STANDING COMMITTEE ON HUMAN SERVICES

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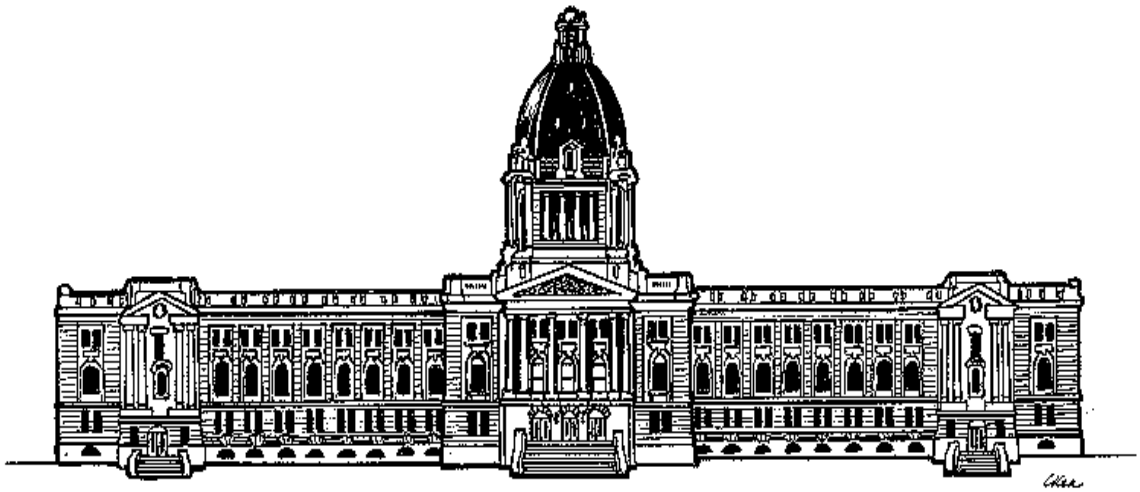

Legislative Assembly of Saskatchewan

Twenty-sixth Legislature

STANDING COMMITTEE ON HUMAN SERVICES

Mr. Greg Ottenbreit, Chair
Yorkton

Mr. Cam Broten, Deputy Chair
Saskatoon Massey Place

Ms. Doreen Eagles
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Saskatoon Eastview

Hon. Jim Reiter
Rosetown-Elrose

Ms. Joceline Schriemer
Saskatoon Sutherland

Published under the authority of The Honourable Don Toth, Speaker

[The committee met at 08:12.]

The Chair: — Good morning, ladies and gentlemen. Seeing as it's now past 8 o'clock, we will begin our Human Services Committee meeting for this morning, and again welcome. Good morning to everyone. I'd like to welcome you to the deliberations of the Standing Committee on Human Services.

Our members this morning are voting members, Mr. Cam Broten and Ms. Judy Junor, and also Mr. Glen Hart, Ms. Joceline Schriemer. Ms. Doreen Eagles will be attending shortly. And substituting for Minister Jim Reiter, we will have Minister Christine Tell this morning.

General Revenue Fund
Health
Vote 32

Subvote (HE01)

The Chair: — We have a busy agenda today as outlined in the agenda. This morning we'll be considering estimates for the Ministry of Health, vote 32, followed by estimates of Ministry of Education, vote 5, this evening.

Committee members, we're now looking at the estimates for vote 32 for Health, central management and services (HE01) outlined on page 90 of the Estimates booklet.

Mr. Minister, welcome and welcome to your officials. Would you like to introduce your officials please and start with an opening statement.

Hon. Mr. McMorris: — Thank you, Mr. Chair. I have a number of officials with me. Who I will introduce are the immediate officials behind me and to my left. And my opening remarks will be very short because I had a very lengthy opening remarks the first set of estimates a couple of weeks ago.

So to my left is Dan Florizone, deputy minister of Health. Behind me to my left is Louise Greenberg, associate deputy minister of Health. To her right is Duncan Fisher, special adviser to the deputy minister. To his right is Max Hendricks, assistant deputy minister and to his right . . . No, I missed by one. To Duncan's right would be Ted Warawa, the executive director of financial services branch. And to Ted's right would be Max Hendricks, assistant deputy minister. As I had said earlier, I have a number of other officials with me. If they are called on and they come to the table, they will identify themselves and where they work, I guess.

I won't have a lot of opening remarks, and I will also make comment that I may be asking my officials to answer a few of the questions, quite a few of the questions, as my throat and my voice may not last. It seems quivery right now, and I don't know if it will last four hours. So I will be relying on my officials to help me get through this four hours. Anyway with that, I'd be glad to answer any questions that the committee may have.

The Chair: — Thank you, Mr. McMorris. First question, Ms. Judy Junor.

Ms. Junor: — Thank you, Mr. Chair, and welcome to the minister and his officials. We did a fairly general round of questioning for the first hour and a half, so now my questions will be more particular.

I want to start off with the chiropractic services and the fact that we have had approximately one month of the new arrangement where only 12 treatments are covered for those on social services or those on a certain income. I would like you to tell me . . . We're now starting to get letters from people and comments from people and phone calls from people who have had their 12 treatments in the month and now are faced with no more for the year. They have found out that there is no special circumstances, there's no appeal. And they are now wondering what do they do for the other 11 months.

[08:15]

There is also still no agreement between the chiropractors and SGI [Saskatchewan Government Insurance] and WCB [Workers' Compensation Board]. That's still being worked on. So the fact that this came in so quickly has caught everyone unawares and basically there is a whole bunch of people who are suffering because of this.

I'd like you to first of all comment on where the agreements are since these are government agencies or at least arm's-length agencies, SGI and WCB, and comment on the situation that is now in place with social services or low-income people and the no appeal and the no special circumstances.

Hon. Mr. McMorris: — Okay. The first issue that you mentioned about the number of visits in the province of Saskatchewan is capped at 12, and that some people on low income — because that's what we would cover, anybody on low income up to a maximum of 12 visits — some people will have surpassed that I guess in the first month. You know, if they're receiving 12 visits a month that's 144 visits in a year. There is no province in Canada that would come anywhere close to that.

The most lucrative agreement — I guess you could call it lucrative agreement or most generous agreement — between any provincial government and the chiropractic association in their jurisdiction would be Manitoba, which would cover 12 treatments, capped at 12 treatments for all their population. British Columbia only covers 10 treatments for low income; Alberta I believe is about 12 treatments for low income; and we are at 12 treatments for low income. The other six provinces do not cover it all. The other three territories do not cover any chiropractic service whatsoever.

So for the people that are looking at 144 treatments in a year, and I know there are a number of examples like that, they wouldn't be covered in any other province up until 12 treatments, what they are covered here.

So it was interesting when the debate was going on and chiropractors were bringing people into the gallery, I had more phone calls I think from people saying, why would we cover 140 and 160 treatments for a person in one year? More of those calls than I did regarding whether the treatment was going to be

covered at all. So on the cap, I think whoever it is would find that there is a cap in four of the provinces that cover, 12 being the maximum, and the other provinces don't cover at all. So that is the cap that has been set and that is a hard cap.

The agreements between SGI and Workers' Compensation Board, there is a tentative agreement right now between the chiropractic association and Saskatchewan Government Insurance. Saskatchewan Government Insurance pays for the full costs of treatment. Yes, the chiropractic association has a separate agreement with SGI. As far as WCB, it has a separate agreement with WCB. And we're not sure if that is reinstated the way it was. We have to, I have to get a little more information on the WCB. I know that SGI has a tentative agreement and we're just, kind of, working on the WCB piece. But I think the most important part is, any person that's expecting 150 treatments a year wouldn't get it covered anywhere in Canada.

Ms. Junor: — Thank you. I'm going to quote my mother this early in the morning. She often said to me, if all your friends were jumping off the bridge, would you jump too? So I'm not exactly sure that that answer about only four other provinces are doing whatever, is going to make a difference to someone who . . . And I understand we're not paying for these. They were a co-pay, so it was a subsidized payment. But the people who are on low income or social services . . .

Social services, I think there'd be a different onus on what happens to these people because now I'm assuming without those chiropractic treatments that kept them either at work or out of bed and moving, that that won't happen any more. So those people will then access a different part of the system. And that was the argument all along, that we have made this . . . This decision has been made without actually looking at what the implications would be in the long run or even in some cases in the short term because some people will immediately be impacted by not having regular chiropractor treatments that would keep them either in the workforce or moving out of their homes or their beds.

So the difference between our obligation to people on social services and the difference of our obligation to someone who's low income or someone who was just getting co-pay at any income, those are three different set of circumstances. And we do have a different obligation to social services people since we will be paying in some way for them as well. If they can't get the chiropractor treatments, then what are we going to pay for them to do to keep going?

Hon. Mr. McMorris: — Well, you know, to your mother's comment about jumping off a bridge: when you see that every other province — not every other province — the majority of provinces aren't covering it at all, we haven't followed along with them. We could have. We could have quite easily followed along with six other provinces and three other territories, so nine provinces and territories. We could have followed along with what they have done over the last number of years and completely quit subsidizing those treatments.

That isn't what we have done. What we have done is followed along with the Prairie provinces, all of which cover low income. Only one province now covers, to a maximum of 12 treatments, the subsidization of chiropractic services in their province. Only one province does that. I wouldn't be surprised in the very near future, you'll see Manitoba move to the standard, the norm, which is 12 treatments for low income.

You can extend your argument to many, many services that aren't covered through Sask Health, or uninsured services. I think massage therapists do an absolutely amazing job in the province. Massage therapy is not covered, and some people rely on that to get to work each and every day. There are a number of treatments that people rely on each and every day to make themselves feel healthier. Those aren't covered.

What we have determined is that for low income, 12 treatments is the norm across Western Canada and that's the decision that we have made and we have moved towards.

More than 9,000, or 85 per cent, will not see a change in their current coverage. In other words, they receive . . . They won't see a change in their coverage because that's about the limit or the amount of treatments they were receiving. So you're talking about a small percentage I guess, is what I'm saying. The average is about seven visits per year. So you're talking about a small percentage that is looking at . . . And I think it would be an extremely small percentage that would be anywhere over the 100 visits in a year of service, you know, requiring chiropractic service.

Ms. Junor: — Then it does speak to my initial comments about the process of appeal or the ability to look at things that would be considered to be special circumstances. Will that be something you'll be considering?

Hon. Mr. McMorris: — Currently there is no appeal process to re-evaluate whether 12 is the proper number. We'll certainly, we could look at it into the future. Now I don't think it will be in this budget year, but we would look at it in the next budget year if people are having problems.

There are as I said, the bigger question becomes what should the number be? You know, I'd be very interested to know from the critic what she thinks the number should be. Other provinces have set a number at 12 visits or one per month.

It sounds like you're advocating for 140 or more visits a year for those that feel they need it. Is that, you know . . . Or should it be at 100 and they have to pay for their last 40? I mean, where does the number lie?

And so we have capped it at 12 like other provinces have. We will look at it after this fiscal year to see that, you know, if it has caused any grave concerns. As I say, this meets 85 per cent of the people that use chiropractic services. The average is seven visits per year, so we're more than above the average at 12 visits per year. But with that being said, we certainly have no problem looking at it in the next fiscal year as to whether we will have any leeway or appeal process for that number. I'll just leave it at that for now.

Ms. Junor: — Thank you, because in no way did I say that I thought 144 was the number you should put it at. What I asked is special circumstance, and since you've said clearly that it's a very small number of people who will fall into that category, so

there should be some ability for us to deal with special circumstances, rather than just have the overall policy appear to apply to everyone, whether it fits their needs or not.

And it's not as if everybody's needs are going to be met, but it is a case of when you need to have somebody's case reviewed, because you're already paying them on social services, they're disabled and receiving non-employable benefits, but there is some onus on us then to deal with those people. And if they're the ones that need the 144, then look at the special circumstances. And I had no way suggested that 144 should be what you do.

[08:30]

But I think we do need to have certainly a review of what happened, give it a year maybe and see how do we track where people who can't get the services that they had before, where do they show up then in the system. There's certainly been an indication that they will show up somewhere else because they do need chiropractic to keep them either working or moving or have a certain quality of life. So there has been a mention of some study that could be done or evaluation done by the Health Quality Council. Is that something that you're thinking of doing?

Hon. Mr. McMorris: — Yes, you know, we'll certainly do that. We'll look at, after the year we'll review what we have done and the effect that that has had. And you know, I don't want to put words in the critic's mouth, maybe it isn't 144. I'd be interested to know what number she thinks should be covered. Should it double what we are doing at 12? Should it be 24? Should it be 40? I don't know.

I mean, we've landed on the number at 12 because that is the standard, I would say, across Western Canada — again, higher standard than what we see across Canada. We cover 12; that's a standard that we have set. I'd be very interested from the opposition's viewpoint then, what is the number that they would put, or would they just leave it wide open?

Ms. Junor: — Well we could go round and round on this, but I guess I'll try one more time. I never said any number. Just because you've jumped off the bridge with the rest of the provinces doesn't mean that that number is the right number. So I do like the idea of having a review in a year to see what has happened because I don't think that there was a lot of thought given into what would happen when this was just categorically cut off. And notwithstanding that no negotiations were done with SGI and WCB and in other provinces, who did alter their co-payment agreements, they did have a three-month lead-in to have the effect, to take an effect date, which we didn't do here.

So it did put, I think, several people at a disadvantage and certainly that is becoming apparent. So what I am saying is that we need to have a review of the effects, and what I am saying is that there should be some mechanism for people who have certain special circumstances to have those looked at in some way. So if you don't have anything else to add, I'll move on from chiropractic then.

And I want to talk about briefly, about the children's hospital in Saskatoon. I attended the gala yet again, and it was kind of flat actually because I think people are a little leery. There was no item on the agenda for the minister or anybody to speak, although Maura Davies, the CEO [chief executive officer] did get up. And I think she was reacting to the mood in the room that there was certainly a degree of uncertainty about the future of the children's hospital, especially since there is now another study on where the site might be.

And of course, having been involved in Saskatoon studies since the early '80s, I think there's a fair degree of fatigue in studying where things should go there. And having seen how far along they are in Saskatoon to consolidating services in different places, and particularly out of City Hospital, there is I think a bit of a worry about, again, moving everything again. And I don't think there's any degree of comfort in the new group that's having a look.

And I was actually working at City Hospital when the new building was planned, and it was planned to be the maternal child centre, the new City Hospital. Somehow or other that went off track and it became geriatrics and rehab and whatever. And maternal child, such as it is, went to RUH [Royal University Hospital] and some to St. Paul's.

So there is a fatigue in Saskatoon, and I think it's hard for people to give up the thought that City Hospital is wasted. I had lots of people think that it's . . . the highest and best use isn't there. But there's also a real worry about another reorg. And there's also another group of people who are worried that we won't actually see this because the latest rumour I've heard is that we're going to see a unit or a ward or a floor renovated at RUH to deal with children's issues. So that thing moving around the city isn't helping either, but it would be nice if you could give us some clarity on the progress of this and the commitment of the government to it.

