions, accounting for $2 billion of the health care expenditure, let us take into account the positive economic effect regarding the single issue of heart disease if more Canadians adopted a healthy lifestyle.

The Conference Board of Canada reports that by increasing our nation's physical activity by just 1 per cent, the savings tied to the decline in heart disease alone would result in more than enough dollars to cover the cost of the proposed tax rebate.

According to the research, both the direct and indirect savings parlay into a total of $386.46 for each Canadian who becomes physically active. Keep in mind that this example focuses solely on the positive return of reducing heart disease alone and is based on a tax credit in the amount of $250.

The overall savings are nothing short of astounding when one considers the impact that regular exercise can have on reducing the occurrence of obesity, diabetes, high blood pressure, osteoporosis, colon cancer, and depression. Not only does this provide a financial advantage for our government, but such an

initiative could further prompt insurance companies to reduce their preferential rates for life insurance policies of those people who qualify for tax credits.

There can be no doubt that reducing health care costs for Canadians while increasing the percentage of the active population would follow other major economic gains. The impact of such a scenario would be felt on productivity and competitiveness in our industries as well. For this reason I would also suggest and urge the government to provide additional incentives for companies of all sizes to provide additional fitness benefits to employees.

Studies clearly support the benefits to companies who develop healthier workforces. Employees who exercise have a healthier state of mind, are more likely to exhibit above-average work performance, have fewer sick days, and are less likely to leave the corporation.

Major corporations globally are seeing the benefits with more than one out of four *Fortune 500* companies currently active in corporate fitness programs. A study released by General Electric in the US shows that after a one-year period, companies whose employees participated in a fitness program reduced their medical expenses by an average of 38 per cent, equalling $647 US.

The government would recoup the costs of this program twofold — through further economies in the health sector and the collection of taxes on improved corporate profits resulting from increased productivity.

In conclusion, it is clear that the most valuable asset to any corporation is its employees. Similarly, the most valuable asset to any nation is its people. Throughout my career I have preached the benefits of fitness on numerous continents and all this experience has convinced me of one thing — that the first step to a healthier individual and ultimately a healthier nation is simply exercise.

Plato himself, one of the greatest philosophers, describes his perfect society or ideal man as one whose foundation is built firmly on knowledge and athletics.

Exercise is the precursor to education required for the enlightened individual. People naturally pursue greater knowledge through the simple task of exercise. To enhance personal results, they investigate nutrition and make better food choices. Finally positive lifestyle changes become a priority and confidence is found. An education of knowledge of one's self is the ultimate accomplishment. What more valuable commodity than our own health do we have?

Anyone in attendance who would like to support this movement, I would ask that they contact any one of my staff at the Pro Fit Athletic Clubs in Saskatoon. Information is readily available for you to take the first steps towards better fitness, and a petition awaits your support.

Furthermore to be aired on SHAW television in September, I will be hosting a 13-week educational series describing the basics of exercise and nutrition designed to introduce viewers through the province to typical fitness facilities.

I thank you for your time and ask that you consider this proposal as time is truly of the essence.

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

Hon. Mr. Melenchuk: — Yes, the question I have is: are you aware of any other provincial jurisdictions or perhaps states that provide tax credits or deductions for membership in fitness clubs?

Mr. Roberts: — I'm not aware of it in Canada, although I do know that there are discussions going on in Edmonton right now for the province of Alberta. And Quebec has put this before council two years ago and it is being reviewed again. So there is definitely interest in it, but to my knowledge it has not been implemented.

Hon. Mr. Melenchuk: — And the second question I have is: would you limit this particular incentive to fitness clubs or would you be looking at other recreational activities, curling fees, school activity fees, those sorts of things? Or are you specifically talking about tax credits for fitness club memberships?

Mr. Roberts: — Well I think it's important that there's some uniformity to the tax credit and what it entails. Obviously the program could easily be taken advantage of for areas of fitness that may be vague. I think it's important that a basis is established that includes parameters that the government agrees provides overall fitness.

Hon. Mr. Melenchuk: — That's the only questions I had, thank you.

Mr. Thomson: — Very brief, Madam Chair. Thank you very much, Grant, for coming down today. I too have been reading the papers and watching the news of late and have been distressed as a representative for the second fattest city in the country. I worry . . . I'm concerned.

This committee has certainly spent a great deal of its time listening to people talk about illness, talk about ways of treating disease, talk about the kinds of facilities that we need for the end of our lives. But I think it's important that we also hear very much this voice that you've brought forward, and that other people have earlier in presentations made, about the need for us to maintain healthy lifestyles throughout as a prevention.

I hadn't really thought about this idea of a tax credit, and I think it's an interesting one. I don't know what the cost of it would be, obviously that's always a difficulty. But I think the message is certainly a good one.

Are there things that perhaps we can also be doing as a province to promote healthier lifestyle without necessarily the tax credit? I think to growing up in the '70s and the Participaction approach that was so prevalent back then, which seems to have fallen by the wayside. Is this a role that you would see health districts doing or communities taking on?

