The committee met at 9:03.

The Chair: — Good morning, and welcome to the Standing Committee on Health Care. This is a legislative committee of the Assembly. It is an all-party committee.

I'm Judy Junor, the Chair. The Vice-Chair is Jim Melenchuk. MLAs (Member of the Legislative Assembly) Andrew Thomson, Kevin Yates, Doreen Hamilton, Brenda Bakken, Bill Boyd, and Rod Gantefoer are with us today.

The first order of business of the Standing Committee was to receive responses to the Fyke Commission or the Commission on Medicare, and our task is to report back to the Legislative Assembly on August 30.

So we're having hearings such as this to hear what people have to say in response to the report and then we'll be reporting back what we've heard to the Assembly. We won't be making recommendations. We'll be reporting back simply what we heard.

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

Mr. Keene: — How about I start, Madam Chair. My name is Tim Keene. I'm deputy mayor of the city of Swift Current, and of course a councillor. To my right is Ron Hilton who is our city commissioner; and to my left is Lyn Johnston who is executive director of our health foundation in Swift Current.

In terms of the half an hour or so we have allotted, if it please the Chair, we would have Ms. Johnson address you first on behalf of our Health Care Foundation, and then I would follow her with some remarks.

Ms. Johnston: — Good morning. I bring regrets from our board Chair, Joan Meyer who is unable to join us this morning due to some family commitments.

> Canada's humanistic organizations, corporations, and institutions, agencies that deliver health care, education, welfare and cultural services, are clearly in financial difficulty. Nowhere are these problems more visible and compelling than in health services.
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> This financial squeeze results from a confluence of many pressures. Almost all health service employees belong to unions, powerful monolithic bargaining units. Diagnostic and life-support equipment is staggeringly expensive. And the capital cost is the tip of the financial iceberg.
>
> Little wonder then that hospital deficits have been a way of life in many provinces where provincial governments have restricted per capita health care spending to below the median of the five Canadian regions. And little wonder it costs the burgeoning western provinces up to 56 per cent more than median expenditures to expand and service their health care delivery system.

If the foregoing statements ring true, it is indeed a sad testimony to our ability regardless of numerous past attempts, to improve our health care system. We have, for all intent and purposes, not advanced since Professor Samuel Martin made these comments some 16 years ago.

When the economic stability of a community is determined by the means of health care delivery, then our economic development strategy for this province needs to step up implementation of the Partnership for Prosperity plan. Decisions on the future of health care would no longer be influenced by economic dependence.

The people of Saskatchewan deserve accessible, technologically current care and treatment delivered by qualified, well-trained professionals.

The cost of providing such service to our residents and the availability of required resources should be the criteria used to determine how best it could be equitably and beneficially delivered.

Health care should not be a political or economic development issue. It concerns only the health and well-being of our residents and providing them with the best possible diagnostic and treatment services available.

The Dr. Noble Irwin Healthcare Foundation was announced in the spring of 1999 as a truly regional and stand-alone organization with a mandate to raise, administer, and disburse funds to improve the quality of health care for the people of southwest Saskatchewan. Residents from our catchment area, which number approximately 55,000, have responded favourably to the creation of the foundation enabling us to commit in excess of $1.1 million toward the purchase of critically needed capital equipment within our first 18 months of fundraising activities.

One of the most significant examples of how Swift Current can facilitate the regional concept of health care delivery lies in the success of one of our first funding initiatives. The renal dialysis unit currently provides services to nine southwest patients. Since its inception some 15 months ago, 37 per cent of its caseload has been from the rural southwest. The true significance is the contribution this regional unit has made to the quality of life of the patients that it serves. The savings in time, patient out-of-pocket expense, patient comfort, and improved quality of life are all measurable. These patients are now travelling minutes instead of hours or not travelling at all to receive the treatment that they require.

The hundreds of thousands of dollars that we have committed for new diagnostic imaging equipment has also proven invaluable in serving the residents of the southwest. Improving outcomes, adding to patient safety and comfort, and providing the opportunity to be technologically current and enhance existing procedures have been the compelling motivation behind the foundation's efforts.

The people deserve excellence in health care and its delivery. They have demonstrated to us a willingness to invest in efforts to attain it. Obviously there is already a degree of understanding that in order to achieve excellence in a truly functional system, a partnership with traditional funding sources is necessary. To

be successful there must however be change. The viability of providing the type of service and support that ensures excellence in health care in every currently existing facility is non-existent.

The costs of staying technologically current are exorbitant and recruiting top qualified medical professionals, at best, requires a willingness to commit to a strategy of support both in terms of offering opportunities for growth and a challenging environment, as well as a commitment to keeping pace with rapidly advancing technology in a variety of diagnostic and treatment areas. Such a commitment can only succeed on a regional level where there exists an opportunity to adopt a more focused approach to meeting the resource needs of such development.

It is difficult to believe that once a true understanding of what establishing regional centres of excellence could mean to patient outcomes, that people would be willing to forego that potential to accept the lower quality of health services that would inevitably result from trying to operate more facilities than we can possibly afford.

The key to unlocking current opinions may lie in the people's confidence in accessibility. All residents have to have the assurance of timely response by well-trained and equipped emergency medical personnel on site and quick transport to treatment.

Given the set of circumstances outlined above, establishing a regional centre for the southwest in Moose Jaw, for example, would not meet that need. The distance and timely access for many southwest residents could create unnecessary hardships and risk.

Other presentations have alluded to the original Health District No. 1 concept, in which Swift Current was a regional centre for the southwest. And for the area we currently service, this still appears to be the best scenario presented thus far. Establishing a pilot project that utilizes that model might prove an invaluable tool in defining a development and delivery strategy for health care in the province.

Still, since its inception, the foundation has been addressing critical need. Ventilators, dialysis units, vacuum pumps, patient lifts, infant warmers, and diagnostic imaging equipment that is failing . . . and replacing diagnostic imaging equipment that is failing and outdated.

Yet we've barely begun to meet the existing needs. Well over $2.5 million is still required for acute long-term and home care equipment needs in the Swift Current district alone. None of which addresses the need for the replacement of an outdated and below grade acute care or long-term care facility.

Are we willing to . . . are we meeting the needs of our people when our residents, after contributing to our society for a lifetime and who now require long-term care, are expected to spend their remaining years in a 40-year-old mechanical bed held together with gaffer tape?

We believe we have been truly blessed with the support of corporations, business, community groups, colonies, service clubs, and individuals which have allowed us to begin to address the needs in our area and start improving the quality of health care for the people of southwest Would these people financially support a foundation in Moose Jaw? Beyond the realm of a grateful patient program, undoubtedly not.

In the near future, we will be communicating with hundreds of our constituents to determine what they are prepared to support relative to a new acute care or integrated facility and to what level. There is no doubt of the need for either structure.

However, we are acutely aware that the funding formula, not the people's willingness to invest, will prove to be the most critical factor in determining the outcomes of any potential capital building campaign in Swift Current. If the funding formula were adjusted to a 90/10 per cent ratio, we have every confidence that the foundation, with the continued support of the people of the southwest would be able to meet the financial challenge. A 65/35 per cent funding formula for an integrated facility is not a possibility and could even jeopardize a new acute care facility by requiring more capital than the generosity of our residents could match.

We believe Swift Current should be the regional health centre for southwest Saskatchewan. We're prepared to continue to work toward fostering an investment partnership with our constituents and the government to achieve this end. In order to plan for change and help meet the needs that would be created by expanded service delivery, we need answers.

What is the government going to do to ensure quality health care is available for the people of Saskatchewan? What measures will be undertaken to ensure it is more effective and efficient? And how and by whom is it to be delivered? We need answers sooner than later in order to plan an integrated strategy to meet existing needs.

By the end of October we will know the level of willingness of our constituents to support the foundations existing and/or potential initiatives, where and how the people of the southwest wish to invest in improving the quality of their health with their own dollars.

We sincerely hope the decisions of this committee and subsequent actions taken by the government and the department will facilitate a continuation of the heretofore successful partnership of traditional and non-traditional funding sources we have established in the Southwest. We further hope that due consideration will be given to the significance of the people's willingness to invest in improving their own quality of health care.

We thank you for the opportunity to express our views to this committee.

Mr. Keene: — Good. Thanks, Lyn. I've circulated my written presentation but I'm not going to slavishly read it. I think the main points that I want to make to this standing committee I'll make orally without a script. First thing is we've circulated, or at least I hope we have, the little map that we prepared.

Our main beef with the Fyke report is that we don't want to be co-located with Moose Jaw. I could sit here and read off the

piece for half an hour but that's the main beef that we hope you folks hear loud and clear, as best we can in here. I feel as though I'm speaking . . . got my head in a milk pail here. But at any rate . . .

A Member: — That's the way it always is.

Mr. Keene: — Yeah, I see why you guys yell at each other because you can't otherwise. You know, like a bad Ducks Unlimited auction. So at any rate folks this . . . we had our engineering department prepare the map that we think works for the people of the southwest of Saskatchewan. You'll see that the boundaries are up over, as we call it, the river — it's the South Saskatchewan River.

We think that the idea of conscripting yourself to rigid health care districts that have been in existence is nuts. Let's get away from that. Why would we do that? Let's think outside of the box.

So when Fyke said we're going to go to 9, to 11 districts — great. We're happy with that. But we don't need to be using the districts that were there before. Let's be imaginative. Let's . . . so when I say in my written report here, when folks up at Kyle or Leader they jump in their pickup truck or they get in their car, they're not paying attention to the health district boundaries when they trade. They're paying attention with where their doctor is or where their implement dealership is or eye doctor or whatever it is. So let's . . . no. 1, I don't think we have to be boxed in there.

No. 2. Let's face it, if Swift Current and Moose Jaw are co-locating two regional hospitals we'll get the short end of the stick. Moose Jaw obviously will get more of the funding because that's just the way it's going to go. We think that that's going to create, more or less, an outpost in Swift Current for last aid as opposed to a realistic hospital. And that's not right.

Swift Current is a large area or the district around Swift Current is a large area. I like to say it's the size of Belgium. I'm probably not that far off. Could we conceive of Belgium having one hospital? They've got a lot more people. But do you think the people down in Consul or the people in Kyle or the people in Herbert want to be able to drive hours and hours and hours to get to the hospitals?

Now our point on all of this as well is that Swift Current or the southwest of Saskatchewan is a pretty viable part of the province. I don't think it should be abandoned and just sort of forgotten about. If we have just a passing notion of what our regional hospital is in the southwest, we have virtually abandoned the southwest and said the epicentre of medical treatment and commerce and trade and everything is going to be that Regina-Moose Jaw corridor. And we're not prepared to do that.

Now the other part of my paper here is that there's been a lot of talk about let's fix up the old hospital — the 1948 hospital — which is beginning to look, quite frankly, parts of it, as though you stepped into Leningrad or Havana. It's not a very nice facility anymore. The folks that work there do the best they can. But it would be crazy — absolutely crazy — to spend 5, $8 million trying to fix that place up. It would be a waste of taxpayers' money.

What we think has to happen is there has to be a brand new hospital built in a proper location. I invite this committee . . . and I don't know if you've got the time or inclination to come down to Swift Current to see our hospital so you know what I'm talking about and see where it's located. It's right in the middle of a residential area. It's a nutty place to have a hospital, but 50 years ago, guess what, I used to toboggan down that hill — well not quite; my older brothers did. But that used to be out in the middle of nowhere.

We've got lots of good spots where a new hospital could go into and that's what should happen. If you go and go in there and jackhammer out a bunch of elevator shafts and stick another million here and there, it's going to look stupid and it's not going to do the job and it's a waste of money.

Now if you're going to spend the type of money to build a new hospital out there, it's really expensive, and we're not for a moment going suggesting it isn't. And the type of money that we're talking about is $40 million or some crazy, big, goofy number like that nowadays.

But I can tell you if the present ratio of the provincial government kicking in X number of dollars, 65 per cent, and we kick in 35 per cent, we can't do it. We'll tell you right now, ladies and gentlemen, we can't do that. It's not going to happen. But if it went to a 90/10 per cent split, we can do that. Somehow or another people like Lyn, and I guess people like myself, will make it happen if you give us the chance. We can't raise a 35 per cent split.

If you're thinking of that and you say we'll give you a new hospital, we'll set it up but it's got to be that split, that's tantamount to saying you're not going to get one. You're going to get 3 or $4 million dollars thrown into that old hospital which will be a mistake. And as I said in our report, our children will say to us, shame on you for doing that. The only thing they'll say is shame on you; what type of goofballs, including myself, did that. So that's the other component to it.

If we're going to try to do it, it has to be at a level that the local community can chip in and do. Otherwise, just forget it; don't even talk about it.

The next thing is we've got some pretty good doctors there. We like to always think of ourselves as unique; I think that's self-serving. But we've got some good specialists there. We've got a good eye man. We've got an excellent internist. We've got a radiologist that's really quite interested in trying to make things happen there. We've got a dermatologist that comes in. We've got a couple of doctors that come in, orthopedic surgeons. It's a good place for medical care.

If, for whatever reason, the little hospitals around — like Leader, Shaunavon, Maple Creek, Herbert — they get shut down or they have a rationalization or radical change, guess what's going to happen? Those people are going to have to come to Swift Current. But if we don't have the proper facility there, what's the point of doing that? They'll be in Regina, and Regina and Saskatoon will be overtaxed way more than they are now. So we got to get ahead of the question. We've got to get

ahead of the crisis. And if we don't, we're going to have Regina and Saskatoon dealing with all of the southwest because they're going to keep on going right past Moose Jaw and they're going to go in there. That doesn't make any sense.

So I guess in my impassioned speech here, the two points that I really, really wanted to get across to this committee, and maybe I'm not doing that, is that we feel that it will be very unsuccessful to co-locate with Moose Jaw. We love Moose Jaw. We don't like their hockey team, but we like just about everything else about Moose Jaw. But it doesn't fit into what we need.

They'll have about 65,000 people in the scenario that we've set out in this little map. We'll have about 55,000 people. But a geographic area, as I say, about the size of Belgium.

Now Dean Smith, on July 10, gave you guys . . . I believe he came in and gave you guys a presentation — there's a written report; it's part of *Hansard* — about his view of what could be done. He's on the health board in Swift Current. Dean's a farmer that lives out in the outskirts of the area and he's got lots of good ideas.

I commend you to read that report that he provided to you. It's in writing. I looked at it the other day. It's excellent. It's in a nice folksy phrase and easy to read.

He talks about the good old days when Health Region No. 1 was started in the great southwest. And regardless of whatever political stripe we have in our province, that was the starting place of socialized medicine in North America. It was the starting place of socialized medicine in Saskatchewan. And whatever political stripe you have and however you want to call it, medicare was borne there.

We would like you folks to consider that as a pilot project, to see whether a true regional hospital would work and buy into that argument that Mr. Smith has in his presentation that there was a lot of co-operation in those days and it simply worked.

Now I have, as I say, a little prepared speech that I filed and whether you read it or not, who knows. But it's there. I'd ask that you take a glance through it, if you could. I'm sure you'll look at a bit of it. When I was coming here, I didn't know whether I was going to read that or just kind of give you my best two points about not working at Moose Jaw and, secondly, that we can't afford the present funding scheme.

I also tell you, from talking to the . . . from what I've heard, that we would have a real problem with physician recruitment and retention, especially of our specialists, if we have Moose Jaw as the heavy end of the equation. The doctors will go to Moose Jaw, the specialists. And why wouldn't they? I'd be stupid to say that they wouldn't go there. Our radiology department would be there. Our obstetricians would be there. Why would they want to be in an outpost in Swift Current? So that's another major concern for us as well.

Now we've got five more minutes. Is there any questions of me or anything that I've overstated or understated?

The Chair: — Thank you very much. Just before I go to questions from the committee, I just want to say I've been to Swift Current and I've been through the hospital and the regional centre and several other things in Swift Current, so I have seen your facility.

And the committee does . . . Hands are going up all over. I'll give Mr. Wall the first question.

Mr. Wall: — Thanks very much. Just a quick question and a chance for Councillor Keene perhaps to clarify. Should this committee make a recommendation to the government or should the government adopt a change in the funding formula for regional centres approximating what you're talking about — you know, 85/15, or 90 per cent/10, in terms of a major capital project, just a comment if you would, and maybe Lyn has something to add to, on the ability and the willingness of the city of Swift Current probably as a community and also as a city perhaps, to work with some sort of a fund . . . you know, to basically line up their share of it.

Mr. Keene: — The short answer is we'll do it. We'll make it work. The city of Swift Current of course is a distinct government and a distinct approach. But I'm satisfied and I think city council is satisfied that the people of Swift Current and the district would jump in like you wouldn't believe on this. It would be a galvanizing moment.

We would do it. Don't worry about that, Brad. It would get done. We'll take care of ourselves if we can just be given a chance. It'll happen.

The Chair: — Before I move to the next question, I just want to clarify for everyone that this committee is not making recommendations. It's reporting what we've heard. So we won't be making any recommendations to the Assembly.

Mr. Thomson: — Thank you, Madam Chair. I want to thank Councillor Keene and Ms. Johnston for their presentations this morning.

One of the toughest issues that we are trying to resolve here is the two competing sets of comments that we're getting from rural Saskatchewan. One is the set of comments that I think you very strongly and articulately put forward today, which is that we need to move forward with change. We need to move forward with regional centres. We need to stop looking at the health care budget as an economic development budget. We need to start looking at it as health care. On the other hand, we have people from much, much smaller communities coming in and saying, don't shut down my hospital.

How do you in the Swift Current region convince your neighbours to throw their lot in with you?

Mr. Keene: — Well I'll say a few words and then Lyn can talk a bit, Andrew, about that because she's in the front lines of trying to get . . . That is an issue that's a problem — I'm not going to dodge the question — because you can't have two things going on at once or you're going to run out of money pretty darn quick.

Our basic position is that at this stage, as we're in the year 2001, let's get serious. We've got to deal with the reality of

what's going on.

I can't speak for the people in the surrounding district. I'm not elected to do that. I am elected to say what the city of Swift Current needs, and it would work well in Swift Current. But I will go so far as to say that the folks in the great southwest would much rather have a strong, good regional hospital in Swift Current and, in my view, have more limited medical attention, if I can put it that way, in their localities, because we can't have it both ways.

And it's an educational process that'll have to take place and I'll leave it to you fellows and ladies to do that. But we've got come to grips with this.

And I come from a rural area. My clients and people that I live with come from a rural area and I don't want to annoy them, but the fact of the matter is you take the best you can out of a bad situation. And the best we can right now is to have centralized medicine with as much augmentation of the smaller areas as we humanly can, that is realistic.

Because it's divide and conquer. If we've got X number of dollars and we're spreading it all over the place, we're going to end up with a health care system that is all over the place.

Lyn, do you have anything to say?

Ms. Johnston: — Well I think communication is the key, developing a real understanding of where we're at and the crisis that we're facing, that we're not able to deliver the type of quality of care that people should be able to expect in our province, by having such widespread delivery.

I also think that people, once they have a comfort level and assurance that they'll be able to access that care and that there won't be the long waits and miles and miles of journeys to get to that care, will become more comfortable with it.

We have a program right now with the foundation that is, built as an investment in agriculture to improve the quality of health care for southwest Saskatchewan. And the response to that from the rural area has been tremendous. And we are getting donations and financial support from throughout the southwest. And I think people are ready, once they hear a viable solution that they can be comfortable with, will be willing to make a change.

Mr. Thomson: — Certainly I have to say it's refreshing to hear the comments and I think one of the most useful things out of this exercise we've been embarking on is hearing from citizens and from the local representatives, because it's very different than the message we certainly got during the 70 days that we sat in this legislative session listening to each other. It's very encouraging to hear that sense of us needing to move forward with change and that communities such as Swift Current are welcoming it.

I don't want to say too much else other than certainly the message about the need to recognize Swift Current as separate and apart from Moose Jaw I think is self-evident. I think it's an obvious conclusion, and that's certainly been something we've heard and I think we recognize here.

Let me just conclude by saying I thank you very much for the presentation. I think that particularly the first set of comments about the need for us to move forward with improving care, recognizing that that is going to mean change, and the need for us to stop looking at the health care budget as an economic development budget are very refreshing messages. So thank you very much.

Mr. Yates: — Thank you, Madam Chair. I have a couple of questions. I'm very familiar with the Swift Current Health District. I was born there and lived my entire life until recently in the southwest part of the province and have several relatives work for the health district in various capacities.

My concern is in getting confidence back in the Swift Current Health District. Many people today that I know — friends from Shaunavon, Gull Lake areas — go to Regina to doctors for specialties. There was a time, when I was much younger, that Swift Current was the location you went for basically all your medical needs if you were from the entire southwest part of the province.

Now do you see the ability to retain and expand the number of specialists and services delivered in the Swift Current area if you were to get a new hospital, were to become a regional centre?

Mr. Keene: — No problem, Kevin, because as you, know Swift Current is the nicest place in the province of Saskatchewan to live. And I regret the fact that you can no longer enjoy that. But having said that, if you have . . . We've got some really dedicated doctors there. We've got guys and some lady doctors there as well.

It's the quality of life. They would like Swift Current. They like to live there. It's the collegiality they have within their departments and so forth. But if you give them something that is better to deal with in terms of the equipment they have and the facility, I can guarantee you as much as anybody can guarantee you, that the doctors that we have there would stay.

And that's a big issue, maintaining what we've got. I mean, we've got sandbags built around what we've got right now but I don't know how much longer that they'll hold. We do have doctors that come and go because they get frustrated with their work and they get frustrated with the equipment and they get frustrated with all kinds of things.

But we've had some great longevity with our doctors there — our surgeons and our specialists. And that tells me something about living and working there.

I think Lyn and I both could comment that if the facility is improved, I don't see any real difficulty in retaining physicians to come to Swift Current if they could feel optimistic about what's going on.

I mean if it's . . . like signing on to a hockey team that you know is going to be a losing hockey team, it's pretty tough to be enthusiastic about it. But if you can sign on to a team where maybe this year is a building year but next year could be great, you'll get players. There's no doubt in my mind about that.

Mr. Yates: — And secondly, I refer to your map that you gave us. Does this reflect the old health region no. 1 boundaries?

Mr. Keene: — I'm not sure about that. I could ask my dad — he's here actually — but I won't. It probably . . . I wouldn't say it did. When we prepared this, we didn't do that by just superimposing the other one on top, Kevin, so I don't know if it is or not.

Mr. Yates: — I couldn't tell you either, and it was around when I left Swift Current. Thank you.

Ms. Bakken: — Thank you for your presentation. I'm just looking at the map and talking to Brad Wall. He indicated that he thinks there's four other areas that have hospitals that offer acute care within this new boundary you've drawn. I don't know if that's correct or not — four or five.

Do you see these other existing facilities playing a role? If Swift Current became a regional hospital, as I think we have sort of an understanding of what that means — offering more services, specialized services — do you see these other areas playing a role in that and being able to offer what we might call secondary care or . . .

Mr. Keene: — Yes. Absolutely, Brenda. Because you can't . . . You know, obviously you've got the Shaunavons and the Herberts. They're very proud of the fact they have a hospital.

And, you know, speaking on behalf of the ladies, if you can have your babies in your local hospital, why wouldn't you do that? And if the confinement and the delivery is routine and the general practitioners or family practitioners feel confident in dealing with that delivery, why wouldn't you keep it there? But if they . . . It's nice for them to know that there's an obstetrician within 50 minutes that they can rely on and do those things.

Certainly major surgery still could be done in Swift Current. But the day-to-day doctoring that so many people do, the blood pressures and the — we have an aging population — the geriatric medicine that has to take place, and the giving of prescriptions, or a little Johnny falls off the monkey bars and needs some stitches, exactly, that sort of what's been going on in the province of Saskatchewan for many, many years would continue. We wouldn't advocate for a moment that those facilities should be shut down.

We would be augmenting what they have there. And with the . . . I like to think Saskatchewan is as technologically advanced as anywhere else on the planet. There's all kinds of diagnostic information that can be just done over the telephone and Internet. Our imaginations are the only restriction on what can be done.

If we have specialists in Swift Current that have a rapport with the doctors in these other communities, that in my view will expand the medical service in a small . . . in a less expensive way, if we have more doctors that want to go to Shaunavon or Herbert or Leader because they know they're in part of a network of medical service in the southwest.

But if you've got doctors out in those small communities that don't have anybody in Swift Current any more or are limited, they're not going to be very crazy about being out there.

So it's a partnership that's working right now. And I think it can be expanded upon.

Ms. Bakken: — And I'm glad you clarified that. Because I think that from my perspective anyhow, what I was hearing you say, was that Swift Current wanted to become the regional hospital and service this whole area on its own.

And it's what we've heard from others that have come from smaller centres is that they don't believe that they can offer brain surgery or whatever or have specialists, but they have a role to play in order to provide accessible care and provide the procedures that they can provide and keep a doctor there, especially for the senior citizens that want to remain in their own communities.

So I'm glad you clarified that and that you see it as a partnership in working together with smaller hospitals.

Mr. Keene: — You see, Brenda, there's a couple of legs here; Lyn's supposed to kick me when I say something stupid or something like that and she can't quite reach over to do that, so that's a bit of a problem.

But I don't want for a moment anybody to think we're advocating let's shut down all the hospitals and these doctors can come to Swift Current and practise medicine in Swift Current, and the people from Sceptre and Simmie and all those other locations will bloody well drive in to Swift Current to see their GP (general practitioner) — no, not for a moment. I mean we'd be . . . That's not at all the issue.

Ms. Bakken: — Well and that's good because I think what we're hearing is that we want to enhance services in rural Saskatchewan and make centres of excellence where we can, not to lessen the service and move everything into Regina and Saskatoon. So I appreciate that clarification.

The Chair: — Thank you. Our next presenters are here so I'd ask our questioners to make their questions short.

Hon. Mr. Melenchuk: — Thank you very much, and thank you for your presentation.

Having had an opportunity to visit the Swift Current hospital and some of the outlying hospitals as well prior to health reform and during health reform, when the original health care reform process was initiated in the early '90s and the boundaries were drawn by local groups, there was a preferential exclusion by outlying areas around Swift Current to not belong to Swift Current as a health district.

And I'm wondering, today is there greater receptivity in those outlying communities, in your opinion, to having a single district with a regional centre, with supportive communities, with acute care services in those outlying areas, certainly not to the level of a regional centre but access for those local physicians? Would that model make sense to the people in the southwest today?

Mr. Keene: — Question better put to them. I'll give you my

opinion on it, doctor, for what it's worth.

I think that these doughnut health care districts didn't make sense then; they don't make sense now. There's no sense of belonging in some of these health care districts from one point to the other because they encompass another jurisdiction. My view, however, is that it was a long process and I in some small way was involved when Minister Simard started the process.

I think people now, in my opinion for what it's worth, realize that all of the fragmentation and all of the distinct little health care regions that we had, made people feel better at the time, made them feel they weren't disenfranchised in the health care problems that existed because of the federal government's approach to health care and the province's.

I think the time has come now that people realize that that's not necessarily the way to go and they would be more receptive, if I can put it this way, to a more . . . bigger health care districts, a more, a better allocation of health care funding and a more efficient health system.

I don't know if I'm answering your question or not, doctor, but my opinion is that I think there would be a greater sense of collegiality between the various people in the southwest than there was before. It's a process. Minister Simard at the time did what she could and, under difficult circumstances, came up with this idea and it was floated out, and I think now is the time to maybe take another look at things. That's my opinion.

Hon. Mr. Melenchuk: — The reason I ask that is we've had a number of presentations from district boards and smaller districts throughout Saskatchewan and it's certainly the impression that I'm getting from their presentations is that they're not opposed to change and that they believe there should be some changes to boundaries, but they would prefer that those boundaries have some common sense elements to them, that they follow trading patterns, that they can provide service delivery. And this seems to be a universal message and I think that we're hearing a similar message from this group today.

Mr. Keene: — I don't think anybody can dispute that any more. I mean that's . . . you know, there's the Stabler report or commission — I can't remember what it was called — and they had looked at the economic things. I mean we've got to . . . If we don't change and think outside of the box in this province, we've got some real problems.

Hon. Mr. Melenchuk: — Thank you.

Mr. Boyd: — Thank you, Madam Chair. I feel somewhat compelled to respond to Mr. Thomson's very political statement that he would very much prefer that people not talk about, during a legislative session, the concerns that there are within the health care system. And we all know what they are, from long, long waiting lists to concerns about acute care problems with patient transfers and loss of doctors and nurses and a whole host of other things.

And I want him to know and certainly everyone to know that we feel an obligation, as the official opposition, to respond to that and to bring forward the concerns that people have about our health care system. And I don't think we'd be involved in this process today or over the last number of days, if it wasn't for the fact that we do have problems within our health care system.

And the one thing I do agree with him is I support his view that it's refreshing when people bring forward new ideas. But there is also room certainly for the concerns and criticisms that they have of a government that doesn't seem to be meeting their needs.

So I certainly support your presentation. I think there's a lot of good in it and a lot of merit in it.

I certainly agree with you that if we're going to — and there's a big if here — if we're going to look at regional hospitals, Swift Current is a natural in terms of that. And the trading areas, as Mr. Melenchuk has said as well, must be respected. And certainly, coming from a community not far to the north of Swift Current, perhaps our natural trading pattern is going the other way, more north and towards you. It's very clear to me, as soon as you get about another 25 miles south of where I live, people do indeed, gravitate towards Swift Current from the Kyle/Leader areas and areas south and north of the South Saskatchewan River.

So we certainly hear you and hear your concerns. And I want you to also know that your representative puts forward — on a very, very frequent basis, both within caucus and within the legislature — his views about the need for a new hospital, and I think presented petitions every day of the legislative session about the need for a new hospital facility within your community. And having been through it myself on a few occasions, it certainly is in need. The community is in need of a new facility. So we certainly are supportive of your need in that area.