Hon. Mr. McMorris: — Yes, I'd be glad to hopefully bring some clarity to the issue. First of all, regarding the Children's Hospital Foundation gala that was held a week ago Saturday, this past Saturday, that isn't the impression that I got from people that were there, that it was flat. The people that I talked to thought it was a very good event. In fact I had the opportunity to talk to Brynn Boback-Lane after and she was very impressed and found that the fundraising was just as strong that night as it had been any other night.

So where the, I think, the idea that it was flat or a little — yes, I think the term was flat — is not what I have heard over and over again. I wished I could have been there. There was no . . . not that whether there was time on the agenda for me to speak or not, I was on that Saturday night — and I know the critic made mention of it in the House when she did a member's statement on it, the fact that I wasn't at the event — I was in Regina here at what was called a Doctors' Night Out that was geared towards recruitment and retention of internationally medically trained grads, with over 250 to 300 people in the crowd, mostly physicians. And I was at that. I had a previous commitment. That's why I wasn't at the foundation gala, and I, you know, had been there the year before.

I'm sure that the critic should know that as the Minister of Health you're pulled in a lot of different directions most every weekend and you have to make choices. And that was my

choice because I was invited first to the gala here in Regina or the Doctors' Night Out event here in Regina that recognized long service of physicians. It's unique I think in most cities, an excellent event recognizing the long service, recognizing the number of retirees first of all, and then some long service awards which goes a long way to help retain physicians, which is a major issue in the province.

As far as the commitment of our government to the children's hospital, it is there 100 per cent. Right now there is a kind of a second look as to where the children's hospital should be located — should it be at the RUH or should it be at City Hospital? It will not be a stand-alone facility, but the RHA [regional health authority], the Saskatoon Regional Health Authority asked for the project to be slowed down to make sure we have it at the proper location. It sounds like the member opposite has chose that it should be at City Hospital.

There had been an announcement that it would be at RUH. There is a number of concerns that were raised regarding RUH and whether it should be at RUH because there is some space constraints. There are a number of issues at RUH. So before we moved ahead and before the health region moved ahead, they said as a health region, with looking at how their services are going to be aligned within the health region, they wanted to pause and make sure that when the decision is made, it is the proper decision.

The money that is committed from government is in government. It will be there once the location and the scoping has been done. What I find not useful is propaganda that went in mailboxes saying that the children's hospital is cancelled. Nothing could be further from the truth. And, you know, I know your leader is going around announcing that, not only through propaganda that's being put in mailboxes, but through talk shows. I know he's supposedly going to be talking about that today, which doesn't help the process at all, because that isn't the case.

The children's hospital is going to go ahead. We are there to fund it. When the location and the scoping has been decided, our money will be there. We will not continue to announce it year after year. I guess we should. Maybe we should announce it year after year just so that people are aware.

Because that certainly was done in Humboldt where a hospital was announced year after year — seven years, I believe, running. It's being constructed under our government. The Preeceville Hospital was announced year after year. In fact the member from Canora-Pelly, who is a very good file taker, he's got every announcement, every newspaper clipping from the Preeceville press or whatever the paper is in Preeceville, showing the announcement being made from as long as eight years ago. And I was glad to be at the opening this year. It finally came to fruition.

Now we could announce the children's hospital. We announced it last year. We could announce it again this year. Our commitment is there. It will continue to be there. But we want to make sure that when the decision is made, whichever location, that it is made for the right reasons, whether it's at City Hospital, whether it's at RUH. It will not be a stand-alone facility. It will be in conjunction with. This is a major, major decision. It will be the largest capital investment ever in the province.

So, you know, I don't know if the opposition just wants us to, you know, to aggressively move forward and not look at all the options before we make the largest capital investment ever in the province or whether . . . I mean I really agree that the Saskatoon Health Region was correct in asking for a pause to make sure that when the final decision is made, it is made correctly. There will always be people that will agree and disagree.

And regardless of when the decisions is made, whether it's at City Hospital, there'll be some people that will not be happy with that decision because they think it should be at RUH. If the decision falls on RUH, there'll be people that aren't happy because they think it should be at City Hospital. That's going to be the reality of what happens as we move forward. But what we can say is — when that decision is made, all the information was gathered — it was the best decision that could be made.

There is a number of people on the board, 16 I believe, that are part of the decision-making board that are looking at it from various aspects to ensure that when we make this decision, a decision that will be in place that will be serving Saskatchewan residents and especially children for the next 30 to 50 years . . . If we take three or four months now or even six months to ensure that the right decision is made, the right location is chosen, the scoping is done properly, I think it's a small investment in time to make sure that the 30- to 40-year, the largest capital investment ever in the province is done properly.

I guess what I'm . . . And again I don't want to put words in the critic's mouth, but I understand from her preamble to the question is that she figures it should be at City Hospital. She worked there and that's where the children's hospital should be. And I'm not sure if that's the case, but what I do know is, I don't know where it should be. There are people that — the 16-person panel or roughly around 16 people, that will receive all the information — that will look at it and study all the options and the pros and cons of every option, will have a far better idea of where that facility should be located than I certainly ever will. And that's why I'm relying on their judgment as well as the judgment of the Saskatoon Regional Health Authority that ask for a pause to say, before we rush into this, let's make sure we're putting it in the proper location.

Ms. Junor: — Thank you. So I will clear up a few things. I did not say that City Hospital should be the location. I explained some of the background that I have with the construction of City Hospital and its original intent, which in no way assumes that that's my position, if I have a position, that that's what it would be.

It's interesting that you've said that the pause came from the . . . the ask for a pause came from the RHA, and I would like to know if you would table that letter for us because there's certainly an interesting correlation between the asking for a pause and this coming at the same time as the freeze on the money.

And going back to my original comment about the fatigue in the district, in the whole area of Saskatoon, about studying — this

location has been studied and studied and studied, along with all the relocation studies that have been done about what should go where, in the three hospitals in Saskatoon. And I'm only aware of the ones from the '80s, but I'm assuming there's more, more happened before that. So I think that the reason that I was up when I was at the dinner, that I got the feeling that things were flat, is because there is no sense that this will actually go ahead. You're not announcing that you're going to do it, but you're not announcing . . . You're announcing that you're going to study it again which means to people that it's not going to happen in the near future.

And what was most telling, what I did mention, is that there was nothing on the agenda for speeches. No one was being asked to speak including the mayor. There was no speeches. But Maura Davies, the CEO, jumped up on the stage and made a comment about what is happening which said to me that she needed to dispel something that was going on in the room. And since I was there, that is the impression that I got. And that was probably the biggest tell that something was not as upbeat as it was the year before, and I've attended, I think, almost all of them. So that was my impression, and that certainly was an interesting thing for Ms. Davies to do.

That being said, I think there are problems with any site that's going to be chosen because City Hospital is now renovated to have a certain function. RUH has, I gather, a huge problem all told. The advice of the latest study has been just to rebuild it. And the district apparently is going to need a lot more hospital space over the next 15 years, so is that part of your look? In Saskatoon, are you again looking at new beds all over for the health system and the children's hospital will fit into that plan? Or once you've looked at the children's hospital, will we have another study to look at the future of RUH and the need for the beds in the out years, in the next, say, 15 years?

[08:45]

Hon. Mr. McMorris: — I think what I'll do is, I'll answer the first, the kind of the preamble, and then I'm going to just talk to my officials regarding the requirement of space into the future.

First I want to talk a little bit about, again, the children's health foundation gala and your interpretation compared to the interpretation that I heard from many other people, some of our MLAs for sure, but a number of people that I saw on Thursday night at a dinner in Saskatoon, where TCU was packed for a very positive dinner. And I talked to a number of people at that dinner that had been at the children's foundation including a number of people from other foundations in Saskatoon that had nothing but positive to say about the fundraiser. I was at the fundraiser two years ago when we made the announcement. And the announcement was made, and we were able to reconfirm that announcement that the province has the money in place, and when the planning and scoping is ready, that the money will be there.

And my recollection from most foundation dinners, fundraisers, they're not there to hear a lot of politicians speak. And even when we had an announcement, people were at the back at the silent auction items, far more interested in bidding than listening to me speak, and I don't blame them. And that is generally the case in most foundation fundraisers. I don't know if you've been to too many fundraisers where you have a half an hour or an hour of people speaking. I never have. And it doesn't matter which foundation, whether it's City Hospital or it's the children's hospital or the Evening in Greece for the Hospitals of Regina Foundation, you don't have a lot of people standing up there speaking. And whether it's Mayor Atchison who'd give a great speech or whoever.

I think it would be appropriate for Moira McKinnon to stand up — Maura Davies sorry; Maura Davies, sorry that didn't sound right — to stand up and give a progress report and where they're at. That makes perfect sense. It isn't to save the evening. Not at all. It was to give a progress report on where they were at because, quite frankly, when people are receiving in their mailboxes from your party that the children's hospital is cancelled could be no further from the truth. So if Maura Davies stood up that night to clarify I would say it's not because there was a flat mood in the room. It's to clarify some of the propaganda and out-and-out untruths that were said in that flyer.

And I'm glad she did because she would feel very passionate about that. We've had talks about it. She knows that our government is committed. We're moving forward with that project when the site location and scoping is done properly. But that would be, I would think, the reason why only one person would speak is to clarify some of the untruths that was sent out in a flyer and that are being around the Saskatoon community, which isn't helpful for anyone, to clarify that. As I said, foundation dinners generally aren't platforms for political speeches, and I'm glad that one wasn't as well.

Now as far as the expansion of services and capacity into the future, I'm just going to talk to my officials a bit further to clarify.

Just a couple of comments to the second part of your question which was around the capacity into the future, on whether we're looking at expanding that, there's a couple of issues there.

I think the first one I will say is that Saskatoon Regional Health Authority has seen an increase of services supplied and needed, I guess, within that health region. And I would say that it's not only Saskatoon. There are other health regions that have seen an increase in services, and that comes with growth.

That comes when you see a population that has increased by over 30,000 people in the last number of years. You didn't see that . . . And maybe there was a bit of an increase in demand in the past, when population was declining, although that's kind of counterintuitive in that where you've got population declining over the last, probably for many, many years, 15 or 16 years at least, that the population was inclining, that you would see a demand in service, increased demand in services. But we do realize that is very much the case right now.

We're seeing a greater utilization of all of our services in . . . and I won't say all health regions but in most health regions, and Saskatoon being one of them. Certainly Prince Albert area is one. Lloydminster is another area. We're seeing increase in population. We're seeing a younger population in the North, and Prince Albert has seen a real increase over the last number of years in births. Their maternity ward is stretched, I guess,

would be the understatement.

So as far as Saskatoon, we do see increases. But we also see, in all of the health regions, efficiencies that are gained that will help offset some of the increased demand on services.

And that's part of the process that we're asking health regions to go through in the next fiscal year, is to look at efficiencies, to do things more efficiently. Lean processes will be introduced in all the health regions to look at streamlining processes so it's not always just about increasing the services but making sure that we most efficiently deliver those services. That is being done.

There is also work within the ministry right now that is being conducted — and it's getting closer to an initial draft — is the 10-year capital plan, 10-year capital health plan for the facilities around the province to see where we need to be in the next 10 years, where those increases in demands are, and making sure that we can meet those demands as the population, I believe, continues to grow.

I think the province is on a bit of a roll now and will continue on this very positive road, positive population growth for many, many years. I'm very positive about it. I think most people in the province are very positive about it and so that also has to be factored in to a 10-year capital plan to make sure that we have facilities that are positioned properly to meet the demand as we move forward.

Ms. Junor: — Thank you. Before I leave this topic, I just want to talk a little bit about the chronology of events that have happened around the planning of the children's hospital. And my first comment, because I need an answer on this one, is you didn't respond to my request to have the pause letter tabled.

The second thing is, you continue to refer to it as the children's hospital and it has been since 1990 considered to be a maternal-child, and all along I have assumed and I think from the announcements that I've seen, including Maura Davies herself telling me that we are committed to this being a maternal-child. And I haven't heard any mention of that, but I know the realignment of services would be significantly different if that's not what the commitment is.

But in '03 is when the health region included locating . . . That's when they were committed to locating children's services in one place. And by '05 there was a commitment from the government to have the hospital within a hospital. There never was a commitment to having a stand-alone. It was always a tower or a pavilion attached to something that was already there. So there was no, I don't think, confusion about that.

In '07, '06-07 actually, the fiscal year, there was provincial funding for preliminary planning. And in '07 there was a comprehensive facility audit in Saskatoon. In '07-08, more money was in for further planning committed to that and in '07, early '07, Royal University Hospital was announced as the location for that, and including comments from Maura Davies that says she was delighted to confirm the location.

So it's not hard to understand people's concern when three years ago the location was already announced, money was put in. The project proposal was supposed to be in the next budget. It seems to be a slow walking for some reason and I think that's why people are a little less than believing any more in things that are said because it doesn't appear to be any, any time soon that anything is going to happen. Because since '07 it has been announced that there's a commitment, but nothing has moved forward.

When in '07 there were already, I think it was May, after the announcement of where the facility would go, the functional plan was completed already and that was outlining the services that would be offered. And the planning was to be complete by '09 and project approval for construction. So what has actually happened since '07 that has made this go on a slow walk?

[09:00]

Hon. Mr. McMorris: — I guess there's a couple of points there. The naming of it, the proper name, is it a maternal-child's, children's hospital or . . . I say it so often I just say children's hospital now. The exact services, that may change. The exact title may change. I don't think anybody should read into the fact that because I say children's hospital that it hasn't, that it's going to be geared just in that area as opposed to a maternal-children's hospital. It's more just for my sake as far as referring it.

The health region itself, through a — we believe, and we're just tracking it down — a bit of a news release, asked for a pause. It was Maura Davies that went into the media and said, because there is a lot of concern as to the RUH — that was the site that was spoken of first, that it was, you know, announced as where the children's hospital would be announced, or would be located — there was a lot of concern since that time.

And as I said, it's been within the last year or so that we as a government have committed the finances. So in other words, it will be going ahead. Unlike in past announcements prior to 2007 it was announced, but there was never any money there. And it was announced like Humboldt was announced and Preeceville was announced and I could name a number of other ones that were announced. We announced it when we had money to go behind it, as we have with other facilities. So that certainly, I would say, ramps up the urgency and importance now. The money's there. We're moving ahead.

Are we definite on a location? The board of the Saskatoon Health Region, as well as the CEO, both had expressed concerns as to, is that the right decision? As I said, when it's the largest capital project ever in health care in the province, is that the right location?

When there are certainly concerns and proponents, concerns with RUH and proponents of City Hospital, is that the proper location? Is RUH the proper location or should it be at City Hospital? I think it's very wise for the Saskatoon Regional Health Authority and Maura Davies who on February 10th, 2010, through a media announcement asked for a pause as part of our due . . . And here's a quote from Maura:

> As part of our due diligence for a project of this size and importance to the people of Saskatchewan, and before moving forward with detailed design, we will work with

> the project manager to validate the site from a number of perspectives.