Mr. Roberts: — I think it's something communities need to be more involved with. Obviously times have changed since the '70s. Children are dominated through television and computers,

which is pretty sedentary. I feel that sports is being neglected, and it's something that needs to have a great deal more attention.

Mr. Thomson: — I . . . earlier today actually, I was mentioning this Twinkie tax to — not to use the pun again but snickers from others around the room — and one of the things that the *Globe and Mail* has today in it is a suggestion that fat is becoming such a problem for our society that we should put warning labels on high-cholesterol products. Now obviously it was somewhat tongue-in-cheek. I think they had one of the warning labels was chips go to your hips, or something like that, but it certainly made the point.

I think we do need to do a lot more to make the point that we have got to take responsibility for our own health.

Mr. Roberts: — Certainly we do. The issue of labelling is another area that I take somewhat of offence to. I do put on a seminar annually for people to attend on how to understand food labels. I do think that food labels are very confusing and there is a far simpler solution, but unfortunately I don't think government has intervened or stepped in to the degree that they should. It's pretty simple.

The majority of people . . . I'll just give you the example of 2 per cent milk, for example. If you were to poll most people, they would say 2 per cent milk contains 2 per cent fat, which is in fact nowhere near the truth. It has 38 per cent fat. But how many people would buy a carton of milk with a giant 38 per cent label on the front of it? Very few. So I think it's important that clearer labelling laws are implemented.

And just to refer also, to you, about the cost of implementing a program. It's easy to sidetrack and talk about fast food and other taxes and other things that could be involved, but I really believe that exercise is where it starts. I think that the cost of this program is minimal and it would be recouped immediately via the health care system.

Mr. Thomson: — Thank you, Madam Chair.

Mr. Boyd: — Thank you, Madam Chair. It's a very interesting proposal, to say the least, and something quite innovative that I haven't heard of before. And I think it has certainly some merit.

I think following up on Mr. Melenchuk's comments about what kind of activities would qualify for it, as a representative of rural Saskatchewan, these types of facilities generally speaking aren't all that available. And I think we would have to look at other types of exercise-type programs or athletic programs, as Mr. Melenchuk suggests, as a possible starting point as well.

And I'm assuming, seeing you nodding in agreement, that you would agree with that as well.

Mr. Roberts: — Yes, absolutely. And I think it has to start in the school system.

Mr. Boyd: — We are constantly hearing more and more people coming to the view that the wellness type of approach to health care is the right approach with people looking at healthier lifestyles; and certainly we would agree with you that an education-type process and starting at very early ages for students and our student population would be a step in the right direction.

Is, in your opinion, the number of people enrolling in these types of programs growing or is it dropping off? Or is it kind of a stationary thing?

Mr. Roberts: — I think on a per capita basis the numbers are down compared to what they have been in the past. And I think the percentages reflect, themselves, as far as Saskatchewan and Saskatoon being very close, with 20, 21 per cent being active. I think that those are paltry numbers, that the numbers should be extremely higher.

And just commenting on your earlier discussion about getting people started at an early age, it's much easier to maintain that lifestyle than adopt it later in life.

Mr. Boyd: — Do you have any evidence to suggest that simply putting in place this type of program will indeed change that? I mean there are all kinds of people that regardless of whether there are any kind of tax incentives or anything else aren't going to be inclined to go with a program of that nature.

Mr. Roberts: — Well you'll always find people that will resist the programs, but I can speak from my experience with people that pass through my doors every day and the momentous changes that I see in them as they transpire into a new individual. It affects their confidence and everything about them. Now of course there are people that don't make the grade and I'm sure that we've all heard of people joining fitness centres and never really using it.

And I think that's the other area, is that that's where fitness is best left to the professionals that provide it and create that incentive. I think that some of the community centres that exist, yes, they're important that they exist but they're not really manned by individuals that are there to motivate the clientele.

Mr. Boyd: — But what I was getting at was I'm assuming that people that come through your door to enrol in your program are more highly motivated to want to enrol in these types of programs. I would also expect that you would see very few people coming through your door saying, oh well, if only there was a tax credit, maybe I could enrol in this program. Or do you actually see that?

Mr. Roberts: — I don't see the request for a tax credit but I do know that personal economic situations are a major deterrent. They do look at this as a luxury and not a necessity. And I could tell you that the rates in Saskatchewan are the lowest that I have seen in the nation. Really people can join a fitness centre virtually anywhere for about a dollar a day. It's a very minimal investment into maintaining health, yet people still do not place that value on themself.

Mr. Boyd: — So cost is a barrier?

Mr. Roberts: — Cost is a huge barrier. If I think the facility was free of charge, in a sense because there would be a tax rebate or a percentage or it was reduced, usage would be twofold.

Mr. Boyd: — Thank you very much for your presentation.

The Chair: — Seeing no more questions, thank you for a very interesting presentation. Thanks for coming down.

The committee adjourned at 21:01.