And while I don't have any questions, Madam Chair, I felt somewhat compelled to respond to concerns that we should all just simply put our head in the sand and not admit that there are problems with the health care system.

The Chair: — Interestingly enough, Mr. Thomson had wanted to be on the list too.

Mr. Thomson: — Madam Chair, Mr. Keene will understand that not only the bad echoing is what leads to us yelling at each other sometimes in here but . . . Just to prove a point, Mr. Boyd and I do periodically agree on some of the items.

One of the questions I just wanted a clarification on, following Ms. Bakken's question and your answer which . . . I want to make sure that you and Ms. Johnston are saying the same thing.

Now you're saying that you want to maintain all the existing facilities in the southwest district which we know costs, for the province, our budget is about 2.2 billion for health care, growing at about a rate of about 8 per cent a year to maintain the status quo; plus we should change the funding formula for regional centres to go from 65 to 90 per cent provincial funding; plus we should fund the additional diagnostics.

But from what I heard from Ms. Johnston's presentation, she

says — and the health centres say — that people would be willing to forgo the potential to accept lower quality health services that would inevitably result from trying to operate more facilities than we could possibly afford.

How do we enhance all of the services and all the programming and move the funding formulas and, at the same time, maintain everything? Is it, as SAHO (Saskatchewan Association of Health Organizations) says, that the problem is just that we're not raising enough taxes?

Mr. Keene: — That's a real problem, Andrew; and I apologize if I'm giving you mixed readings on this.

Clearly there's a finite amount of money in a budget, and our emphasis on behalf of the city of Swift Current is that at this stage in the history of the province of Saskatchewan there has to be serious consideration given to having a regional hospital in Swift Current. I don't know whether that will result in declining medical service in the great southwest as a result of that. Nobody can say. I would hope that it would actually improve.

But I'll tell you this, Andrew, if we keep going the way we are, where all of the money is being spread out all over the place, we're going to end up with a very mediocre — I shouldn't put it that way — an inefficient medical system. And I'm just saying that. That's just an absolute fact of that. Put the politics aside, that's going to happen.

If we work as a partnership with the rural areas and have a realistic goal as to what we're going to provide in terms of medical service in the rural areas in combination with a regional hospital, I think we can succeed and keep everybody happy. But I don't think it should become a political potato tossed back and forth in this room as to what should be done.

I think the fact of the matter is, quite frankly, is that if there's a partnership, and that's what Dean Smith said in his report on July 10 — I ask you all to read that again — he said let's deal with it like we did in Health District No. 1, because there was still . . . there's probably more doctors in the rural areas in the '50s and '60s when that was implemented than there are now. More people, but more doctors. And it worked, because they recognized certain things had to happen in Swift Current and certain things should happen in the rural areas. It was a partnership.

So I don't know whether that's an answer or not, Andrew, but I don't think I'm in conflict of what Lyn's saying. I think we're on the same wave. And I . . . you know, I'll dance around the issue a bit — it's a problem. It's a real problem for you folks sitting in this building to come up with a workable solution that'll keep everybody happy. And guess what? You're not going to be able to do it.

I know for a fact you're not going to be . . . (inaudible) . . . because there's a lot of . . . you get people appear before you all the time from the rural areas and they have their very real concerns, and then their urban areas are probably wondering why the heck are you catering to the rural areas.

There's a division in this province that I guess is up to you guys to sort out. I don't know whether it'll ever happen, but I really would like to see it happen and health care is one of the best ways of doing it, Madam Chair.

The Chair: — Thank you very much. And that being the end of our questions, I'd like to thank you all very much for coming today and giving us your written and personal presentations.

If our next presenters would come and take their seats at the table.

Good morning and welcome to the Standing Committee on Health Care. This is 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, Doreen Hamilton, Brenda Bakken, Bill Boyd, Rod Gantefoer are here with us today, and Brad Wall has been here this morning.

The first order of business for this committee has been to receive responses to the Fyke report, or the Commission on Medicare. And we are being asked by the Legislative Assembly to report back to the Assembly what we've heard from groups and individuals on their responses to the Fyke Commission, back to the Legislative Assembly by August 30.

We have half-hour presentations set aside and sometimes we're on time and sometimes we're not. But hopefully within your half-hour, we have a few moments at the end for questions from the committee.

So you can introduce yourself and begin your presentation.

Ms. Deiter: — Thank you. First of all, I want to thank you for allowing us to be here to make this presentation. My name is Connie Deiter, and this is Lil Sabiston. She is a board member for our organization. She has been a founding member as well, so I'm really pleased that she's here to answer any questions that you may have regarding our organization. And this is my colleague from Saskatoon; this is Marlene Larocque. Her and I are both program coordinators for the Prairie Women's Health Centre.

And with that I guess I will continue with the presentation. Our presentation this morning is a verbal presentation but this will be followed up in the next few weeks with a written submission.

Just to give you a little background on our organization, the Prairie Women's Health Centre of Excellence is a partnership of women's groups, researchers, policy-makers, service providers committed to women-centred, participatory, action-driven policy research. We are one of five centres located across Canada dedicated to improve women's health by generating knowledge and providing policy advice, which can be used to make the health system more responsive to women's needs. To this end we're making this presentation today.

Saskatchewan's pride in serving as the birthplace of medicare is often linked to the former premier, Tommy Douglas and, while Douglas's efforts are praiseworthy, numerous women were instrumental in building community support and in shaping favourable attitudes that made the implementation of a public health care system a possibility. Prairie women worked

tirelessly for the establishment of a publicly funded, locally controlled system, which would ensure that medical assistance would be available to all.

This is still true today. The health system relies heavily on the paid and unpaid work of women. Indeed some estimates have 80 per cent of health care workforce are women. Women also pay taxes which help support the health care system.

Women in turn depend on the health system for care and services. They are frequent users of the health system and more commonly experience the social inequities that lead to poor health. This is especially true for Aboriginal women. Poverty among women and violence against women for example, are endemic social issues.

Given the interdependent relationship that has emerged between women and the health system, women's voices are crucial in discussions about change.

The central goal of this brief is to provide an analysis of the commission's report through a gender lens. It's hoped this presentation will encourage the standing committee to review any changes it recommends through this same gender lens that will account for differing policy impacts on men and women.

This brings us to our first comment on the report. We recommend that gender be included in the determinants of good health as outlined in the commission's report on page 35. In support, Health Canada, the world health population model, and the Beijing Declaration and Platform for Action all call for greater equity in women's health to inclusion of women's voices in policy and program development.

In Saskatchewan the voices and vision of women are important to consider for they comprise slightly over half of the population. Women use many of the province's health services and provide crucial care related work. They serve on district health boards and occupy positions of prominence in health care deliveries organizations.

While family relations are changing, women continue to serve as primary health providers for themselves and their families. They often accompany others on trips to health providers and serve as a liaison between the health system and ill family members.

Women's intensive involvement with the health system provides them with the unique perspective on what is working in the system and on the changes that would facilitate greater effectiveness.

For example, Lil Sabiston can speak to this in greater detail, but most health care workers in rural hospitals and clinics are farm women. In this time of further economic hardship for the farmers, rural women employed in the health care system are providing the basic needs of the family farm.

In the health context, changes that benefit women deserve strong consideration and implementation. A collaborative, caring, cost-effective, quality-oriented environment that reflects women's expertise will strengthen the current system.

At the time the Commission on Medicare released its final report outlining an action plan for the delivery of health services in the province of Saskatchewan, the Prairie Women's Health Centre of Excellence was finalizing its own consultative process.

In the fall and winter of 2000 and 2001 women in the province of Manitoba and Saskatchewan discussed the priorities in women's health. In Saskatchewan meetings were held in Regina and Saskatoon and a separate meeting was held with Aboriginal women in Fort Qu'Appelle to ensure their voices formed part of the greater agenda . . . final agenda.

From these discussions came the Prairie Women's Health Centre of Excellence action plan in Saskatchewan-Manitoba. The action plan strength lies in its effort to reinforce the voices of prairie women in articulating their concerns about the health system and their vision for positive change.

The final action plan for women's health in Manitoba and Saskatchewan lists 12 areas that require immediate action. There are 12 priority areas to address these concerns of women who are marginalized and who have difficulties into getting health care.

The top four are: reduce poverty among women and address the consequences of poverty on women's health; improve conditions for formal and informal caregivers; address the specific health needs of Aboriginal women, and address violence against women.

I have with me a copy of the final action plan, which I'll be leaving with you at the end of this presentation.

We encourage the commission to consider the action plan when recommending changes to the health systems. From these discussions a number of essential strategies emerge for improving the health care system for women.

They are: consult with women on how health services should be changed to meet their needs; and to make changes based on women's input; expand the range of publicly funded services and provide a full range of services to all women, particularly in rural and remote areas and between districts; support the development and use of the most effective practices in women's health; develop a women's health strategy in Saskatchewan Health and a women's health unit with authority to recommend policies and programs for women.

Adopting these guidelines would help to ensure that the health system reflects and takes into account women's concerns and needs. The action plan encourages a collaborative, interdisciplinary approach to health and to addressing population health.

As health system changes are considered, we urge the standing committee to remember the implications that socio-economic conditions have for women's health.

Overall, we found the report on medicare includes many praiseworthy recommendations. Notably there are recommendations contained in the report that dovetail with the women's health agenda formulated by our advocates.

These include the commission's emphasis on primary health networks staffed by interdisciplinary teams echoes the calls by women's health activists for a health delivery system that builds on community-based services as its foundation. We support the creation of a primary health care network staffed by interdisciplinary service teams, provided that adequate supports are established. Furthermore these networks will provide the ideal opportunity for the implementation of midwifery in Saskatchewan.

The community care centres proposed by the commission provide an opportunity to community-based care and reduce the burden on unpaid caregivers. These centres should be adequately staffed and integrated with a fuller range of community services like home care, mental health, housing, and etc. We advise the community care centres should provide services for respite, convalescence, and palliative care.

These centres need to be accessible in communities throughout the province to provide publicly funded, professional care close to home to meet the needs of those who need care and those who provide unpaid care. We advise both patients and caregivers should be defined as clients of the system and call for a meaningful consultation with caregivers to design services responsive to their needs.

There should be a redistribution of the health care spending towards primary care and health promotion and away from expensive high-tech equipment which has less impact on the overall population's health.

We are supportive of the goal of creating a quality health system providing that this concept is broadly defined to include aspects of health delivery that are important yet not measurable. This could include treating women with respect and dignity and ensuring that women's choices in relation to health services are optimized.

The Prairie Women's Health Centre of Excellence strongly endorses further dialogue on health services delivery to Aboriginal people, particularly women. The action plan for women's health contains numerous recommendations for addressing the health needs of Aboriginal women. Importantly, it stresses the need for full participation in policy making, program delivery, human resource planning, and ensuring that health services for Aboriginal people are appropriate and culturally sensitive.

We are encouraged by the commitment to a population health model and to the developmental strategies that address the determinants of health. However, as mentioned previously, gender is not recognized as a determinant of health in the report. We strongly recommend that gender be included in policy and program development. Women need adequate income, housing, freedom from violence, etc., as areas of public policy requiring action and recognition that expenditures in those areas may make a greater contribution to women's health than advanced medical technology.

We support province-wide planning for specialized services to ensure high quality. However, the action plan for women's health notes that rural women face particular difficulties in accessing services. We emphasize that rural women need to be a part of an effective health reform and a part of primary health teams' network.

The Prairie Women's Health Centre supports the enhancement of policies and program delivery models directed towards public health promotion, prevention, and population health. We also recommend the adoption of a northern health strategy, provided that special care is taken to address northern women, particularly northern Aboriginal women.

We support a quality council but we recommend the importance of including paid and unpaid caregivers as a source of expertise on any quality councils, and equitable representation of women. We would also like to emphasize that quality cannot be reduced to a one-size-fits-all standardized treatments. The commission should recognize the diversity among people and provide services which are reflective of, and responsive to, that diversity.

Women have not always been served well by the health care system. Doctors have dismissed women's complaints; failed to provide adequate information; provided treatments which were not adequately tested on women; overlooked women's symptoms because they didn't match the disease profiles based on male experiences; performed unnecessary surgery; overmedicated; medicalization of normal life processes, etc. Quality concerns have been at the heart of women's critiques of the health system.

We support better human resource planning and management and information systems. We suggest consultations with women and other health care providers to address the health care system changes and working conditions which have created high levels of stress and dissatisfaction. We recommend consultations with Aboriginals to include them in greater numbers as employees within the health care system.

There are very workable strategies about which the Prairie Women's Health Centre have a wealth of information taken from across the country. We are prepared to share that information and expertise with the commission.

We encourage the commission to address the conditions of work, high levels of stress, and concerns of women working in the health system. Poor working conditions undermine the ability to provide high-quality care and undermine the health of health care providers.

We support increased provincial funding for health sciences education and health research. We recommend increased research and training in women's health.

We recommend expanding the range of health care services and that they be 100 per cent publicly funded. The Prairie Women's Health Centre of Excellence is supportive of a publicly funded, effective, health care system directed towards the achievement of maximum population health. We endorse public funding for an expanded range of health care services, not just physicians' services and hospitalization.

We oppose the privatization of health care financing as it increases the vulnerability of those unable to pay.

We recommend redistributing spending towards those areas which have a real benefit in terms of population health and redirect money that goes towards expensive technology and drugs which produce marginal benefits. While we recognize and encourage cost-effective measures, we maintain that they are above adequate social resources to maintain and enhance medicare.

The Prairie Women's Health Centre is supportive of the view of governance structures and those changes where warranted, if they are supported by evidence of those changes and answering questions as to what services, where and how health services will be provided in the province in the future.

Again, the intention of this presentation is to provide a woman's health perspective on health reform and to encourage further dialogue with women on anticipated changes.

While the Prairie Women's Health Centre of Excellence is supportive of the general direction in the Fyke report, we are disheartened by the disadvantages to women that result from the health reform initiatives of recent years. For nearly a decade the province of Saskatchewan has been engaged in revising and reforming the health system. The successes related to this process are outlined in the document *Health Renewal is Working, Progress Report, October 1996*.

From the standpoint of women however, health reform incorporates numerous problematic features. The report, *Missing Links: The Effects of Health Care Privatization on Women in Manitoba and Saskatchewan*, carefully delineates the impact of health reform on women and in the prairie provinces.

The impact of health care reform on women has not received the attention it deserves from the research community, although some women have been voicing their concerns about the adverse effects these changes have had on their lives and their health.

The situation points to the need for a more thorough assessment of the impacts of health care privatization and other aspects of health care reform on women. A copy of this report will be included in the formal written presentation.

Owing to this, the Prairie Women's Health Centre reiterates its argument for the application of a gender lens in relation to anticipated changes and for the inclusion of women at all levels of the health care system delivery and decision making.

In conclusion, as in past times when women's activism laid the groundwork for the medicare system, the modern women's health movement has been at the leading edge in recommending crucial changes to the health system.

These include the enhancement of preventative measures aimed at the promotion of good health, the development of models of community-centred care, and the need to involved citizens in decisions about their health.

It is our position that health system reform should build on these achievements by ensuring that women are fully considered and included in the renewal process. Thank you.

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

Hon. Mr. Melenchuk: — Thank you very much for your presentation. Certainly a lot of your focus was on expansion of best practices with regard to women's health and support of these best practices. And you would be in support of the Fyke recommendation to increase the budget allocation for research and, obviously, would like to see some of those extra research dollars go to developing best practices in women's health. Is this correct?

Ms. Deiter: — Yes.

Hon. Mr. Melenchuk: — The other question that I have is that when you made your comment with regard to supporting population health, and basically saying that decreasing the amount of funding for pharmaceuticals and technology because there was not too much evidence to support that it does a whole lot of good, well we've had some presenters, including representatives from pharmaceutical associations, who gave examples of how certain medications have markedly decreased health care costs in other settings.

The example given was the drug Tagamet and all of the, basically, other drugs that have since come from Tagamet. The prior treatment for ulcers and ulcer-related diseases was a surgical procedure, vagotomy and pyloroplasty is what it was called, and there was common . . . 20 years ago every surgical slate in every hospital in North America where you would have five or six or seven of these cases every day. Now you don't even see those cases any longer because of this particular medication.

So the argument that they mount is, and the example that he gave was cymedadine, is that this has decreased the hospital admission rate and the surgical procedures. One medication and the cost savings are immense to the health care system.

So I'm just wondering what research you have to back the statement that you made that pharmaceuticals are expensive and don't really have an impact in terms of population health.

Ms. Deiter: — Well I'll answer that by saying that it wasn't sort of a blanket statement and that really when you're talking about . . . We're talking about the socio-economic conditions that lead to those particular conditions and how we can best utilize the money to address some of those concerns to deal with that.

Hon. Mr. Melenchuk: — So what you're basically saying is that there is a role for pharmaceuticals, but there's also a role for population health and there has to be a balance between the two in any health care system — that would be a more appropriate statement?

Ms. Deiter: — Yes, I think what we're trying to say is that, you know, there really should be a more holistic approach in deciding where the money is going to be spent. And that certainly there has been . . . there seems to be a fair amount of attention being paid to pharmaceutical and more technical forms of addressing health concerns.

Certainly, we're not here to say that the pharmaceutical industry and medical technology has not made great changes in terms of overall world health concerns. I mean that's not something that we're suggesting.

But we are suggesting that if we do take a more holistic approaching in addressing health problems that I think we'd spend our money wisely.

Hon. Mr. Melenchuk: — And the final point is that throughout Fyke . . . of course his focus was quality, and basically that quality needs to be measured and evidence should be the measurement for any health care system. So would you agree that best practices should be measured and based on the best available evidence?

Ms. Sabiston: — I certainly would agree with that statement, yes.

Hon. Mr. Melenchuk: — That's all the questions I had, thank you.

The Chair: — And we have with us this morning the Minister responsible for the Women's Secretariat.

Hon. Ms. Hamilton: — Thank you, Madam Chair, and presenters welcome. We had a conference If Gender Mattered this year and a lot of the information that you brought forward was well received by the women. You've done a lot of work in gathering that information.

So I guess I'm wanting to talk about almost your first statement, the gender lens, and perhaps the role of Women's Secretariat when we're looking at health reform, are you contemplating that we would utilize the work of the secretariat to — whatever reform takes place — make certain that we have that in place before we would move forward on reform?

Ms. Deiter: — Well certainly. That would be a suggestion. As well as the Prairie Women's Health Centre we have, as I said, five centres across Canada with expertise in women's health research which . . . numerous reports and studies are available. And we'd be certainly open to meet with you on that.

Hon. Ms. Hamilton: — The areas that you mentioned, I think, are again areas that have surfaced through some of the work that's done on what are top of mind issues. One that comes up regularly I think for us to try and address — and I know members have been on a committee looking at that with the children in the sex trade — is the area of women and violence. It comes up very high on your survey as well.

So when we're talking about perhaps looking at health initiatives, it's broader than even the report that you're talking about. You're suggesting that we would look at, in other areas, how we're working to address the issues that are on that list.

I think of the sandwich generation as the other one. We're talking about caregivers.

Have you got an analysis of some of the work that's been done this year — there's been initiatives for early childhood — some of the areas that we've worked on addressing the issues that you have of concern? Are you doing some follow-up work on how that is impacting on . . .

Ms. Sabiston: — We have some excellent work on caregiving that's been done in the last year or two. Some of the research has been done right here in the health districts in Saskatchewan and there's been some excellent recommendations come out of some of those projects.

There's also a project I believe that was commissioned by the Health department in Manitoba on the prostitution and the sex trade. It was very well received by the press and we feel that a lot of the things . . . the research that was done was very good quality.

Right across Canada there's a lot of work that's been done on health reform. And we have a cross-Canada committee that's working on recommendations. I believe they're going to make presentations to the Canadian Health Commission. And they have done a lot of work on changes for women in health.

Health affects women a great deal. And I live it. I live in rural Saskatchewan, so I have seen some of the . . . especially with older people that aren't accessing health care and able to because they can't drive or have no relative that can take them. So we have real concerns about changes that the Fyke Commission could implement in the rural health districts.

I am the Vice-Chair of a health district and we've had a lot of comments from some of our people that have concerns, and mostly elderly women that really have a hard time to get to appointments and things.

Hon. Ms. Hamilton: — That leads me to my last question on accessibility in rural areas — rural women, but you're also talking about rural seniors. And do you believe within the model that Fyke puts forward in primary health care and whether or not we label something a hospital, a community care centre, that if there's help closer to the people and the health care provider is meeting the needs of those people, it would be a better model for us to follow? And what would be some of the areas you see, when you say you're supporting primary health care, that could address that?

Ms. Sabiston: — My biggest concern is diagnostic services in the rural area. If it's called a hospital or a community care, it doesn't matter as long as people get help when they get there. And we need the doctors. And unless we have diagnostic services in the local areas, we will not have the doctors stay there. They need those tools to work with. Those are very important.

I recently heard of a case about 40 miles away from my farm, of a young woman that had some bad effects with some medication she was taking, and I saw the doctor immediately after and he was still shaking his head because he was this close of losing the young woman because of it. If they would have had to take her all the way to Regina, I'm much afraid she wouldn't have made it — a young mom. And so if you save one life, to me it's worth it. Very important to have access in the rural area.

I know there's less of us out there because of the crisis that

we're going there, but we're still important, we still plan on living out there, and we need the services, especially health care.

Mr. Thomson: — Thank you, Madam Chair. Actually I had two questions. One concerning access in rural areas, which Ms. Hamilton has asked. The second concerns the situation for women in urban areas. Just about half a million people live in our four big cities. Obviously more than half of those are women. A large number of them are . . . an increasing large number are Aboriginal in background.

We rely very heavily in our big cities on the very large, impersonal tertiary care centres to provide the care — often backed up. We have not made the big investments into community care, partly because we've needed to maintain infrastructure elsewhere.

We've heard testimony from others who have suggested that we need to invest in two or three more clinic-type settings in our inner cities to provide a more holistic approach to care for women and citizens in the urban core of our cities. I'd be interested in your opinion on that. Do you think that the way that we have structured the, and are so heavily dependent on institutional care here in the big cities that that's been a detriment to women's health? Do we need to bring it down to the street level?

Ms. Deiter: — I'm sorry. My friend has . . . she has laryngitis but she's here for moral support anyway. It's more a matter of accessibility, not where they're located.

Mr. Thomson: — By accessibility then we're talking about possibly the need for more community clinic type settings or areas where you've got primary care teams established, rather than just having, say, a doctor's office here and then being shunted over to the women's health unit perhaps at General?

Ms. Deiter: — I really don't have any research on that. But I can tell you from my experience of being an Aboriginal woman who has lived in the city of Regina, who has — my sister Christine works with the safety services centre in the inner city; she works with children who are exploited in the sex trades — and also my involvement with the Four Directions here in Regina, and it's been my understanding that most of the problems with Aboriginal women, I think, is really . . . should be focused on preventative care and a more holistic approach. And in which case, I think clinics would be something that they would feel much more comfortable in rather than — and it'll be less expensive — rather than in a hospital sort of institutionalized centre.

Mr. Thomson: — Thank you.

The Chair: — Thank you very much, and thank you for your presentation this morning, for coming down despite your ailment, for coming, and hopefully we will get something in writing from you. I look forward to that. Thanks again.

I'd invite our next presenter to take a seat at the table here. We are passing out your written submission.

I'd like to welcome you this morning to the Standing Committee on Health Care. It's a committee of the Legislative Assembly, an all-party committee.

I'm Judy Junor, the Chair of the committee. Dr. Melenchuk is the vice-chair. Andrew Thomson, Kevin Yates, Doreen Hamilton, Brenda Bakken, Bill Boyd, and Rod Gantefoer are with us this morning.

The first order of business of the committee is to receive responses to the Fyke Commission, or the Commission on Medicare, and we are to present what we've heard back to the Legislative Assembly by August 30. So we're having hearings such as this, 30 minutes per presenter. And we apologize for being late this morning.

Within your 30 minutes, hopefully you'll leave a few minutes for questions from the committee. If you want to introduce yourself, please begin your presentation.

Ms. DeJong: — Thank you, Madam Chairperson. My name is Bev DeJong. Thank you for the opportunity to make a presentation on this most important issue of health care and the Fyke report.

My remarks to the committee today will be comprised, firstly, of background on my reasons appearing before the committee. Secondly, I wish to comment directly on the Fyke report and its recommendations. And finally, I wish to comment on transportation as it relates to the delivery of health care services in this province.

I present today as a private citizen and I do not speak on behalf of any group, organization, or community.

My background is rural Saskatchewan. I grew up on a farm. I have lived and worked in Saskatchewan all of my life. Today I live in semi-retirement with my husband in a small community by Regina Beach.

We are part of the Regina Health District and we commute to Regina for our medical services and needs. We receive ambulance service from Regina; an approximate one-way 45-minute drive from the hospital locations in the city. We are serviced by a first responders program.

My interest in health care is long-standing and results in part from my parents' participation in the movement to bring public health care to this province. My mother was a nurse who graduated from nurse's training in the early 1930s. She knew from first-hand experience not only the cost of health care, but the cost of the lack of health care.

My parents farmed and in a rural community my mother was the only person for some miles around that had any medical background. She was called on many a time to administer to a sick neighbour who was unable to afford a trip to the hospital or the doctor.

My mother's experience moulded my parents' viewpoint on the value of a publicly funded health care system. The benefits of the system were very clear to them. They worked hard to make the system a reality.

Subsequent to the introduction of medicare in this province in 1962, my parents, who earned a modest income from farming, invested financially in the establishment of a community clinic in our town.

Additionally my mother worked for some months as an unpaid nurse in the clinic that eventually failed due to the failure of the clinic's doctors to receive hospital privileges from an anti-medicare hospital board.

No matter the number of people that stopped talking to them or the businesses that would no longer serve them, including our family dentist, their resolve did not fail.

Both my parents have been deceased for some years. I continue to admire and be proud of their small role in bringing publicly funded health care to Saskatchewan. Because of this background, I have always been acutely aware of the benefits of medicare and how tremendously important this system is to the well-being of citizens.

I continue to appreciate that young couples can start families without incurring large medical bills. I continue to appreciate that when you have a chest pain or a stomach pain, you can go to your doctor or emergency ward and not worry about how much it will cost.

My late sister required extensive medical treatments as a result of multiple sclerosis and cancer. My young niece has cerebral palsy and the public health system provides her with a wide range of services from special needs equipment to specialists' opinions.

My family and I highly value these services. Accordingly when I hear that the medicare system is in trouble it causes me concern to the extent that I chose to come here today in spite of the terrifying prospect of being televised, and being in a roomful of politicians.

Before turning my remarks to the Fyke report I would like to comment on the general state of the health care system. For the last few years we have been inundated with reports concerning the dire state and dissatisfaction with the health care system.

A recent Leger Marketing survey reported in the July 9th issue of *The Leader-Post* that 56.6 per cent of Canadians are satisfied with the health care system, a number which rises to 61.7 per cent in Saskatchewan.

The July 13th issue of *The Leader-Post* printed an article concerning a survey by PricewaterhouseCoopers indicating that of 2,600 Canadians surveyed 94 per cent they are satisfied with the medical treatment and care they received in the past year.

My evidence of the system's health is anecdotal, but I would have to say that for every bad story I hear about the system, I hear eight or nine good ones. We have instances in our very small community of individuals facing life-threatening illnesses receiving immediate and excellent care. In neighbouring communities we hear similar stories.

Complaints about inadequacies in the system most often seem to come from persons with non-life-threatening health problems such as hip replacements. Anecdotal evidence also leads us to believe that often it's the ability and knowledge of an individual doctor in managing the system that is the determinant of how quickly and adequately services are obtained.

Regardless, based on the information in these surveys and our own personal experiences, I think the system may be in better shape than we have been led to believe. However, I think it is still clear that there are some problems, including the accelerated pace at which we are funding medicare, our concerns about health professional shortages, and waiting lists and delays for non-emergency services.

Accordingly, I would now like to turn my remarks to the Fyke report. I am not a health professional and as mentioned previously, I make my remarks as an interested citizen. I appreciated the comprehensiveness of this report and was very impressed with its readability and the extent of its recommendations.

I see the report as a proposal to modernize and update the medicare system in response to current and future demographic trends and in response to changes in medical and health advances in the last 40 years. In general I concur with the recommendations of the Fyke report: a system of primary health service teams and centres, regional hospitals, with tertiary centres in Regina, Saskatoon, and Prince Albert makes sense to me.

The reality is that our population has been shifting from rural to urban and will continue to do so. A recent CBC (Canadian Broadcasting Corporation) show reported that within 10 years 85 per cent of Canadians will live in urban centres. I would imagine that population trends will be a consideration of the quality council if it becomes a reality.

The report's arguments that specialists require a critical mass of patients who need care, the need to access specialized diagnostic equipment, and the ability to consult with peers are difficult, if not impossible to disagree with.

A few days ago on July 21st *The Leader-Post* printed a summary of research reported in the *New England Journal of Medicine*. The article indicates that lung cancer patients survive longer if they have surgery at a hospital that does the operation frequently. And further studies of heart surgery and treatments for a variety of other medical conditions likewise have shown that practise makes perfect.

Our objective as indicated in the Fyke report should be this quality of service, and I would support the plan for the location of specialties in specific locations within the province.

In some of the presentations to the committee, which object to the network of health care services, the main objection is the potential loss of a local hospital. I understand that communities do not wish to lose their hospitals. However, the concern often centres on job loss and the economic spinoffs, as opposed to loss of the hospital and quality health service. In most cases, however, health services requiring specialists are already only available in larger centres.