Those are Maura Davies's words from the Saskatoon Health Region on February 10th, and we are certainly accommodating of those words. I guess we could have said — and it would be interesting to hear what the member opposite would think — but I guess we could have said, sorry Maura, we are not going to pause. We have chosen the site and I don't care what anybody says. This is where the site is going be. This is where the location is going to be. This is where our money is going. I don't think that would be very responsible.

So what we've done is listen to the people on the ground in that health region, the board and the CEO as of February 10th that says, give us a few more months and let's make sure we do this correctly. And certainly that's the decision that was made as we move forward. That doesn't mean that the facility or the project is cancelled which, as I said, you couldn't be further from the truth — and quite frankly it does more harm than anything else to the project — that couldn't be further from the truth. The project will go ahead with a, I guess, a bit of a . . . with a second look to make sure that all the due diligence has been done appropriately. And I could, if you would like, probably get the news release that was sent out by the Saskatoon Health Region on February 10th stating that very thing.

Ms. Junor: — That would be helpful to table that. I just want to go back to one of your comments before I move on, that you said there's never been any money involved in this project. And I would like to read the chronology again: that there was a commitment for the hospital within a hospital in May of '05, and in the next budget, provincial funding was there for preliminary planning. And as you have said, this is the biggest project to come along for quite a while, so we would assume there would be planning to be needed. So there was money in '06-07 for preliminary planning, '07-08 another 1 million for planning. So to say that there was no money ever invested in this is not leaving the correct impression with this committee and the public that are watching.

I would like to actually talk about . . . And I'm happy to see that you might put back maternal-child into the concept because I don't think it's going to . . . I think that's the logical thing. It's always been there and I'm hoping it stays. But you're talking about, the money is there. Could you tell us where the money is exactly and how much is it?

Hon. Mr. McMorris: — So regarding the money for the children's hospital, I think the question was, where is it? I want to touch on the one thing that you had mentioned earlier. And you were saying that some money had gone in for planning, and absolutely money has gone in for planning. What I had said is that there was no money going in for the construction. The $200 million that we've committed was never committed before until our government committed it. So there was some money that went into planning and scoping by the previous government, as with our government.

So if I was misleading, I wasn't misleading on the intent to mislead that there was no planning done. But what I was saying is that there was no capital dollars for the construction. But if you want to call that misleading, then I would ask you to take out of your propaganda that the children's hospital is being cancelled. That is misleading. Because there is $200 million. The $200 million is controlled through Finance. I believe it's still in CIC [Crown Investments Corporation of Saskatchewan]. That has been earmarked for this facility. And as the money is needed, it will be drawn on through Finance, through CIC to make this project a reality.

There is a, as I said, a lot of work being done through a committee that has been struck to look at the scope and location of this facility. And I'm going to turn it over to Louise Greenberg to kind of go through what that committee has been working on, what that committee has been doing. Because certainly it leads to the questioning that the member has had.

Ms. Greenberg: — Thank you. Some of the responsibilities of this panel . . . And this panel includes membership from a wide variety of sectors including government, the Saskatoon Health Region, physicians, parents, and members at large. What we're doing is looking at four criteria, four options, two of which involve the Saskatoon . . . actually three involve the Saskatoon City Hospital and the fourth involves the Royal University Hospital.

So what we're looking at are these four site options in Saskatoon, is to look at renovating the Saskatoon City Hospital. The second is to do new construction at City. The third is to look again at Saskatoon City Hospital and look to see how we can combine both the needs of children and adult in terms of trauma and subspecialties. And the fourth is at the Royal University Hospital and that would be combining having both the children's hospital there along with the adult requirements of trauma and subspecialties.

Some of the discussions that have been going on that have started with the panel is that you have to, it's important to address both the needs of children and adults in terms of specialties. For instance, in trauma and in specialties, some of the same physicians that treat adult trauma are going to be treating children trauma in the ER [emergency room] along with some of the specialty areas, and we're trying to be cognizant of that in terms of the physicians that are available in Saskatoon and how they cover off both children and adults.

There's a number of criteria that we're going to be looking over the next number of weeks. There's meetings scheduled in May and the first part of June to look at criteria in terms of impact of safety and of quality patient care. It's very important to improve the patient and family experience in any new facility or construction that's done, looking at relative capital costs, looking at also the incremental operating costs and what the new costs will be for having an expansion, look how this fits with other relevant capital plans that are going on in the city of Saskatoon, at the University of Saskatchewan, and at the Saskatoon Cancer Agency.

We need to examine too the impact on teaching and research, look at implications for location and relocation of other clinical and clinical support services and staff, and also see how the service realignment that the Saskatoon Health Region has been working on will work in terms of future population changes and health needs over the next 10 years.

The committee is also trying to look at the shortest time to occupancy and infrastructure considerations and impacts. One of the things that the advisory panel talked about that was important was being very transparent in the material and the discussions that are going on. And a website has been set up which is providing information to the public. It has questions and answers. It's also asked for briefs to be submitted — short briefs, I believe, up to 500 words — to be submitted to the panel, and we're going to have access to every brief that comes written over the next month.

There's also a discussion about the possibility of doing some sort of a town hall meeting in Saskatoon where individuals can come and have a discussion on a number of questions and ask questions to the Saskatoon Health Region.

We're trying to have an open and transparent way of communicating in order that people don't think that things are going on, I guess, secured away and not being open about some of the discussion and the decisions. As the minister pointed out, it's a fairly important decision because it's the biggest project that has been done in Saskatoon at 200 million and it will have important impact and considerations for the future.

Hon. Mr. McMorris: — I have one other, also to the point about when it was communicated that there would be a pause. As I said, there was a news release from the Saskatoon Health Region on February 10th, and I have it here and so I'll pass that along. As well as then on April 15th, the members of the review committee — for lack of a better . . . validation panel is what its proper name I guess — the committee members are here, and you've also already heard a little bit of what that validation panel, the work that they have been doing. So I will forward, table not only the news release, but also the announcement naming the panel that will oversee this.

[09:15]

Ms. Junor: — Thank you. My first question is about the comment about money in CIC. Is it included . . . How is it displayed in CIC?

Hon. Mr. McMorris: — You would have to ask through Ministry of Finance those questions.

Ms. Junor: — Ted can't tell me?

Hon. Mr. McMorris: — Pardon me?

Ms. Junor: — Ted can't tell me?

Hon. Mr. McMorris: — Well I don't know. He maybe can, but I think those are better questions through the Minister of Finance.

Ms. Junor: — So you said you think there's 200 million, or you're sure there's 200 million?

Hon. Mr. McMorris: — I know there's 200 million.

Ms. Junor: — And so it could be displayed as debt in the CIC?

Hon. Mr. McMorris: — So, regarding the money, the cash for the children's hospital. It's held in CIC. Now where it's held and how it's held, we do not have any of those particulars. Those would be better asked through the Ministry of Finance and I guess CIC eventually, when they appear in front of committees as to how and where that money is held. That is not our responsibility in Health.

But what I will say is I know that the money is being held; that when the project — again, site location and the scoping — is done, the money is there. The cash is in the bank to move this project ahead.

Ms. Junor: — Thank you. Back to Ms. Greenberg's comments about the work of the validation panel and the three site options at City and the one at RUH, it just begs the question, what was being done up to this point, from '05 on? Were none of these things considered? I certainly have heard all of them. So what is new in this? What has made this a new exercise?

Hon. Mr. McMorris: — I'll start with a bit of an answer and then I'll turn it over to Louise who can kind of fill in the details. What is different between 2005 and 2008-09, let's say, or '09-10, the difference is is that there was money put towards the facility. I mean when there is no money put towards a facility, you know, the study can go on and the sense of urgency isn't there. When all of a sudden the cash is put on the table and said, let's do this; that changes everything. I think people took a, certainly a much closer look as to the options that are available, that were available.

That probably was not the case, or the urgency wasn't there until cash was laid on the table. Once the cash was laid on the table and the government was not only just talking about it, which has been done for many years, but was planning and had the money to build it, all of a sudden I think a number of eyes kind of focused in on where is the proper location. So I'll turn it over to Louise and she can fill in anything else.

Ms. Greenberg: — Thank you. The functional plan, as you stated, was done, was submitted or completed at the end of 2007. There was still work that needed to be done on a functional plan, and there was discussions that went on within the Saskatoon RHA, the discussions within the ministry.

And last year there was an RFP [request for proposal] issued for hiring a project manager and an architect. And they both have been hired, and they both are working with the advisory panel and with . . . There's a steering committee, too, that's been created, just internal. They are working with them to sort of take it to the next step. The money, as the minister indicated, was committed in, I believe in the '09-10 budget in terms of the 200 million.

What we wanted to do, in sort of making the four options that the advisory panel was looking at, the work has been done in terms of the functional plan, but it's really about do you locate it beside City? Do you build it within City? Do you build it besides the Royal University Hospital? But inserted in that was making sure that the provisions of looking after both trauma and specialties for children and adults was covered off.

Ms. Junor: — I just hate this committee to leave the impression with the public that all the work done up till this

point has been superficial or not useful. And even when I quoted Maura Davies in '07 saying, "I'm happy to announce the location at RUH," and then have all of this said, it appears that all that work was done in a vacuum.

And the fact that there was no money committed does not actually explain any of these things that logistically were going on in the district with good intent and with a fair amount of rigour, I would think. And to now say or leave the impression that it wasn't done or it needs to be redone, that is what I don't actually think is a good answer.

So I'm assuming that people that are listening too, that have been involved in this for a long time, would be as skeptical as I am that this functional plan that was done, and people hired, and then to look at renovations at City, new construction at City combined with adult trauma and subspecialties, all that was done already. And to now trot it out as if the 200 million commitment somehow made it more valid or made it have to be redone, I don't think that's a good impression to be leaving.

And I don't think that's a very good answer either. So if anybody has any comments on that before I move on, I'd be happy to hear them.

Hon. Mr. McMorris: — I would say that then you've misunderstood. Because the functional planning work that has been done is very important work and it goes into the project as we move forward. That isn't a waste of money at all. And never did I say that; you're the one that said that. The functional planning and the dollars that have gone in have been very valuable dollars and have moved the project ahead.

What I did say, is when there is cash on the table and the decision has to be made, is it going to be — notwithstanding functional planning but — where is the site location? The functional planning still is very valuable at regardless of which site location, whether it's City Hospital or RUH. What I did say though is, when people realize that the government is serious and not just talking about it, they're putting money on the table, this has to be done, they're taking a serious second look and that's what the Saskatoon Health Region had said. We want to pause and make sure that the location is right. All the work that we've done is valuable, absolutely. But we want to make sure that the location is right.

Ms. Junor: — I'm just reading the press release. And one paragraph just stands out all by itself, and the second last from the bottom, it says:

> In 2007, the Ministry of Health accepted the Region's proposal to locate the CHS at Royal University Hospital site. This site was chosen after extensively consulting with staff, physicians, and volunteers. It was also chosen as an appropriate site based on the fact that it is in close proximity to existing maternal and pediatric services, the University of Saskatchewan, and the Cancer Centre.

And it in no way says anything about why they would change their mind. It's an interesting paragraph to include because the question is then, why put this panel in to review what we've already done and the decision we've already made? So thank you for the copy of the news release. But it does raise the same question I've been raising, and it doesn't answer it actually.

Hon. Mr. McMorris: — If you would look further on up in front, or above I should say in the news release, you would see that yes, there . . . First of all, that paragraph that you read, that was . . . certainly consultation had been done with staff and physicians. There was a lot of push back. And as I said, in either site, there is going to be push back when the decision is made.

But there was a lot of push back when they realized that the money is on the table and it's going to be at RUH. That's why the health region board and the CEO went with this option to pause, and through these perspectives include the following: the impact on patient care and patient-family experience, capital costs, incremental operating costs. All of those things need to be looked at again before that final decision. RUH is very much in the running and may be the one. But I don't think it is unrealistic to step back and say, now that we have the money, are we making the very right, the best decision for the next 30 to 50 years of maternal-child care in this province?

And I'm surprised that if you think that a delay of six months or however long this takes is a waste of time. I'm very surprised at that because I personally think that it's a very valuable pause to make sure that when we put the money in, the decision has been thoroughly looked at from both perspectives.

Ms. Junor: — You mentioned six months or whatever. Do you have a timeline in mind for the end of this committee's work?

Hon. Mr. McMorris: — So we believe that there's been a couple meetings conducted. There'll be another meeting in June. So the committee is doing their work. We think realistically, you know, sometime through the summer, recommendations will go to the Saskatoon Health Region as to the committee's decision.

Ms. Junor: — So do you anticipate having it ready for the next budget cycle?

Hon. Mr. McMorris: — This really isn't necessarily reliant on the budget cycle because the money is held — cash — through CIC, that if we had to, we could move it when construction begins.

Ms. Junor: — So you're anticipating this review to be done by fall and a recommendation to come forward?

Hon. Mr. McMorris: — No. I believe I said through the summer. They're meeting again in June. They're getting close to making their recommendation. It will go to the Saskatoon Health Region who will review it, maybe have some questions, maybe go back to the committee with more questions. I don't know. So we'll let that work out.

But I would think it would, the final recommendations would go to Saskatoon Health Region sometime through the summer. And you know, I guess as time flies, I think the final decision would be made by early fall.

Ms. Junor: — Thank you. All right. My next topic is back to finance. Before we let Ted relax back there, you might as well

bring him up.

I've had a chance to look at some of the things that were discussed in the first hour and a half we had together and talk about the general budget. And we talked about the operating deficits that were in last year's budget, the '09-10. And my question is, have any of the RHAs had to transfer funds from their capital accounts to fund their operating situation? And that'd be '09-10 I'm asking.

Hon. Mr. Warawa: — If you like, there was funding that was transferred from the capital accounts to be allowed to be used for operating expenditures in 2009-10. In the prior year, in '08-09, a sum of money — I believe about 156 million — was paid for long-term care facilities to the regional health authorities. That money was not being used in '09-10. Construction wasn't proceeding as fast as they had thought.

In order to utilize that money for, I guess, general operating purposes, what we've allowed the RHAs to do is to take a portion of the cash that was available for the long-term care buildings and use it for general operating. We offset then a reduction. By using that money, we reduced their grant payment to the RHAs in '09-10 as well.

So the money came across. The cash was used from the long-term care facility funding, and the operating funding was reduced by that amount. So in that transaction, there was no real impact to the operations of the RHAs. We replaced what would have been grant funding from the GRF [General Revenue Fund] in '09-10 with cash that was held for the long-term facilities by the RHAs. They didn't have to change their operations as a result.

[09:30]

So the other day when we were talking about RHA deficits, I was going back to that tradition when we talk about operating deficits. The $12 million number and the $7 million in Saskatoon, that refers to that shortage between what they require for revenue and what they require for expense. That might have an operating implication. This transaction — it amounts to about 122 million of cash that was transferred — doesn't have an operating implication.