The data makes it quite clear that Saskatchewan residents are

over-hospitalized and that we have an excess of hospital beds for our population. It makes sense that we would divert these resources to areas of need such as primary care, home care, long-term care facilities, or chronic care treatments like dialysis.

We seem to have romanticized the hospital in this province and for sure we have politicized it. It's unfortunate because it takes away from the importance and scope of the broader medicare discussion.

The hospital is just a building, a physical structure. It's easy to see when it goes up and it's noticeably gone when you take it away. What's really important however is the services that can be provided in our communities. Services of a primary health team member, it may be a primary health care centre; 24-hour telephone access to health services, home care, and support services would be welcome additions to many communities including mine.

While we struggle for health resources, I believe it is absolutely wrong to maintain unnecessary hospitals. On the other hand, we must be prepared to provide the proposed replacement resources in a community to ensure that its health services will be maintained before a hospital is closed.

It's impossible to comment on all the recommendations in the report and I'm somewhat reluctant to highlight a few for, in my mind, they come as a package. Nonetheless, for the sake of brevity, I would like to highlight several of the recommendations that impressed me.

I strongly endorse the recommendation for the quality council, particularly its position as arms length from the government. The report suggests a good mix of representation and my own bias would be that the member representation from people with non-medical backgrounds or training be generous. Too often experts are biased by their expertise and I think it's important that this council can receive a strong non-medical perspective from its own membership.

The Fyke report has made a case to continue the health districts but in smaller numbers. I see a lot of administration and a lot of duplication of effort when we have large numbers of districts and I think it is quite important to move to smaller numbers. I think it can provide some cost savings, as well as help to streamline the provision of health care services.

I would like to give a big hurrah to the Fyke report for pointing out that it is inappropriate for physicians or anyone else who is on contract to or directly employed by the district to serve on its board. This is a clear conflict of interest and I personally have found it really annoying to see board members with an axe to grind.

I would also agree that if citizens do not show more interest in running for the elected positions on the health board, the government should make all appointments.

On page 25 of the report, we have a recommendation respecting the role of the Department of Health. The report recommends that Saskatchewan Health take lead responsibility for the development of a province-wide plan for the location and delivery of specialized services based on standards established by a quality council. As well, the mandate of Saskatchewan Health for overall planning should include a province-wide strategy for human resources, as well as an overall strategic plan for the purchase and maintenance of capital equipment and construction and maintenance of facilities.

I agree with this proposed role for Saskatchewan Health and I mention it as I will be referring to it later in my remarks.

One of the biggest issues we have in health care is Aboriginal health. The Fyke report lacks depth on this issue. In view of the projections for Aboriginal population growth and the significant health issues being faced by Aboriginal people, it's extremely important to move with urgency on the recommendation on page 61 of the report. That recommendation is to begin a structured dialogue involving representatives of First Nations people and the provincial and federal governments on how to improve and coordinate the delivery of services.

The conflicting information we receive on the state of the health care system speaks eloquently for the need to continue the development of performance indicators as proposed on page 54 of the report.

Lastly I wish to comment on user fees. I absolutely do not support user fees. Unless the fees are large, the contribution to the system would not be significant, particularly after you take away the cost of administering the fees. Who would be hurt? The people who can least afford to pay, the very people for whom medicare is to provide the greatest protection.

Additionally, if we had user fees and someone couldn't pay, would we actually refuse service? The answer should be no, because as Canadians, I think we have decided that we are not that kind of society.

I now wish to make some comments on transportation. Because my most recent employment was with the city of Regina as the manager of their paratransit service, I bring some professional background to this area. My experience with the Regina special needs transportation system made me keenly aware that a lack of transportation whether you live in the city or the country can be a complete barrier to health care services.

The Fyke report briefly addresses this matter on page 19, and I quote:

> When travel is required it can be particularly challenging for seniors and low-income families. Primary health networks can be instrumental in supporting municipal governments and voluntary service organizations in their efforts to address these needs.

The words "particularly challenging" understates the reality of the situation. I repeat that a lack of transportation can be a complete barrier to health care services, even if the service is two blocks away.

For most of us I think it is not asking a great deal to travel for health services. We love to travel for everything else. People travel to shop, to play bingo, to go to the bar, to visit, and to holiday. People living in larger cities often have to travel significant distances for all their health services.

However, what about the person who uses a wheelchair? How do they access health services? What about the person who has Alzheimer's? How do they get to an adult day program? What about the recent heart attack victim with instructions not to drive? How do you get to your rehab treatments if you had a knee or a hip replacement? Or what about my friend who lives out of province? Her 82-year-old mother who has never driven her own car, must now access dialysis treatments 40 miles away, three times a week.

Most of us have family and friends we can call on for transportation assistance. But what if you can't, or if use a wheelchair that won't fit in a conventional vehicle?

Changes in the delivery of health care have already increased transportation requirements for people. Additional changes as proposed in the Fyke report will further increase transportation requirements.

Because of the many other big issues that government has to deal with, I am concerned that once again the issue of transportation will be overlooked for that small group of citizens who need help.

While the Fyke report suggests primary health networks can be instrumental in supporting municipal governments and voluntary service organizations in their efforts to address transportation needs, I would recommend that the provincial government take the lead in this matter.

The provincial government has a program called transit for the disabled which is managed by Municipal Affairs and Housing. The program, which has been in existence since 1975, provides special needs transportation funding to municipalities on a cost shared basis. The program has been reviewed several times with minor adjustments made but has never been updated.

Because of the introduction of health districts in the province, population shifts, and further proposed changes to the delivery of health care services, this program must be substantially revamped or a new program introduced.

I am aware that the Regina Paratransit system in recent years has been hugely impacted by changes in population and health care demands. Greater numbers of persons receiving dialysis treatments, attendance at adult day programs, rehabilitation treatments following hip and knee replacements are just some of the health related reasons persons require special transportation assistance.

A recent *Leader-Post* article indicated that the city of Regina had sent a $380,000 bill to the Regina Health District to try and recover its cost for health care related trips on its paratransit service.

Several years ago the city of Saskatoon paratransit system simply stopped providing trips initiated by the health care system and threw the ball back in the health district's court. As a result, in Saskatoon the health district pays for adult day program trips and other directly related health care trips.

In other words, what Saskatoon receives through its health budget, Regina receives from another cost-shared grant from another government department.

I'm not here to make a case for either method. I do, however, wish to make a case for the provincial government to coordinate, develop, and provide adequate funding for a special needs transportation strategy.

Just as Mr. Fyke has proposed that the Department of Health have a mandate for the overall planning for health, a government agency should be mandated to develop and coordinate a transportation strategy for those individuals needing transportation assistance. In this way health services for all Saskatchewan residents can be ensured.

Currently, because special needs transportation services are operated through the municipalities, there is, I believe, unequal access to special needs transportation systems. There is inadequate liaison with health districts. There is no incentive for developing inter- or intra-municipal transportation services. There is inadequate rationalization of capital expenditures, such as scheduling systems and vehicle purchases.

There is inadequate liaison with STC (Saskatchewan Transportation Company). There is a lack of integration with transportation systems that are utilized for school purposes.

Additionally, there should be coordination with emergency medical services and medical transportation systems.

Finally, there must be adequate financial support for special needs transportation systems.

In summary, I would like to repeat my unwavering support for the continuance and strengthening of a publicly funded health care system.

In general, I support the recommendations of the Fyke report. However, where communities will lose hospitals, I think it is imperative that their replacement health services be put in effect prior to the hospital closure.

Secondly, I would recommend that the provincial government provide adequate funding and take a lead role in developing an up-to-date and coordinated special needs transportation strategy for that small group of Saskatchewan residents that require transportation assistance. This will ensure access to health services by all residents.

Thank you again for the opportunity of appearing today.

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

Mr. Thomson: — Thank you, Madam Chair. I'd like to thank Ms. DeJong for also coming. I think just, while I don't have a question, I'll just comment and say that I think that your comments particularly as they affect special needs transportation are very fair and accurate — that we do need to think more about provincial coordination of these, not simply within the cities themselves, but within the districts and how the local communities surrounding the larger centres are dealing with it.

If anything will become a bigger issue as populations age, this will certainly be one of them. And so I appreciate you very much bringing this to our attention. This is the first time we've had, I think, had presentation on special needs transport. It's much appreciated. Thank you.

The Chair: — Seeing no further questions, I would like to thank you very much for taking the time and making the effort to present such a thoughtful presentation today. On behalf of the committee, thanks for coming.

Our next presenters could take a seat at the table. Good morning and welcome to the Standing Committee on Health Care. It's an all-party committee of the Legislative Assembly and our first order of business as a committee is to receive responses to the Fyke report and report back to the Legislative Assembly what we've heard. We won't be making recommendations. We'll be reporting back the various submissions, what we've heard in response to the Fyke Commission or the Commission on Medicare.

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

We have 30 minutes for the presentation and, hopefully, at the end of the presentation within that 30 minutes we have some time for questions from the committee members.

If you would like to begin by introducing yourself and who you represent, then we can begin the presentation.

Dr. Wilson: — Certainly. I'm here on behalf of the Saskatchewan Psychological Association which represents and regulates doctoral registered psychologists in the province of Saskatchewan.

I'm Dr. Laurene Wilson. I'm the vice-president of the association. This is Dr. Elizabeth Ivanochko, who is the president of the association. And this is Dr. Tim Greenough, who is a member of the association. We have authored the document which we have submitted to the committee.

On behalf of psychologists in Saskatchewan, I want to thank the committee for its attention and for the opportunity to present feedback regarding the final report on the Saskatchewan Commission on Medicare, that is the Fyke Commission.

In my presentation I'll address both strengths and areas where we feel that planning may be directed to enhance the likelihood of achieving the desired outcomes envisioned in the report.

I will also address what psychology can offer in health care reform. I would like to share the discipline's empirical evidence regarding the value of psychological interventions in mainstream health care, mental health, health promotion and prevention, amongst other critical areas.

To begin with the strengths of the commission's report, we believe that these points are echoed by many other presenting organizations, so I would like to keep these brief in order that we may focus on the areas for strengthening and focusing future attention. And we do elaborate on these points in our document.

The Saskatchewan Psychological Association supports the following principles and concepts discussed in the report: the emphasis on fairness and the aim for protection of universal health care; clearly articulating the fiscal reality of our current health care system; demonstrating the need to alter the present structure of delivery in keeping with reform in other Canadian provinces; proposing an alternative service delivery system which is multidisciplinary and collaborative; emphasizing health promotion and injury and disease prevention.

Other strengths that we see are the identification of the need for quality and accountability enhancement, the identification of weaknesses in our current health care system, recognizing the need for provincial leadership in several areas, and a renewing of health sciences education research funding.

At this point I would now like to turn to highlight five issues where the Saskatchewan Psychological Association feels that planning needs to occur in order to enhance the likelihood of achieving Fyke's goals.

The first item is a definition and philosophy of health. There is no definition of health included in the Fyke report. We feel that this is somewhat of an oversight. The World Health Organization's definition of health includes the absence of disease but also a complete physical, mental, and social well-being of the individual.

In addition to this, we feel that the philosophy of care should be more clearly articulated. Up to this point, our health care system has been strongly biologically biased with a downgrading and even demoralizing of psychological factors to date.

We feel that this sort of a definition of health and adoption of this sort of philosophy can be of assistance in public education and promotion, that it is consistent with Fyke's recommendations, and it is a necessary foundation for future planning. Psychologists would enjoy collaborating on this issue in future planning efforts.

The second issue that I would like to address is the fact that successful teams and health care systems include psychologists on primary health care teams. We would like to make the point that all health is influenced by psychological factors. Research informs us that health systems committed to providing the right service to the client at the right time, the optimal time, including psychologists integrated in primary care, are systems that are economically sustainable and achieve optimal health outcomes.

There is overwhelming scientific evidence regarding the effectiveness of psychological interventions at all stages of health care, from primary to secondary, tertiary and other areas in reducing health professionals' workloads, in reducing costs to the health care system, and providing more appropriate and effective interventions and outcomes for patients.

Some of these results that I will discuss come from 20 years of research conducted by the psychologist, Nicholas Cummings, but other research that I will cite has been done by the World Health Organization. These specific replicated results that I'd like to note here today are, firstly, that 60 per cent of physician

visits are by patients with no demonstrable physical disease. These figures rise to 80 or 90 per cent if we include stress exacerbated conditions.

Persons with emotional distress are higher medical users. Medical costs are 46 per cent higher for patients with untreated stress. Individuals with anxiety disorders use medical resources at 40 per cent higher rates, preferring to seek medical services rather than mental health services. Medical costs are 70 per cent higher with untreated depression. Survivors of interpersonal violence such as martial assault and childhood sexual abuse are also higher users of services.

Rather than revealing psychological problems to medical personnel, depressed patients, for instance, will disclose things such as physical complaints, pain problems, fatigue and sleep problems. Other health professionals do not identify psychological issues as effectively as psychologists do.

Psychologists working in primary care yield utilization rates, outcomes, and patient satisfaction that are much higher than traditional rates or . . . and traditional referrals on an outpatient basis to outpatient clinics.

Medical utilization rates decline significantly following psychological intervention. So for instance some of the research has shown us that with psychological treatment we see a 49 per cent reduction in visits to family physicians alone.

The overwhelming majority of patients can be helped with between 15 sessions or less; and the average is eight. Another 10 per cent may use up to 19 sessions on average to have the sorts of benefits that I'm talking about today.

Failure to provide psychological services in our health care system has encouraged somatization and an overutilization of medical services. What we see is a cycling through of people visiting their family physicians repeatedly, seeing specialists, going from specialist to specialist seeking second opinions. These are the sorts of outcomes that we see.

I would like to emphasize that rather than psychological services then bankrupting the health care system, it is the failure to provide these services that does so.

Psychologists look forward to bringing this empirical knowledge to collaborative planning processes in the future, regarding multidisciplinary care in the province of Saskatchewan.

The third point I would like to address is human resources, access, and fairness. The Fyke report discusses the principle of fairness and we feel that access is related to this.

Despite the evidence that I've just presented to you about the effectiveness of psychological intervention in primary care, Saskatchewan has the lowest level of psychological services in Canada.

Service levels are much worse in rural areas, where vacancies remain open for lengthy periods. And across Canada we know that there's a difference in urban residents having three times more likely the chance of seeing a psychologist than rural citizens.

Psychology has strategies for recruitment and retention. We also have the infrastructure available in our university programs and in our internship program in Saskatoon on which we can build. But it is important to note that at present we have many fewer training positions than adjacent provinces. So for instance, our internship training programs has two positions, where in Alberta there are 16 training positions in psychology internships.

We would welcome the opportunity to work on provincial planning committees to improve the status of health human resources for psychology as well as other professionals in order to support the visionary change in our health care system that is proposed by Mr. Fyke.

The fourth point that I would like to make today regards illness and injury prevention and health promotion. This aspect is mentioned in the report, but we feel even understated even to the extent that it is emphasized and we feel that further elaboration is essential.

Lifestyle is a major determinant of health. Smoking, addictions, exercise, diet, violence, and accidents — and just this morning on the news was a story about seat-belt use — and other human behaviour, all of these things negatively impact on health and well-being.

Also psychological adjustment and mental health are necessary precursors for physical health and physical well-being. Psychological research has been at the forefront of understanding health behaviour change in individuals, with applications and research also informing us about how to successfully alter population behaviour.

A few questions that we noted in areas for further examination in terms of health promotion and prevention, with the proposed reforms, how will behaviour be changed in a population level? How will an altered system offer incentives for such desired behaviour change? Who will be responsible? How will the funds be guaranteed and how will it be protected from the usual clinical service and crisis demands?

There must be protected financial commitment for successful reform. Given the critical and central nature of this area for successful reform, psychologists would welcome the opportunity to share their expertise, again in realizing the goals laid out in the Fyke report.

My fifth and final point does concern the issue of central and tertiary care and rural service. Here we have just a few questions to raise. We note in the report, firstly, that there are three centres proposed. We also noticed that larger provinces have fewer areas than this. And we do wonder, can this be a sustainable and realistic proposal that is made in this report? Simultaneously we appreciate the economic and emotional impact for rural areas on the proposed changes in reducing their hospitals and such services.

A final point in the area of rural service is that rural practitioners' credibility, the appreciation of their requisite expertise in managing a multitude of issues across all ages,

across just so many different problem areas, this must be enhanced and appreciated in order to improve the valuing of their skills. That will be an asset, we feel, both to recruitment of professionals and their retention, but also to the rural citizens' confidence in their health services and in the sorts of service changes that are proposed by Fyke.

Psychologists would like to be of assistance in seeking solutions to these difficult issues and balancing the needs of rural and urban service and the preservation of universal health care in future planning.

In closing, on behalf of psychologists, I again want to express support for many principles included in the Fyke report, the commissioner's work, and our legislative members' collaborative efforts to seek solutions to the serious situation facing health care.

Saskatchewan is the birthplace of medicare and we have an opportunity to set an example once again for the country and the world to follow, using the Fyke report as a launching point.

We hope to have contributed by identifying areas warranting further attention and to have educated members about the expertise of psychologists in many areas discussed by Fyke. We look forward to the opportunity to work closely with the government in many capacities in ensuring that the citizens of Saskatchewan have access to quality and effective health care which they expect and deserve.

Thank you.

The Chair: — Questions?

Mr. Thomson: — Thank you, Madam Chair. I only have one question.

First of all, let me say thank you for a very thorough presentation, including many appendices which I hope we'll have a chance to take a look at as we get ready to prepare our report.

The question I have concerns centralization, regionalization, and care in rural areas. The comment that you make about us having a difficult time filling positions I think is one not unique to psychologists. This is one of the difficulties we have in retaining specialists throughout the system. Fyke recommends regionalizing many of the specialized services into 10, 14, 20 — whatever the number may be — regional centres.

Is this something that, from your association's perspective, you think could be used to help attract more professionals and retain professionals into regional centres and then provide care into smaller centres perhaps on a clinic basis?

Dr. Ivanochko: — One such possibility would be the utilization of mobile teams. We could have teams that would originate in the larger centres, but travel. We have the possibility of technology which would support distance consultation.

And Regina Health District, I know, is looking at such possibilities and I'll refer the question to Dr. Greenough as well, who could respond, from Saskatoon.

Dr. Greenough: — I think in terms of your comment, I think the move to regionalization would be an improvement. I think it creates a core group, a multidisciplinary group that then is able to provide mutual support. And so I see that as an enhancement or a potential enhancement.

It still speaks to the issue of having the infrastructure to support recruitment and retention, even into those areas. And I think that requires some dialogue with our training institutions in order to . . . and provide opportunities for students to be in rural placements during their training. I think that would go a long way as well, in enhancing our recruitment retention strategies.

Dr. Wilson: — Can I just add on that we do have a model, an excellent model next to us in Manitoba where given certain planning in their internship training program, they have been able to successfully recruit and retain doctoral psychologists out in very northern regions and that, through particular strategies that they've used like cross-appointments to the university, to the medical centre.

And so I think there are ways that we can contribute to this planning process to make recruitment and retention more successful in our province as well. And we know that it works in Manitoba.

Dr. Greenough: — I think of the generalized . . . (inaudible) . . . professions as well, as part of an overall strategy.

Mr. Thomson: — I said I only had one question but I may have misspoken myself.

The other question that arises from your presentation is the question of the number of tertiary centres. You've expressed, or your association's expressed some concern about the idea of moving to three from two. Is that a concern, overmaintaining critical numbers of specialists, or is it a case of simply spreading financial resources too thinly?

Dr. Wilson: — I think it was strictly based on the evidence presented by Mr. Fyke himself, was that there are certain population bases needed to provide services. And for him to have said that and then also proposed three areas, we just wondered how that conclusion was reached, I think, was a question just for consideration.

Mr. Thomson: — Thank you, Madam Chair.

Mr. Boyd: — Thank you. I want to explore with you a couple of things, three actually. The family doctor in my home community tells me that he sees a decline in the condition of mental health of his clients, his patients, on a steady basis. As he sees the removal of services from an area, he believes that people look at it and they are very, very concerned that the loss of services will result in them not having adequate care when they need adequate care.

And I'm wondering if you can help us understand that a little bit and whether that is something that you see or hear on a regular basis.

Dr. Ivanochko: — Yes, it is something that we see. And in fact psychologists have been active in working with rural populations, particularly with respect to farm stress. I can't give you I think a concise response right now but I can tell you that yes, the perception, we think, is a very valid one and we have evidence of that.

We also have evidence of ways in which responses can constructively address problems so that people have other methods of dealing with social issues, rather than to incur personal difficulty, personal symptoms.

Mr. Boyd: — And I'm also interested in, on page 7, the statement that 60 per cent of physician visits by patients have no demonstrable physical disease or concern. Could we take a step in logic and suggest then that less services mean less sickness?

Dr. Wilson: — Could you repeat that question?

Mr. Boyd: — My physician will tell me the same thing that you have shown here, that many of the visits that people make to a physician may not be necessary. They have no demonstratable health risk to them. So is the next step in logic, if we remove services, if we reduce the number of services, does it mean less sick people?

Dr. Wilson: — What that is saying is that we haven't been providing the right services for those people. And that those people need assistance with such things as Liz was just talking about — farm stress or whatever — but that we were talking about sort of the traditional medical philosophy. That hasn't been the system that has worked for that patient population. That isn't the most effective means of intervention with that group.

Dr. Greenough: — If I could just add, it seems to me that it speaks to the need for a multidisciplinary approach. And that there needs to be some other resources that support the general practitioner when they are in, you know, their individual practice or rural area so that they can provide a more appropriate service and have some options which presently frequently do not exist.

Mr. Boyd: — The last area I wanted to explore with you was the idea or the thought that perhaps three tertiary centres would be unaffordable or simply not necessary based on the evidence of other provinces. In Alberta I suspect it's Calgary and Edmonton only, and in Manitoba, Winnipeg only.

It would make for an interesting debate I'm sure in Saskatchewan and indeed in this legislature if we were to suggest that perhaps one is enough, and that obvious and logical choice of that one centre would be in Saskatoon.

I'm interested in what the thoughts would be of many people in Saskatchewan if we were to go that far to extend the visionary view, as some people call it, of Mr. Fyke that one tertiary centre surrounding the University of Saskatchewan in Saskatoon, obviously with the College of Medicine there and many, many other facilities there, that that would be adequate. From your perspective, would that be adequate?

Dr. Wilson: — My own personal feeling is that this is a political question and that we were commenting simply based on the evidence of the adjacent provinces. And I don't feel that it's our place to say what the right answer is. I think that's a political debate and decision that has to be made. But that's my own opinion. I don't know if the other members would like to comment.

Mr. Boyd: — The reason I raise the question with you is because we are being told by many presenters that part of the reason why some rural communities are concerned about the loss of services is simply turf protection.

And to move one step further in terms of whether we need three tertiary centres, two tertiary centres or whether one is adequate, I agree with you, I think it is a political question and are we into another area of turf protection.

Dr. Ivanochko: — I would like to make a few points. I think if you look at population distribution in the other provinces, you often have a rationale for the location of tertiary centres. I can't quote you the statistics but I'm aware, for example, that the population of Manitoba is significantly concentrated around Winnipeg. The population distribution in Saskatchewan is quite different.

The issues with respect to I think, public acceptance, would have to do with, number one, the dislocation issues; and number two, the amount of perceived need to use a tertiary care system.

And we had talked about, for example, enhancing the public's confidence in rural physicians and in the paramedical or the multidisciplinary team. We believe that if we could foster that confidence in rural Saskatchewan in the teams that were administering primary health care, that there would possibly be less need to accelerate the nature of the difficulty to the point where residents were using tertiary care centres.

Mr. Boyd: — Well I suppose it begs the question, is it really any different for a person from Maple Creek to go to a tertiary centre in Regina, or is it any different than a person from Regina going to a tertiary centre in Saskatoon? Distance is relatively equal. If the same sort of services were offered in their locale to have . . . or to be asked by society to accept the fact in a progressive way that we are going to move to one tertiary centre rather than three.

Dr. Ivanochko: — I think the possibility of a question for the Fyke Commission as well would be, do we need as many people in Saskatoon using tertiary care facilities as in the more qualified or the more specialized services when it is possible to answer many of the questions of lifestyle-induced symptoms or stress-induced symptoms with primary care teams.

Hon. Mr. Melenchuk: — Thank you very much, Madam Chair. Just while I've been listening to the discussion on tertiary centres, just for clarification, I think that Mr. Fyke is a supporter and proponent of generally accepted population dynamics for creating tertiary care centres.

And the general rule I think accepted across Canada, is that when you break down your health care system into primary, secondary, and tertiary, that you need population support of

roughly 10,000 for an integrated primary care network; 100,000 for a secondary centre; and a million people for a tertiary centre. So in Saskatchewan that would mean one tertiary centre.

But the point, the only point that I would wish to make is that tertiary centres bring on this idea that they have the full range of tertiary support. But you can have tertiary services in secondary centres, but it wouldn't be a tertiary centre.

And I think that's what he's referring to in terms of Prince Albert being a tertiary centre. What he really means is that some tertiary services could be provided in Prince Albert but he's not advocating to have another burn unit in Prince Albert.

I think he's saying that Saskatoon will have the burn unit. It'll have the gamma knife for neurosurgery and things of that nature. So it wouldn't be a full spectrum tertiary centre. But because of the wide-based geographic nature of Saskatchewan, that some tertiary services should be provided in other locations other than Saskatoon or Regina. Okay.

The Chair: — Seeing no further questions, then thank you very much for your presentation and coming today.

I'd invite our next presenters to take a seat at the table. We're getting one more chair, I believe.

I'd like to welcome you this morning to the Standing Committee on Health Care. It is a committee of the Legislative Assembly. Our first order of business is to receive responses to the Fyke Commission or the Commission on Medicare. And our mandate is to report back what we've heard to the Legislative Assembly.

This committee won't be making recommendations. It'll be reporting back what we've heard. Our presentations are 30 minutes, and hopefully within that 30 minutes we have time for questions from the committee.

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

If you'd just introduce yourself and who you represent, then begin your presentation.

Mr. West: — Okay, I'll start out with the introductions. My name is Gordon West and I'm the president of SABAS which is the Saskatchewan Association of Boards of Addictions Services.

With me, I have Barb Robinson who is the Chair of NECADA (North East Council on Alcohol and Drug Abuse Inc.) — that's in the Melfort-Tisdale area. Next to me is Angus Campbell. He's a member-at-large with SABAS, the author of *The Grand Vision,* and the first chemical dependency or addictions worker in Saskatchewan, back from the '50s.

Next is Joe Penkala from Saskatoon. He's the Chair of the Larson Intervention House in Saskatoon. And next is Russell Dann. He is the director of the George Bailey Centre in Humboldt. And then back behind is Terry Romanow, who is a staff member of Sinclair Jamieson Foundation in Moosomin.

And I'll just start out by telling you who we are. The members of SABAS have been committed partners in health care renewal. We appreciate the opportunity to be an integral part in the process of addressing the challenges that our medicare system is facing.

We are grateful to be given the opportunity to be able to express our support for many of the recommendations offered by the Commission on Medicare as well as to share some of our concerns and observations that we encountered while reading the *Caring for Medicare: Sustaining a Quality System* prepared by Mr. Kenneth Fyke.

SABAS is a provincial non-profit organization established in 1978 and consists of 22 community-based volunteer boards that provide addiction services to community members in the province of Saskatchewan. We believe in taking responsibility at the local level as part of the wellness response to alcohol and drug abuse, addictions, the disease of alcoholism, and gambling issues within our communities.

As service providers, we offer services in all 30 health districts in the province, including detoxification programs, in-patient and outpatient services, methadone programs, the driving without impairment program, and the safe driving program. Lastly, and most importantly, we play a significant role in providing community education and prevention programs in our communities, especially the schools and for our professional colleagues.

Our board also consists of agencies within the First Nations, Métis, rural and urban populations.

And with that, I'll turn the mike over to Barb Robinson who will give the presentation.

Ms. Robinson: — Thank you. We believe that if we are not a part of the problem, then we're a part of the solution. The staff we hire to provide the above services are highly skilled, trained professionals committed to the well-being of the community and community members. They often provide services at less cost and can acquire resources through community connections and support.

SABAS board members, elected at the local level, represent a vast source of educational knowledge and experience. Current members of SABAS Board of Directors represent an example and a potential of what is described in the Fyke report, type of quality council. Our only mandate is for addictions, the disease of alcoholism, and alcohol and drug abuse issues.

Our members . . . we have a wide range of members. For example, we have a chartered accountant; a well-known author and retired addictions worker; a Presbyterian minister; retired police chief; regional Chair of educational representative for the Addictions Intervention Association, which is a national and international accreditation body; program head of the chemical dependency worker program at SIAST (Saskatchewan Institute of Applied Science and Technology).

Also we have the current president of the Saskatchewan

Association of Chemical Dependency Workers, an expert in the driving without impairment program, as well as representation from Justice, the current president of the Community Development Society of Saskatchewan, as well as addictions workers and business persons.

So we have a wide representation. We meet on a regular basis and have consulted on several occasions to come up with some of the responses to Mr. Fyke's report.

SABAS is pleased to support many of the ideals in the commission report. Being community-based organizations, the themes of integrating individual teams into primary health networks, teamwork, and particularly enhancing the 25 to 30 community care centres, and creating quality council is at the very core of our belief that community wellness begins at the community level.

We are, however, deeply concerned about the significant understatement and lack of insight into the significant contribution alcohol and drug abuse, the disease of alcoholism and chemical dependency, plays in the total devastation of the health care system.

Devastation ranges from extremely high costs in emergency rooms to chronic mental, emotional, social, and physical health problems. There is also the toll it's taking on our health care service providers who are unable to keep up the chemical abuse problems due to demanding cases of workloads, lack of professional training, and awareness of the total effects chemical use, abuse, and gambling have on clients.