Ms. Junor: — So the capital accounts that the districts have, they traditionally were considered to be restricted. And so if you moved the 156 million from long-term care that was, I would assume, in this restricted capital accounts line or process, did you check with the Provincial Auditor before doing so because if this is an acceptable financial transaction from an accounting perspective, I'd like to know that.

Mr. Warawa: — Well we did have conversations with the Provincial Comptroller, and we did release the funding. So the funding was held restricted in the capital account when it was paid in '08-09, but we did send formal notice to the regions that the money can be released and used for that purpose.

Ms. Junor: — When you had your conversations with the auditor, what did he say about the practice?

Mr. Warawa: — I didn't. We spoke with the comptroller.

Ms. Junor: — The comptroller, then what did they say?

Mr. Warawa: — The transaction is, as long as we're disclosing, you know, have made the, I guess, the disclosure of what the funding was for, and we've released it with notice properly. You're allowed to move funding too and have it used for general operating.

Ms. Junor: — So we talked about the forecasts that were in the budget in '09-10 that 12 of the 13 RHAs . . . you have forecasts for each of them. And could you advise us the estimated deficit or surplus for each of the RHAs in the '09-10?

Mr. Warawa: — Did you want that including accounting for the transaction for the long-term care? Or just what is . . .

Ms. Junor: — Yes. Can you separate them? Like give it to me, but you can separate them? You might just want to table it rather than tell us because we'll have to go back and read *Hansard* or take notes as we're doing it. If you're going to give me your estimated deficit or surplus for each of the RHAs, can you table that?

Hon. Mr. McMorris: — The numbers that we would have right now would be, what they would be is third quarter forecasts from the regional health authorities. And that's what we were talking about the last time we were together with estimates. We're a month past the fiscal year, so in the next couple weeks, I would say that the health region and the boards will be discussing the upcoming — and have probably already — the upcoming fiscal year, as well as reviewing the last fiscal year. But any audited report, any final . . . the numbers from a health region usually come in around June, I believe, in that area. So I mean we could give you some numbers. They wouldn't be exact. They would be more what we had already talked about from the third quarter because, as I say, the boards are discussing that over the next couple weeks as far as where they landed from the last fiscal year and where they're going in the next fiscal year.

Ms. Junor: — So you don't have a report on the forecasts for each of the districts estimated deficit or surplus for the last year?

Mr. Warawa: — At last committee, we spoke to a $12 million net number for regions, and that was based primarily on what we know about third quarter from the regions. There is added to that that amount for the long-term care transaction which we do know. The total for the long-term care was 122 million that we released and allowed them to use to offset grant funding from the province. I guess both those numbers are reported together — the operating deficit, as we traditionally talk about it, and the deficit that results from the long-term care transaction. I don't have final numbers for the operating deficit. But we do have third quarter numbers which is the 12 million that we talked about last committee. Now those would be out of date, I guess, very soon here. So depending on what you're looking for.

Ms. Junor: — What I'm actually looking for is each district. I don't want the aggregate. I want each district's estimated surplus or deficit for last year. So when it actually comes in, then we find out what it actually . . . did they meet it or was it right? So I don't want the third quarter. I would want to know

what you started off with ’09-10 for each of the RHAs, not the aggregate or not the combined, and I’m assuming you have that some place.

Mr. Warawa: — I don’t have where they finished ’09-10 yet.

Ms. Junor: — No but you estimated, I’m sure, what they had, or they estimated and give it to you when they put in their budgets in ’09-10.

Mr. Warawa: — Oh, as we were working to . . .

Ms. Junor: — Yes.

Mr. Warawa: — But that would have been the third quarter forecast.

Ms. Junor: — Okay well then that would be good. But I want it from each. I don’t want it as a combined. I want it broken down for each region.

Hon. Mr. McMorris: — We’ve got quite a bit of time yet this morning, so we’ll get that to you.

Ms. Junor: — Okay.

Hon. Mr. McMorris: — We can get that to you well before the end of estimates today because we have quite a bit of time.

Ms. Junor: — And more time coming I think. So my next question then is the 2010-11 fiscal plan. Does any of it provide for the RHAs running a combined operating and capital deficit? And if so, which ones? And I would like to know the difference. If they’re running a deficit, which is capital and which is operating?

Mr. Warawa: — And are you referring to the summary statements again? Is that what you’re looking at?

Ms. Junor: — Referring to the fiscal plan for 2010 and ’11.

Mr. Warawa: — Well we don’t anticipate any of the regions . . . We don’t start the year in anticipation of any of the regions running a deficit in their operating accounts. So we assume and, I think, we’ve planned for the regions to balance. So the number that would be either in the summary statements or any number that were showing in our estimates would include a number that has the regions where they’re expected to balance in the upcoming fiscal year.

Ms. Junor: — That’s a whole other question then because I know many districts are being told they need to cut X amount to meet . . . They have targets. So if they don’t meet those, then they are expected to run a deficit, I would assume. So they’ve been given targets to meet which many of them are saying that they’re going to try their very best, but I don’t think many of them have a lot of . . . I don’t think they have a great belief that they can actually do it.

So it’s interesting that you’re assuming that they’re all going to come in balanced because we’ll wait and see, I guess, on that one. But I want to talk again about the debt that is as follows, that you gave us in last Monday or whenever we were together, and the obligations that the RHAs have. They pay their own interest. Do they also negotiate that interest rate themselves?

Mr. Warawa: — Yes.

Ms. Junor: — So that’s what I thought. So my question would be if the government, if the GRF would take it and Finance would take it, that would, I’m assuming, bring the interest rate down and save quite a bit of money. And why aren’t we doing that?

Hon. Mr. McMorris: — So there’s a number of kind of different layers and levels to the question. I’m not sure how many of us will take a crack at some of the different layers and levels. I know Dan Florizone will touch on it a little bit. I just wanted to say that at the start of every budget process, it’s always worked as . . . And Ted mentioned that they always budget at a balance they plan on coming in at the end of the year. They work through their meetings right now with the allotment that they have received — an extra 123 or about $123 million to the regional health authorities and increases of 123 to the regional health authorities. They take that and they look at how they can manage their affairs to come in at a balanced budget. And that’s been the case last year, the year before. Every year health regions work to come in at a balanced budget.

[09:45]

Now there’ll be variations through the year. Some will be increased services demanded. Some will be through a pandemic, for example, that will throw those numbers off-kilter a little bit. But health regions have been going through this for a number of years. Not over the last couple of years, but since health regions — first of all districts, then health regions — were set up, were allotted X amount of dollars to run the business within their health region. And most work hard to . . . All work very hard to come in at a balanced budget.

That hasn’t always been the case. I mean there was a number of years ago where health regions, two health regions were running some pretty heavy deficits. Their spending was greater than the money that was received from government.

It’s going to be a very challenging year for health regions. And we talked about it the last time we were together in estimates that it will be a very challenging year. They’re looking across the province to find about $35 million worth of savings, roughly, from status quo where they would need, status quo to the 126 that they’ll be receiving. There is a shortfall and so how do they best conduct their affairs and try and find efficiencies to meet that?

We’ve already seen some health regions such as Saskatoon looking internally at their executive, at their inner workings, and trying to find efficiencies. I gave some examples the last time that we were in estimates just on premium time and issues around sick time and the amount of dollars that add up in those different areas. And that’s just one of many areas that the health regions will be looking at to try and come in at a balanced level with the funding that we’ve received.

I am in full agreement that it is challenging. It will be challenging for the health regions, and I’ve heard it from board

Chairs and we're hearing it from CEOs. Not to say that it can't be done, you know. They think it can be done but it will be challenging, and tough decisions will have to be made. And that's, you know, the process that they'll be going through over the next few weeks and months as they set their course for the next fiscal year on the money that was allotted to them like it has been over the last number of years for health regions.

I'll just turn it over to Dan as far as the debt piece. Maybe before I do that, one of the things that was mentioned in the Patient First Review through Tony Dagnone was a shared services organization that we think has a lot of merit, that we'll be working towards and are working towards right now. But one of the issues in a shared services organization, in other words kind of a central agency that looks after certain services within all the health regions. All the health regions buy in, and we, you know, receive some efficiencies through, you know, if it's one purchasing agent, for example, as opposed to 12, if it's kind of a centralized HR [human resources] — and these are just kind of blue-skying right now. If it's centralized on financial issues, some of the efficiencies that could be found.

You had mentioned whether we should be consolidating debt in the GRF. Perhaps the health regions, if they combined their debt, could get a better rate because of the combined debt. There are some issues when you just flip it over into the GRF, and I think maybe I'll turn it over to Dan. I don't know if I've . . . I'll turn it over to Dan because he's got some thoughts on it as well.

Mr. Florizone: — Great, thank you. Since the time of formation of regional health authorities in 2002, there's been a great big piece of policy consideration within the ministry itself, within Saskatchewan Health, on this question of covering off the debt of the previous health districts, the pros and cons of doing that and what either perceived or real incentives might be created through such a payoff or a consolidation.

One of the difficulties that we run is that it's very easy for organizations, particularly regional health authorities, to run a deficit. And in fact to manage to budget, it takes a great deal of discipline. One of the difficulties that we had with respect to consideration of these options was that if every time a debt was run, a debt was paid off or consolidated within GRF, there was very little control and certainly fewer incentives to see balanced budgets. So while dollars don't drive everything, certainly patients do. It was extremely important and continues to be extremely important that these authorities run balanced budgets and don't spend . . . Even if in a single year they spend more than they take in, at least they have sufficient cash reserves to be able to cover that.

The taking on of debt is a very big concern. It would be equivalent to allowing deputy ministers to take on a debt. We're accountable to central government. We're accountable to this budget process. And to have regional health authorities, as separate third parties, taking on the debt of government was something that was viewed from a policy perspective to be an inappropriate incentive.

Ms. Junor: — The question I had was that the debt right now is . . . Given Ted's comments of last time, there's about $89 million. And he thought about 50 is associated with the CMHC [Canada Mortgage and Housing Corporation] debt, which apparently can be renegotiated, and should be. And that would be a different kind of saving.

But my question was, the rest of the debt, the 30 million. And it is, I think you answered — I'm not sure — in that answer did I hear that each district is negotiating their own interest rate with their own lender?

Okay. Then that doesn't seem to me to be efficient. And when you're talking like the deputy minister was about incentives to save money, even if we were borrowing the 30 million at, say, a 6 per cent and the GRF, Finance, can borrow at 3 per cent, that's almost $1 million savings. And why wouldn't we do that? I mean I understand incentives and discipline and all that stuff, but $1 million a year in debt payment that's unnecessary doesn't seem to be a very prudent use of the whip.

So I think that we should look at — we as government or you as government — should negotiate the debt, at least this non-CMHC stuff. I'm pretty sure it's . . . I'm advised that you can negotiate that again too. And if the RHAs have to hold it themselves and pay it to you, but you've negotiated it and so you are the underwriter or whatever, because eventually we are anyways — the province has only got one treasury — and so it doesn't seem to me to be prudent to be wasting $1 million at least in only the 30 million debt.

The other 50 million, I don't know how much is wasted there. It's still our money and it could be certainly spent better in health . . . $1 million a year could be better spent in health than to give it to some bank.

So I do think that that's short-sighted that we don't renegotiate that on behalf of the districts and still maintain, I don't know, whatever hammer you want to have, so that they pay the debt and still keep their house in order each year. And I understand that most of the debt is held by only a few of the districts, so, say Regina, what part of the debt does RHA, does the Regina hold? What part of that $80 million debt does Regina hold?

Hon. Mr. McMorris: — I would just like to answer some of the commentary beforehand and then Ted will answer the specific issue regarding Regina Qu'Appelle. A large portion, as was said, is with CMHC on improvements that were done. And some of the rates are higher perhaps than what we could get if we renegotiated. But it's like anything now. If you have a mortgage and, you know, I mean I've certainly been through this where the, you know, you signed at a percentage and the rate drops, and you want to negotiate, you can renegotiate and you can get that lower rate, but you pay a penalty.

So it's not just a clear savings. It's not like you can walk up and say, interest rates are 2 per cent now; we're signed at 8 — I want the 2 per cent; I don't want the 8 per cent. That's pretty logical, except the bank is going to say, we're going to lose X amount of dollars moving from 8 to 2 over the term of your agreement and we need to be paid out on that. So it isn't as simple as just saying — and not that we won't be looking at it and trying to find efficiencies — but it isn't as simple as saying, we want a lower rate with no penalty, because that isn't quite how it works.

As far as consolidating, you know, any of the debt that is incurred as we move forward certainly will be looked at, and as I said, with a shared services agency organization, can look at consolidating that debt to receive a better interest rate as we move forward. Absolutely. I think it makes perfect sense, but this is the way the health regions had been run for a number of years, not the last two years, and we want to relook at that, and as I say, move into perhaps consolidation of that, so that, of debt, so that we receive a better rate.

But this has gone on for as long as the health regions have been around. If they incur some debt, they financed it on their own in past and up until this point. And it makes perfect sense to look at it through a consolidated group, but as far as the CMHC issue, there will be penalties to renegotiate. Not that it shouldn't be looked at and determined whether the penalties are greater than the savings or vice versa. That can be looked at. But I'll just maybe turn it over to Ted.

Mr. Warawa: — So as we move forward with new debt, it would maybe easier to look at you know a consolidated financing approach for the regions. Debt that's existing in the system, there's other negotiations that would have to happen in order to consolidate that debt. So not knowing for sure how that would work out, I'll just leave it at that.

You'd asked specifically about Regina's debt. Its share of the CMHC . . . And this is at the fiscal year end '09, and I'll try and update that as best I can. But again without final numbers, we don't know exactly where they ended this year, but they had about $3 million worth of CMHC mortgage debt. In total they had $2 million in other debt that would have been associated with borrowing. So at last year, they had about $5 million worth of debt. We've added to that, this year in Regina, another $7 million as we've moved the ownership of Pioneer Village to Regina. It had a $7 million mortgage, so in total, Regina's share of that debt would be about 13 million.

Ms. Junor: — Thank you. And the same question for Sunrise.

Mr. Warawa: — Sunrise has a larger historical operating deficit that they've been carrying forward. They had, in the previous year again, about $9 million CMHC-related debt, $5 million in other debt that would have been associated with things like energy performance contracts that they've undertaken. That was our estimate at the time. But they also have a $10 million line of credit that's still outstanding. So in total for Sunrise in '09, they had $24 million of that debt would have been theirs.

Ms. Junor: — Do you have any idea what their borrowing rate is?

Mr. Warawa: — It would depend on, each piece of that debt would have a different rate. I wouldn't have that handy, and I wouldn't know how to blend it. New amounts, I think . . . Well I'd have to check. I just don't have their exact rates on each piece of their debt handy.

Ms. Junor: — Could you check and give it to me?