The rest of this presentation will now focus on our feedback and comments regarding issues we believe are either overlooked or not expanded enough in the report.

In the area of networks of primary health care centres as well as community care centres, the idea of primary health teams is not a new idea, but it has slowly emerged as a result of past health care renewal initiatives. This is essential and we believe that whatever issues plague a person affects all areas of their life.

These recommendations will certainly assist in providing highly needed services at the local level and it'll allow people to access primary health care services and highly trained heath care professionals without having to travel great distances. We're talking about the 25 to 30 centres that have been projected.

The danger in this is that many health care providers are trained in specific disciplines and, when trying to cover areas that they are untrained in or have had little training in, they experience a tremendous amount of stress, as do the clients they are trying to serve. A good example of this is home care special care aides trying to give home service care service but are encountering substance abuse and gambling clients.

Emergency room staff are encountering patients under the influence who have been physically and mentally hurt but they do not have adequate training to work with the real issues that patients are entering the emergency services with, especially those that keep the revolving door or repeated access to services.

So we're therefore concerned that in the overall scheme of things the practice of integrating services will lead to generalists who will not be able to serve adequately in any capacity.

As an example of the need for specialized training to work with the client needs, the SIAST Woodland Campus chem. dep. (chemical dependency) program has reported 18 per cent of nursing students now in social work, psychology, and who work in justice are now requesting advanced training in addictions work because their caseloads are supposed to be in justice or mental health but the addiction issues are surfacing and they're not sure how to deal with them or they're becoming aware that they're missing some of the issues.

Likewise, addictions workers are requesting education in areas like dual diagnosis, so that addictions workers . . . their major role is not dual diagnosis but certainly to be able to work in part of that integrated team, to be able to have some idea of how to refer clients that need to have both treatments at the same time.

That's one of the areas in dual diagnosis we talk about is serving the needs of the client with both an addictions issue and with a mental health issue, rather than dealing with them as one. The sobriety issue is very important.

Another recent example around how integrated services might interfere with addictions if we get too integrated is that we were at a specialized training seminar in Regina that Alcohol and Drug Services provided called denial management. Approximately half of those attending the training were from dual diagnosis treatment programs, mental health, and corrections while the remaining participants were from addictions services.

During the training, the overwhelming response by those not trained to deal with substance abusers and addictive clients was that there definitely needs to be more people qualified to work with substance abusers and those suffering from the disease of alcoholism as they require training and assessment procedures not used, especially in mental health.

What can the health care sector do in working with other key partners to promote health and wellness, which was a heading in the report? On page 49 of the commission report, reference is made to Quint, a community-based, economic development agency. It stated that they have done well in creating jobs and improving housing in five intercity neighbourhoods.

It's also stated on page 18 that family, friends, and community volunteers have always provided crucial care, nurturing and support that is depended on by the formal health care providers. We certainly endorse this, as it is the spirit of community-based organizations and community individuals who commit to taking on some responsibility for our communities. What's missing from the report is any further reference to the role community-based organizations can play in providing significant health care services.

When the Bureau of Alcoholism was created and then continued to evolve, it masterminded one of the most enviable structures for addiction services in Canada. With the structure, it allowed access to many resources. It was very efficient. It provided critical direction to staff, for staff, for standards. It

started a process of enhancing addiction worker delivery service standards and also functioned as a central location for the dissemination of human print and video resources.

Materials and services were available to the general public and professionals as well. SADAC (Saskatchewan Alcohol and Drug Abuse Commission) also implemented the Saskatchewan model of recovery services. But by 1993 SADAC was decommissioned and all responsibilities were turned over to the health districts. This has caused addiction services to deteriorate in many communities, especially at the prevention level.

Keeping addictions as a core service has allowed basic clinical services to be provided. And also some of the advertising and promotional services that were provided at the provincial level were lost when we were decommissioned and we haven't been able to get that support back, which influences and interferes with community activities. If we're trying to do health promotion, especially when addictions and substance abuse, disease of alcohol is involved, then we don't have this, a common set of materials to deliver to the community. But it's just one of the issues.

If there's to be any consistency in addiction services, the department may wish to visit the structural model on how services were provided by SADAC. Other disciplines may benefit from doing so as well.

Under SADAC there were 35 funded agencies that provided addiction services. There were community-based organizations that were providing high quality services for less than government-run agencies. SABAS, those of us that are here today, the 22 agencies are what remains of those agencies. So in the process of integration some of our organizations were forced into amalgamating with the health districts.

Where the agencies were transferred the volunteer boards dissolved, leaving no voice in the healing of their communities and in many cases we lost grassroots input into prevention and community education. Sometimes we were amalgamated without consultation, and other times we were told that if we didn't amalgamate then we wouldn't be able to enjoy the same salaries that other addictions service providers had. So that was one of the incentives to have community-based organizations transfer into the health districts.

SABAS believes that community-based organizations providing addiction services are vital to the balance, health, and well-being of addiction services in Saskatchewan. There needs to be something in place to prevent the forced amalgamation of community-based organizations.

The Community Development Society of Saskatchewan and the International Community Development Society adopted six principles of good practice professionals are to use when promoting community development which also includes promotion of wellness in the community, which is one of the areas that they're looking at is the wellness through mental health and through addiction services.

And their principles include to engage community members in problem diagnosis so that those affected may adequately understand the cause of their situation, and as professionals working towards healthy communities, we are also to actively work to increase clientele leadership capacity, skills, confidence, and aspirations in the community development process and to help community members understand the economic, social, environmental, psychological impact associated with alternative solutions to the program . . . or, sorry, to the problems.

That was one of the advantages. It still remains one of the advantages of CBOs (community-based organization) in addictions services is that we're community-based, the community knows who we are. We have input from the community so we can direct the issues, the economic, the problems that substance abuse and the disease is creating in our own communities. We can address that at the local level.

Also evidence shows that in order for communities to overcome their problems, they must include grassroots people in the education, particularly in prevention programming and decision making.

On one hand it's satisfying to see that the Fyke report, that volunteers are important, but there's no provision for the significant role that they can play in the future in terms of service delivery. Often professionals are burning out trying to keep up with the community wellness projects when the community members could take responsibility for problems brought on by lack of education and apathetic attitudes towards health care issues, whether it be diabetes or substance abuse.

Shift in population. On page 56, Mr. Fyke's report, it is stated that:

> Many of the services provided by districts (e.g. addiction services, pre- and post-natal care, mental health problems) are needed by relatively small numbers of people. As a result, to deliver these services effectively, a health district requires a reasonably large population . . .

While this may justify larger health districts, there is a dangerous assumption that fewer numbers may indicate less health problems, therefore require fewer services.

On the contrary, when it comes to substance abuse and addictions, evidence-based data indicates that substance abuse, the disease of alcoholism, chemical dependencies, and gambling problems are taking a severe toll on society, both to the individuals, the family, and economy, including astronomical costs to the health care system.

SABAS, also through scientific research and evidence based on research, believe alcohol and drug abuse and the disease of alcoholism play a significant role in contributing to serious problems and financial burdens encountered by the current health care system. Yet the development of preventative treatment and rehabilitation programs for those afflicted with chemical dependency has been neither easy nor swift.

Public apathy and prejudice have hampered the process, compounded by the virtual absence of either political will or commitment.

The effects of substance abuse are very well documented in

literature. And I'd like to go through just some facts, particularly those that pertain to our province.

Last year alone, 20,293 people received care through addictions services. Now that's the provincial statistics for our provincial organizations, which include the community-based organizations and those funded directly through the health district.

This however does not include any statistics from our First Nations communities. They're using the health care system but the stats don't necessarily reflect because we have two separate statistical-taking processes.

There are slightly over one million people in the province. This means at any given time, approximately 100,000 people are affected by alcohol and drug problems daily. That's due to the stat that one out of every ten Canadians report a problem resulting from his or her drinking.

Also one in four children come from alcoholic homes. For every one person who has a problem with alcohol, there are on an average of at least four others who are directly affected on a daily basis — children, friends, and co-workers.

Also currently in the news was 20 per cent of all senior admissions to hospital — due to complications of prescription drug use. And some of that is directly related to substance abuse and the lack of awareness of what substances can do and prescription drugs can do for seniors.

An overall stat for Canada, 6,000 deaths due to alcohol use. This is alcohol, not the illicit drug use, so this is just alcohol. Also in 1992, $7.5 billion were costed out to the national economy just due to alcohol problems. So it's costing our health care system a lot of money.

Fetal alcohol, fetal alcohol effects, fetal alcohol syndrome have significantly increased in the last 10 years. Again the current government has begun to look at that by offering $11 million this year alone for starting to work with those people who are affected by it.

HIV (human immunodeficiency virus) and hep C (hepatitis C) have also greatly increased. Larson House, one of the few detox centres is running at 95 per cent capacity with 18 beds. And reports from medical doctors and from addictions counselling units is that there's a six-week, at least a six-week wait list for clients to receive admittance into in-patient programs and outpatient detox programs.

Lastly in terms of some facts for Saskatchewan, often individuals suffering the effects of substance abuse and/or addictions are misdiagnosed as having primary mental disorders, mental health disorders, health care problems when it's often substance abuse issues.

The people presenting previous to us, talking about health admissions to hospital where there's no identifiable disease, it could be the disease of alcoholism or certainly as a result of circumstances surrounding alcohol and drug abuse, emergency rooms having people under the influence coming in through altercations, and so on.

Dr. Shepard is another research scientist who talks about the economic costs that are not only major consequence of alcohol and drug-related problems, but the consequences are extremely varied ranging from illness and accidents to unemployment and family disruption. In some cases, death results from alcohol or drug-related illnesses, accidents, and suicide.

Physician services, hospitals, mental health centres, and alcohol and drug treatment centres, and also with regards to ambulances, prescriptions, home care, laboratory tests, research, education, and health administration.

We've also had an opportunity to witness some of the effects of alcohol and drug abuse this week with four deaths in our province. And while it may not have been directly related to the health care system, the cost for search and rescue and the cost for coroner reports, all that money gets diverted into those kinds of activities or into the justice system, could be used for funding into the health care system if the prevention area of addictions and substance abuse were dealt with.

1993, *Socioeconomic Evaluations of Addictions Treatment* report: alcoholics usually incur health care costs that are at least 100 per cent higher; and in the last 12 months before the treatment of addiction, the costs are close to 300 per cent higher. Dr. Hobbs also states that 25 to 40 per cent of patients occupying general hospital beds are there for treatment of ailments that result from alcoholism.

They've concluded that interventions for chemical dependency are among the most effective, cost-effective health care treatments available.

Dr. Langenbucher, another person who has studied and done significant research in the area of the cost of addictions to society, describes in his paper, socio-economic research, that when fully implemented an efficient approach to the treatment of alcohol-related problems will result in one of the largest pools of cost savings in a reformed American health system. Our system is not a lot different than the American health system if we were to put more monies into addiction services.

Also Dr. Langenbucher states that addictions treatment significantly reduces overall health care utilization and encourages more appropriate use by alcoholics, drug addicts, and even their family members. In addition treatment reduces social costs of addiction, promoting better job retention and employee behaviour, lowers predatory and property crimes, reduces AIDS (acquired immune deficiency syndrome) risk, and other positive outcomes.

Lastly, accordingly to Dr. Langenbucher, he says the average of non-alcohol drug abusers to the health care system — and these are American prices but again not a lot different than Canada — the system is approximately $200 for a regular person. Costs for treated abusers, so working with people that acknowledge that they have the disease or they're abusing, is about $600.

Of extreme interest is that for the cost of the untreated substance abuser is approximately $800 per person. So people that are untreated are accessing health care services and costing more money than if they were accessing because of their disease or substance abuses.

The last item that we wish to comment on is quality control council. The last major area of support we wish to endorse is the development of a quality council. We believe that if this province is to receive quality care, there must be a system in place to monitor delivery of services, coordination of services, create a forum for standardization of services at each health care delivery sector and, lastly, to provide a forum for professionals and grassroots people to access when they wish to express support and concerns.

SADAC was an example of quality control councils for addictions services. Reinstating a structure of Saskatchewan Alcohol and Drug Abuse Commission would provide standardized services with alcohol and drug services and community-based organizations, as well as the other disciplines wishing to access the services. Ultimately this'll save millions of health care dollars. Reinstating SADAC would allow for the active development of health care standards and maintain the professional integrity of addictions services.

SABAS takes pride in being part of a team of health care professionals that provide primary services to a significant number of people in the journey to wellness in our province. We believe that substance abuse and addiction services provide a significant contribution to our health care system, but we also know that to be most effective we need to continue to be a part of the health care team.

We would like to encourage the Commission on Medicare to clarify their vision of health care delivery. We would like the commission to ensure that each health care sector be seen as a part of an interdisciplinary team. They could be in an integrated location but that there be, that the disciplines maintain their integrity in the services and not get lost in government tendency to swing so . . . too far one way or the other, meaning totally integrated or totally absent of services.

SABAS believes that community-based organizations providing addictions services are vital to the balance, health, and well-being of addictions services in Saskatchewan. There needs to be something in place to prevent the forced amalgamation of community-based organizations.

And we appreciate the opportunity to express and support our concerns, and to support the advancements that are helpful, and thank you for your time and attention. And we would like to be more than willing to help the government to assist in any way that we can. Thank you.

The Chair: — Thank you very much. Questions now?

Ms. Bakken: — Thank you very much for your presentation. I'm very interested in this whole area of addictions services and I'd just like to ask you how SADAC better served the people that need this service than SABAS does?

Ms. Robinson: — I'll start out and then I'd like to have some of the other representatives express their opinion as well because we represent a wide range of services.

SADAC had a set of board members that represented many sectors of society so that they presented information and had the ability to provide input into the policies and procedures that were being implemented in the province. It also provided a profile for alcohol and drug abuse policies and procedures.

But more importantly, besides having the stability to guarantee alcohol and drug services having a major role in health care services, it also had an area, a physical location, and they offered significant amount of training and professional development for not only addictions workers but also for people who were in social services, in justice, in mental health where, if they needed some updating or they did want training, they could just phone and there was a pool of people that were available.

If people needed to have information about what addiction services were available in their community, they could phone that number and they would be able to have access to somebody, that the person would answer the phone and say there are services here, here, and here. So it was very easy to access that way.

There was also a central location for a significant amount of training and resource materials. So there again, community members and other professionals and addiction services could phone up. There were library catalogues available for different videos, different slide programs, different books on resources on developing community action programs. And also within that, they were starting to develop the Saskatchewan model of recovery services.

So on one hand, I want to be very clear, we are enjoying addiction services and the partnership that we have with the CBOs and the clinical, the basic clinical services that we're providing.

But with SADAC, we're also beginning to create standardization, so committees were being made . . . created to study how to create — or sorry — standardized treatment programs and accreditation. They just started dabbling in how to make sure that addictions workers met standards, training standards. And also were into being able to . . . into prevention.

But the whole idea of prevention, working in the communities, all fell apart when SADAC was dismantled. So it got handed out to the health districts and there was central . . . (inaudible) . . . But I'd also like to have anybody else make comments.

Mr. Dann: — Well I think you covered most of the points, Barb.

My feeling with SADAC was that it provided some cohesiveness for addiction services within the province. They pulled everybody together and got them focused on addictions. And they did that through the training that Barb mentioned. It was available to addiction workers and other people in the communities as well.

At that time when SADAC was in place Saskatchewan was well-known as a forerunner in addiction services and providing a quality of service. I think we still have a quality of service, but we're not forerunners anymore in Saskatchewan.

I left the province for a while. When I came back SADAC was dissolved shortly after that, and I seen it decline in the

cohesiveness of addiction services in the province. We're kind of a hodge smodge of stuff now instead of that focused . . . that we had before. And I think we've really lost a lot in that.

Ms. Bakken: — Just one more question. I know that in Saskatoon there's been a movement towards further detox centres. I believe a facility called a . . . (inaudible) . . . detox to help stop the revolving door of emergency and the justice system, and I'm just wondering if that's still underway, and just your overall impression of how we could improve access to services.

I believe you said that there's a six-week wait, which my understanding is that's just not acceptable. When people need addiction services, they need them now, not six weeks down the road. So if you could comment on that.

Mr. Penkala: — Larson House, Larson House has been invited by the Saskatoon District Health organization to participate, and we're very anxious to become involved in that. It's a question of resources. The resources aren't in place. The proposal and the plan is to provide 12 brief detox facility beds within our facility. In addition to that there's also a request to provide 10 long-term beds for — we call them halfway houses — people, that have gone through the system of detox and some rehabilitation, have a support system within our facility.

Now this is very much accepted by Larson House and its board and it's being promoted by Saskatoon District Health, however, financing is a problem. There's going to be a 6 or $700,000 addition capital expenditure, and there will be an increase of probably $750,000 into the operational costs, which will be an ongoing cost for providing this service that's going to be a tremendous asset to the community in terms of addiction services.

Ms. Bakken: — What's your overall opinion on the need for more services in Saskatchewan as a whole or do you have any comment on that?

Mr. Penkala: — We're presently slated as an 18-bed detox function or facility, and we are running at 95 per cent and that's almost constantly . . . we're constantly full.

We have resource problems. There aren't enough resources when you're . . . For example, we have two detox workers during any one shift attending to 18 people plus all the other necessary things within running a facility such as Larson House and it's reflecting on stressing our employees. We simply can't keep up.

It also reflects back on our clients that can't get access to the treatment. And it just works its way right down through the chain.

Ms. Bakken: — What do these people do when you cannot take them into Larson House or I guess the bigger question is when they need in-patient treatment on a longer term, where do they go or what happens to them when they cannot access the service when they need it?

Mr. Penkala: — Well the unfortunate situation that exists there is when they are detoxed, and that's our function, they have to return back to the community or to the environment which they came from. And in most cases, that environment isn't conducive to rehabilitation and we often see them coming back. And it's a recycling process that takes place and this is very unfortunate.

We also aren't so naive as not to believe that this problem is of a nature where there's recycling and people do get into trouble again and again. But we feel that there's an opportunity lost by the fact that these people are not offered the continuum of rehabilitative services.

Ms. Bakken: — Has this presentation been made to government to enhance services in the province?

Mr. Penkala: — I'm not specifically involved in that. But yes, there are discussions and negotiations going on. Yes.

The Chair: — Thank you. Dr. Melenchuk to wrap us up.

Hon. Mr. Melenchuk: — Thank you very much, Madam Chair. Just a couple of questions with regard to the recommendation for reinstating SADAC.

Now the base question arises is that under the centralized model which was the SADAC model, the coordination and monitoring of outcomes occurred at a central level, and the provision of services were through community-based organizations. Are you suggesting that a central coordination monitoring of outcomes is more efficient than a regional model?

Ms. Robinson: — What we're saying is that the centralization is more efficient in terms of the overall management, but it provides the liaison back and forth for the community. So when we're looking at those 35 to 40 communities, that there is a . . . they're moving back and forth.

So they have the central location of resources, communication, training, annual meetings, inter-agency meetings, but also, as Joe was talking about, when they send the clients out of detox for example, they can go back to the communities. The problem of course is the wait list, even in outpatient. But yes, it was very efficient.

Hon. Mr. Melenchuk: — And the suggestion by Mr. Fyke, in terms of enhanced services in 10 to 14 regional centres, I think his assumption was that addiction services would be a component of this enhanced service in these regional centres. I guess it's when you trying to find what is the best model — the previous model obviously is better than what we have now — but where the system evolves to, we don't know if that will be an effective model as recommended by Fyke.

So I'm just wondering whether we should be centralizing addiction services on the coordination aspects or whether we should see if we can have those regional centres look at addiction services in a more comprehensive way. Because certainly the point made that some of the smaller districts just don't have the resources to provide addiction services or certainly not coordinate them, whereas a larger regional centre may have those resources. So could you comment on that.

Mr. Dann: — I would say that as long as they didn't downsize

the services in those smaller communities, 14 regional offices would be all right. But if that's all we have, it would do a disservice to the general public. Because especially with our SGI (Saskatchewan Government Insurance), the safe driving program clients, these are people without driver's licences, they need to be able to access services within a reasonable distance. Otherwise it's a very, very serious hardship on them to get to, say, one of the 14 centres.

That would be one of my concerns with that.

Hon. Mr. Melenchuk: — The second question that I have is with regard to the whole concept of addicted youth and whether we should be looking at separate facilities, and could you comment on that topic?

Mr. Dann: — Yes, dealing with addicted youth is a serious problem, and I'm not sure that what we've got now is adequate.

I believe, you know, that at this point in time our in-patient youth facility is dealing with the more serious youth that are addicted. But there's a lot of other addicted youth that could use a facility that would maybe meet their needs a little better. But they wouldn't really fit in to what we have right now as far as we don't want to make matters worse for them instead of better.

Ms. Robinson: — Excuse me. I'd like to elaborate as well. The comments I made earlier about all or nothing, to bring up Whitespruce was a facility for youth. However, there were some activities that were implemented and policies that were implemented that didn't make it efficient, so it fell apart.

Now we have Calder Centre in Saskatoon that's trying to deal with the group of adolescents, but they're integrated with the adults and it's not working. So a combination of what was working in Whitespruce and what they're trying to deliver, because the program in Calder may be working but the geographical location is not working.

The other comment about the 12 . . . the 14 centres, what we're missing here with the adolescents and the bigger picture is prevention and promotion. And the proof is that if the community is invited and active in the promotion of wellness and can provide local statistics about what alcohol and drug abuse, the disease is doing to our community, then we have more input and more influence in the community in terms of prevention.

So going into the treatment programs is serving our clinical purposes, but we can't lose the community-based opportunity in the province, located in the communities, to do that prevention part. It has to come from within the communities or it isn't going to work.

I've been involved in the industry since 1978, and I started out as a volunteer, going into the schools, doing presentations. Then I became a professional addictions worker, still went into the school. When we started the focus on the Saskatchewan model of recovery — which was needed — we lost the piece about prevention.

And our services have gone up. We're providing basic clinical services, but we're not reaching the prevention part. So our caseloads, fetal alcohol syndrome, all of that's rising, but we aren't getting to the prevention piece that's costing the health care system a significant amount of money.

So I don't want to lose sight. Ten to 14 sites is not going to be efficient if we believe in the principle of community development.

Mr. Dann: — That would tie in with an earlier question around whether we have adequate services or not. And my sense on that is that we don't. What we have is the people that are working with substance-affected people, or addicted people, are so overburdened just with their regular caseloads that they don't have the time to do the prevention and community development that we should be doing.

And we know it needs to be done, but you can only do what you've got to do; and when you've got a caseload like most of us have, it takes priority. And so the reality is we really aren't adequately serviced at this point in time for addiction services in the province.

Hon. Mr. Melenchuk: — And the final question I have is with regard to Saskatchewan as compared to other jurisdictions in providing addiction services. Many jurisdictions outside of Saskatchewan, well in the United States for example, rely on major employers as providing addiction services through their human resource departments.

Are you aware of any major employers in the province of Saskatchewan that are providing comprehensive addiction services to their employees?

Ms. Robinson: — I can answer some of that. In our province we have a provincial . . . and then they're also connected to the national employees' family assistance program, people. They do provide professional development for their employee assistance personnel and for their referral agents, but it's not a provincial-wide activity. Although those that happen to know about it can register for some of their programs and training that they offer, but it's not provincially advertised as such.

Mr. Dann: — One of the things that addiction services does provide is employee assistance, program assistance to . . . like I've done for cities and for large businesses in the past through my community-based organization.

But I'm not aware of anything in the province like what they have in BC (British Columbia). They actually have an in-patient treatment program that's an employee assistance program. We don't have anything like that here.

Hon. Mr. Melenchuk: — It would be fair to say then that the vast majority of employer organizations and employees would access the regular community-based programs in the province of Saskatchewan . . . (inaudible interjection) . . . Okay. Thank you very much.

Ms. Robinson: — The role that SADAC played . . . interestingly enough Alberta has taken on the design, and has a alcohol and drug abuse commission. And it's a lot cheaper to do training as addictions workers than it is to provide a Ph.D. in psychiatry or psychology to provide the training, plus the

addictions people have the expertise so they can do it quicker, less preparation, so. Thank you.

The Chair: — Seeing no further questions, then on behalf of the committee, thank you very much for your presentation today.

I'd invite our next group of presenters to take a seat at the table.

Welcome this morning to the Standing Committee on Health Care. The committee is 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, Doreen Hamilton, Brenda Bakken, Bill Boyd, and Rod Gantefoer are members of the committee today.

The first order of business that the committee was charged with doing was receiving responses to the Fyke Commission from interested groups and individuals, and we are to report back to the Legislative Assembly what we heard. We will not be making recommendations to the Assembly. We'll be reporting back what we heard from interested people and groups.

Our presentations are half an hour. We apologize for being late today, but this has been happening quite often. We are trying to give 30 minutes, and hopefully within that time we'll have some time for committee questions.

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

Mr. Crowe: — Thank you very much, Madam Chair. To the members and guests, I welcome this opportunity to speak to the Standing Committee and wish to, on behalf of our First Nations, provide this information.

To my left is Jean Bellegarde, who is the director of the First Nations health services program with the File Hills Qu'Appelle Tribal Council and a technician who's involved with the Fort Qu'Appelle Indian Hospital Holding Corporation. That's a body that is charged with the responsibility of building and designing the institution.

On my right is a member of the Touchwood Qu'Appelle District Health Board, Mr. Chuck Ward, who is not necessarily somebody who's involved in the actual activity that has taken place other than the fact that he's on the district health board. But it demonstrates the kind of partnership and the relationship that we've been building within the town, the community, and the surrounding communities — the partnerships that we're looking forward to building on because of the history, the dynamics of our area. And we welcome him, Mr. Ward, to be with us.

To the members and guests, I would just like to say it's my first time to ever make a presentation in this hallowed Chamber. For some of the people that have been in Fort Qu'Appelle, we have one just like it back home, a little bit different but similar function and certainly I'm pleased at the opportunity to be here. I have been introduced on many occasions . . . or a couple of occasions but it's the first time that I've been actually down at the floor, so I welcome that opportunity.

The presentation that I have is to identify the vested interest that we do have in our facilities and institutions relating to health care for First Nations people and the surrounding community. As well we have a framework and a vision for First Nation health care that we would like to expand upon within this presentation. Perhaps it does not touch upon some of the recommendations of the Fyke Commission or even address them, but I think it's important to realize and recognize the fact that these are still out there. Our vision, our framework that we see health care for First Nation communities.

I am making this presentation on behalf of the File Hills Qu'Appelle Tribal Council, and as well the Fort Qu'Appelle Indian Hospital Holding Corporation which represents both the Touchwood Agency Tribal Council and the File Hills Qu'Appelle Tribal Council.

So to get right into it. The File Hills Qu'Appelle Tribal Council is comprised of 11 First Nations communities located in the Qu'Appelle Valley/File Hills areas, with two communities located in the southwest part of the province. These communities include Piapot, Muscowpetung, Pasqua, Standing Buffalo, Neekaneet, Wood Mountain, Peepeekisis, Carry the Kettle, Little Black Bear, Okanese, and Star Blanket. Total population is approximately 11,000 and it spans across four different health districts.

The tribal councils' mandate is that of a political and service institution with a goal to develop a First Nations infrastructure that will provide quality programs and services for First Nations both on- and off-reserve by way of Treaty Four governance and capacity to building at the community level.

Our mission is to assist our First Nations in development of productive, healthy, and safe communities which manage their own destiny. Some of the guiding principles respecting health service delivery include the First Nations world view and the First Nations philosophies based on the holistic view of health that includes spiritual, mental, physical, and emotional components.

The inherent Aboriginal rights are reserved, recognized, and confirmed by the process of treaty making. The inherent rights to health and traditional health were reserved and recognized in the treaty-making process and by the signing of the treaty agreements. The spirit and intent of treaty impacting on treaties and the treaty right to health provides for the implementation and enforcement of both traditional and contemporary First Nations health system.

The traditional system recognizes the traditional healing practices consisting of plants, animals, and minerals. The contemporary health system includes access to medicare, hospitals, dental care, optical, and community health service and programs.

Their respective governments represent both parties to the treaty. The Crown represented by the federal government is obligated to implement provisions of the treaty through federal jurisdiction, and First Nations, collectively, as parties to the treaty, are obligated to implement the provisions of the treaty

through First Nations jurisdiction.

The framework of the Constitution Act, 1982 and the Royal Proclamation of 1763 and the treaty recognizes and guarantees the inherent and treaty rights to both the traditional and contemporary health systems. The framework provides for the recognition of federal government's legal, statutory, fiscal, and trust obligations impacting on the First Nations health system and health rights.

Under wellness, implicit in the creation of health districts several years ago was the belief that cost of health services in the province could be more effectively managed by the use of district-wide coordinated delivery system. The process of health education and grassroots needs reviews was to identify and correct operating inefficiencies in the existing system. This process became known as the wellness model. The model of wellness is a way of viewing the body and mind as a coordinated system which is influenced by factors in the environment such as diet, social factors, attitude, and cultural beliefs.

It is important to note that First Nations have for thousands of years been utilizing this approach to healing. While certain traditions were lost over the years, the traditional healing approach is returning to our communities. Healing in our First Nations communities generally meant treating the physical, mental, emotional, and spiritual elements of our well-being. The general belief is that people get sick because of disruptions in the connections between body, mind, and spirit.

In order for a revamped health system to meet the needs of First Nations people both on and off-reserve, the system must be culturally sensitive to the physical, mental, emotional, and spiritual needs of First Nations. The College of Physicians and Surgeons must recognize the traditional values of First Nations, and work with First Nations in integrating traditional values into the contemporary health system.