Mr. Warawa: — I could check . . . [inaudible].

Ms. Junor: — Okay. And just before we leave the districts with their capital and operating deficits, you took 122 million out of the 156 million for long-term care. Did you leave the other 34 in for long-term care construction?

Mr. Warawa: — Yes, it's still sitting with the various regions.

Ms. Junor: — And aren't targeted to projects. And so it is in a restricted account?

Mr. Warawa: — It is still restricted for long-term care projects.

Ms. Junor: — Okay. Thank you.

Hon. Mr. McMorris: — Just wondering if I could just add one note regarding Sunrise. One point is that there's about $10.1 million that Sunrise has been working with — $10.1 million of deficit that Sunrise has been working with. When regions, when the 32 districts became 12 health regions, when Sunrise combined the regions in their area, there was — that was back in 2002 — there was a $10 million debt within those districts that then became the responsibility of the Sunrise Health Region. And they've been working on that.

There always has been I think maybe a little bit of an irritant for Sunrise, even though that is factored into the grant given by provincial government, but a bit of an irritant that they have that debt over their head, which really as a region they didn't assume, but because of districts and the assumption and consolidation of districts, they ended up responsible for.

Ms. Junor: — So they would probably benefit the most, obviously if there was some renegotiations done on their CMHC and their other debt, some help from Finance that could get better rates for them. Because I know the irritation, I've been around for that one for a while.

I just want to move on to some of the staffing comments. And we talked a little bit about SHIN [Saskatchewan Health Information Network] last time and its amalgamating. When it amalgamated with HISC [health information solutions centre], does the SHIN FTE [full-time equivalent] count? It doesn't show up in the GRF, so when amalgamating was done, have there been more FTEs lost that don't show up because SHIN is a Treasury Board Crown?

[10:00]

Hon. Mr. McMorris: — I think what I'll do is I'll have Max Hendricks answer those questions. And I imagine you'll have more around SHIN and HISC, so we'll have Max here to answer some of them.

Mr. Hendricks: — If I understood your question, actually SHIN doesn't have any FTEs attached to it. All of them are within the ministry with the health information solution branch.

Ms. Junor: — So when the amalgamation occurred, there was no loss of FTEs?

Mr. Hendricks: — To which amalgamation are you . . .

Ms. Junor: — HISC and SHIN. I understand they amalgamated. Is that not the fact?

Mr. Hendricks: — No, they're treated as separate entities. SHIN is a Treasury Board Crown corporation which receives funding from Canada Health Infoway, that sort of thing. The actual FTEs are located within the ministry with HISC.

Ms. Junor: — So I understand the department is shutting down HISC and amalgamating it with SHIN. Is that not the case?

Mr. Hendricks: — That's correct. That's the future plan, that we would actually reinstate the Crown corporation so to speak so that it actually did take employees into that. And this reflects . . . Our ministry is one of the few ministries that doesn't belong to the ITO [Information Technology Office]. So the corporate part of our work is shifting over to the ITO this fiscal year. And so, appropriately we think that the FTEs for the Crown corporation belong in the corporation.

Ms. Junor: — So back to my question then. There are going to be FTEs lost or not, whether they're displayed in the department or whether they're displayed in a Treasury Board Crown?

Mr. Hendricks: — So right now there are, I think it's either 82 or 87 FTEs with the health information solutions centre. They're actually displayed in the ministry. Some of those, and it hasn't all been worked out yet, but some will transfer to the ITO. And the remainder will transfer to the Crown corporation.

Ms. Junor: — So are any of those displayed in this year's budget reductions of FTEs?

Mr. Hendricks: — No, not in this year's budget reductions.

Ms. Junor: — And is this amalgamation and shutdown going to occur within this budget cycle?

Mr. Hendricks: — Yes.

Ms. Junor: — So then we will find out when the FTEs will be lost? And if there are any, when will we find out? Next year's budget?

Mr. Hendricks: — Yes. If the transfer occurs at some point during this fiscal year, it will be restated in next year's budget.

Ms. Junor: — Are you anticipating job loss?

Mr. Hendricks: — No, we don't anticipate any job loss.

Ms. Junor: — Okay. I think the Chair wants to break before I go into my SHIN questions.

The Chair: — Yes. Thanks, Ms. Junor. We'll break for less than five minutes, just for a little bit of a comfort break, and we'll be back promptly. So we'll have a recess for about five minutes or less.

[The committee recessed for a period of time.]

The Chair: — Welcome back. Welcome back, ladies and gentlemen. We'll carry on with the second portion of our Human Services Committee estimates of Health this morning. Ms. Junor, you have the floor.

Ms. Junor: — Thank you. Back to SHIN. And I know, since I was on the actual original board of SHIN and have been through it with many iterations on my part and SHIN's part, how difficult it is to convince sometimes our colleagues that an electronic health record is necessary to strengthen this system, and actually to not only increase quality and safety, but save us money.

And it's been a difficult sell that money should be put into computers, what people see as computers, rather than bedside nursing. I've had those arguments, and I understand the difficulty the minister would be having.

So I want to just simply ask how committed you are, Mr. Minister, and your government to the electronic health record and the electronic medical record. And the money in the budget is decreased, and so are there going to be new initiatives or are we going to just see status quo?

[10:15]

Hon. Mr. McMorris: — So regarding the electronic medical health records and the whole modernizing, I guess, the health record, you know, I certainly am committed. Our government is committed. It was very loud and clear in the Patient First Review. Tony Dagnone identified it often in fact. When we did the announcement of the Patient First Review and the release of the Patient First Review, the findings, Tony, although it may be symbolic, didn't give me a hard copy but gave me a stick for my computer electronically so that to show how important that the electronic health record was as we move forward.

So our government is definitely committed. But you know, I think any minister would know when you're around the Treasury Board table, you're always battling for money, and you want to see as much go to that as possible. You have to work to convince your colleagues, and we are working on that. I know that we've been working on a bit of a tour of some of the areas and sites within the province that are more advanced, to take some of my colleagues around to show how important and how it can make the whole process much more efficient it is to moving the health care ahead, moving health care ahead in the province.

The other piece that is often lost on the electronic health records is, if you're trying to recruit new grads, how important that is. It's one thing to recruit a physician that may be kind of midway through his career or to the end of his career where electronic health records haven't been as important, but it really is a recruitment issue as we move forward. So it is very important.

You had asked about the budget and the exact numbers in the budget. It'll show a decrease of about $3.9 million year over year from 2009-10 to 2010-11. What needs to be said, what isn't in those numbers is the fact that in this past fiscal year we were able to pay $14.5 million ahead, so the money available for electronic health records in this fiscal year is greater than even in the last fiscal year because we're able to pay some money ahead. So there'll be no reduction at all in services and

the rollout of the electronic health record.

You know, we have the PIP, the prescription information program. RIS/PACS [radiology information system/picture archiving and communication system] is being rolled out throughout the province, being expanded. There are a couple of health regions that are up and running. It's being expanded, as well as laboratory is kind of the next area that will be worked on.

It is a huge investment and it is always . . . You know, when you look at how much money we've put into electronic health records, if you look over the last 10 to 15 years, some would say that's a lot of money. It isn't a lot of money compared to many other companies and firms. You know, I mean, WestJet blows us out of the water as far as their IT [information technology] and what they can do compared to what we do within the province of Saskatchewan with our electronic health records. So although the investment looks large, it isn't in a proportion of spending compared to many other companies in the province, or not in the province but many other companies that understand the effectiveness and the efficiencies that can be gained by electronic health record.

So I guess the bottom line being that it will be moving ahead as fast as we can make it move ahead. There is no reduction in spending for the electronic health record.

Ms. Junor: — Then to my question about status quo, or will there be new initiatives funded this year? You mentioned labs. Is that new?

Hon. Mr. McMorris: — I think maybe I'll turn it over to Max to respond to that.

Mr. Hendricks: — So in this fiscal year, we'll continue to roll out PACS [picture archiving and communication system] into other communities that don't currently have it. So Regina, Yorkton will see PACS come online this year.

In terms of the lab repository, that's our next build-in. We're actively pursuing that. We have engaged the preliminary work to be done, so we hope to actually see lab results across the province sometime, or at least rolled out, begin rolling out in this fiscal year. Some regions, for example, Regina already has lab information, and it's got a functional EHR [electronic health record] within the region that's being used by some physicians. So it's already happening, but we need to have the provincial solution.

Ms. Junor: — So you anticipate that coming with the new initiatives from this year's money.

Mr. Hendricks: — Yes, we will begin developing the lab repository this year.

Ms. Junor: — So do we have targets in SHIN? Like how many physicians are committed to the EMR [electronic medical record]? Do we have some targets?

Mr. Hendricks: — Yes, we do have a target to have 80 per cent of physicians online by 2014. In fact the experience has been that they want it as fast as they can get it. Our take-up rate and the demand for adoption has been greater than we can actually roll it out, so we've added additional resources to try and expand the EMR into their offices.

Ms. Junor: — So what's the percentage of physicians right now that are using it?

Mr. Hendricks: — I would have to guess that's less than 20 per cent currently because we just began this process. But we anticipate that it will go actually ahead of target in terms of rolling it out. We've selected our vendors. We have four preferred vendors. And so those vendors are actively installing EMRs in physician offices.

Ms. Junor: — So I thought it had come in before now. You said you're just starting it.

Mr. Hendricks: — We developed the program, but we went through a process where we had to select the vendors and put them through compliance testing. So actually the first vendors, just in last fall actually, were available to be installed in physician offices.

Ms. Junor: — 20 per cent that are online right now just came on since last fall?

Mr. Hendricks: — I'm guessing it's somewhere in that range, yes. They're going fairly quickly. It's either 20 per cent have signed up or 20 per cent have come online.

Ms. Junor: — But only since last fall. So is this something that comes out of SHIN's budget, or is this something that's in the SMA [Saskatchewan Medical Association] contract?

Mr. Hendricks: — This is a separate agreement with the SMA after the last . . . sort have been parallel to the last agreement. So we have, when fully implemented, $10 million a year going to support the EMR. But fortunately Canada Health Infoway, with the newest $500 million that was provided by the federal government there, some of that money's going to be coming back to the province to support the implementation and adoption of the EMR. So we're hearing we could get anywhere from 4 to $10 million through that fund.

Ms. Junor: — So that's going to be apart from bargaining because that's an issue of funding that's going to be different. The funding stream will be different if it comes from the feds.

Mr. Hendricks: — Yes.

Ms. Junor: — So it isn't something that's going to hold up bargaining.

Mr. Hendricks: — No.

Ms. Junor: — And will not likely be reflected in the cost of the contract then.

Mr. Hendricks: — No.

Ms. Junor: — Okay, I think that's my SHIN topics for right now. I did see at one point that the department had a strategic plan. Do you have one for '09-10 and '10-11?

Mr. Hendricks: — Yes, in fact we do have one for ’09-10 and it’s in draft form right now for ’10-11. We’re hopeful to have that finalized by early June. So there is a strategic plan, in fact two. You might have seen a variety of versions, so just to clarify, we have a plan for the ministry. We have a plan for the system as well. And we’d very pleased to make those available to you.

Ms. Junor: — Thank you, I appreciate that. So my next line of questioning is, since it has a connection to the debt and the deficit of districts . . . Before I leave that, I’d like to know, there’s been some, certainly a lot of talk in the media, and I’m sure there’s been talk around lots of water coolers about premium time, sick time, and all those things that are cost drivers in the system and that there’s some interest, in fact, high interest in achieving savings by reducing those.

There was something called premium hours per FTE. And on average, I notice that my information says in ’06-07 that figure was 9.9 hours premium hours per FTE. In ’07-08 it was 10.1, so it’s rising. In ’08-09 it was 12.3. Again that’s quite a significant rise. And so what are the estimated premium hours per FTE in ’09-10 and then following that, the targeted reduction for ’10-11?

Hon. Mr. McMorris: — The numbers that you used, first of all I’m not familiar with those numbers, so could you maybe explain to me where you . . .

Ms. Junor: — I received them from someone who’s doing research for me, that premium hours per FTE in the RHAs on average were in ’06-07, 9.9; in ’07-08, 10.1; and ’08-09, 12.3. So my question was what is the estimate — since we have those numbers already — what would be the estimated hours per FTE for this last year. What were the estimated hours, and what’s the targeted reduction for ’10 and ’11?

Hon. Mr. McMorris: — So that is for a full year, not for a quarter?

Ms. Junor: — It appears to be. It says ’06-07 so I’m assuming it’s a whole year. Those are the average premium hours per FTE. Somebody has figured this out, probably in Ted’s shop.

Hon. Mr. McMorris: — Because we have some numbers that are different than those and I’ll kind of go through those. They don’t really relate at all to what you had mentioned, but this is what we have as far as premium hours per FTE, and I won’t go by the health region or the Cancer Agency. I’ll just go global as far as all of them combined over the last number of years, and you’ll see that over the last few years we’ve seen an increase in our staff complement.

But in 2007-08, there was an average of about 48.4 premium hours paid per FTE. In ’08-09 it went up to 52. But in ’09-10 it dropped back down to 50 premium hours per FTE. So it had bounced up. I mean it has been increasing steadily over the last number of years. It slowed; I think would be safe to say that it slowed. That increase slowed from ’07-08 to ’08-09. So we’ve seen it, you know, increasing, increasing. That increase slowing in ’08-09 to now a decrease in ’09-10 from 52.2 down to 50, and we see a further reduction target which we have set out in 2010 and ’11 of about 45.

So what we’ve done is we’ve slowed the increase, to stopped it, to reduced it, and now we hope to see a bigger reduction in ’10-11.

Ms. Junor: — So then my question would be, how do you anticipate slowing this down next year and keeping the trend?

[10:30]

Hon. Mr. McMorris: — Well I think RHAs have already been working on that. You know, first of all the increase in the number, in this case registered nurses, for example . . . The increase of registered nurses in the province, I think, over the last two and a half years from a declining number to now increasing by 75 per cent of our target is reflective in these numbers. ’07-08 we started on that path. ’08-09 continued. ’09-10 saw the numbers increasing which is reflective in the decrease in premium hours paid and will continue to see, I think, a decrease as the workforce expands some, but also as health regions, you know, target this area. You’ve already heard some musings from the Saskatoon Regional Health Authority, that they are going to be targeting premium time pay and trying to reduce that. I’ll think you’ll see other health regions entering into that too.

Last year in 2009-2010, the estimated premium time paid in this area was $88.628 million. So you know, it doesn’t take a large reduction, you know, to see those premium time hours come down to see a huge savings. That’s a lot of money spent on premium time — over $88 million, 88 and a half million, a little over that, in ’09-10. And that’s after we have seen a reduction.

I can’t imagine what would’ve happened to those premium time hours had we not put a concerted effort into the workforce and increased the number of nurses working. For example if we used registered nurses, the number of registered work nurses working over the last couple of years, that number would’ve, I think, continued to balloon. We’re for the first time seeing a bit of a reduction after many years of increase.

Ms. Junor: — I guess I ask the question again. At the FTEs, would the premium hours worked per FTE, is that across the board all disciplines, or do you have a breakout for RNs [registered nurse]?

Hon. Mr. McMorris: — Okay. So the numbers that I had given earlier were all combined, all health care combined, not just registered nurses, but all the unions combined including out of scope. So you combine all the health care workers; those are the numbers of premium time per FTE. I don’t know if we have all unions, but we can . . . I have some numbers regarding SUN [Saskatchewan Union of Nurses]. And I mean, there’s many other providers. And if you wanted to get into detail on each provider union, that would take some time, but we could probably move in that direction if you wanted to.

Regarding the Saskatchewan Union of Nurses, the number of premium hours per FTE is reflective of what I had given already regarding all people working within the health system. But I’ll recite these numbers: in 2007-2008, the premium hours were about 84.7. They went up in 2008-2009 to 87.4.

But I think then, in 2009-10 — the year that we’ve just come

through — we've set some targets. We've increased the number of nurses. You're starting to see the benefit of, I think, the initiatives that have been launched and, in 2009-2010, it was 79.2 premium hours paid.

That being said, when you talk to most people that have kind of studied this and see these trends forming, they'll all say that it will take a while; it'll take two or three years. There's a two- or three-year lag. You can increase the staff, but there's still some premium hours paid out for sure. But you'll see a trending down and that's what we have seen.

I think if you were to compare historically, further back, the premium hours over the last 10 years were probably increasing year over year quite significantly. We saw that trend slowing from '07-08 to '08-09 and for probably the first time in many years. And you know, I don't have these numbers back further, but we see it dropping down in 2009-10.

Ms. Junor: — So have you established targets, say, for SUN, to decrease that 79.2 to a certain amount for '10-11?

Hon. Mr. McMorris: — Well again, that is not necessarily . . . I mean we're asking the health regions. It is the health regions themselves that will be dealing with that.

But let me just check with my officials.

So we haven't set targets provider union by provider union or Saskatchewan Union of Nurses. We haven't set targets that specifically, but I will say that probably health regions will work on that. That is the health regions' responsibility and, again, you've heard some musings from various health regions on how they were going to achieve that.

What we have done is set more of an overarching target for all of health and, as I said, we were at, you know, in '08-09 we were at 52. We've dropped down to 51. And we're looking at a further reduction of about 11 per cent as a target, down to 45 in '10-11. So an aggressive target, but certainly I think, as we see again the staffing complement increase, we think a target that we can manage.

Ms. Junor: — So for SUN, since you have the numbers for SUN, do you have a breakdown of the premium hours that are attached to sick time, overtime, and WCB?

Mr. Florizone: — Thank you. I just wanted to clarify. The number you were looking for, was it associated with premium time? Or you wanted to know the actual costs of WCB and sick time?

Ms. Junor: — No, the ones we were talking about were on premium hours per FTE. So I wonder if you have the breakdown — when you gave SUN's premium hours for the three years, what the breakdown of those premium hours is into sick time, overtime, and WCB.

Mr. Florizone: — No, we don't have that. And in fact, the system has not done a good job in tracking. There have been some assumptions that certainly sick time and WCB, creating that vacancy or those vacant hours does generate premium time. But we don't have a breakdown in accordance with that. Now what we do have is targets set and actual dollars spent with respect to WCB and sick time, separate and apart from premium time.

Ms. Junor: — Well my concern and my reason for asking this is because the districts that I have heard and the reports that are in the media, everyone seems to be targeting sick time and suggesting, you know, massive abuse of this and for various different reasons.

So I'm wondering if the actual money spent is that significantly in sick time because I've also heard that some districts are considering hiring their own doctor to validate your sick leave or your medical leave, which of course, you know, I'm sure you understand the concern that will be in all the unions when this appears to be kind of a draconian approach. But . . .

Mr. Florizone: — I do have those numbers. And I'm sorry I misinterpreted the question. The amount spent on sick time in '08-09 as a province was just short of $60 million. So that is not at . . . And I'm not suggesting that that is the premium pay. That was separate and distinct. This is the amount that's paid specifically to those staff that are off sick — $60 million last year. I also have the trends if you'd like to hear those as well.

Ms. Junor: — Can you just table them?

Mr. Florizone: — Absolutely.

Ms. Junor: — Okay.

[10:45]

Mr. Florizone: — And with respect to WCB, I do have the trends on WCB as well that show both by time loss claims and by days. The costs would be reflected in premiums that we pay to WCB. So those certainly are a matter of public record as well, and we could certainly table those for you.

So we really have three targets here that have been introduced to regional health authorities that are prompting some of their thinking. And these are targets around creating safer work environments and reducing WCB days and claims; around sick time — and there is a very significant portion of this related back to the health of the workplace — so very substantial costs that are associated here; and then premium pay targets that have been established. So all three we've set out in a strategic and operational direction for the system.

Ms. Junor: — It would probably be good for the districts to talk about the WCB and making healthier workplaces rather than what has come across as fairly finger pointing and punitive when you're suggesting that people are sick Mondays after a concert or on a long weekend or all those sorts of things that just are . . . They serve to irritate the workforce and I really don't see . . . I understand the concern and maybe even some validity to it. I don't know. But it seems to be that's the one that's getting all the attention, and maybe that's not the one everyone is saying.

But it would be useful if there'd be some focus on WCB and premium pay and overtime and all that and ways to do that as a package of reductions and initiatives rather than focus on sick

time and some of the less than useful comments that are being spread around.

So I would like to get into a whole other topic, and I think I'll move next to drugs. There's definitely an increase in drugs every year. And the utilization of the drugs in '09-10, the actual cost, do we have the actual cost in already for '09-10 of actual drug usage, the cost and the utilization lift?

Hon. Mr. McMorris: — So the expenditure in the drug plan, in just the drug plan and the prescription drug plan this year is $317.768 million. But within that area, within the drug plan and extended benefits, which include other programs such as SAIL [Saskatchewan Aids to Independent Living] and supp health, the total spend this year in 2010-11 will be $382.658 million. Those aren't large increases at all over the past year.

There was some savings, lots of savings being found — some through generic drugs and other areas that we found over the last couple of years. So the increases aren't large, but those are the numbers. As I said, for the drug plan and extended benefits is about 382 million-plus and for the drug plan in and of itself is 317 million-plus.

Ms. Junor: — So one of your comments leads me to my next question. It isn't a big increase. So in past years there's been quite a large increase in utilization and the cost of drugs. So do you anticipate some of the savings that you see and you mentioned that some drugs are coming off patent?

Hon. Mr. McMorris: — So a couple of things, and as I had mentioned and you also agree, that the increases are not very large compared to maybe some of the numbers we saw in the past. And there are a couple of reasons for that.

First the reason is, is that, for example, in 2009-2010, we didn't spend as much as we had budgeted. We are probably $22 million under what we had budgeted. So we take that into consideration as we move forward. And some of those savings, again, we're seeing increased utilization maybe at a lower rate than what we saw in the past, but we're also seeing some of the drug costs come down quite significantly because of drugs being . . . the purchase of generic drugs coming off of patent, for example. That would probably be where the largest savings would be.

Ms. Junor: — Thank you. And do you anticipate any new drugs? Like is there a breakout of estimated costs of new drugs that are going to be added to the formulary over the year?

Hon. Mr. McMorris: — So that is built into the numbers that I had quoted before, is a little bit of utilization as well as increase . . . drugs that are being added to the formulary, which happen on a regular basis where drugs will be added to the formulary. That's kind of offset by drugs that may remain on the formulary. There'll be the odd one that will be dropped off, but certain drugs that will be on the formulary, but you'll see their usage decrease quite significantly because of an advancement in another drug that is more effective. So it's offset a little bit by drugs that aren't being utilized as much and offset by drugs that are coming on to the formulary, some more expensive perhaps, some in a generic form that would be less expensive. But we continue to build that into our estimate as we move forward.

Ms. Junor: — The process of recommending drugs to go on the formulary had two separate committees, if I recall. Are those committees still in place and what is their role?

Hon. Mr. McMorris: — There were two committees and so what we have done is combined those two committees into the drug advisory review committee, drug advisory committee of Saskatchewan. We've combined the two former committees into one I think to streamline the process and to . . . I think there might have been some overlap there and we felt that it could be effective combining the two into the one committee that reviews.

Ms. Junor: — So do you have the roles and responsibilities of the committee or the expected, you know, what their activities are, terms of reference, and who's on them?

Mr. Fisher: — We don't have the formal terms of reference here. I do have a list of the membership of the committee that I can leave with you today. But in general terms the committee reviews all drugs that come on to the publicly funded formulary for the drug plan with a view to providing specialized advice to the minister and the ministry on drug-related matters. There are 14 members on the committee, two of whom are public representatives.

The terms of reference for the group is a little bit different than from the previous two groups, the drug quality assessment committee and the old formulary committee, in that we've tried to avoid the duplication that existed in the previous system by incorporating the review of all drugs for hospital formularies. And we will be moving probably this fall to a review of all oncology drugs under this drug advisory committee of Saskatchewan.

Ms. Junor: — So has their role significantly changed? The combined committee will still function with the roles that were done by the other two committees. Nothing's been lost or added?

Mr. Fisher: — No, nothing's been lost. But as I said, they will be looking at the hospital formulary and the oncology formulary more than they did in the past.

Ms. Junor: — So is there going to be any anticipated increase in dispensing fees for the coming year?

[11:00]

Hon. Mr. McMorris: — So there has been an increase, last year on August 1st of 2009. And that increase was in effect until July 31st of 2010.

So as we come up to that date, that rate is $9.15. That's up from the last rate that was in effect from '07 to '09 which was $8.63. So we're up to 9.15. There'll be another increase as of August 1st, 2010 which will take us to the end of July of 2011 and that rate will be $9.43.

That is the maximum rate that a pharmacist could charge for dispensing. They don't have to charge that rate, but that is the cap that has been set through negotiations with the Pharmacists' Association.

Ms. Junor: — Do you have that in percentage?

Hon. Mr. McMorris: — No, but I'm sure Ted can . . . The increase as I said going from 9.15 to 9.43 is a 28-cent increase which would account to about a 3 per cent, 3.06 per cent increase year over year.

Ms. Junor: — Thank you. My next question is, I'm sure everybody that deals with drugs is watching the Ontario situation regarding generics. And I'm wondering if this government, your government has any plans of following the Ontario lead.

Hon. Mr. McMorris: — Yes, regarding the generic drug companies and their professional fees that will go to pharmacists and how that all works with provincial governments, Ontario has been quite aggressive. I think it'd be easy to say that they're kind of out in front on this in some of the policy changes and moves that they have made. Alberta is also moving in that direction.

I think it's safe to say that probably every province is looking at this and seeing how best to move forward. Is the system that we have right now, with professional fees being paid to pharmacists, the best system to have? I think all would say no, including the pharmacists. But what should that system look like?

That's why we're working very, very closely with our Pharmacists' Association and asking them to put forward a proposal that would help deal with this issue of professional fees and generic drug companies. I know I've met with a number . . . the generic drug company association. They have concerns with the way the process is working right now, but they also have concerns, as do the pharmacists, on some of the moves that Ontario has made.

So we're working very closely with our Pharmacists' Association. That will hopefully have them put forward a bit of a proposal, that we can both agree on — as well as the generic drug companies — to address this. And that will help hopefully to drive down the cost of the generic drugs, but also see pharmacists compensated for the work that they are doing because that's the offset. I mean it's fine for the generic drug companies to lower their costs, but then will pharmacists be reimbursed for all that they feel they need to be reimbursed for — if it isn't through professional fees — through the generic drug companies. So we're working on it, but I don't think it would be fair to say that we're moving in the same direction as Ontario right now.

Ms. Junor: — So is there a breakdown somewhere or is this displayed someplace as a cost under the drug plan, the cost of the program, the professional allowances? Because I'm assuming we're doing the same thing, so do we have it broken out of how much of the drug plan costs are these allowances?

Hon. Mr. McMorris: — That kind of goes to the heart of the matter. The professional fees paid through generic companies to pharmacists in no way comes through the drug plan or comes through government at all, or nor did it in other provinces. And so it's always difficult to try and get an estimate. We don't know the exact reimbursement to pharmacists from generic drug companies and so, you know, that becomes the very most difficult part. And that's why, as I say, it's not run through the Ministry of Health or through the drug plan at all. It's usually straight from, it is straight from generic drug company to pharmacists.

But that being said, we understand that if those monies are going as professional fees, the generic drug costs are probably higher than what we should be getting them at. If we can drive down that cost of a generic drug to the actual costs and then reimburse pharmacists through the provincial government, that would seem to be a much cleaner plan as we move forward. And I think everybody would agree with that. It's just the structure and how that looks.

Ontario has moved forward, as I said, pretty aggressively. Caused some concern I think for all parties, including the pharmacists, including the generic drug companies. We want to kind of work through this in more of a controlled fashion, having buy-in from especially the pharmacists and ourselves to agree on a process to address this issue.

Ms. Junor: — The reason I ask that is because in one of *The Globe and Mail* articles, I see that Ontario has estimated — understanding the flow of where the money comes from and where it goes, but — that by eliminating this option or this practice, it will save their annual generic drug plan, it will cut it in half. It's now $1 billion. It would cut it in half. So they obviously must have a track of how much this costs, so I thought we might have some similar figure or some similar answer.

Hon. Mr. McMorris: — That article, and you know as they said, it's an estimate. It's hard to determine exactly what the reduction will be. Some will say half. There's variations from province to province as you know.

We have a standing offer policy in Saskatchewan where Ontario doesn't. I think the standing offer policy allows us to get some of the generics at a lower cost. Ontario doesn't have that policy in place. So it wouldn't be fair to compare the estimated savings in Ontario. And it's not . . . that's what it is; it's estimation to a possibility here in Saskatchewan because of variations in policy to begin with with the drug plan.

That being said, if you were to hypothetically in Ontario reduce the cost of generic drugs by half, you know — I don't know what the number was, but let's say $500 million — that $500 million was probably going not to the full extent but going to reimburse pharmacists. I don't think any provincial government could say that by changing policy they'll cut their drug costs in half and still have pharmacists who want to practice within their province. There has to be an offset. What that offset looks like again needs to be negotiated, needs to be talked about.

But it isn't, I don't think it's fair to say — and I don't know what the conclusion of the article is — by simply changing policy, Ontario could cut their drug costs in half without huge ramifications on the pharmacists' side.

Ms. Junor: — And they don't qualify it with anything. It's just that they've said that it will eliminate. They didn't even estimate it will.

Just back one moment to the drug, the new drug advisory committee. The terms of reference are being worked on. When will those be available?

Mr. Fisher: — I don't have them with me today, so I can provide them to you.

Ms. Junor: — But you could share them.

Mr. Fisher: — Yes.