Utilization of health services by First Nations. In 1999 the national working group — Health Canada, INAC (Indian and Northern Affairs Canada), and First Nations — on the development of a continuing care framework reported that in Saskatchewan region in 1996-97, on a standardized per 1,000 population basis, hospitalization rates for the on-reserve First Nation population are over twice as high, 110 per cent, as the provincial rates, and 73 per cent higher for off-reserve First Nations population. On average, every on-reserve First Nation resident spends about 7.5 days in hospital compared to just over 3 days for non-First Nations residents.

Chronic conditions constitute another major antecedent risk factor for eventual institutional care. A recent summary of chronic conditions among First Nations in Saskatchewan found that in 1996 there were 9,214 individuals with 9,891 conditions listed in the chronic conditions registry.

On-reserve residents aged zero to 24 years have chronic condition rate of 54.2, one out of every 18 people. The rate increases dramatically throughout each age group from 150.5 or about every six people for the 25 to 44 age group, to 2000 for the 80-plus groups, which is an average of two chronic conditions per person. People over 65 are about eight times as likely to suffer from a chronic condition per person. Diabetes, diseases of the circulatory system including heart and hypertensive disease and . . . how do you say that?

A Member: — Atherosclerosis.

Mr. Crowe: — That word and diseases of the musculoskeletal system are the top three chronic conditions accounting for 53 per cent of chronic conditions.

Within the File Hills Qu'Appelle Tribal Council, there are approximately 480 individuals on the chronic care list on-reserve in 1996. Approximately 55 per cent are diagnosed with diabetes and high blood pressure. A disease related to diabetes is the most common condition.

The future demand for continuing care in the communities and institutional care for First Nations is on the rise. Until we can defeat diabetes and promote healthy lifestyles for First Nations, we will continue to experience high utilization rates in the health system.

First Nations health services program. One service component of the tribal council is the First Nations health services program which provides a basic level of service in the area of home health, water quality monitoring, health education, prenatal nutrition, diabetic education, nursing, and health planning. One hundred per cent of the operational funding is achieved through the federal government and services are limited to on-reserve clients.

In the surrounding communities, the gap in service exists for First Nations off-reserve. One of the main reasons is that First Nations are not at a comfort level in accessing services from non-First Nations who are not familiar with customs and values.

The First Nations health services program was envisioned as the core of the new Fort Qu'Appelle Indian Hospital just as the traditional healing centre would be a focal point of the First Nations health services program. The program was developed based on a series of consultations with First Nations community health staff and other health professionals.

The main areas identified among the workers was that of home care, respite care, palliative care, traditional healing, diabetic care, liaison, counselling services, and employment and training. It is with this vision of identified health services that the tribal council has been attempting to develop programming to meet the needs.

Two new program areas include diabetic centre. The tribal council has identified as a priority the need for increased services in the area of diabetes. In this regard, proposals were submitted to the federal and provincial government for action in the area of diabetes management and control.

The program would see renal dialysis, outreach programming in the area of monitoring and testing, education prevention, nutritional educational services. In addition, it is proposed that a 10-bed unit be established in order to let clients come for four days and regulate their diabetes and receive support in a holistic manner.

Implementing a hostel unit would see a likely decrease in admissions in the acute care side and provide the necessary support system especially to newly diagnosed diabetics.

Diabetes afflicts more than three times the rate of Aboriginal people than that of the general public and the rate is growing. It is having serious health and economic impact among the provincial populations and in the File Hills and Qu'Appelle First Nations. Our population demonstrates one of the highest rates of the disease among the province's First Nation communities. Diabetes compromises the health of the individual and puts them at a greater risk for other ailments such as heart disease, hypertension, stroke, lower limb amputations, and kidney and eye disease.

The proposed program will implement the following strategies to address the prevention of diabetes and care for those living with the disease.

Provide culturally and socially sensitive services. Provide the service of renal dialysis so that individuals do not have to travel distances for treatment. Establish a prevention program that will delay the development of diabetes and its related complications. A case management approach by coordinated services to address the needs of our diabetic clients; regular monitoring of diabetic clients; individual diabetic needs will be assessed.

Individual treatment programs will be established; physical activity; stress management. Regular screening of high-risk groups and individuals will be implemented. Diets and prescription drug panels will be monitored and support given to the clients. Follow-up programs will be established for clients once they are released from the hostel/hospital. Diabetes education and counselling will be provided. Community staff and tribal council health staff will be provided with additional training regarding diabetic interventions.

Our shared vision centre. The tribal council has proposed that mental health be incorporated into the new facility and into program planning. The main thrust of the centre would focus on delivering coordinated and consistent healing programs that would meet the needs of First Nations and non-First Nations through holistic and self-empowering approaches.

It is proposed that the program would adopt the holistic approach with combining traditional methods as well as Western practices and alternative methods. Programming will result in positive short- and long-term benefits in the physical, spiritual, mental, and emotional well-being of First Nations, not only in the tribal council area but to all people in need.

It is noted that under the non-insured health benefits program approximately 33 per cent of prescription drug usage is of the central nervous system, which includes analgesics, antidepressants, sedatives, and the list goes on. On a national basis Health Canada spends approximately $5.2 billion annually on prescription drugs for First Nations and Inuit people.

Together First Nations, Health Canada, and Sask Health must work towards reducing dependence on prescription drugs and the issue surrounding these over-prescribed drugs. It is viewed that First Nations are masking their emotional and mental issues by high utilization of prescription drugs. In this regard it has been proposed by the tribal council that attention be given to alternative methods, such as incorporating traditional healers into a Western model of treatment for people experiencing emotional and mental issues.

The issues of jurisdiction must be removed and new strategies implemented that provides for a more efficient and effective delivery of programs and services to meet the First Nations people.

Commitment must be made by the different levels of government for the diabetics centre to be part of the new facility. Included is the need for commitment from governments for continued operational funding to be provided to support this service.

The Fort Qu'Appelle Indian Hospital. In 1995 the federal government transferred the operation of the Fort Qu'Appelle Indian Hospital to the tribal council. The Fort Qu'Appelle Indian Hospital Board of Directors has been established with representatives from the town of Fort Qu'Appelle, village of Lebret, surrounding municipalities, and the Touchwood, File Hills, and Qu'Appelle First Nations agencies.

This board is operated at arm's length from the tribal council. Budgets are negotiated annually with the Touchwood Qu'Appelle District Health Board for the operational requirements of the hospital via an affiliation and operating agreement.

Under the Transfer Agreement, the federal government guaranteed the construction of the new hospital under First Nation ownership and control. Funding for construction was subsequently transferred to the Saskatchewan government for the construction of three facilities in the province.

In April 1999, the Fort Qu'Appelle Indian Hospital Holding Corporation was established as motion no. 542, made by the owners, dated March 29, 1999. The object of the corporation is to oversee the capital project and to ensure that the special role, nature, and legacy of the Fort Qu'Appelle Indian Hospital for First Nations people is appropriately reflected in the planning and designing of the replacement hospital.

Following lengthy years of discussions surrounding the future role of the new facility, a role review report was completed and submitted to the federal and provincial governments for review and approval. In January 2001, a meeting was held with Pat Atkinson, then minister of Health, to discuss the draft review. A subsequent meeting was held with Minister Nilson in June 2001 to discuss the report and seek commitments regarding the proposed programs.

In summary, the holding corporation is requesting 14 acute care beds; clinical services already being provided; a traditional healing centre with an elder preparation suite; space for existing and expanded First Nations health services program; diabetic centre which would accommodate dialysis services, health promotion, counselling, monitoring, testing, management clinics, and 10-room hostel treatment unit; mental health program which would provide in-patient and outreach services in the area of diabetes, palliative care, and other mental and emotional issues; emergency birthing; fetal alcohol assessment

and programming; and 25 long-term beds for First Nations and non-First Nations.

The issues surrounding the planning and design though is the lack of commitment from government to proceed beyond the schematic design. The five-year agreement between the federal and provincial governments is near expiration with little or no substantial progress made to the project. It appears that the project will be further delayed with the Fyke Commission report and the need for analysis on the implementation of the recommendations.

Commitment is required by federal and provincial government for the capital project to proceed in a timely manner, and further that support be given for the enhanced program which would be lodged in the new facility.

I just want to make another point that is not contained in the presentation, our final point. Presently this is our final day of a traditional healing and medicines gathering down in Fort Qu'Appelle hosted by Okanese First Nation, situated at the Treaty Four grounds reserve. Chief Day Walker and the Okanese . . . Chief Marie Anne Day Walker-Pelletier and the Okanese First Nation have done a great job at bringing together a number of traditional healers and have done a wonderful job of providing wellness for a lot of our people.

The point that I'd like to make is that our traditional ways are still alive and well and they must be respected by western conventional practices, not overtaken but respected and hopefully at some point in time compatible with each other.

That is our presentation, Madam Chair, and I thank you for this opportunity.

The Chair: — Thank you very much for bringing this important element into what we've heard. I'd now entertain questions from the committee.

Mr. Gantefoer: — Thank you very much, Madam Chair. And thank you for coming this morning.

I want to pick up on the statement you made fairly early on in terms of recognition of the traditional healing practices of Aboriginal tradition and heritage, and the work that's being done to incorporate that into current medical practice and how the College of Physicians and Surgeons may be involved in that.

Is there some ongoing discussion in terms of looking at traditional practice and recognizing it under the mandate of the College of Physicians and Surgeons? And secondly, is there some work being done with the College of Medicine, College of Nursing, and those colleges in order to build sensitivity and respect and appreciation for traditional healing practices?

Mr. Crowe: — Thank you for the question. I am not aware of any discussions that are taking place. We certainly can facilitate those discussions on both issues, the ongoing discussions and the culturally sensitive activities. We want to be facilitators in this process; we don't want to just put the problem forward and hope somebody corrects it.

But we do want to facilitate a way and a means of making sure that all is being respected in that respect and certainly we want to be part of that process. And we demand to be part of that in order to ensure that that cultural sensitivity is there. And it is very important and very helpful to a lot of people, not only the First Nations people but non-First Nations people that use these ways as well.

So I'm not aware of any existing discussions, but we would like to facilitate it if we have that opportunity.

There are presently some situations that are taking place individually, but it is very specific to the specific service being provided. And I don't believe that there has been any policy or activity other than certain specific instances where support is given.

Mr. Gantefoer: — At the University of Saskatchewan, there is some initial planning occurring in terms of an integrated health sciences facility and program, the object of which is to bring together the colleges of Medicine, Nursing, Kinesiology, Pharmacy, and a number of the health services programs.

And it may be by way of my suggestion that perhaps the Aboriginal community, through the FSIN (Federation of Saskatchewan Indian Nations) or whatever appropriate body, may find it useful to at least participate or offer participation in that planning process with the university because I think there is a role for having a greater sensitivity and appreciation and incorporation of traditional healing practices into some of those health sciences programs that may prove to be very beneficial.

Mr. Crowe: — Thank you for the recommendations.

The Chair: — Thank you.

Hon. Mr. Melenchuk: — Thank you, Madam Chair. And thank you for your presentation.

I too was intrigued by your first comment with regard to the College of Physicians and Surgeons, because it's not usually a role I see them performing as a regulatory body responsible for the licensing of physicians, the standards of medical practice, and of course the disciplining of physicians that were required.

But they do have a role in terms of quality aspects, in terms of the overall health care system. But I think in terms of the traditional values of First Nations and how this relates to a contemporary health system, that all the stakeholders need to be included in that discussion in terms of how we can have a more culturally affirming health care system.

And we had an excellent presentation with regard to a northern health strategy and the role of a more holistic approach of your health care system. But just based on that comment, I would suggest that a wider base than just the College of Physicians and Surgeons needs to be incorporated, along the lines that Mr. Gantefoer was getting at.

The question I had for your area is with regard to your recommendation for a diabetic centre. Currently how are these services being provided to the First Nations in your area, or do you find that there's inadequate service being provided to

diabetics in your area?

Mr. Crowe: — Very much inadequate service of diabetic care to people in our area. I know of too many people that have died in the past 10 years because of illnesses related to diabetes, either through lack of knowledge or not effectively addressing the health situation and the lack of education that was required.

Presently our home care program, our home care program in the tribal council . . . about 90 per cent of our home care nurses deal with diabetics and ailments related to diabetes. No other symptom or no other disease is catching our attention. We almost have three or four out of the ten staff that we have dedicated to pretty much diabetic services, and it's because we . . . it has been so rampant in our communities over the last few years.

Although it's always been around, it's been all that much more rampant in the last few years that we just can't keep up with the limited resources for the kind of services and the education, the training that's required. And we really need to bring attention and focus to that ailment.

We know that there are ways and means of dealing with diabetes. We have to address the preventative side and the after-effects of it because we . . . just too many of our communities and too many of our people are afflicted with diabetes.

There are just not enough resources that we can . . . We have the infrastructure to develop that. We have the vision. We have the framework. What we need is some will to get behind the activities that we're doing in order to make a difference in the lives of our communities and community members.

I really would impress upon this committee and anybody who would listen to me through the need to move ahead with the model that we have. We have a very sound model. We think it is one that will bring the kind of focus and attention, and for people who think that they might be afflicted, to give them the courage and knowing that there's support there so that they would quickly correct their lifestyle methods and seek the treatment that's necessary.

I just know too many people and close friends and relatives — both my family and my wife's family — that have passed on because of the ailments related to diabetes.

Hon. Mr. Melenchuk: — The reason that I was making that point is we've had several presenters talk about chronic diseases. And we've had several presentations with regard to the support of diabetic education, prevention initiatives, and of course treatment initiatives, and using the chronic disease model and having a centre-oriented approach to the whole spectrum in treating diabetes which is . . . this is a good model that I think many presenters have brought forward.

The last question that I have is with regard to the Fort Qu'Appelle Indian Hospital and this seems to be the lack of movement in terms of a new facility. And the question I have is, where is the resistance? Is it just a lack of coordination between the federal and provincial government? Has the federal government already provided the funds to the provincial government or is there no . . . or the agreements haven't been made? Or what is the actual reason for the holdup?

Mr. Crowe: — Very truthfully, I really believe that the holdup right now is because of the review that's taking place in the Fyke Commission and the government's desire to re-evaluate the kind of health care services that will be delivered in our area and other areas of the province.

I respect . . . I don't mean that as an inflammatory comment; I do say that's the reality. The money has been provided to . . . the dollars have been provided to the province. The province has agreed in principle to fund the project. We have the go-ahead for schematic designs. I would like to be in the position where we are actually talking about the kind of programs, and successful negotiations on the kind of programs that are going to be housed in this facility. So that is the most honest answer I could give.

Mr. Ward: — I'm here as a citizen of Fort Qu'Appelle who just happens to be on the health district board at the same time. The population of the town of Fort Qu'Appelle is approximately 2,500. There is another 1,500 people who live in the surrounding resort communities around the lakes. So we're looking at a base of 4,000, plus around reserve populations of about 11,000, not all of which live within the health district. But we have a huge population to be served by that hospital.

Currently we are receiving acute care, emergency care, and diagnostics through that facility. The facility is old; it is in constant need of repair and should be replaced. I believe we have a population base in that area to support an acute care centre. Even though we are only 45 minutes from Regina, we utilize the acute services in that hospital continuously.

The emergency part of it is used by . . . Any time people go on holidays they do stupid things. They end up with sprained ankles, broken legs, broken fingers; they end up in the emergency room at the Fort Qu'Appelle Indian Hospital because it's there and it's well serviced and they receive good service there.

As the health district we are looking to provide service to our people and currently we are getting it from the Indian hospital, and we are supporting a new facility that will continue on providing the services to our people.

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

The Chair: — One more question to wrap up our presentation.

Hon. Ms. Hamilton: — Thank you for your presentation and your discussion and compelling reasons for the centre in Fort Qu'Appelle.

I guess my questions are of a broader nature because some of the presentations earlier did point to the Fyke report talking about a lack of the Aboriginal component and the further dialogue and discussion with Aboriginal people.

Your comments about a tribal council's mandate is a political in-service institution with a goal to develop First Nations

infrastructure that will provide quality programs and services for First Nations both on— and off-reserve.

I'm trying to, in my mind, put together — if you could help me — how in the larger urban centres and off-reserve, rather than developing separate infrastructures for all of the health care needs, how we would be able to begin that dialogue, who to dialogue with on the kinds of things that would assist in access for Aboriginal people to health care.

I know within the hospital systems there are now the Aboriginal centres, and that they're beginning to understand the need to incorporate traditional values in the health care system. But I think at the grassroots level, at the street level in a city like Regina, how we would be able to have an understanding of providing services or infrastructures, that don't duplicate, but understand and provide services that would be accessible to Aboriginal people?

Mr. Crowe: — That question could be answered in a number of ways. First of all, the need for a dialogue and to ensure that our First Nation or Aboriginal components are part of the health care delivery system, I think, must begin with presentations like this and the continued dialogue and the follow-up that has to take place so that agreements and understandings can be arrived at. That's in the general sense.

In the specific sense, there are a number of ways that we think we can build upon. First of all the First Nations health services program within the tribal council is one group of professional people that have an idea of what kind of services should be delivered and how to be delivered, to be utilized by the existing institutions whether they be district health boards or even clinics, community clinics, for the purposes of providing and sharing information.

I look at one of the shining successes, or at least I think it's a success at this point in time, the Native counselling services operated by the Regina District Health Board and the fine work that's been done by Lynda Francis and her staff to try and create and make awareness of some of the services that are available to them, for First Nations people. She has a background in nursing, she has a background in health care and health care delivery, and is able to do that in her capacity as administrator to be able — and in a culturally sensitive way — to be able to provide that kind of information to individuals that are walking in for whatever reason.

And I think it's those kinds of successes that we have to build upon, and also bringing them into the discussion and dialogue that takes place, that is required to take place, so that we're not necessarily duplicating services but providing the proper service at the first instance.

The Chair: — Thank you very much. And without any further questions, I'd like to on behalf of the committee thank you very much for coming today and adding, as I said before, this perspective to what we've heard. The committee will be recessed until 1:30.

The committee recessed for a period of time.

The Chair: — I'd like to welcome the next group of presenters to the Standing Committee on Health Care.

This is a committee of the Legislative Assembly, and its first order of business is to receive responses to the Fyke Commission or the Commission on Medicare. The committee will be reporting what we've heard back to the Legislative Assembly by August 30. We'll not be making any recommendations. We'll be reporting back what we've heard.

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

We have 30 minutes set aside for presentation, and hopefully within that 30 minutes, there's a few minutes for questions from the committee. If you want to introduce yourself and who you represent, then proceed with your presentation.

Mr. Gerla: — Good afternoon, Madam Chair, hon. members. Thank you for allowing us the opportunity to present a submission to the Standing Committee on Health Care regarding the Commission on Medicare report.

My name is Bill Gerla. I'm a retail pharmacist owner. I've been practising retail pharmacy for 17 years, the majority of that in rural Saskatchewan. I'm from Humboldt and I've been on the Representative Board of Saskatchewan Pharmacists since its inception in 1998. And I'm currently Chair of the board.

And with me is Dean Bradley, the executive director of the RBSP (Representative Board of the Saskatchewan Pharmacists). Dean will give his introduction.

Mr. Bradley: — Thank you, Bill. The Representative Board of Saskatchewan Pharmacists was created in 1998 with the mandate to act as the provincial advocacy group for the approximately 1,100 pharmacists in our province.

From 1998 until June 30, 2001 we operated as a division within the Saskatchewan Pharmaceutical Association. However, effective July 1, 2001 we are pleased to announce that the RBSP is now incorporated as an autonomous, not-for-profit pharmacist advocacy organization, legally and financially separate from the Saskatchewan Pharmaceutical Association.

This move will make the RBSP directly accountable to its membership and more effective in representing their interests. This separation will also help the RBSP to better serve . . . or better achieve its mission statement.

Our mission statement is: to be responsible and accountable to the membership in an advocacy role, supporting advancement of the profession through innovation and facilitation; promotion of professional pharmacists' services; appropriate remuneration for pharmacists' services; protection of the interest of the pharmacists; and public education and health promotion.

Upon learning of the appointment of Mr. Ken Fyke to review Saskatchewan's medicare system, the Representative Board of Saskatchewan Pharmacists spearheaded the creation of the Saskatchewan Pharmacists Coalition on Medicare to serve as a single voice for the pharmacists in our province.

The membership of the coalition includes executive members of the Representative Board of Saskatchewan Pharmacists, The Saskatchewan Pharmaceutical Association, Saskatchewan branch of Canadian Society of Hospital Pharmacists, the Canadian Pharmacists Association, as well as representation from the College of Pharmacy and Nutrition at the University of Saskatchewan.

The coalition represented all aspects of pharmacy practice and representing all these aspects we had advocates and regulators, community and hospital pharmacists. We are confident that the recommendations we put forward in our submission will result in healthier patient outcomes and better use of health system funds by enhancing the contribution of the pharmacists on the health care team.

Our recommendations were submitted to the Commission on Medicare on December 15, 2000 and a presentation was made to Mr. Fyke on February 8, 2001. Copies of those were distributed to the committee members earlier today I understand.

We were encouraged by the recommendations Mr. Fyke made in his final report. The report takes into account the key recommendations made by our coalition, in particular, that pharmacists are the drug therapy experts in our health system and therefore should be more involved in drug therapy decisions. We see tremendous opportunities for the advancement of our profession and the role of the pharmacist to provide optimal drug therapy to the residents of our province and we look forward to working closely with government to implement many of Mr. Fyke's recommendations.

However we are also concerned that some of the recommendations may negatively impact some of our members, particularly those practising in rural Saskatchewan settings. Our submission to the commission was focused on three main questions.

The first question, how can changes be made to the structure of the delivery of health care? We believe that more collaboration between health professionals to encourage a team environment is required. To achieve this we recommend the development of a multidisciplinary committee to develop and implement evidence-based medicine initiatives to encourage collaboration between health professionals. Therefore we will fully support the recommendation to create a quality council that would use evidence-based medicine to improve the quality of health services in Saskatchewan.

We also believe that pharmacists, particularly those practising in community settings, require better access to clinical patient information such as diagnosis, diagnostic test results, and lab values. Our colleagues practising in hospital settings currently have access to this type of information and have made significant advancements for our profession by working with physicians and other professionals making valuable and respected drug therapy recommendations.

Providing access to this clinical information would allow pharmacists, regardless of practice site, to make expert drug utilization decisions. We further suggest the development of an electronic universal health record that would ensure that all essential patient information accompanies the patient throughout the health system with the appropriate access controls in place.

Therefore the RBSP endorses the commission's recommendation for the investment in information systems including the development of an electronic health record with the condition that pharmacists be permitted access to the important clinical information they require to effectively fulfill their role on the health care team.

The second question we looked at was, how can pharmacists increase the cost-effective use of medications? Pharmaceuticals taken appropriately are one of the most cost-effective health interventions currently available reducing costs elsewhere in the system. However, supplying medications without appropriate management will inevitably, inevitably cause cost increases. To achieve cost savings, it is necessary to ensure pharmacists are reimbursed in two ways — first, for the drugs they sell, and second, for the informational services they provide.

We recommend that the government work closely with pharmacists to develop innovative, alternative reimbursement programs that can advance our profession into this new millennium. The key to increasing cost-effectiveness of medications lies in encouraging evidence-based medicine.

We feel that pharmacists' involvement with initiatives such as academic detailing and specialty clinics should be implemented in all health districts throughout the province. We also believe that prescriptive authority for pharmacists, in which the physician would perform the patient assessment and determine the indication for treatment and the pharmacist would choose the optimal drug therapy to achieve the treatment goals, would result in more cost-effective use of medication.

Furthermore, we endorse the concept of a comprehensive drug use management strategy as proposed by the Saskatchewan Pharmaceutical Association which proposes a number of initiatives to improve utilization of drugs in our province.

We are very encouraged by the commission's recommendation that all team members should be rewarded appropriately and allowed to use the full scope of their training and skills. The RBSP completely endorses this statement. As we stated earlier, pharmacists are the drug therapy experts and should be more involved in drug therapy decisions.

Our current system of reimbursement for pharmacy services is outdated and has not kept up with the evolution of our profession. In the last quarter century, pharmacy has expanded its role within the health care delivery system from a profession focusing on the preparation and dispensing of medications to one in which pharmacists provide a range of patient-oriented services to maximize the medication's effectiveness.

Examples of these services include disease-state management for conditions such as diabetes and asthma, medication review, consultations, preparation of patient care plans, advanced patient education, smoking cessation programs, and preventative measures such as wellness programs.

The third question was, what should be the primary health care

role of the pharmacist? The primary health care role of the pharmacist should be based upon the positive attributes of pharmacy practice, namely the three A's. Pharmacists pride themselves on being available, approachable, and accessible. We can get the most out of these factors in a number of ways, particularly with respect to public education and awareness. Any significant change to the delivery of health services must be accompanied by public education.

Because of the high level of trust, availability, and accessibility of pharmacists we urge this committee to consider that pharmacists could be the key disseminators of information such as the roles and functions of various health providers in the system, how these professionals work collaboratively, how and where to access these professionals, and when it is appropriate to access health services.

The commission recommends the formation of primary health services teams in which the health providers work collaboratively to ensure the right set of skills is applied in each situation. We endorse this recommendation since pharmacists, in addition to being the drug therapy experts, would also improve primary health services by acting as the key information providers about the health delivery system.

I'll now turn it over to Bill Gerla for the remainder of our presentation.

Mr. Gerla: — The Representative Board of Saskatchewan Pharmacists represents all pharmacists practising in our province in community and hospital settings, in urban and rural centres. Our members have told us that they have serious concerns with some of the commission's recommendations.

Since the Fyke report on medicare was made public, we have received numerous calls from pharmacists regarding the recommendation to close up to 50 rural hospitals. In today's environment the pharmacy service is dependent on prescription volumes. In communities where hospitals close there will eventually be no physicians. Without the physicians the pharmacies will close.

On a daily basis pharmacists are giving medical advice on non-prescription products or therapies. This advice in many instances saves the health care system money by preventing doctor and emergency room visits and by improving the quality of health of individuals. Without pharmacies where will these people go for advice.

The Fyke report talks about setting up primary health care teams which involve the pharmacist. We agree that pharmacists should be one of the members of the team. We do not feel that these teams can or should replace the traditional structures that are currently in place, i.e., hospital/physician/retail pharmacy relationship. Pharmacists are ready and willing to take on their expanded role. There are two things holding us back right now. One is reimbursement for these services; two, the demand on pharmacists is increasing at a greater rate than the availability of pharmacists.

We mentioned reimbursement earlier. The demand for pharmacists provincially, nationally, and globally has increased dramatically in the past two years, and it is only going to continue to increase. Under the mutual recognition agreement for the profession of pharmacy in Canada, the provincial borders opened up on July 1 of this year.

These reduced barriers, along with higher wages in other provinces, have led to an increase of University of Saskatchewan pharmacy graduates leaving the province. To be competitive we have to increase wages and we have to create an environment in which pharmacists can practise as a primary member of the health care team. We want to work with the government in order to benefit pharmacists, patients, and the overall medicare system.

In closing, we wish to emphasize that pharmacists, optimally deployed and involved in drug therapy decisions, can and will make a big difference in the health outcomes for Saskatchewan residents.

In today's environment, we feel that pharmacists are suboptimally deployed. We are confident that adapting the structure of the health system to allow pharmacists to become more involved in drug therapy decisions will result in more optimum drug utilization.

We urge the committee to consider our recommendations. We look forward to working with the government to further develop and implement the recommendations contained in our presentation.

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

Hon. Mr. Melenchuk: — Thank you very much for your presentation. The question that I have is with regard to your comments on rural Saskatchewan and what we'd heard from previous presentations.

Now there is a good network of pharmacists available throughout Saskatchewan, is my understanding, but you're having a problem with recruitment because the demands are exceeding the supply.

You've maintained that the current positioning of pharmacists, hospital/physician/retail pharmacy. I'm just wondering about rural Saskatchewan, with the development of primary health care teams. Do you still see the existence of retail pharmacy outlets on Main Street, Saskatchewan, even though that pharmacist may be incorporated into a primary health care team in that area?

Mr. Gerla: — Yes, we do. The retail pharmacy, the pharmacists like I had mentioned, does a lot more than just the prescription business. We do do over-the-counter medications. And I — working in a retail rural centre, and we are an extended hours store — I see numerous people in the evenings. I get numerous calls, almost on a daily basis, and I'm giving advice.

And without us being there these people are going to have to . . . I know in many instances they'd be ending up at the hospital for emergency measures. There are many instances where mothers will phone, and over the phone I'm able to give them advice and save hospital visits. So I definitely feel that

there still is a need for retail pharmacies in rural communities.

Hon. Mr. Melenchuk: — The next question that I have is with regard to the linkages between pharmacists, physicians, and what we've heard from many presenters from rural Saskatchewan that they will not be able to recruit and retain rural-based practices if those physicians do not have access to acute care beds.

So obviously this has an impact for your organization. If there is a decrease of acute care beds in rural Saskatchewan and there is a loss of physicians, and that obviously means there's likely going to be a loss of that pharmacy location as well. So you would probably support what many of the presenters have told us that there needs to be acute care services accessible to local communities in rural Saskatchewan.

Mr. Gerla: — Yes it is.

Mr. Bradley: — That's correct.

Hon. Mr. Melenchuk: — And the final point that I have with regard to your presentation is the reimbursement aspects, and could you elaborate. Are we talking about salaried models for pharmacists, or are we looking at incentive contractual arrangements, or what did you have in mind along that line?

Mr. Bradley: — Well the current system of reimbursement is based . . . you know the pharmacy receives a fee for each prescription that is filled, and that suited the profession, you know, maybe 25, 30 years ago.

The profession has evolved to a point where the dispensing is sort of . . . it's sort of an aside now, and it's the information, it's the counselling, it's the identifying drug-related problems, contacting the physician to make recommendations on how to resolve the drug-related problems. That's really what's become sort of the core of the profession now and yet the reimbursement hasn't reflected that to this point.

We're examining several models that are out there. It's still . . . the ones that we're currently discussing with government, with the drug plan and extended benefits branch, is sort of still a fee-for-service type of model. I realize there's other models out there, there's capitation agreements, there's salaries, there's other ones. And we would be, you know, open to looking at everything that's out there. We need to do something to better reflect what pharmacists . . .

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

The Chair: — Any further questions from the committee? Seeing none, then thank you very much for your presentation.

I'd invite the next presenters to take a seat at the table. Good afternoon and welcome to the Standing Committee on Health Care. The standing committee is a committee of the Legislative Assembly, and its first mandated activity was to receive responses to the Fyke Commission or the Commission on Medicare.

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

The committee will be presenting back to the Legislative Assembly what we've heard in our hearings, such as here, and what we've heard in our written submissions. We will not be making recommendations. We'll be putting a report in of what we've heard, a compilation of what we've heard.

And we've set aside half-hour blocks of time for presenters, and hopefully within that half an hour, you'll leave some time for our committee members to ask a question or two. If you want to introduce yourself and then begin your presentation.

Mr. Palko: — Madam Chair, and committee members, first of all we want to thank you for the opportunity to present our views here today.

We are here on behalf of the town of Hudson Bay, the rural municipality of Hudson Bay, and all of the citizens in surrounding areas that access services in Hudson Bay. And we've come to express our concerns regarding some of the recommendations in the Fyke report.

My name is Harry Palko. I'm a 40-year resident of the town of Hudson Bay — 35 of those years were spent in the school system — and my wife and I have chosen to retire in that community where I am currently serving as mayor.

My co-presenter is Rosalie Daisley. She is a practising RN (registered nurse) in our acute care and long-term care integrated facility. She's a resident of our RM (rural municipality) and is our representative on the Pasquia Health District Board.

Hudson Bay is a unique, somewhat remote community of 2,400, located in the northeast part of the province. We also have about 1,400 people in our rural municipality and a very large catchment area that is hard to define in terms of population. It all depends on the activity with hunting or snowmobiling or firefighting.

The most accurate number I can give you for our health service area would be that our medical clinic currently has about 5,000 active files. And those clients are cared for by currently five physicians, though not all practising full-time in our clinic.

We are a 24 hour/7 day a week community. Our main industries are forestry, agriculture, and tourism. We're also a loading base for the provincial fire protection service.

We would like today to provide you with some scenarios of typical work life as it happens in some of these major industries.

Ms. Daisley: — Looking first at the forest industry, an area of 2 million hectares or 4.5 million acres is managed. This area is bordered by Cumberland House to the north; Endeavour, Usherville to the south; Carrot River to the west; and the Manitoba/Saskatchewan border to the east.

In this area 1.5 million solid cubic metres of wood is harvested

annually and 132,500 man hours are spent involved in that harvesting; 24,000 semi loads of wood are hauled to the OSB (oriented strand board) and plywood mills in Hudson Bay annually — and we have two OSB mills — and 5,000 truckloads of wood are taken to Carrot River each year. The average haul is 120 kilometres one way for a total of 5.76 million kilometres per year.

As well there are 3.5 million seedlings planted yearly in the reforestation projects.

The timberland area is managed by 25 full-time forest lands employees. The harvesting operations employ 450 to 500 people six to nine months of the year, while reforestation employs 100 to 150 people for two to three months of the year.

As well there are 450 employees working in the three mills in Hudson Bay 24 hours a day/7 days a week.

Forestry harvesting operations are potentially hazardous — rated in fact second on the list of high-risk occupations.

Mr. Palko: — To protect that forest industry we're fortunate to have an excellent fire protection service. During the fire season, 15 firefighters are on standby with the potential for more fire crews depending on the fire hazard level. At times, we could have an additional 500 people live in the Hudson Bay area when active firefighting is taking place. On average there are approximately 50 fires per season in our area.

Increased air traffic in the Hudson Bay area is a given during firefighting season. Helicopter flights in and out number six times per day dependant on conditions. As well, planes fly in from Prince Albert and La Ronge to refill with fire retardant chemical on a regular basis, and these flights increase in frequency dependant on the fire situation.

Ms. Daisley: — Looking at tourism. While Hudson Bay sees a large number of tourists during the summer months, it is a hive of activity during the winter and fall months with snowmobiling being a major attraction. During rallies, as many as 75 machines are in motion per day. We have 594 miles of groomed trails, which are used by 8 to 10,000 snowmobiles annually.

As well, hunting seasons lasting from late August through into December attract a large number of people. These people come from any place in the US (United States) and Canada to hunt bear, moose, elk, and deer in the hundreds of square miles of prime forest land.

Mr. Palko: — And the final major industry we want to address is agriculture. The Hudson Bay Dehydrators Co-operative is part of the agricultural-based employment in our area. The Dehy ships an average of 10,000 tonnes of pellets by rail per season from its plant just west of Hudson Bay. There are 25 people employed in full-time and seasonal capacity.

As well, grain and mixed farming provide economic activity. Farming is well known as a high-risk activity across our province, and certainly Hudson Bay area has seen its share of time-loss accidents through machinery and chemical incidents.

These scenarios listed are all high-risk for injury, and even when safety is stressed and good intentions are the norm, the fact remains that accidents happen, and they have happened in the past in our community.

Ms. Daisley: — In the Fyke report, it has been recommended that there be a deletion of acute care services in all but 14 regional hospitals outside of Regina, Saskatoon, and Prince Albert.

We ask you then, where are the people of Hudson Bay and area going to access immediate 24-hour emergency care? Will we have laboratory and radiology services available? What will happen to our dental, optometric, and chiropractic services if there are no diagnostic services to aid such care? What ambulance services will be available in our community if the transfer of people is necessary? And will the qualifications of our ambulance personnel be sufficient to handle emergencies if trauma care is more than an hour away? And who will be responsible for the costs of accessing care at a long distance?

We are some distance from any major centre — 116 kilometres to Tisdale, 156 kilometres from Melfort, and 330 kilometres from Saskatoon. Some of our seniors are on fixed incomes and would not be able to afford the increased costs that distance to acute care services would add. We feel certain that there will be a movement of senior citizens out of our rural area if they cannot access both acute and diagnostic services close to home.

Mr. Palko: — The number one concern of people moving to our community addresses what health care services are available. Questions regarding acute care services and medical staff top the list. A decrease in these services will mean that people will look elsewhere for employment. Weyerhaeuser, Saskatchewan's largest forest-related employer, has had some difficulty in the past attracting the specially-trained personnel it has needed for operations in rural settings.

However the presence of a range of good quality health care services here in Hudson Bay has been one of the major reasons that some individuals and families have overlooked our isolation to move here to work. Lack of medical care will have a negative impact.

Industry is vital to the growth of our Saskatchewan economy but if we're not providing the services necessary to promote such growth, including local health care services, we will see a decline in our province's ability to support its residents and encourage growth in all sectors.

The Fyke report has suggested that the present number of districts be reduced to 9 or 11. The monies saved by combining these smaller districts we feel will be minimal. The Pasquia Health District, of which Hudson Bay is a part, and our local integrated care facility, have been able to operate within budget to provide quality health care to the residents of our area.

We also feel the loss of local participation in health care would be to our detriment if districts became larger. It has also been suggested that people working in health care no longer be allowed to serve on district health boards. Our past experience has been that such local people have provided invaluable experience to our health boards.

Ms. Daisley: — Health care services like the primary care project in Hudson Bay are positive examples of creative ways to manage health and illness. Through this project, medical, public health, nursing, mental health, and preventative care supported by acute and diagnostic services, provide a range of care close to the client's home. These innovations enhance what we already have to provide long-term wellness, and to save money.

On behalf of the larger community of Hudson Bay, we would ask this committee to consider the unique needs of our residents and visitors. For the resident who was injured in the mill with a life-threatening head injury, for the person on the snowmobile who's leg was broken on a remote trail, for the visitor suffering from anaphylactic shock at a lake an hour's drive east of Hudson Bay, for the man who suffered a life-threatening back injury in an eastern bush operation, for the hunter who had a heart attack and needed immediate medication, for the farmer whose limb had to be cut free from the power takeoff of his tractor, for the plane crew at a crash site in the bush, acute and diagnostic services located in Hudson Bay are a must.

In the Hudson Bay catchment area there is no time limit as to when an emergency situation can occur. Our community has industrial-related activity at all hours of the day, each day of the week. To offer our residents in this area of the province an equal chance at good, quality living, we must be able to aid them in their distress close to home at all times.

Mr. Palko: — We would like to thank you again for this opportunity to present our views. We look forward to future discussions on this issue. Thank you.

The Chair: — Thank you very much. And I'll take questions from the committee.

Hon. Mr. Melenchuk: — Thank you very much for your presentation and for being here this afternoon. The question I have is with regard to the physician complement that you have in Hudson Bay.

Now you have five physicians, some of them not working full time, but I understand you have a fairly stable physician group there that have been there for some time. Is that correct?

Mr. Palko: — We recruited the current Hudson Bay medical group about 20 years ago, around 1980. We've had to replenish single members from time to time. Recruitment in Hudson Bay is a challenge as in any area in rural Saskatchewan, but we've been able to meet that challenge.

We have an excellent situation, we believe. We have a partnership between the Pasquia Health District, the community, and the Hudson Bay medical group and we share the responsibility of recruiting.

Hon. Mr. Melenchuk: — It's my understanding that, I think 20 years ago, there were practice location grants available from the provincial government to allow physicians to set up practices in rural and remote areas of Saskatchewan. And I think that group did benefit from that grant.

Since then we've also had negotiated incentive packages between the Department of Health and the medical association for rural and remote incentives to attract and retain physicians in rural Saskatchewan. This has been the direction of government and I think that that direction will continue.

It is my understanding that the physicians in Hudson Bay are comfortable with the facilities that they have and the practice, type of practice that they have. And it is your belief that loss of acute care services in Hudson Bay would probably mean the loss of your physicians and of course a fairly significant blow to the community as a whole. Is that correct?

Mr. Palko: — Absolutely. We have very excellent health care services there, surprising to many people because it's such a small centre. There certainly is life-saving capabilities there in personnel and equipment and it would be a tremendous blow to lose that.

Hon. Mr. Melenchuk: — The final point I just wanted to make is that I know several of the physicians that practice in Hudson Bay and they are considered experts in the practice of rural and remote medicine and certainly have been on numerous panels and committees in terms of creating rural practice as a specialty in Canada as a whole, in rural and remote areas.

So recognizing the location of Hudson Bay, the fact that it is a long way from many other jurisdictions, and because of the nature of the industry within Hudson Bay, it's certainly the feeling and I think of the Pasquia Health District that it wouldn't be possible to lose acute care services in that community. So that's the only point that I wanted to make. Thank you.

The Chair: — Seeing no further questions, then thank you very much for coming today.

I'd invite you to come right down to the table. We're going to be able to start early if that's okay with you.

Welcome to the Standing Committee on Health Care. I know you probably needed a minute or two to collect yourself but we're running a little early for a change.

As I said, welcome to the Standing Committee on Health Care. This is a committee of the Legislative Assembly and our first order of business is to receive responses to the Commission on Medicare or the Fyke Commission. We're not going to be making recommendations to the government. We're going to be reporting the responses of what we've heard.

This is an all-party committee. I'm Judy Junor, the Chair. Dr. Melenchuk is the Vice-Chair. Andrew Thomson, Kevin Yates, Doreen Hamilton, Brenda Bakken, Bill Boyd, and Rod Gantefoer are with us this afternoon.

We've set aside half an hour for presenters and hopefully within that half an hour we'll have some time for questions from the committee members. If you want to introduce yourself and where you're from, you can begin your presentation.

Mr. Thordarson: — Madam Chairman, we're from the RM of Elfros No. 307, Elfros, Saskatchewan. I am the reeve, Evans Thordarson, and with me is our deputy reeve, Henry Bzdel, and

we both will have some remarks to make.

Good afternoon to everyone including Dr. Melenchuk. I must, before we start, point out I'm quite familiar with Saskatchewan's medical system, our hospital systems. I do carry with me the odd chronic illness that one year when I did check my expenses incurred through Sask Health it was over $50,000. So I've had a little bit of experience and certainly recognize the difference between the facilities available in rural Saskatchewan or in a major city hospital.

However what we're concerned with, our RM, is that we consider the recommendations of the Fyke report to be basically another attack on the infrastructure of rural Saskatchewan, and this is being done at a time when the provincial government is talking about revitalization of rural Saskatchewan. And certainly as farmers and as members of the RM council, that we're very, very concerned with revitalization rather than the destruction.

One thing that we must point out is that a rural community is an entity and that our senior citizens are a very, very vital part of that entity, and it doesn't make us happy to see them leave. And we've had quite a few experiences of that because of the fear of removal of health services from rural Saskatchewan that people having spent . . . the families having spent a hundred years in the community have left sons and daughters and grandchildren behind to move to the city where they would be closer to medical care, and we don't want to see a further erosion of that.

We would like to emphasize that these communities were built by our grandparents or great grandparents and they have served the community for at least four generations. We would have to point out that it was never easy for these people. We're well aware of their history in developing the total infrastructure including hospitals, municipal hospitals, and municipal doctors as well as free-standing doctors, that we're well aware of the thing. And we must emphasize that there is actually recurring within the communities is a consideration that if we have to protect our communities, maybe we have to revert to the example of our forefathers and mothers and do it on our own and do it without the participation of the province. And the feeling is that strong.

And as I pointed out, and I'll emphasize again, I have used the medical system and I'm well aware of the advantages and disadvantages, yet people need that security in the community. That in our community we just built an $8.3 million senior citizens facility. That cost the rural ratepayers — ignoring income tax but just simply on our municipal taxes — it cost us about three and a half million dollars.

Possibly we should simply start doing this on our own and suggest maybe that the provincial government withdraw from it if you're going to be involved with it and withdraw the services — not at our request.

There are several other things that we would like to deal with and I believe that Henry Bzdel would like to go into them. So if I could pass it over to him.

Mr. Bzdel: — Yes, I'll just touch on what Evans said here. And then I guess, looking here today, we've got members of parliament from both sides of the government here. Talk to the people out in the country there. They're petrified. They are totally petrified that there's going to be no hospital because to them it's very important.

Regina or Saskatoon is a long ways from Elfros if we have no hospital closer than that and an ambulance there.

And the other thing I'd like to touch on a little bit is in this, in Mr. Fyke's report here. It's very interesting where he got the information there. Now there's a 9-district model and an 11 district model there. And if you guys have a copy of that you have a look in there.

Like to me, we don't want to lose any hospitals. I don't want to go one town against another; one RM against another one there. We need them hospitals there. We can't lose any more there.

But I'm trying to figure out where the wisdom was here in drawing up this here report here. And I wish Mr. Fyke could be here. He signed this thing. At the end of the day he should be here to be accountable for this thing here.

How in both scenarios there — like we're in the Living Sky Health District there — that Wynyard is not there for a hospital there. Like we got a population, we got major industries in there, and stuff like that. And in neither model district Wynyard is not even in the picture there.

And what is really hard to figure out there, they have Lanigan there, which is great. I want Lanigan . . . we want Lanigan to have a hospital there. Lanigan is 18 minutes from Humboldt; where Wynyard, if you look at that map there, we're central from Yorkton to Saskatoon to Regina. We're right in the middle and we don't even get on the map. I have a real problem with that.

And also, Evans Thordarson and myself and the council feels that . . . We're in favour of bigger health districts. What we have is not working. You know it and we know it, what we have there.

And I guess the key is, is you got to hire some key people in there and make the right decisions, not political decisions or whatever — everybody trying to protect their turf there.

But definitely the money's all going into management, not into the nursing and the hospital where it should be there, and I think you people are aware of that. It's just . . . it's all top heavy, these districts here.

Mr. Thordarson: — Well I would just say in regards to this that we do believe — and we argued this with the commission on municipal amalgamation last spring — that one of the reasons we were very reluctant to look at it is because of our experience with the health districts. And I think the crux of what Henry was saying about larger districts is we believe that we are suffering because of mediocrity in management. And we would suspect with larger health districts we could get a different level of management.

I think that's part of the reason . . . well we just wonder how many competent managers there are around. And possibly if we

saw, you know, a dozen rather than the number we have now or health districts, we might be better served that way, as well as possibly it would also be less expensive.

We realize the problems in attracting rural doctors but I think that most people are ready to fight, conduct the struggle. And like I said, the preference in rural Saskatchewan as far as we can read is to do it ourselves if the government doesn't want to do it or doesn't want to participate.

We recognize that you've probably heard all this before and many times maybe we're less polite than some of the other delegations you've had in, but we certainly hope you take this into account. We hope that you understand that the economics of a community is not simply dollars and cents. It's too easy to make decisions on the basis of dollars and cents.

And we recognize that what we're suggesting could be more expensive but there's a human element in there, in the economics that you can't account for in dollars and cents. I've never read anything by some of these health care economists, and I don't know if they go into that at all or not. We believe that very, very strongly.

I guess that is all we have to say and we thank you for listening to us. And we trust that we're in a new era in Saskatchewan and the attitude toward rural Saskatchewan, and that the government will accept that to have a community, it costs money. So we thank you.

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

Mr. Boyd: — I want to thank you very much for your presentation here this afternoon. I think it certainly speaks to the concerns that people in many communities in rural Saskatchewan and northern Saskatchewan have with regard to the Fyke committee.

And the question that I would have falls in the area of acute care services. Do you feel that if there is a loss of acute care services in your area, that along with it will follow the loss of doctors, nurses, pharmacists, and other businesses from the area?

Mr. Thordarson: — Definitely. Definitely. And you know, if we were going to be totally honest and frank, you know they . . . the suppose the major element here is the fear of — and it's not simply the senior people, it's basically everyone with the availability of health care — whether it's a rational fear or not, it's a real fear; it's a political fear. And I think rural Saskatchewan's prepared to act on its own.

Mr. Thomson: — Thank you, Madam Chair, and I'd like to thank the gentlemen from Elfros also for their presentation this afternoon. I have a question about the type of services in the area and what the expectations are.

Obviously people from across the province — rural citizens, urban citizens — all get our health care from different places and at different levels. I think you allude to that at the start of your presentation. What is the expectation as to what kind of services you should have in the local community? What kind should there then be at the, I don't know, what the nearest regional centre would be, probably Humboldt in this case, and what would you expect in terms of services in Saskatoon or Regina?

Mr. Thordarson: — Well I don't know how well I can answer that; maybe Henry could answer it better. But certainly we expect a hospital if a hospital means acute care; and we expect trained nurses and nurses on duty 24 hours a day and doctors. And enough doctors that life is tolerable for the doctors. They're no different than we are. Life changes. The doctor of 40 years ago is as rare today as the farmer of 40 years ago. They want a little bit of freedom. There has to be the ability to not be on call 7 days a week and 52 weeks of the year.

I think that we have to put some emphasis into clinics, community clinics. It was a bad political word at one time and I guess that we've grown past that and we can use the term community clinic now. I think we require that.

And as I said that would include some acute care. I think that our system . . . our service town is Wynyard and the system we have now with the senior citizens home built basically onto the hospital I think is a very good idea. We maybe spent a little bit too much money building it but the architecture shall be interesting for a few years.

As far as Saskatoon or Regina is concerned, or the city hospitals, that certainly there has to be access to them. My own knowledge of them is that my family physician is in the University Hospital, the Royal University Hospital in Saskatoon. That's where I go.

And I think that that service probably has to be increased because I do believe that and I recognize that the level of expertise . . . well a medical degree isn't a medical degree isn't a medical degree, that the standard of proficiency is very different, and that there should probably be that screening system in the city hospitals rather than direct referral to a specialist from the rural doctor.

And who knows what's going to transpire in people's minds in 20 years.

The other problem is duration. We have a situation of a young woman who was an emergency procedure in City Hospital in Saskatoon, was sent home the next day and ended up — 200 miles out of Saskatoon — and ended up in a Regina city hospital a day later. You know, that sort of thing that there probably has to be some emphasis put into observation. That is you either do that in the rural hospitals, the referral back to the rural hospital for observation, or those facilities have to be made available in the city.

I don't know if Henry has anything more to say.

Mr. Bzdel: — Yes. Are you done?

Mr. Thordarson: — Yes.

Mr. Bzdel: — I would just like to add I guess . . . and I suppose we're trying to protect our turf there. And like Mr. Thordarson said, like Wynyard is the main hospital for the ratepayers in the

RM of Elfros and Big Quill and all around.

Also you people got to be aware of, Wynyard has industry there. And we got Lilydale which is very big and it's growing. The talk is twice the size of what it is now and I think they believe about 450 to 470 employees now. And we got Quill Resources there.

The other thing that we have that a lot of people forget, we have three First Nation peoples bands all around Wynyard that all come to Wynyard, two south and one from the east there. I shouldn't say all but I'll bet you the biggest part of them, they utilize the Wynyard facility there.

And the other thing that I think should be made aware of there, on the Yellowhead Highway, which is a very busy highway, Wynyard is the biggest town between Yorkton and Saskatoon and you need a hospital. You need acute care beds there if there's ever an accident or whatever there.

We have four doctors in Wynyard there. How will we ever keep them there if there's no hospital? They're gone. And we're very fortunate to have four doctors in that town there.

Mr. Thomson: — By way of conclusion I would say this certainly emphasizes many of the points that we've heard over the last couple of days as we've met with people from Central Plains District, Living Sky District, Wadena, Wynyard, who have talked about the need for us to look at it beyond just a district level which I think you're saying today. That we need to take a look at the needs of the area and understand the need for 24-hour care. I think even Fyke recognizes that, that there's a need — a large need — in the province for 24-hour care.

The questions that you've raised about how we keep the doctors, how we keep the diagnostic services I think are questions that have got to be addressed before changes are made.

And by way of conclusion I want to say obviously, you know, thank you for coming today. The government has obviously made no decisions about what, if anything, out of Mr. Fyke's report will be implemented.

One of the good things about this exercise is I think it's allowed us to have a good discussion as legislators with citizens throughout the province and to hear first-hand the concerns. So you've done I think a very good job articulating those and it certainly reinforces in my mind many of the discussions we've had over the last couple of days. So thank you very much for travelling here.

Mr. Thordarson: — I'd just like to add one thing and that is that I'm a founding member of the — and now vice-president — of the Agricultural Producers Association of Saskatchewan. It's a new organization and if we have one objective, it's the revitalization of rural Saskatchewan. And certainly this is a fundamental part of it we think.

So we thank you very much for hearing . . .

Hon. Mr. Melenchuk: — Thank you very much, Madam Chair. I just have one question. Many of the presenters that have come forward talked about the recommendation in Fyke for travel times to acute care services. In Fyke it's referenced at 60 minutes and 80 minutes. Most of the presenters and a large number of board members from various health districts felt that the current standard for physician travel to access acute care . . . to be on call for an acute care institution is 30 minutes and in some occasions 45.

Would you agree that it would be more suitable that we have that 30 minute time frame in terms of travel to an acute care service as opposed to what's recommended in Fyke of 60/80 minutes?

Mr. Thordarson: — Well as I suggested I believe to Mr. Boyd, that a lot of the concern is simply a fear. I emphasize our grandfathers and fathers and, you know, they were a lot further away. I guess that it was because of that that they did build the system that they did build.

I don't know. I guess it's a question of . . . I guess the further away you get the lack of security. And I think realistically I don't know if 30 minutes or 60 minutes is that much different in most . . . in the vast majority of cases. But it's that insecurity that people get and more insecure as they get older, you know, with that distance. They don't relate maybe to the hands on the clock so much as the conceived idea that that's a long way.

Hon. Mr. Melenchuk: — Just a final comment. Towards the end of your presentation you talked about the human side of the economics, more above and beyond dollars and cents. We have had several presenters who talked about population health and the determinants of health, and their feeling was that things like employment, supportive communities, security of person in their homes in communities, and accessibility of services are important determinants of health. Thanks.

Mr. Bzdel: — I'm sure that you people are aware of it, but we had a meeting in Wynyard there and the paramedics were at that meeting, and it was a real eye-opener for me there and maybe you people are aware of this. And he said something has to change in Regina and Saskatoon and these major hospitals, and I guess where he was coming from there, and I didn't know this was happening, and for example, they rush a patient in from Wynyard to Saskatoon. He can spend there six hours waiting for a release. They don't know if they're going to keep the person or send him home. He sits there.

Meanwhile there could be two heart attacks in Wynyard. We need him there. He's six hours in Saskatoon hospital just waiting to get a release so he can go back, and he said without that piece of paper you can't leave until they let you go there. To me, I think something could change there, like something . . . it shouldn't take that long, I guess. Either they have a bed for him or they don't or they're going to keep a person in or they don't and let the person get back to where he's needed.

And I wasn't aware of that, maybe you people were. But he said you could spend six hours easy waiting before you get that slip of paper to leave to go back and a lot of times without the patient. But they just . . . you can't go unless you're released there.

The Chair: — Thank you very much. Seeing no more

questions, on behalf of the committee, we really do appreciate the time you took to come and present today. Thank you again.

Mr. Thordarson: — Thank you very much. I'd just like to say in leaving that we realize now why there's so much chatter during the legislative session is that the acoustics here are so bad you can't hear anyway.

It was very nice having an opportunity to meet you and I must say that, myself, I'm impressed by the individual MLAs who are here and that their interest is such that they're sitting here listening to the same stories.

The Chair: — The committee will recess for 15 minutes.

The committee recessed for a period of time.

The Chair: — Good afternoon and thank you for coming early. We're actually ahead of ourselves.

This is the Standing Committee on Health Care, and it's a legislative committee. Its task, its first task is to receive responses to the Fyke Commission and report back to the legislature on what we heard. We won't be making recommendations; we'll be just reporting on what we've heard during these hearings. We've set aside half an hour for the hearings, and hopefully within that half an hour we have some time for questions from the committee members to yourself.

It's an all-party committee. I'm Judy Junor, the Chair. Dr. Melenchuk is the Vice Chair. Andrew Thomson, Kevin Yates, Doreen Hamilton, Brenda Bakken, Bill Boyd, and Rod Gantefoer are our members today.

If you want to give us your name and if you represent anybody or any organization and then begin your presentation.

Mr. Wenaas: — Yes, it's all right to sit here, is it? Yes, my name is Carl Wenaas. I'm from Eastend. I have what I call a small, single-person think-tank which I call High Country Consultancy. I'm a little younger than our dinosaur and I don't have as many big teeth.

Now you've probably received a supplementary presentation like this which you've just received. I will not be reading from this. This I have distributed for background information. I want to direct my comments more particularly to the report of the Commission on Medicare once I have drawn in some of the relevant observations from the material I have distributed.

In what amounts to a preamble to my presentation this afternoon, I have prepared a few pages of text and tables, which sketch the broad outlines of developments in health care of the 20th century. This is intended to give some perspective on what is described in an overly flamboyant way sometimes as a health care crisis.

What we have seen in the 20th century was the recognition of the germ theory of disease and the marshalling of our forces against infections and communicable diseases caused by germs. Sanitation, the creation of safe water supplies and sewer systems, turned cities from the hellholes of contagion and death that they had been for centuries. The beginnings of powerful scientific applications of vaccinations and inoculations began to strike down the communicable diseases that once spread from person to person by germs, those tiny enemies of health.

I have pointed out in the material that this resulted in a very sizeable reduction in infant and child mortality and a consequent substantial increase in life expectancy at birth. But I've also pointed out that life expectancy at age 20, 40, and older was not much different in 1971 than it was in 1871, which you may find surprising. It merely reflects the fact that the 20-year-olds who were the survivors of a whole host of childhood diseases — and I was one of those survivors — had developed the resistance apparently to other diseases.

The discovery of anesthesias, X-rays, and the application of sanitation made invasive surgery possible. And this has been largely responsible for the more gradual increase in life expectancy of the older population, which has taken place in the last quarter century. New drug therapies have had the same effect.

The health care workforce has drastically changed also. A century ago, physicians were practically the only health care workers, and his work was largely performed through home visits. Very few patients were treated in hospitals.

Much of the 20th century was spent in the joint expansion of hospitals and the nursing profession. On the other hand, the ratio of physicians to population was changed very little. Births, once occurring almost entirely at home, were transferred to hospitals leading to sharp reductions in infant mortality and in maternal deaths.

Surgery of course required the specialized facilities of hospitals, and more and more people went to hospitals to die rather . . . to die there rather than at home. Recently emphasis has shift from hospital to home care, although surgical interventions have become more elaborate thus requiring a greater range of hospital facilities.

Paid health care . . . or the health care industry has grown from about 1 per cent of GDP (gross domestic product) a century ago to about 9 percentage . . . to about 9 per cent today. Most of this increase has taken place in the last half of the 20th century. By 1950, health care expenditures had risen to only 2.6 per cent of GDP.

Measured crudely by life expectancy at birth, that smaller increase in the ratio of health care expenditures to GDP was more cost effective than the much-increased expenditures since 1950. The increased expenditures of the last half-century have been reflected in the increased life expectancy of older people although at higher costs for each year of life expectancy that was added.

Reports like that of the Commission on Medicare are necessarily made within the context of the long-term growth of health care expenditures. What level of expenditure is appropriate? The Fyke report says no more money is needed in Saskatchewan, yet health care expenditures in the United States, driven more largely by market forces, are about double in per capita terms and the US dollars than those in Saskatchewan. Do we conclude that half of the health care expenditures in the US

are wasted? Even at that the Fyke report says that Saskatchewan people are over-serviced.