Ms. Junor: — Okay. Thank you. Mr. Chair, I'll turn the questions over to my colleague from Cumberland for the moment. Just one remark though: I'm not done with the drug plan, but we're stopping here for a moment.

The Chair: — Mr. Vermette.

Mr. Vermette: — Thank you, Mr. Chair, to the committee, and also to the minister and your officials. I guess within the budget itself, some concerns back home, and I would like to maybe have those issues addressed here in estimates.

And looking at . . . To the minister: can you tell me what improvements, in light of the concerns we're having with mental health issues in the North . . . And it might be, you know, seen all over as a rise, but I know in the North there's a lot of mental health issues that our young people and our younger adults as well, and I guess in general probably impacting the whole community, and it might be different reasons why. But what is the plan? And what is your ministry's plan to address some of the issues?

And I think about it under the mental health and I guess the youth suicide and suicide in general, the mental health concerns that are hitting our communities, impacting them pretty bad from our leadership concerns and our community members' concerns. And I guess, just as in general, what do you see is the plan and the responsibility of your ministry to address those concerns?

[11:15]

Hon. Mr. McMorris: — Thank you for the question. And I just want to start by saying we're very aware of some of the concerns and some of the issues that are happening, you know, around the province, but more prominently I think probably in northern Saskatchewan with youth suicide and some of the problems that that entails. You know, it is an absolute tragedy, and I know the numbers have been increasing over the last few years.

I wish it was as simple as, I wish it was as simple as saying this is the problem and this is the solution; we can identify the problem, which the problem is, you know, if it culminates in youth suicide. There are many, many levels below that and many, many issues below that — from standard of living, to isolation, to family support. There are many issues that lead to the culmination. So we can kind of see some of those, those reasons and factors that get us to that point.

Solutions aren't quite as easy. I mean if it was one solution, you could ask, what is your solution? We don't have a solution because there isn't a solution. And if there was a solution, it would've been done many, many years ago. It would've been done immediately. Now if we could all of a sudden find what that solution is . . . It is a number of solutions, some of which will be effective in some areas; some won't be as effective in other areas.

But I will tell you that we're very aware of the problem. We take it very seriously. Any time you hear of youth suicide, it is a tragedy. What I'm going, what I'm going to do . . . Or even it's not even necessarily a suicide, but it's some of the mental health issues that you'd talked about.

I'm going to get Louise to talk a little bit about what has been done over the last couple years and some of the ideas as we move forward, some of the money that's been spent, some of the work that's being done in a multi-ministry approach. Because these aren't just health issues and they're not just education issues and they're not just social service or not just justice, they're all combined. They all intertwine. And it isn't one ministry that has the solution either, you know, the solutions and policies and programs that will help reduce our multi-ministerial. And that's why the committee has been struck. So I'm going to turn it over to Louise to explain in more detail.

Ms. Greenberg: — Thank you, Minister. As the minister stated, mental health and addictions are important issues facing youth in the North, and it's a complicated issue that's not easily solved. The ministry provides funding for mental health workers in the three northern, in all the health regions, but particularly in the three northern health regions, including Mamawetan, Keewatin and Athabasca, along with P.A. [Prince Albert].

In Keewatin, there are eight mental health staff. Mamawetan has got seven and a half, and they're all trained in suicide prevention and intervention. There are two new positions in La Ronge and Beauval that we've put in which are dedicated to improving access to mental health services for children, youth, and their families. Athabasca has two and half mental health staff, and there's also in-patient services. And when a psychiatrist is needed, we do, using the Northern Medical Services, have fly-in services from Prairie North and Saskatoon for treatment.

In 2009 we started to participate in an inter-ministry committee led by the ministries of First Nations and Métis Relations and Corrections on looking at a number of services that we can do across government to youth in the North. This committee has actually identified a number of ongoing activities and a number of services that need to be provided for the future. One of the things that we're doing on the suicide is that there's been funding provided for $300,000 to the Métis Nation Saskatchewan through the Aboriginal health transition fund program which is a federally run program. They are hiring three coordinators in the North — I believe, it's going to be Cumberland House, Ile-a-la-Crosse, and I believe La Loche — to work with youth on a number of things including suicide.

The committee, this inter-ministry committee, is also looking at some short-term, medium and long-term solutions that are required for the North because besides just dealing with the

immediate problems, there's also the need to look at education, other activities such as sports, community development because there's a lot of things that need to be done in the area of giving youth support.

Mr. Vermette: — I guess then, and that's a concern where I think a lot of the leadership . . . and I've heard them very clearly. And some of the youth that have lost their friends and I've talked to a number of them. They think that same feeling of hopelessness, despair. And it is amazing how it is impacting them. And if you look at the different things that are not being done and currently under the previous government . . . And there's enough to blame to go around.

But let me make it very clear. More needs to be done. And people are feeling like the current situation is governments — whether it's provincial, federally — are turning their back on the North, Aboriginal communities. They're not feeling this so-called engagement you may be expressing really well and the dollars you're putting into it. I'm sorry to say, if you look at the numbers, they're not going down. So you know, the impact that your programs are doing right now and decisions that are being made that impact the young people in northern communities, First Nations, and Métis — I'm sorry to say — are not doing it and more needs to be done. It's very frustrating and you watch it. And when you see our young people and loved ones and any community member losing their battle with depression — if that's what it is — or the hopelessness . . . More needs to be done.

And I think the government has to come in with different partnerships. It can't be just one area. There's a lot of issues that have to be addressed, but those issues have to be a strong commitment by the government to say we will deal with those. So to hear you saying . . . I want to make it very clear that the front-line workers that are there, I know they're doing everything they can. And no one's questioning that. I'm not here to question that. More needs to be done.

We can't afford to lose any more of our youth. So the government has to start doing something and doing more than what it is doing. And it may not be just one department. It has to be through a partnership. But I'm going to take it, you know, and go back and those issues will come out.

And I just want to make it clear that I think solutions . . . Northern people aren't asking the Ministry of Health to fix their problems. That's not what it's about. They want to come up with ideas. They have solutions. They want to present those. And it has to be the government to look at all different areas of the North, not just Health, your one area where you deal with some of the issues, you know, and that will bring me further to some of my, I guess, to other questions I want to ask.

But I want to make it very clear: northern people are very proud. They want to do their part. They want to work and we know that. The economy, they want to be a part of that. Our young people want to get an education, but there are things that they need to have a level playing field and that just can't be one department. It has to be a commitment by the government to northern people, Aboriginal people once and for all.

And don't say that yes, we hear and we understand and we're putting a little money into it. That's not what I'm talking about. There has to be a commitment once and for all. We should not lose another youth or any community member to suicide in our province, period. More has to be done.

So I want to go also to addictions now. And I'll put my next question, Mr. Chair, to addictions. And you can comment on the comments I've made. That's fine. However addictions also, it's out of control. We will do something as leadership, and we've already done that. There'll be some opportunities for us as, I guess, northern people to come up with some plans and we're going to do that on our own. We don't expect the government to do it all. But where we come together with partnerships or ideas, we want to make it very clear that when we come to the government with some solutions on options we have to have the government and the Ministry of Health support to do that. Otherwise we are losing a battle, and it is a battle. We're in it right now.

Our young people, it affects all communities, and it's not just Aboriginal. The drugs, the addictions — it's out of control. We know that it's all over. So there's more work to be done. What is your plan with addictions? And I'm talking about drugs, alcohol, and where do you see things improving? And I want to make it very clear. I know the front-line workers; they're burning out. There's so much of a workload. So I just want to see where your ministry is going in that area and what your plan is for northern Saskatchewan.

Hon. Mr. McMorris: — I'll answer it broadly, and then I'll get Louise to kind of get into more of the detail regarding the addictions side of it. And, you know, I hope I can take you for your word when you said this is not a political. I mean these problems hadn't started in the last two years. These problems have been for a very long time, and you know, we're looking at solutions just like the previous government looked for solutions, and they're not easy to find.

Engagement, we're working on engagement. We have to get community leaders engaged. Some are more engaging, and some are more apt to come forward than others. It isn't the easiest; they just don't automatically come forward. And we're working on trying to engage the community leaders to work with us, to hear what their suggestions are and see which we can implement, see what we can do. But this has been an ongoing issue, and it will be ongoing into the future.

You know, I would agree with you. The absolute goal is to never have another child commit suicide anywhere in the province, especially in the North. That is a very laudable goal, and I would agree with that. That hasn't been the case over a number of years, and you know, as we move forward, our intent is to work towards that goal.

On the addictions side, it is a major issue not only in northern Saskatchewan but throughout the province. We have got an advisory council that have been looking at this and coming up with some recommendations. I've seen a few already that I think would be very, very positive. Again none of these are stand-alone ministry. I can tell you, and that's why I'm very happy to see the ministries that are involved in our committee to look at solutions for the North. And it covers many ministries, whether it's Corrections, whether it's Justice, whether it's

Health, Social Services, Métis, First Nations and Métis Relations. All of those ministries are around the table looking to try and address the problem.

This is not a problem that we are ignoring at all. We are working towards finding solutions. The solutions are combining resources from various ministries. But also it isn't for us to go and dictate what the supposed solutions are. It's to engage, to find out what we can do and working with the community leaders in the North, hearing what their ideas are, and moving forward on those ideas.

I'll turn it over to Louise on a couple of other areas that speak very much to the engagement of community leaders on some of the committees that we have been striking.

Ms. Greenberg: — One of the comments and I'll probably speak to both mental health and addictions in a combined way because they do go hand in hand.

Well we heard last year, when we provided funding to several communities in the North to look at summer programming, was a need to have youth councils. And there has been work going on. And there's been desire by youth to be involved in looking for solutions on issues related to addictions and to mental health issues. So some of the youth town councils, there has been interest. I don't remember which communities expressed between . . . and it's more on the west side, where there was expression of interest for creating youth town councils.

There was also discussions. We met several times with — I wasn't at all the meetings with some of the community leaders from the North — a number of the mayors where there was discussions with them on what they perceived as some of the important things that we should work on. And that has been ongoing, these discussions.

The areas too that we heard back or that we've actually been providing and I won't give you the numbers, but we have given extra resources over the last few years for addiction youth workers in both Keewatin and Mamawetan Health Regions. And they have been given funding for doing some work in terms of prevention coordinators.

The other area to remember . . . and it is a multi-faceted approach because it's just not health. We have our regional inter-sectoral coordinators are what we call RIC. We've had one in La Ronge, and we've recently approved funding and hired an individual to be located out of La Loche who will work with the community and look at a number of areas, not only including the health side, but also things dealing with services regarding children but employment, education, and some of the other areas which would be deemed important by the committee that would serve with this RIC coordinator. So that actually will be helpful on the west side.

[11:30]

The other thing that we've been doing that I'm involved with . . . and it only really touches on the First Nations side and not Métis. But two years ago we established a memorandum of understanding with FSIN who represent 74 First Nations, and Health Canada. And we've had a number of task groups working away. And they presented recommendations last week, and one of them is on mental health and addictions.

And these recommendations speak to a number of things that we've heard, including being able to provide seamless delivery for mental health and addictions support regardless of whether you are in an RHA or whether it's provincial or federal dollars. So we've heard that. We've had recommendations with regards to having better or more addiction treatment provided to First Nations, north and south. We've also had discussions with First Nations on how to look at some of the needs for First Nations because the First Nations are ones . . . more of our clients who do go into our addictions services are both First Nations and Métis versus non-Aboriginal.

The other work that we're trying to do with the MOU [memorandum of understanding] is up in the areas of employment and looking at our health human resources, which is another important component of being able to provide a future for people in the North because addictions is really an outcome of everything that's come before, and it's a cumulative effect of things — where you don't have a support system, you don't have a job, you don't have hope culminates in the areas in dealing with addictions. So there is a lot of work going on.

And what's most important though is that it has to involve the voice being heard and engaging people at the community level and also the community leaders because it's no use being developed in Regina and expecting that it's going to be carried through in the North. As you point out, a northern voice has to be there in order to solve some of the issues.

Mr. Vermette: — I guess I want to go a little further into this. And to the minister, I was hoping, you know, your comments previously about I hope this isn't politics. And you know, it's sad if you think that because it isn't at all. We have some serious issues back home. They are very serious. I know the government at the end of the day has decisions to make. And the people back home will hold you accountable. You have the opportunity to assist and give resources.

And when they make recommendations for solutions, as a government, whether it's yourself as your Ministry of Health or other government departments, I don't think people are playing politics that are . . . The things that are impacting their lives. They're not interested at the time about which party. They just want help for their issues whether it's mental health, addictions. They're not interested in who they're going to vote for.

So I just want to make it very clear. The people I'm hearing from have serious issues. They're very concerned. And I haven't got into talking, to be honest with you, I want to make that very clear. It is about the issues that are impacting their lives, their young people, their communities. So I want to make that clear for the record, very clear. I'm just a little surprised you would even go there but anyway . . .

Hon. Mr. McMorris: — Well let me just clarify because what I said is I was glad that this was not going to be made political was my statement. I was glad that you referred to what was done by a previous government and what is being done now. I think we would all agree that there is more to be done. I don't make this . . . This is not a political discussion whatsoever.

When you start talking about mental health and addictions and some of the problems that we face, not only in southern Saskatchewan but perhaps even more prominently in northern Saskatchewan, this has no political lens on it whatsoever.

What is most important is that people in those areas are getting the help that they need. Are we to that point yet? I'll agree, absolutely not. Has any other government found solutions? It's a work in progress continually. I said I was glad that you weren't making it political is my statement.

Mr. Vermette: — Well if that's the case, then I'm glad to hear that because I know there will be recommendations coming forward to your ministry. And when we do that . . . And I think the northern people and the First Nations, Métis work together to come up with solutions and leadership and community members, parents impacted, and brothers, sisters impacted that . . . And we will. We will come up with some ideas and things that will help us deal with some of the issues. I'm not expecting government to. But when we do that, we hope, and hearing your tone, I truly hope that when that happens you will support that 100 per cent and try to get the ministries that would be involved with resources to come in and pitch in a hand once and for all.

If you're clearly saying it's not politics, I appreciate that, and I will be comfortable with that. And we'll move on to the next question. So I want to thank you for that. I'm hearing there's a commitment from you and to deal with the issues. And I want to thank you for that.

So at this time, I'm going to go into another area, and it's diabetes. It's very concerning amongst First Nations and Métis, northern people. I guess you're hearing a lot of concerns. People that are impacted and there's different reasons, and I know we have to change our lifestyle. And there's different things that we can educate, but I think we have to do more. And I'm curious to see what your plan is and what the ministry's plan is when it comes to diabetes, what you've done with the budget currently. Where are you going? And what improvements are you going to make? And are you going to cut things or what is your idea, especially for First Nations and Métis and I guess northern as a whole?

Hon. Mr. McMorris: — Again like the previous couple of questions, I will start with kind of an overarching statement. And again I'll turn it over to Donna to kind of delve into the detail. Like I said, I don't have the knowledge or the voice probably to get into all the detail that Donna can tell you on.