We know that health care expenditures are directly related to wealth. Rich countries spend a higher proportion of their income on health care than poor countries do. The two factors are interrelated. Rich countries have more discretionary income, which they can spend on health care as well as other things. More expenditures on health care lead to better productivity.

In poor countries like much of Africa, for example, without outside aid, little can be done to deal with the AIDS epidemic while a lot has been done in the rich countries like the United States.

Then turning to Saskatchewan we find that in the last quarter century per capita health expenditures in the province have generally been lower than the national average and certainly lower than the other western provinces except, interestingly enough, Alberta in recent years. Yet it can be argued that Saskatchewan should be spending more per capita than the national average since we have a higher proportion of older people and our population is more widely scattered.

Are we spending too little or are we maybe just more efficient? I'm afraid that the Commission on Medicare does not help us very much because of the quite remarkable number of what I call unsupported observations, examples of incomplete analysis, and irresponsible recommendations. These do not inspire the reader with confidence, especially when they are framed within the quixotic interpretation of the health care industry made by Commissioner Fyke.

The whole report of the Commission on Medicare should therefore be graded at this stage, before the provincial government acts upon any part of it.

Let us begin by assuming that a superior report would be graded at the level of 100 out of a possible 100 while an adequate report would be assessed at 95.

In this case we will begin with 95 and make the appropriate deductions for unsupported observations, incomplete analysis, and irresponsible recommendations with appropriate additions for strong features of the report.

A prominent, unsupported observation is to be found in the conclusion of the commission's report as follows:

> Based on numerous studies and experience elsewhere, it is a virtual certainty that quality problems in Saskatchewan cost hundreds of millions of dollars annually.

If this is a conclusion intended to be taken seriously it should be buttressed by examples. Where in Canada or the United States is the health care budget being cut by hundreds of millions of dollars in recent times? Where, in fact, is health care expenditures per capita significantly below that in Canada?

And if we should cut down, do we cut down on staff, staff salaries, research, surgical interventions, drugs? Is everybody else out of step but our Kenneth? Maybe this is just, maybe this is just rhetoric. Deduct 10 down to 85.

Another unsupported observation in the report is a death toll of 300 people a year in Saskatchewan if we assume the rate of clinical error in the province is the same as in the United States. But why do we assume that the rate of clinical error in Saskatchewan is the same as in the United States when the systems may differ significantly. Is clinical error endemic in the systems which would seem to suggest that it's inherent in the industry and beyond control? If no study has been done for Saskatchewan, why make the observation at all? Deduct 5, down to 80.

Another sentence from the report:

> In health services better costs less.

What about the case of the United States, where while we may wonder about 14 per cent of GDP going for health care, we do recognize that some of the best medical centres in the world are located there. Deduct 5, down to 75.

In the area of incomplete analysis we must put the question of the age structure of Saskatchewan's population to the fore. When examining the magnitude of Saskatchewan's health care expenditures, one should not ignore the fact that Saskatchewan has the highest proportion of population over the age of 65 of any province in Canada. This is important since the age group 65 years and over has several times the rate of health care expenditures per person of the rest of the population. In one of these reports there is a number.

Without allowing for this factor, any comparison of health care expenditures in Canada is going to be misleading. A study by the Manitoba Centre for Health Policy and Evaluation, published in June 1997, found that in 1996, in order for Saskatchewan to have the same level of health care expenditures per capita for each age group as in the rest of Canada, Saskatchewan would have to have the highest overall expenditures per capita; exceeding BC (British Columbia) by 8 per cent, Alberta by 22 per cent, Manitoba by 4 per cent, Ontario by 11 per cent, etc. Yet the Commission on Medicare ignored this factor and did not pay sufficient attention either to the effect of Saskatchewan's scattered population on costs, deduct 10 down to 65.

There are other examples of incomplete analysis which I shall not include in this assessment.

Now we come to the category of irresponsible recommendations. The most blatant of these is the recommendation to establish an autonomous quality council. It flows from what I have called a quixotic interpretation of the health care industry, the view that, quote:

> A quality culture will be the next great revolution in health care.

This seems to assume that quality has not been a feature of health care in the past, which is scarcely correct. Indeed, quality is and has always been at the core of health care. This is what people, as clients, have consistently judged health care on, and so it is not appropriate to state otherwise. It is ridiculous to state that, quote, "quality will be the next great revolution in health care" just as though that was something new.

Thus a quality council will really be equivalent to a council on health care overall and is a startling example of poor management planning. We already have the Health Services Utilization and Research Committee which has made many reports, including one on *System Performance Indicators: Towards a Goal-Based Health System*. We have the Saskatchewan Association of Health Organizations which was established to coordinate the activities of the health districts, although the commission, interestingly enough, does not mention it.

But more particularly, we have the Saskatchewan Health Information Network with an annual budget, apparently this fiscal year, of about 11 million and total expenditures to date of around 60 million. I do not want to be unkind, but it is doubtful whether there's been very much impact on health care costs or health care quality since its establishment.

It is intriguing to note that the Commission on Medicare recommends, quote: "(Continuing) investments in information systems including the development of an electronic health record," without mentioning SHIN (Saskatchewan Health Information Network) at all. Yet I had thought that was to be one of the major functions of SHIN. We have a right to know what the commission is contemplating here. The recommendation is so unacceptable that I would deduct 15, down to 50.

The proposals to amalgamate health districts and to close more hospitals is not a surprise. But are they based on any other views than that bigger is better. The commission . . . the commission like so many others is in trying to sneer at the preference of rural people for some availability of service other than that which would come from the main centres.

That may well mean indeed higher quality health care just because the surroundings in a local facility may be more familiar and more friendly. Deduct at least 5, down to 45.

Now I am much inclined to feel that in Saskatchewan they . . . that instead of adding a new sort of research facility we should probably be amalgamating the ones we already have.

Now, okay, here I'm going to be a little nastier. I said let us deduct another 5, just for the lines of general guff being dished out of this report, down to 40. But I'm going to add up 5 for the comments about fairness, and that brings us up to 45.

I regret . . . 45 used to be a failing grade when I went to school. Yes, I give the report a failing grade.

Thank you very much.

The Chair: — Questions from the committee. Seeing none, then thank you very much for your time this afternoon.

The committee will stand recessed until 25 after 3.

The committee recessed for a period of time.

The Chair: — I'm sure other members will be coming along shortly so I think, given everybody's interest in travelling, we'll proceed.

Welcome to the Standing Committee on Health Care. This is a committee of the Legislative Assembly and its first order of business is to receive responses to the Fyke Commission from interested parties, individuals, or organizations.

We are not going to be making recommendations. We'll be submitting a report on what we heard to the Legislative Assembly August 30.

This is an all-party committee. I'm Judy Junor, the Chair. Dr. Melenchuk is the Vice-Chair. Andrew Thomson, Kevin Yates, Doreen Hamilton, Brenda Bakken, Bill Boyd and Rod Gantefoer are here with us this afternoon.

We've set aside half-hour blocks of time for presentations and hopefully within that half hour we have some time at the end for questions from the committee if they have any. If you want to introduce yourself and where you're from, you can begin your presentation.

Mr. Moss: — Yes, Madam Chairperson, members of the committee. Good afternoon. Thank you for the time that you've given us to make this presentation today.

My name is Alan Moss. I'm the Chairman of the Wolseley Health Committee. With me is Dwight Dunn. Dwight at the moment is a member of that committee. He is a past chairperson of that committee and he will be dealing with the majority of our presentation today.

The presentation was originally drawn up by the Wolseley Health Committee but at the point where we had what we thought was an okay presentation, we then took it to the Wolseley Chamber of Commerce, the Wolseley town council, and the council of the RM No. 155.

What we were looking for from each of three bodies was any input that they may have wanted to give us into the submission and then, what really we wanted eventually, was their support so that we could come into here today with, if you like, a unified position from Wolseley and its surrounding area.

Madam Chairperson, if there is to be a round of hospital closures as a result of the Fyke Commission's recommendations, we could this afternoon if you wish, or we can at any time, give you many logical reasons why the Wolseley Memorial Union Hospital should not be slated for closure.

However, in our presentation we tried to stay away from anything like that. It seemed to me that you wanted an answer to what was in the Fyke Commission, and what we have done is tried to stay with what were the worrisome parts of the recommendations.

And so with your permission, Madam Chairperson, I would ask that Dwight be allowed to make that presentation now.

Mr. Dunn: — Thank you. And I feel a little sheepish about reading this out when you've actually got a copy there that you're reading along. So we'll carry it through and I suppose we'll then leave plenty of time for you to ask any questions at the end.

The Fyke Commission no doubt contains many ideas of substance which need to be further explored. We wish, however, to present to you some of the negatives as they apply to residents of rural Saskatchewan.

Whatever aspects of the Fyke Commission are implemented, they will not drastically change the way that urban residents access health care. We do feel, however, that rural residents will suffer dramatically as a result of any decrease in available local service. Even now, residents must make journeys of upwards of an hour or more in order to see specialists and possibly receive treatment.

If more hospitals are closed, people will have to make increased journeys in order to receive even basic treatment. For an urban person, a taxi or public transit ride solves the problem. Rural residents do not have access to these luxuries and must rely on sporadic bus service to the city or on the goodness of friends or neighbours to transport them to the centre where they will eventually access care. This care may be a surgical procedure or a specialist visit.

As the population of rural Saskatchewan continues to age, this will become an increasing problem, possibly leading to one of two things. The increased migration of people, especially seniors, to urban centres where they can obtain the services, which they need, further decimating the population of rural Saskatchewan. Or people's health care needs are not being met because it becomes too troublesome, especially for the elderly, to make the necessary arrangements to see their physician.

And something that came up — and this is an aside — but something that came up after that, it was pointed out to us that this is also adding an expense to the cost of rural residents having to travel for appointments in the city, and gasoline, travel costs, and all the rest, which are not shared equally by urban residents.

It is possible to suggest that the hospitals will still remain open if Fyke's recommendations are carried out; that they will just have a different name and that people will still be able to receive treatment in the building. The problem involves the level of treatment that will be available if we no longer have doctors staffing the facilities. We are being told over and over by our physicians that if their ability to use the skills they possess is taken away, then they will likely leave rural Saskatchewan.

While this may be or may not be fearmongering among the doctors, it certainly does make the general population not feel too secure about the future of quality rural health care.

The doctors also assure us that while it is still difficult to attract new doctors to rural Saskatchewan, one of the incentives continues to be that they can practise the skills that they have as long as hospitals continue to offer the services that are currently available. This is not to criticize the level of care, which can be given by other health care practitioners. It is simply a fact that doctors are trained to be the primary providers of acute care.

Fyke's concept of replacing hospitals with health teams does not seem feasible. The district in which we live has difficulty already in attracting qualified people to serve in rural Saskatchewan. If we cannot attract, for example, the services of a physiotherapist or other such specialist, then the concept of the team approach is weakened. The more specialists we fail to attract, the further the erosion of the team's usefulness.

The possibility exists that if Fyke is implemented to its fullest extent, we could see closure of all the hospitals in our health care district facilities in Moosomin, Broadview, Wolseley, and Indian Head. This would lead to a situation where there was no acute care facility from the Manitoba border to Regina, on a stretch of the Trans-Canada Highway that is for a considerable distance single lane highway.

If highway accidents were to occur, with few doctors and no acute care facilities along this stretch of highway, the consequence could be . . . the consequences could be devastating, especially the further from Regina the accident occurred. This type of situation cannot be left in the hands of first responders, ambulance personnel, and the staff of health care centres.

Fyke sees it as being realistic that members of the population are within an hour journey of being able to access emergency care. As we are currently served by the hospitals in our health district, we are well within those limits. However, if our hospitals no longer exist in their present form and there is a reduction of available doctors, then we fear that we will fall outside this one-hour time zone.

This could be true with devastating consequences in the case of a farm accident where the ambulance must find . . . first find its way to the scene of the accident and then get the patient stabilized sufficiently to transport to an emergency centre. Again, without being critical of the skills and training of the ambulance personnel, we wonder about their ability to stabilize to the same extent as a doctor, keeping in mind the doctor's more extensive training and the facilities available to the doctor as they presently exist.

It is also a concern in rural Saskatchewan after winter sets in, that an ambulance journey of 40 minutes in regular winter driving conditions can suddenly take twice as long in inclement weather. With the availability of acute care facilities and doctors along the route, the potential danger of a winter storm to the patient being transported can be lessened.

Following surgery in a city hospital, patients are being discharged increasingly early to convalesce in their local hospital or at home, presumably in order to free up bed space in a city hospital for a new patient. Should the hospitals outside the major centres no longer be served by a doctor or no longer be equipped as they are now, this type of early discharge may not be possible.

The reality then is that waiting lists would grow considerably longer or these major facilities would have to open previously closed beds. Economically and logically, this makes little sense compared to the early discharge system now in place.

Somewhat related to the previous point is that it seems as if people recover quicker, if recovery is to be the final outcome to a medical condition, when they are in familiar surroundings and close to family and friends. The worry of being far distant from

their home community and the concern about family and friends having to travel long distance for visits can only be detrimental to the recovery of the patient. Feelings of isolation and depression are not conducive to patient recovery.

Again this is not to criticize the quality of care in a larger facility; it is the extraneous circumstances that are the culprits.

In his report, Fyke seems to be stressing quality over quantity. Quantity is what the large acute care centres deal in, and rightly or wrongly the long waiting lists have placed this expectation on these facilities, that quantity must be increased to cut down the waiting lists.

This is not to deny that these centres also provide quality health care, but this quality is sometimes brought into question by the very health care workers in these larger centres who maintain that, because their numbers are so few and therefore they are overworked, they do not have the time for the extras of care that used to be provided. Rarely is quality of care an issue in rural hospitals.

If one of the intentions of Fyke's report is to save money and to increase the sustainability of publicly funded health care system, it would not seem like much of a saving is being achieved if the facilities are still open and being staffed. Staffing costs account for approximately 80 per cent of all health care dollars. Why not therefore leave the hospitals as they are with the availability of doctors and necessary equipment?

In 1994 the Federal, Provincial and Territorial Advisory Committee on Population Health, in its publication entitled *Strategy for Population Health — Investing in the Health of Canadians*, stated that the determinants of health are, quotations, "the underlying conditions within society that determine health." In its definition of these determinants, it included income and social status and employment.

At any time when there is a modification of the health care system, be it in the form of downsizing or closures, some people will lose their employment and consequentially their earnings. In rural Saskatchewan a person's salary from employment in the health care system or in any other profession is often a second income to supplement the low farm revenues of many Saskatchewan farm families. Remove this right to income from employment and you effectively remove one of the determinants of health from that person and that person's family. This is not the city where the possibility of a new job may exist less than a kilometre away.

The provincial government's economic strategy, *Towards 2005, A Partnership for Prosperity* identifies a shared vision for Saskatchewan in the 21st century. It is a vision of strong prosperous communities and neighbourhoods in our cities, rural areas, and the North. If there is any further erosion of the health services that we now possess in rural Saskatchewan, then the government's very own philosophy may well only apply to urban areas.

Without health services it is difficult to attract new industry to rural Saskatchewan. It is difficult to attract new residents and we are indeed in danger of seeing rural Saskatchewan further decimated as more people move to the cities and in increasing numbers to other provinces.

We would now respectfully offer the following solutions trying as best we can not to be political.

We see a need to put on hold all buildings of new facilities, especially acute care facilities which are not at least 51 per cent complete. Why keep construction going when the government of the day has not yet indicated where its major centres for acute care are going to be. We respectfully suggest the fixing of the problems which exist in urban hospitals before tampering with rural hospitals. The smaller facilities seem to be doing well in supplying the service they are expected to provide.

When the problems that we hear about in urban hospitals, especially a need for bed space, have been addressed, then the government can maybe look at changing the structure of rural health care. Do not change anything until the replacement system is fully established.

If we are going to have the ambulance people stabilizing a patient for transportation to a larger urban centre, then they must be as highly trained as doctors in this skill because, at present, it is the doctors that do the stabilizing in the hospitals which we currently possess. Take away the doctors and the facilities in which they practice before the replacement system is adequately established and rural patient care will definitely suffer.

Utilize rural hospitals for more things like chemotherapy, dialysis, and minor surgery, and get specialists to conduct rural clinics. Encourage efficiency in the health care . . . in health care. It must be possible to devise a system that rewards accountability and hard work and penalizes inefficiency.

Finally, we attach a copy of a letter which Alan will discuss here from the physicians of the Pipestone Health District as well as the chamber of commerce and the town and the RM. And I'll just let Alan carry on and conclude with those remarks.

Mr. Moss: — Okay. The final three pages are the motions or letters of support which we got from the three bodies that we had gone to — the chamber of commerce, the town of Wolseley, and the Wolseley RM.

The letter that we attached ahead of that, this is a letter that appeared in the local newspapers within the Pipestone Health District. It was approximately one week after the Fyke Commission was originally released.

Because it was in the public domain and because we wanted to take one paragraph out of it specifically, we decided to include the whole letter. We're not sure if maybe you've had this letter before. The signatures on the bottom are all of the doctors, I believe, within the Pipestone Health District.

The paragraph specifically that we wanted to highlight is on the second page of that letter, the page which concludes with the doctors' names. And it's the first paragraph at the top, three lines down:

> A further concern is the recruitment and retention of

> physicians in rural Saskatchewan. A recent survey conducted by the Saskatchewan Medical Association showed than an increased scope of practice is the main reason physicians are drawn to work in rural Saskatchewan. Should Pipestone's four acute care hospitals be reduced to community care centres, in effect glorified first aid stations, retention and recruitment of physicians will become next to impossible (it is hard enough at present anyway)!

The reason we wanted to highlight that was simply again, if you go back to early in our own presentation we talked about the thing that people fear a great deal is . . . and regardless of whether it's fearmongering or not, the general population are very much afraid of not having access to doctors and not having access to hospitals.

And this was simply an attempt to illustrate that this is what the doctors are saying, that if they can't practise the skills they have, they will leave.

Now we don't believe all of them will leave. I mean we have to be realistic about this. But we have to also think that maybe some of them will, and as they leave it might be more difficult to attract . . . we're very, very lucky in Wolseley. We've had a man and a wife team now for nigh on 30 years. We now have a young fellow practicing in Grenfell, but living in Wolseley. This gives us three doctors together where they can get every third weekend off kind of thing.

And this is sort of the worry that we have. If we lose these people, particularly the young fellow that just came to this practice in Grenfell, we're very much afraid that we might not be able to replace them.

And so I don't want to dwell on that letter and read the whole letter. I'm sure you can read it yourselves, and possibly it's even been presented to you . . . unless you particularly want me to read it, Madam Chairperson.

Effectively that's our submission. Now we don't know where the next 15 minutes goes to.

The Chair: — You don't have to cover every minute. We do have now an opportunity for committee members to ask you questions. Questions from the committee?

Mr. Yates: — Thank you, Madam Chair. I have a number of questions and I want to start by getting a feel for the services delivered in Wolseley and the community itself. How many doctors . . . Or what is the number of doctors working out of Wolseley today?

Mr. Moss: — We have two, a man and a wife team, who work specific to Wolseley. We also have a doctor living in Wolseley who now looks after Grenfell and who has admitting . . . Well I guess he's got admitting privileges all over Pipestone, but he admits into the Wolseley Hospital. So we actually have three doctors admitting there.

Mr. Dunn: — And one of the things that really affects the longevity of these doctors is the fact that they can at least get every third weekend off or part of a weekend off. Whereas before, particular being a husband and wife, you know, they would have to leave on their own, kind of a thing, to have any time off at all.

And I just saw a piece in *The Globe and Mail* over the weekend where a young medical resident was saying why he wasn't going to come to rural Saskatchewan and that was precisely why, is because he would have 7 days a week, 24 hours a day service. So we are blessed with this. And this young doctor has said to me in no uncertain terms if he can't practice the medicine he's trained for, he's got all sorts of options. We all know that they can leave, whether they be specialists or GPs.

Mr. Yates: — My second question is I'd like some feel for the services that you deliver from the Wolseley Hospital. Are there minor surgical procedures? Are the beds generally used for acute care or respite care? Could you give me some idea of utilization of the facility in Wolseley?

Mr. Moss: — Right. One of the neat things about the facility is it is attached by a walkway to an adjacent 80 bed long-term care facility. Okay. That was done approximately five years ago. It was a local initiative and it was a further attempt to prevent any more erosion of the services we had.

The residents of the long-term care facility can be moved very quickly through that, if I could refer to it as a tunnel . . . it's not a tunnel; it's a very beautiful passageway. But they can be moved from there right to the elevator at the hospital where they can be dealt with either upstairs, if they're going to be admitted or downstairs, if they're going to need care.

We have no operations which take place there.

We have again, three doctors who are servicing any acute care needs where people come in with the necessity either to be treated or stabilized for transportation.

The hospital has become in effect, what most small rural hospitals probably are now, it's become an all-encompassing building. We have the home care people working out of there. We have a visiting podiatrist. We have visiting . . . we have an eye person from Melville. We have a massage therapist from Regina, actually from Lumsden. I'm not sure what else, but we have lots of services going. Like we haven't left the rooms empty if you like, within the building. They are being used.

The average daily census I would guess — although I don't know; I used to know when I was on the Pipestone board — I would guess it's somewhere around five to six.

Mr. Yates: — I had that information . . .

Mr. Moss: — Okay, fine. And I wanted to say that the two doctors used this in Wolseley. I'm not sure about Dr. Kirkman since he's been here, but they are tending to, if you like, not admit unless there is a need to. Like, they are saying if it's possible to deal with as home care, then let's deal with it that way.

Mr. Yates: — My next . . .

Mr. Moss: — I'm sorry, I wanted to add obstetrics as being dealt with there also.

Mr. Yates: — My next question has to do with co-operation with neighbouring communities, neighbouring health districts. One of the things that we've heard from many presenters across the province is the co-operation with various communities has allowed them — or other health districts — has allowed them to enhance services and look to the types of things they may be able to do for their citizens in the future.

Could you let us know if you have any sort of joint programs with neighbouring communities, neighbouring health districts? Do you deliver renal dialysis or any of those types of services in conjunction with another community, or any enhanced services at all?

Mr. Dunn: — Yes. Alan's the former member of the health board, so I'm going to leave him to field that one.

Mr. Moss: — And I'm going to field it with difficulty. I no longer know if we are in any way co-operating with other areas, and I believe you had the Pipestone presentation yesterday. We did, at the time that I was on the health board, we were co-operating with North Valley. But I'm not sure — like this is three years since I left the health board — I'm not sure exactly in what.

We had situations where, for example East Central made an appeal to us to go into a joint funding of a native treatment facility in Yorkton. I'm not sure what came out of that because it was just happening at the time that I came off the board.

I have to admit I'm giving you a rather weak answer here and I'm going to stop because I really don't know of any other things.

Mr. Yates: — My final question is, what is the distance between Wolseley and say Indian Head and Broadview, in mileage?

Mr. Dunn: — I'm guessing now but I'm thinking about 35 kilometres to Indian Head. At least 30 to Broadview, 30, 40 . . . maybe 40 to Broadview.

Mr. Yates: — Thank you very much.

Mr. Boyd: — Thank you, Madam Chair. And thank you for a very excellent presentation. I apologize for missing the first few paragraphs of the presentation.

We have been hearing from numerous groups that have appeared before the committee that the team approach to provision of health care services is becoming more and more the norm in rural Saskatchewan, and very important in that.

And hearing what you are saying in response to Mr. Yates, that it certainly appears to be the case in Wolseley as well, that that type of delivery of service, having more than one doctor and other health care professionals as well, is clearly working well. Am I to understand that?

Mr. Moss: — Right.

Mr. Boyd: — The other question that I had is surrounding the whole area of the impact upon a community when there is facilities that are downgraded. And the concern, that I'm hearing from you as well I think, that it may result in just . . . in more than the loss of doctors or the loss of nurses and other health care professionals. But you may lose, in addition to that, other services, complementary services — the pharmacists, perhaps even other businesses, that sort of thing.

Is that the expectation or the concern that your community has?

Mr. Dunn: — Yes, I'd say that you've . . . you're absolutely right. Health care services are one of the things that people look at when they're moving into a small community. I've been in business, in the real estate and insurance business there for years and so I talk to people who are potentially moving into the town.

I had a couple just last week who said that they were . . . they had two questions, whether or not we had a kindergarten through grade 12 school; and number two, was there medical services there? Would they be available for their kids to have if there's accidents and so on, that they would be able to have local health care?

And those are the two criteria that they were using in order to be able to move . . . to base their decision upon moving.

It's all about infrastructure. And it's clean water, it's having K to 12 schools, proper schools, and it's to have medical doctors in those communities providing those kinds of services.

I'm just hoping that when the government has formed the Department of Rural Revitalization that they recognize that this is all about infrastructure. You can't revitalize rural Saskatchewan if you dismantle the infrastructure system. We have to have schools for the kids or there won't be any kids there. And we have to have medical treatment or people cannot afford to be living in rural Saskatchewan.

Mr. Boyd: — Does that same thing apply to seniors retiring to your community or continuing to live within your community? We heard from a couple of other presenters that there was very serious concerns from seniors that with the loss of services they felt at risk, and as a result of feeling at risk, they would seriously consider moving from that community or not retiring there in the first place.

Mr. Dunn: — One of the advantages we have, and it's almost unheard of in urban Canada right now, but the doctors will make house visits to seniors on a regular basis, as on a needed basis.

And yes, I've seen people move away because their children who live in other provinces now are concerned that they're not being able to look after themselves.

One of the initiatives we're using in Wolseley is to investigate the possibility of building seniors housing in which there would be a common area for meals and somebody's checking on people to find out if they actually need . . . you know, getting their medication and when they need to have people in.

Indian Head has done a project called Hayes Haven, and it's been very successful in that respect. The meals are provided.

They have an option of doing their own meals or they can have the meals provided in the central area.

But it still requires . . . seniors obviously need more health care than non-seniors. So yes, they can't be living here in rural Saskatchewan if they don't have access to medical doctors.

Mr. Boyd: — Thank you very much for your very concise précis of your concerns from your area. I think they mirror very much the concerns of other presenters that we have heard throughout the last number of weeks.

Mr. Thomson: — Madam Chair. One of the issues Mr. Boyd has alluded to and certainly has come up from other communities is the question of health care budgets being used for economic development. You've spoken in your brief today about the fact that we need to take a look at the role of hospitals within the communities. Is it your position the health care budget should be used for health care, or for economic development?

Mr. Dunn: — Clearly health care is for health care. What I'm talking about is infrastructure and you're talking about rural revitalization and the two are not isolated. If you do not . . . you cannot have economic rural revitalization or rural economic development without infrastructure in place. It's that simple. And it does have an economic impact, but it is part of the essential ingredient that creates the vitality and the possibility of growing the economies in rural Saskatchewan.

That's integral along with value-added agriculture and all the other economic things that go with this. But if you don't have the infrastructure there, you're not going to have value-added agriculture; you're not going to have industry moving into these communities because these people are going to vote with their feet and go where they can get those services.

Mr. Moss: — I think maybe when we talk about things like if a hospital closes people lose their jobs, it's a statement of the obvious. And I'm not trying to belittle the statement. It's a very serious statement. I don't think anybody would suggest that we keep a hospital open to keep people employed. The hospital is there to provide medical care for people.

But the spinoff is, if you do close it, if there's a chance to say well okay we can get health service 60 miles away and we will close that facility, then the spinoff does then become an economic spinoff as well as all the other things that Dwight mentioned.

Mr. Thomson: — So is it your view then that these are equal considerations that we should take into account, or should we take into account really just the service issues around the population's needs for health care? Or should the question of the jobs become a factor?

As I take a look, I understand Mr. Dunn's approach that this is about infrastructure. But I look down the highway at Grenfell which doesn't have a hospital. Certainly the citizens of Grenfell have as much need for infrastructure and economic development as the citizens of Wolseley. What is the argument that you would present to Grenfell as to why we shouldn't invest in a hospital? Or should we simply say those who want it, if you build it, they'll come.

Mr. Dunn: — Well I don't think there's any question that Grenfell was one of the first 52 hospitals that were closed and I don't . . . I suspect that they, in a perfect world, they would rather still have their hospital there. Having said that, they are blessed at least now by having a doctor that serves in their community every day. And he now is there because he can admit his Grenfell patients into the Wolseley hospital. If that were not there, they would lose their doctor.

And I think you put that question to the people of Grenfell, and they would be wanting to make sure that Wolseley hospital stays open so that they keep their doctor.

Mr. Thomson: — Again, I think this is one of the issues which we have not heard a consistent message on because there are varying views as to what extent the health budget should be used for economic development or to support economic initiatives. Clearly there is a relationship. But this is one of those question marks I think that has been identified by this committee through listening to the presentations.

I'll conclude by saying what I have said to I think most groups. The government obviously has made no decisions what, if anything, out of Fyke will be implemented. I think it's a very fair comment to say that there's a great deal of fear. Certainly that fear has been, has come to the surface. We understand that and the government is obviously waiting for this committee to report before coming to a conclusion on what, if anything, it'll do out of Fyke.

So thank you very much for attending today.

The Chair: — Thank you, and seeing no more questions, on behalf of the committee I'd also like to thank you for taking the time to come and present us with your views. Thank you.

Mr. Moss: — And thank you for giving us the time.

The Chair: — Our last group of presenters can take a seat at the table. And you have the honour of being the very last group to present at these hearings. I'd like to welcome you today to the Standing Committee on Health Care.

This is a committee of the Legislative Assembly and its first order of business is to receive responses to the Fyke commission. We'll be reporting what we hear back to the Legislative Assembly on August 30. The committee is not going to be making any recommendations. Our task is to simply to report what we've heard.

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

We have half an hour set aside for the presentations. If you want to begin by introducing yourself, and then proceed with your presentation.

Mr. Bourassa: — Madam Chair, thank you very much for the opportunity to present to the committee. Members of the

committee, my equal thanks to you for creating this committee and having us speak to the Fyke report.

My name is Richard Bourassa. I'm the administrative Chair of Bourassa & Associates Rehabilitation Centre. This is Doctor Jack Reilly, a Saskatoon orthopedic surgeon and one who serves as our surgical Chair for our day surgery unit, and this is Roxanne Grambo who is from our senior administrative support team.

I'd like you . . . I understand that you have our report. The text of the report I will ask you to read at your leisure or to refer back to. We would prefer to speak to a PowerPoint type presentation and make it less of a reading exercise. So if you go to page six of the initial text and then the page after there is appendix A which is the PowerPoint presentation. In the absence of a slide or projector we defer to this type of presentation for efficiency of time.

Again, thank you for allowing us to present. Our main purpose in presenting today is to present a vision for multidisciplinary health care delivery from the perspective of a private centre and its professional medical associations.

For the purpose of familiarizing you with the context of physical therapy and rehabilitation services in Saskatchewan, I took two pages from our Web site to indicate the scope of practice, in case you are not aware, in private sector health care delivery in Saskatchewan.

Those of us involved in private health care service delivery in Saskatchewan, as you might suspect, feel somewhat at odds with the system at times and are frequently unwilling to present information because we fear the effect of private sector delivery in this particular jurisdiction. However the time has come, we feel, for us to make the committee aware and to make the people of Saskatchewan aware that there is a place for a private public relationship in Saskatchewan for the benefit of the people of Saskatchewan.

Our rehabilitation centre, as you will see, is a multidisciplinary centre. It has 40 staff. It has eight consulting medical professionals, most of whom are medical specialists such as orthopedic surgeons, neurosurgeons, etc., who function in a multidisciplinary manner in Canada Health Act safe practice in Saskatchewan and fully respective, we feel, of the spirit of medicare in Saskatchewan.

Our mission statement is fully consistent with the World Health Organization's sense of a more medical social context to health care, as opposed to simply an acute care health delivery model.

The services on page 3, as I referred to earlier and which I'll develop a little later on in the presentation, refer to a broad range of professions who practise in a multidisciplinary scope, most of whom practice the majority of their professional lives in the public system and who choose to work part of their professional lives in a private system for many reasons.

I'd like, first of all, for the committee to be aware of the history of private practice physical therapy services in Saskatchewan. I doubt that this is well-known to you, and it in certain context mirrors the issues in a very small way, it mirrors the issues that are occurring in medical services in Saskatchewan today.

In 1962, shortly after the initiation of medicare in Saskatchewan, physical therapy services were part of the same MCIB (Medical Care Insurance Branch) process that paid physicians, optometrists, chiropractors, etc. In 1965, for a number of reasons, physical therapists were eliminated in the private sector, were eliminated from the MCIB payment system and moved towards the SHSP (Saskatchewan Hospital Services Plan) system.

In that system, private practitioners negotiated a contract that was paid for and delivered through the hospitalization system as opposed to private sector fee for service that the other professions enjoyed. This held until the early 1970s and 1980s, when the public system started to run into difficulties with funding physical therapy services, especially for outpatients. At that time a number of physical therapists chose to go into a fee-for-service arrangement with their patients completely unfunded by the public system.

This is again in the early 1970s and '80s. There was considerable lobby at the time from our professional associations to have the same access to funding privileges as other professions.

In hindsight, Madam Chair, I would suggest to you that our experience in the private sector providing complementary services to the public system has been extremely positive, both for our profession and for others of our associates who choose to work along with us.

In 1962 there were nine private practice physiotherapy services providing services to the people of Saskatchewan. Presently there are close to 30. And the nine that existed in 1962, by and large continue to serve through the public system in contracts with the local health boards as opposed to with . . . directly with Saskatchewan Health.

So today we have a situation where there is a true private sector physical therapy service that exists. A private system that exists concurrently with the public system and who co-exist very well and who function very well for the service delivery to their clients.

The private sector growth in physical therapy has been substantial. The number of therapists who left the province because they could not access the physicians of their choice and the style of delivery of their choice prior to the private sector delivery system was substantial. We've been able to attract many of those back, and we're able to retain many of the graduates from the school of physical therapy in Saskatchewan because of the increased career opportunities that exist.

To a large degree, I would like to pay tribute to the SGI and WCB (Workers' Compensation Board) programs who make extensive use of these private sector delivery programs and who essentially provide the baseline funding for survival of these clinics. However, more and more we are seeing other third party insurers from outside of Saskatchewan more than willing to pay the service requirements for delivery of these services.

Keep in mind that none of these services, none of these services

come out of the public purse. All of the services are either paid for directly by the client or more often than not covered by third party insurers, many of whom are from outside of Saskatchewan and many of whom are associated with work or employment contracts with their employers to provide additional health services.

The spinoff of our experience in the private sector in the last year has led to a very important development. Again, one we want to carefully explain as we present today.

In March of this year we opened a day surgery clinic in Saskatoon to service those individuals who were not obstructed from using this type of service by the Canada Health Act. At this point in time that primarily is Workers' Compensation patients.

At a conference in Saskatoon sponsored by the Saskatoon Chamber of Commerce, one of the chief officials of WCB challenged local providers to realize that they are sending a substantial amount of patients outside of this province to receive diagnostic imaging and surgical procedures, most of them in Calgary.

WCB asked us, as a group of professionals, to consider ways that we could provide that locally, to keep that income in Saskatchewan and to provide those services in-house.

None of these procedures required extensive additional knowledge or experience that were not available in Saskatchewan. These were simply procedures . . . simple procedures that could not get into the public queue with sufficient time frame for an insurance company to tolerate the income replacement loss.

To speak to the day surgery clinic and to its benefits, I would defer to Dr. Reilly at this time.

Dr. Reilly: — When the day surgery clinic was started, I was asked to become involved and to give some advice as to how it should function and what it should be. And I envisaged a high quality, state-of-the-art day surgery service. And in fact that is what we have been able to provide. And it's simply a high quality surgical service right now for workmen's compensation board patients, allowing them to stay in province, allowing the Compensation Board to keep their patients at home.

We've made this service available to all surgeons in Saskatchewan. Right now it's primarily orthopedic surgery because those were the bulk of patients who were moving out of province. And this service is available to any orthopedic surgeon in this province. He can come to this centre, he can bring his patient, we will provide a family physician based in Saskatoon to help look after the patient so that the quality is not compromised by the distance.

And from a surgeon's perspective, this is a very definite practice enhancement for surgeons. Also for anesthetists who work in this clinic, for nurses, and for the physiotherapists who see these patients prior to the surgery and immediately after the surgery and in fact are often present during the surgery. It exposes them to enhancement in their professional life that they would not normally have.

The other big advantage that surgeons see in this small clinic is that there's a very streamlined administration — you are in fact looking at the administration — which therefore is . . . facilitates exposure to rapidly changing technology. And I'm an orthopedic surgeon and the technology in my world changes month to month sometimes. It makes it easy for us to access technology that sometimes takes several years to come into place in the public system.

It allows us to in fact essentially field test some of the new developments that come along. And we have already done so in one area, which is in a written brief, in the area of post-operative pain, as you might imagine, dealing with patients from across the province doing surgery that can sometimes be fairly extensive, as the day surgery procedure, we had to get involved in pain control mechanisms that up until now weren't available in the public sector. We did that.

There are no . . . these things are now available actually in the public sector in some areas; for instance, definitely in Saskatoon. And this was a combination of surgeons, anesthetists, and nurses figuring out a way to provide patients with pain control who were not going to be in the hospital.

Also from a surgical point of view, this is a very definite plus in the areas of recruitment and retention. It's a small part of what an orthopedic surgeon does. And 95 per cent of my activity is in the public sector, but this is a very nice alternate for me on days when I am forced not to work by the public sector, and there are many of those days.

Research is underway, and teaching. We already have had several students come through the centre.

And so therefore we have recruitment, retention, research, and teaching all funded by the private sector, in a very small way, but nonetheless it is happening. And we felt that you should know that this was happening. And the patients are very happy with the service. The surgeons and the professionals involved are very happy with the setting.

The milieu is state of the art and we look very optimistically to the future.

We are very cognizant of the Canada Health Act and are very happy to be well within what I consider to be the spirit of the Act.

Mr. Bourassa: — Thank you. Further to the day surgery unit, pain management services has been a strong part of our service delivery for the last several years.

We have a multidisciplinary pain management team consisting of a pain management anesthetist, Ph.D. (Doctor of Philosophy) level psychologists, physical therapist, occupational therapists, and exercise therapists are the key groups in most pain management service programs in the world.

You should know that the pain management anesthetist on our team is a former Saskatchewan anesthetist, currently practising in Kamloops, who we bring back every three weeks for a two-day clinic in Saskatchewan.

He left Saskatchewan for practice reasons but is happy to come back to Saskatchewan to function in this multidisciplinary setting. One of the main reasons he left was because he was a single provider of pain management and did not have the multidisciplinary team around him.

We are currently looking towards a central rural location to centre a pain management screening service as an extension of our service. This would occur in one of the existing health centres in Saskatchewan — one who is struggling to some degree in the financial perspective to keep their unit functioning. We feel that we can help them, as well as help our own service delivery, by providing some private sector use of the facility if it's so allowed.

Our vision is to provide an explanation and an argument that there should be a private public partnership. Keep in mind that, as you consider this, that these are all funded . . . these services would all be funded by non-public funding, chiefly by third party insurers at the present time. And we'd also like you to realize that the physical therapy model, although small, has been through a process of movement from the public to the private sector.

Madam Chair, if you'll allow, I'd like to read the four recommendations that we make directly because I think they are best expressed by simply reading them as they stand.

The first recommendation that we'd like to make is that the Standing Committee on Health Care in Saskatchewan recognize that private rehabilitation service centres which offer a comprehensive range of complementary services are critically valid and beneficial to serving the needs of Saskatchewan people.

Recommendation no. 2: that recognition and acceptance of these models of services will be incorporated into the health care delivery system strategies of the Government of Saskatchewan presently as it reacts and adopts recommendations and evidence of the Fyke Commission and other federal commissions.

Recommendation no. 3: that local Saskatchewan expertise and resources be used wherever possible to provide complementary private sector services. We believe that Saskatchewan practitioners, many of whom are born and raised and continue to exist in this province by choice, recognize the special circumstances that exist in this province and would be responsible in integrating services rather than competing with the public services, truly enhancing services for the benefit of all citizens.

And recommendation no. 4: that Saskatchewan government officials recognize the health provision opportunities that exist in Saskatchewan and work in the same entrepreneurial spirit that this province is so well known for to develop these opportunities for the benefit of the public and service providers.

In particular, let us not work towards exporting our health care professionals and patients to those jurisdictions with more foresight but rather work together to develop these opportunities for the benefit of this province and regain a reputation for innovative, quality health care programs.

Madam Chair, and members of the committee, that is our presentation. We'd be happy to answer any questions that you may have.

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

Hon. Ms. Hamilton: — Thank you. There are many areas of health care I think that are in this category of some ability to utilize a system through the third party insuring system. But I'm not clear on your recommendation no. 3. And I'd like you to comment a little bit further on how your statement is interpreted cognizant of what the Canada Health Act says and where you fit into the public administration. Or are you totally separated from publicly administered health care? And what are some of the . . . in recommendation no. 3, what are some of those other services that you would be talking about here?

Mr. Bourassa: — Well, the purpose of recommendation no. 3 is to indicate that we believe that there is a ethical, reasonable, and responsible way to integrate private health care in this province.

Carefully stated, I'm not sure that that would be the case if large corporates were to arrive in this province, many of whom have hovered over this province for quite some time wanting to provide private health care services. We think that those would directly compete with the public system. And speaking for I think many of my colleagues, we want to see the public system thrive. We are not interested in competing with the public system. We are interested in providing complementary care.

For example, in the area of the day surgery unit, this year 200 surgeries will be removed from the public system waiting list, which will free up those surgical times for public patients who have no third party coverage.

Other services . . . none of our services delivered in the public sector make use of any public administration or financing. So anything that we remove from the public system that can be insured or paid for by other services in our mind would simply free up more time to provide those services to the public, especially keeping in mind that these services are globally funded.

So that if, for example, a certain health district has a global funding for a million dollars per year to provide their program, if many of those programs are provided to third party insurers who would be willing to pay for that — this is now coming out of the public purse — these would be removed from the public program so that true public access would be enhanced.

Have I answered your question?

Mr. Boyd: — Thank you, Madam Chair. And thank you very much for your presentation, and I think a great thank you is also in order for the services that you provide to the people of Saskatchewan, very innovative services that appear to meet a growing need out there. I was very interested in your comment that your facilities complement the public system. And I wonder if you'd care to expand upon that at all.

Mr. Bourassa: — Dr. Reilly would you care to start the discussion?

Dr. Reilly: — Most of the facilities that Mr. Bourassa is talking about are in the realm of physical therapy, and although I'm not personally involved in those services, they do complement the public system.

Many of the patients that I see who for instance will have injuries or joint replacements and have third-party insurance can access those services rather than going through the publicly funded, hospital-based physiotherapy services which, I have to tell you, are extremely focused on patients when they are in hospital, give excellent care to patients when they are in hospital, but can't cope with patients when they are out of hospital. They simply don't have the funds to do so, at least don't appear to be able to do so. And so in that respect, they are complementary.

Mr. Bourassa sees many patients who have never, of course, been in the public system regarding the injuries that they have if they were Compensation Board patients from the outset. But he does see patients who have had surgery and other services from the public system and then exercise their right to use the coverage that they have, many of them with their jobs. And so in that respect, the services are complementary.

Mr. Bourassa: — In addition to that, Mr. Boyd, the WCB and SGI systems, I think most public facilities would now defer that to the private sector so that it could free up their time to provide services to catastrophic conditions such as stroke rehabilitation, the cancer needs, the needs that are paramount to be delivered in a public institutional setting. It isn't necessary to occupy those valuable therapists' time with conditions that require care, but can be provided in the outpatient sector and funded by third-party insurers.

Mr. Boyd: — Speaking of the third-party insurers, WCB and SGI patients, it sounds like, make up a significant portion of your clientele. What would the percentage of WCB and SGI patients be?

Mr. Bourassa: — I'm speaking only for our facility. At the present time WCB would make up 40 per cent of our patient load; SGI, 20 percent; and the remaining 40 per cent, about 20 per cent of that . . . pardon me, 20 per cent of the total are patients who choose to enter our facility and pay for their services even though they may have access to the public system. For whatever reason, and there are a number of reasons, including access and timely access, they choose to pay, and then they're reimbursed by third-party insurers. Many of them just pay that service on their own.

The remaining 20 per cent, we have made a consistent effort to attract the third-party insurance system, the Canadian system — for example, Canada Life, Sun Life, Great West Life, those insurers, many of whom want comprehensive rehab programs for individuals who are off work and are on income replacement benefits with them.

So we are attempting to diversify, but for some service providers it would probably go as high as 60 or 70 per cent reliant on WCB and SGI, at present.

Mr. Boyd: — In addition to WCB and SGI are there any other government agencies that use your facilities?

Mr. Bourassa: — No provincial government services at present because the line given to most patients is that they must use the publicly funded system. We've had many inquiries but that is the decision made by most of the public health system bureaucrats.

In the federal system, RCMP (Royal Canadian Mounted Police), DVA (Department of Veterans' Affairs), and increasingly the First Nations people who can access additional funding are accessing our services.

Mr. Boyd: — We have been told by other people who have presented prior to you in these hearings that allowing private services to operate within Saskatchewan presents a, quote, "slippery slope" towards an entirely, I assume, entirely private health care system. How do you view that?

Mr. Bourassa: — I'd like to make a brief statement, then I'll defer to Dr. Reilly as well. I think it comes with responsibility and having a vested interested in the survival of the public system. And I think that local care providers want the public system to survive and want to provide complementary services.

Again I would worry about the motives of others, particularly larger corporations coming into this province and providing a large what they would call complementary services, I think are going to directly compete with the public system.

I would encourage this committee and the government to ensure that any private sector delivery services are truly complementary and enhancing to the public system as opposed to directly competitive to. Dr. Reilly?

Dr. Reilly: — I guess if you're afraid of the slippery slope you probably don't want to know that you've been living with it for 15 years already — but you have. As you know from our brief, many patients have been sent out of this province to our neighbouring provinces to have expedited surgery done by the Compensation Board. We see no difference. In fact we see significant advantages that you can see to doing that surgery at home.

I'm sure you all have constituents who have had major surgery done in the United States. And anyone with any money can choose to do that at any time and come home and be looked after. And I have patients who have done that on many occasions because they simply won't wait for the public system.

So we live with the slippery slope always. And I would agree with Mr. Bourassa that there is a very sensitive and caring way to introduce and carry out this kind of service without destroying medicare.

Mr. Boyd: — So indeed services such as yours can, and obviously have, coexist with the public system and complement each other.

Mr. Bourassa: — We make a conscious effort to be complementary to our public colleagues and to ensure that when we're discussing programming that we're not at a competitive level.

Having said that, many of the public systems, two — Saskatoon

District Health and Regina District Health — operate private sector clinics directly in competition with private sector services. We don't debate that and the need for that, but the health district provides this type of clinic on a fee-for-service basis to WCB and SGI and retains those funds, despite the fact that the infrastructure and the overhead are covered more by the public purse. We don't debate that and we would encourage the public system to look more and more at attracting more funding to supplement their services.

So I think, as Dr. Reilly says, it all comes with responsible delivery of the service and ensuring that you're not competing. There is no advantage in this small province for the public and private sectors to go loggerheads and compete at a high level. It would be grossly irresponsible and it would lead to a disastrous consequence.

And again, I would strongly encourage the committee to make sure that there are appropriate guidelines in place to avoid that.

Mr. Boyd: — Given that statement, are there other areas of health care services where your approach to the delivery of health care services could be facilitated and used, do you believe?

Mr. Bourassa: — I am involved in some committee work with the chamber of commerce in Saskatoon. And the chamber of commerce has certainly given me permission to indicate that they have a Health Opportunities Committee whose sole purpose is to try to regain Saskatchewan, particularly Saskatoon's reputation as a centre of medical excellence and to attempt to create this private public sector relationship for the benefit of all.

Some of the discussions for example in the area of transplantation — and I speak somewhat out of my scope, more from a business and administrative perspective rather than a nephrologist or someone with expertise in transplantation — but there is discussion that would suggest that, with the expertise that exists in this province for transplantation, there would be no reason why a transplant centre couldn't exist on a private basis and bring people from out of province and out of country to provide those services in this province.

There would be nothing better for the practitioners involved and the spirit of the medical providers in this province to be recognized at that level, to have that recognition and to be recognized with that level of expertise in the areas that we have that expertise. And there are many areas of expertise that exist in this province in that same light.

Dr. Reilly, do you want to comment further?

Dr. Reilly: — Yes. I think Mr. Bourassa is absolutely correct. We have . . . the one area he did pick on, kidney transplantation, it's certainly not what I do. But we have I believe the longest kidney transplant survivors as a group in North America, right here.

Kidney transplantation, much of it was pioneered in St. Paul's Hospital. And we have never capitalized in any kind of business sense on that. But that expertise still exists.

The standard of orthopedic surgery for instance, in Saskatoon and Regina, is well above that available in many of the northern states — in fact almost anywhere in the States except the most major centres that people hear about. Our surgeons are better trained and have much more experience than most of the surgeons practising in the areas where our patients go to have their expedited surgery done, in Montana and in the bordering states. And so we certainly could capitalize on many of those areas.

Mr. Bourassa: — At a level also of Dr. Reilly's interest — the area of total joint replacements; hip and knee, for example — in talking to Dr. Reilly, and I hope that you will validate this, but Dr. Reilly will do two or three times the number of total hip replacements than a prominent Los Angeles orthopedic surgeon, simply that the volume is here.

There's no reason why people would not travel to this province to receive that at a fee, probably provided in the public system and enhancing the public system, so that surgeons can do surgery and that there is appropriate surgical time and appropriate reimbursement to keep these people here and their expertise here.

Mr. Boyd: — If you were asked to no longer operate in Saskatchewan, if someone were to say that your facilities are no longer welcome in Saskatchewan, what loss to the economy would there be, to the province's economy?

Mr. Bourassa: — There are some 25 private sector rehabilitation centres functioning in Saskatchewan at present, probably averaging 15 staff members per clinic. I'm speaking, Madam Chair, without all my notes in front of me. But I would expect that that plus the revenue generation that comes from that would be substantial. I would have to place a calculator in front of me to calculate it.

Plus the absence of these clinics would also put more burden on the public system, and I think we would fall back to a system where patients are primarily responsible for their own rehabilitation rather than a guided rehabilitation system.

Dr. Reilly: — One of the losses currently happening, for instance, would be patients travelling out of province, by the Compensation Board alone for MRIs (magnetic resonance imaging) in Calgary — 400 last year, more than that this year. They are paying enough for those MRIs that we could probably fund a separate MR unit in this province and run it 12 hours a day and treat 1,600 patients.

Mr. Bourassa: — Many of whom would be public patients . . .

Dr. Reilly: — That money is just disappearing. Financial opportunities lost, I think, are losses.

Mr. Boyd: — My final question, Madam Chair, is Dr. Reilly, you made the statement that this facility allows you to perform more surgical procedures, and as a result of that, I think you made the statement something along the line that the public system forces you not to work. And I wanted to explore that a little bit.

Dr. Reilly: — Every third Friday is a holiday. Every week

throughout the summer, we have two of six operating rooms closed in each of the three tertiary care hospitals in Saskatoon. We have had — and I don't know exactly the number — but we have lost well over a thousand operating room days in Saskatoon in the past year because of staff shortages, anesthesia shortages, money shortages. The system is not able to use the services of the people that it has to the fullest. So we all have enforced days off.

Mr. Boyd: — So in spite of the fact that we have significant waiting lists in this province for your services, you are not able to provide them because of system limitations?

Dr. Reilly: — I would not wish you to turn this into a political statement by me in anyone else's favour, but right now the resources are not being used to the maximum efficiency, as I see it.

Mr. Boyd: — Thank you.

Mr. Thomson: — Madam Chair. I want to pick up right where we've left off here. With the resources not being currently used, some would argue that one of the reasons the resources are not currently used is that they're misplaced. We're talking about high-end specialty services. This is one of the things Mr. Fyke addresses.

We are heavily invested in infrastructure, heavily invested in a very broad and accessible system, accessible in terms of base care and in terms of location. Mr. Fyke advocates that what we need to do is to concentrate more on quality and to take better . . . make better use of the 2.2 billion of public money that we're using currently, to make sure specialized services are better utilized, that we have operating rooms available.

I think it's important that we understand that that's one of the reasons we have difficulty according to Mr. Fyke. And I'm wondering, would you agree with that assessment of Fyke's or do you perceive it differently?

Dr. Reilly: — I honestly don't know if I agree or not. I mean I'm essentially a front—line worker in your high-end, high-tech services. I can say some very good things about the services. The way it's structured right now if you are very sick, very ill, you get exceptional care. So therefore from my perspective, health care in this province for those who need it is significantly better than it was 10 years ago and much better than it was 20 years ago. And of course we're paying for that; it's expensive.

There's a system in place right now where if you need to have . . . if you must have hip replacement or a knee replacement in Saskatoon, you can get it within four months. And many of our patients do access that service.

Our problem is that there are many more who should have those things done who can wait, and those are the ones who do wait. And so there is a prioritization that goes on that offends a lot of people. It's not a major problem for me other than the fact that I have patients waiting two years, two and a half years now, to have joint replacements. They are not sitting at home in agony. If they were they'd be done four months from now. They can't golf, they can't dance. They don't qualify.

I don't know what Mr. Fyke, how he would propose to better organize the system. These things are expensive.

I should tell you that despite the fact that they're expensive, they are significantly cheaper than they are in United States. All the things that we buy are cheaper and our costs are less. So I don't think the money is wasted and I don't think the system is bad.

And no one ever asks me what I think about the waiting list but I've just explained to you, I think, how I feel they function. I do believe that the people who need to get things done get them done.

Mr. Thomson: — The challenges I think with any managed care system, be it Canada's medicare system, be it the American HMO (health maintenance organization) model, is attempting to balance out the resources and capacity and need. These are all challenges. I mean it's just classic economics that drive these things.

I am interested in knowing . . . Now you . . . From what I understand, let me phrase it this way, from what I understand from your presentation today you are saying that there are ways that we can still function within the Canada Health Act, that we can still function within the prescribed licensing system that we have for health care facilities in Saskatchewan — legislation passed by this province not many years ago — still operate within medicare, and work to enhance this system without undermining the Canada Health Act or medicare or moving to a two-tier American-style model. Am I correct in understanding that?

Mr. Bourassa: — You're correct in noting that there are many procedures, for example in the day surgery unit or otherwise, that are not covered by the Canada Health Act. The Meredith principle with The Workers' Compensation Act development. Workers' Compensation Boards are not bound; neither are many of the federal agencies.

When you talk about the economics, the reality, for example, of an insurance agency like the Workers' Compensation Board is as follows. Someone injures their knee and is off of work. They're 10 days into that work injury. They go to see Dr. Reilly and they perhaps are not qualified for urgent access. Some of these people wait in excess of several months up to a year for the simple 30- to 40-minute procedure.

The income replacement benefits per month paid by the Workers' Compensation Board for that individual are many hundred times more the cost of the surgery that would be done in 7 to 10 days from Dr. Reilly's office visit. That's the economics of the non-Canada Health Act, and presumably this was thought of when The Workers' Compensation Act was first formed.

Workers' Compensation Boards are meant to have an expedited system by their exclusion from the Canada Health Act. And they are able to expedite these services with private sector arrangements.

Mr. Thomson: — I'm sorry to keep you here as long as we are today, but it's an important issue. And I think it's important that

we separate out two of the different functions that are being performed at . . . I guess you call it the . . . do you call it a centre? At the rehabilitation centre. I was going to call it a clinic, but at the centre.

One set obviously are basic physiotherapy and advanced physical therapy needs, which have traditionally been provided in large part on a private sector basis.

The second though are these new, these 200 surgeries that you've recently started performing for orthopedics that comply with the Canada Health Act, that comply because they are through third-party insurers, in this case namely SGI. I think that that's very important that we understand there's two separate issues here.

Because really when we went from medicare first coming in, really when we went from hospitalization in this province coming in, the idea was that basic hospital services were covered. Then it was expanded to medicare where a larger number of services were covered.

In the late '80s, early '90s, there was a series of de-insurance where things were moved back into the private sector. The one thing that has not changed though from '44 is the idea that hospital services, those surgeries, should be publicly funded and publicly managed.

Now as I understand, what is happening is the way this works within the Canada Health Act is that it is still a closed system. It's not a case that I can walk in and say my knee surgery is more important than Ms. Hamilton's, and because I'm willing to pay you more, I can get the surgery done. This is still managed care within a publicly funded system.

Dr. Reilly: — You can buy Mr. Bourassa's services to help your injured knee, but you can't buy the surgery unless the Compensation Board is your primary insurer. The only non-Compensation Board patient we have treated is actually a Saskatchewan . . . a native of Saskatchewan who lives in Angola, works for an oil company, had a bad knee injury, was told he shouldn't have anything done in Angola, came to Saskatoon and paid for his surgery.

Mr. Thomson: — Okay, I appreciate the clarification because I think it does help for us to understand that, number one, the Canada Health Act and publicly funded medicare still works and that this is not a case where you're advocating against that. And number two, that I want to make it clear that this is not something that I think Fyke is looking at, where we would move to a point where everything has to be covered by the medical care, that this is a case where the physical therapy services or rehabilitation services will be shut down or absorbed into the medicare system.

This is one of those issues that I think you pointed out, where they have been able to make sure the lists are better managed and that public resources are better utilized. And if that is what I understand, then I very much appreciate you coming here today to share that with us.

The Chair: — Thank you. Mr. Yates, to finish us for today.

Mr. Yates: — Thank you, Madam Chair. Just one quick question. We don't often, or I haven't often had the opportunity to ask a physician, if they had the ability to put in place some priorities for surgical waiting lists, are there things that you could recommend that would help the process?

Dr. Reilly: — I was actually part of . . . I don't know if you've heard of the western Canada waiting list project. I was the Saskatoon representative at the western Canada waiting list project that put in place a type of questionnaire, if you like, to help prioritize patients who needed to have hip and knee replacements, because that's the area that I work in primarily. And so those tools are available.

We actually haven't adopted that yet. Actually, I shouldn't say that. We have adopted that. We don't use the questionnaire but the system in place in Saskatoon right now does adopt that. You will have your surgery done faster if you can't walk from here to Ms. Junor than if you can walk around the block, and so we are prioritizing. The problem is that the primary caregivers are doing the prioritization and we're having to revisit these people.

I now routinely see people every six months who have been . . . who are on a waiting list waiting to have a joint replacement, that I really don't need to see because the vocal ones, they call and they say I'm worse, I need to be seen. It's the old lady who sits at home and slowly deteriorates to the point where she can't function and doesn't tell anyone.

And so we're trying to organize a . . . (inaudible) . . . that catches these people when the waiting lists are so long. It's not that they can't get into hospital. They can. We can make it happen and many of you tell your patients, if you're bad enough, you'll get in. The doctor just has to make it happen. Well that is true, but you don't tell them that you personally are not bad enough, you can't get in yet.

Mr. Yates: — Thank you very much.

The Chair: — Seeing no more questions, thank you very much for an interesting end to our hearings.

We will entertain a motion to adjourn until 10:30, August 21. Mr. Thomson so moves.

The committee adjourned at 16:49.