But what I will say is that we know that diabetes is a major issue in our province, and it will continue to be. The numbers are increasing, so it needs to be addressed. And I think quite often — and I know Donna will talk a little bit about it as she goes through — about the education because we can spend all sorts of money on treatment, on dialysis and, you know, after the fact. It's how do we prevent it in the first place.

And so public education is so hugely important, you know, learning what our lifestyle choices are and how that affects us into the future. It's pretty easy to make the choice now and if you don't think that I'm going to have any consequences and then have to pay with the consequences after. I mean the vast majority of our resources go to dealing with the consequences.

And some will argue, and I will argue at times, that we don't do enough on the front end to educate, to try and inform people of how you prevent because . . . especially when it's type 2 diabetes. You know, if it's type 1 that's a different issue. But type 2 is generally lifestyle issues and how do we . . . You know and I know there are perhaps . . . Some will say there's some predisposition culturally, and so we have to take that into consideration.

But the vast majority of times, it's lifestyle issues that we need to work on, and sometimes it's because we just don't understand the consequences. Sometimes it's, you know, we need to assist people. Even though they may understand the consequences of those choices, we need to assist people, you know, to change their lifestyles. Whether it's recreational facilities and I know, you know, you could quite easily make the case in northern Saskatchewan, we don't have enough, although it's great to see the La Ronge Ice Wolves at a one and one record and playing tomorrow. You know, that is huge. Those will be huge role models into the future for people in that area. I mean, I don't think we could ever put a price tag on how important that team is and their success into the future because it becomes a role model.

But what I am saying is that, you know, there is areas that it's education. It's also making sure facilities are available, so if people want to exercise and through the winter months and if they need to exercise indoors, that they can. All of those things need to be put in place.

Donna will kind of give you a breakdown of some of the spending that we do, and as I said, the lion's share is on the back end.

Ms. Magnusson: — Thank you. My name is Donna Magnusson. I'm the executive director with the primary health services branch. As the minister indicated, in the province we spend something like $57 million annually on programs and supports for what we call "care of patients with diabetes," and that can include everything from drugs to dialysis, right on down the line.

But what we have taken a focus on is looking at what are the educational needs both for providers and for patients in terms of diabetes. So we've had a number of initiatives under way with the advice of the provincial diabetes advisory body and working with SIAST [Saskatchewan Institute of Applied Science and Technology], a partner. We've developed a number of learning modules for both patients and for providers on, like, insulin dose adjustments, risk identification of the foot, why people with diabetes need to take care of their feet, clinical practice guidelines. And we developed one called "Diabetes in pregnancy, gestational diabetes," and that was actually recognized by the diabetes education nationally and is being used nationally because Saskatchewan did such a good job on that.

But in addition to some of those other things, we've also worked with what we call the Live Well program, again focused on patients and how to manage their chronic diseases because we can do one part of the care in the hospitals and those areas, but if we don't help them to manage at home, it's going to come back. So that's been a major focus on what the province has

been doing.

Mr. Vermette: — Okay, thank you. I guess when you look at the mental health, addictions, and diabetes, and I know regular health authorities provide the regular . . . and I want to say regular; we'll say just the basic services that they provide.

Can you and your ministry provide to the committee, so that I can get a copy of, anything for the northern Saskatchewan that you are doing different, other than norm, that a normal health care process that goes on? If it's a different program, something unique, different that you're trying in the North, I would like to know about it. You know, just to the committee, if you could provide the committee with a list of programs that you are currently either moving on or going towards that you're going to pilot or ones that are already out there, I would like a list of them, so it would be nice to know what different projects maybe you're doing in isolated communities.

But why I say this because some of the comments I've heard of about programs that are going out in the North that are being developed, and they're pilots. And you know, when the media went to interview them, nobody knew what these pilots were, like, what are you talking about, not a clue. So I mean, to be listing off communities that are involved in a pilot and then the media goes to interview them on this exciting thing and none of the communities had any idea of what are these pilots. They're not happening. So maybe on paper they happened, I don't know.

But anyway, just want to say to me that would be interesting to know exactly what they are and it would be helpful if you could provide that to the committee.

Hon. Mr. McMorris: — Yes, we certainly will. It'll take a little bit of time. I mean, Louise talked about a few programs earlier, and certainly Donna has talked about a few. And some are specific to the North. Some are provincial programs. But we can give you a breakdown of that over the next couple days.

Mr. Vermette: — That would be helpful, thank you. I guess my last, I guess, area I want to discuss, I've been quite concerned — and I think raised petitions in the House — with long-term care for La Ronge in the North, Creighton, as well as there's different areas.

When we asked for the information and you provided to the critic and I got a copy of that . . . was the waiting time that our seniors have to endure in the North. It's just about one full year. To me, that is a sad reality when I look at the other health authorities and you look at their waiting time to get into a long-term care facility. And some of them in their own communities had to go maybe 10, 20 minutes away from their community till a bed was open in their community. And to me, any community that has to wait . . . in the North is one year. There's something wrong, and something has to be done. So what are your plans for long-term care?

And I look at the North in general, but I know La Ronge is really pushing hard and they're finding . . . And Creighton as well has some issues. And Creighton, their issue is a little different. And maybe I'll let you answer the La Ronge one, and then I'm going to go on to Creighton.

[11:45]

Hon. Mr. McMorris: — I know you had just asked about La Ronge. Again what I'm going to do is, is kind of do an overarching kind of policy . . . not policy but explanation from the ministry, and then I'll get Roger to talk about La Ronge specific. And he could go and even talk about Creighton if you want. I think that was your other area of . . .

Mr. Vermette: — I'll bring the question to you.

Hon. Mr. McMorris: — Okay. The whole issue around long-term beds around the province is an issue. I mean it's calculated on a ratio of number of population, 1,000 over the age of 75, how many beds per health region that would dictate. Every health region is a little different. Some health regions have quite a few more beds per age of 75, 1,000 population, other health regions are lower. Some health regions manage it through, you know, more home care to make sure that seniors can stay in their own accommodations longer. But there comes a time where long-term care is needed.

We get just as many concerns, I think. I would think, I know myself as the MLA [Member of the Legislative Assembly] for Indian Head-Milestone, when people have lived in a community all their life and there isn't a bed available for them and they have to move to another community — and you say it might be 10 or 15 minutes away; there's a lot of times it's an hour away — even within the health region that I, in the area that I represent. And that creates grave concern.

Unfortunately, there is nowhere that I know of in the province that we have . . . You know, if you use the hotel analogy — vacancies or no vacancies — everyone says, no vacancy. We don't have a lot of beds waiting for people. That isn't quite the way the system works. But I will acknowledge absolutely that some of the waits in northern Saskatchewan are longer and are unacceptable, and we need to do some work on that. I think one health region we're pretty close to the proportion of beds with the rest of the province, another health region, not so much. And we need to look at addressing that.

But I think the important part is, you know, we can continue to build more long-term care beds, and whether we ever build enough in the right location depends on where you're from and who you are. You'll say no, you didn't build enough or you didn't build them in the right location. There's always going to be some concern there. In certain areas we do know that we need to increase the number of beds because it is lower than the provincial average by quite a bit.

That being said, some health regions have managed this issue very, very well. One of the areas that probably we receive some of the fewest phone calls from have the lowest number of long-term care beds per capita in the southern part of this province because they do so much work on other areas such as home care and making sure that seniors are able to stay in their accommodation as long as possible.

I'll just turn it over to Roger to give you some kind of . . . I know you know the area very well, La Ronge, but to give you from the ministry's perspective where we're at there.

Mr. Carriere: — Good morning, I'm Roger Carriere, executive director of community care branch. In La Ronge right now there are 18 beds. And you're right, there are . . . The wait times can be long there. Laura Ross, in her looking at issues in long-term care, did do three consultations in the North, and that will help inform the ministry where developments need to take place in the North.

Mr. Vermette: — Well I guess we won't go over the numbers, but I believe the numbers are 16 and two are for respite. So there are 14 regular and two for . . . just to be clear on the numbers for La Ronge.

A Member: — That included both . . .

Mr. Carriere: — Yes, that included both regular and respite beds. The total was 18 I had, yes.

Mr. Vermette: — Well the numbers we got from and the report we got was there's 16 of them. And there's almost one full year waiting.

And if you look at the numbers, I guess — and I want to go back to this — the numbers your ministry provided to the critic when we request a written question on the numbers, there were some that had I think 18 days, 20 days, 30 days, but La Ronge was 340-some days, just about 350. Anyway, just about one full year. And we talk about that. To me, that should be very clear.

And you've made comments about there's different circumstances. But when people from La Ronge or the North have to go away, we're not talking about 45 minutes or an hour that they're away and eventually a bed opens up and they get to go home. Well people have to be away, and some do not . . . There isn't opportunity to speak the language, Cree, whether it's Michif, Dene, and they go to a facility where nobody can communicate with them or very few can. It puts that individual in such a spot, and you know, that's the sad reality of what's happening.

I'm hoping, okay . . . And we're going to continue to work hard in La Ronge and the North to bring the attention to your ministry and to make it very clear that it's time. There has to be a focus on long-term care for northern Saskatchewan, La Ronge being the one that's pushed really hard. I mean we've had hundreds of signatures on petitions; I know a lot of support from the leadership. The mayor and community members are very clear: it is our priority, and we're going to work hard. A plan has to be, you know, come forward. What does it look like, you know, a long-term care facility? I mean you want to make it very clear. It's going to be a plan that will accommodate the needs of our community.

But I just wanted to share that information with you because I know it's not going to die, and we're not going to let it go away in the sense of not bringing that forward and that argument, strong argument forward, about the need and seeing the difference. It's appalling that there's almost one full year versus anywhere else in the province. That shouldn't be happening, and that needs to be addressed. And we will do all we can from back home to address that. I'll make that very clear.

And we have a commitment from community members, from people and community members that have been impacted with their loved ones going down south. And it's a sad reality. They lose their loved one down south, then they bring that individual back home to bury and to have the service and stuff. And just to watch that whole process, and I've experienced that recently with family, people that have, you know, they're friends. And to watch what's gone on, you know, that to me is a sad . . . And it has to be addressed. And for whatever reason, maybe it's the timing, I don't know and it just happened to be the awareness or whatever, I'm not going to get into it, but the need is there and it has to be addressed.

And I'm hoping we can address that in a positive way for the community. It's about our senior. It's not about anything else other than they need their support of the government to do that. We're going to fight hard and, I mean we're going to, and if that's what it is — a fight — fine, or, you know, we know you know about it. We hope you will do something about it and we're going to move forward as a committee and as a group and I know they're getting together and they're trying all they can.

So we are going to have to do all we can to make sure, you know, the importance with your ministry and the officials. And I know the health authority will do all it can to support us and we're going to keep working away at it, and that's all we can do. If we don't do that, then I guess we're not doing the service to our seniors that live in La Ronge and the North, that have to wait.

I want to talk about Creighton, Creighton. I met with a number of different individuals, and the concern that they're having with the . . . I met with the mayor and council, and the concerns they have with the long-term care. There is not a long-term facility in Creighton, so they take their loved ones to Flin Flon in long-term care, which is a short distance away. But they also would like a facility.

And unfortunately, what happens when the individual from, resident from Creighton goes into Flin Flon — I'm being told and very clear and here's the frustration — they have to give up their health services card for Saskatchewan Health. Now that's what I'm being told. And I have trouble with understanding that, because why would they have to give up their Saskatchewan Health coverage to move to Manitoba and go into Flin Flon?

Maybe you know about that, but that's one of the issues that was raised to me. And I would like to know. Why can . . . And if that is so or isn't so, at the end of day something has to be worked out where that's not happening. Oh, I mean to me it just means communicating and working out some type of a deal, a MOU that where you could do that. So I'll just see what your ministry has to say.

The Chair: — Mr. Minister, before you respond, Mr. Vermette had quite a few points there, and seeing as it's getting close to 12 o'clock, this will be the last answer before we wrap up for the morning.

Hon. Mr. McMorris: — The issue with people going from Creighton to Flin Flon — and as you said, it's quite close — is an issue with residency. They become residents in Manitoba. So it's legislation that says, dictates if they are living in Manitoba

— which is what they really are doing; they're living in Manitoba — that they have to become a resident of Manitoba.

That being said, we can certainly look into it. There are other examples of border towns that there's specific legislation that deals with the border town. We would have to look at changing legislation in order to allow this, we believe. It would have to be a legislative change to allow this to happen, which then becomes quite a bit more onerous as opposed to perhaps a memorandum of understanding between the two provinces, which we do with Manitoba.

I mean, there's many communities along the east side of our province, west side of theirs, that people will go back and forth. But in that case, people will go back and forth. They don't become residents. In the long-term care case, it's because they become a resident.

Mr. Vermette: — Okay. And I guess I just want to make some final comments, Mr. Chair, if I could, and just finish up. I know we're just about, I guess, ready to adjourn here.

I'm going to mention it when I get back home. I'll be meeting with Creighton, and we'll go over that stuff and the information you provided. We'll take it and make sure they understand it. If there was an issue, we'll get a hold of the ministry and try to work through that way in a positive way to address the issues that they're faced with and their residents are faced with.

I guess I want to, last thing I want to say, Mr. Chair, is I know there are issues that have to be raised. And, you know, your ministry has a lot of the northern, I guess, issues that I addressed today here, or I brought up and you have addressed, I guess, with some comments. I know it's your ministry's responsible for it and I do. And I think the people want good health care. They feel that they have a right to that.

And in a very positive way, I want to say this very clearly. When the plan comes together . . . And I think individuals have their issues and concerns, and I said that earlier.

I know it is your department and yourself as you're, you know, the minister responsible. It lies on your shoulder and you are the government and it is your responsibility. I hope that when those issues come forward to your ministry and you as the minister and hearing what you've said, that you're committed to addressing some of the issues, and I do.

[12:00]

So I want to thank you for your commitment to the North — and we will be bringing those issues forward — and your officials. And thank you for your time, Mr. Chair of the committee. Thank you for listening to some of the northern issues and I hope in a positive way, can be addressed.

The Chair: — Thank you, Mr. Vermette. Mr. Minister, would you like to respond before we close?

Hon. Mr. McMorris: — Really not to the comment. I think we've had a pretty good dialogue. I would like to table one of the requests from the critic regarding health regions and operating forecasts; so I have that for her before she leaves. And I think there's some other information that we'll be getting to the members opposite when we put it together.

I wanted to thank all the officials for being here. The time just absolutely flew by. I mean what a great way to spend a Monday morning. And so I want to thank all the officials for being here and helping me answer the questions as well as I've been able to. It's because of the great work that they do behind me. So thank them and I guess we have two hours to look forward to some other time.

The Chair: — Thank you, Mr. Minister, and thank you, committee members and officials, for coming out this morning. Seeing as we will be returning to the House this afternoon, we will need to adjourn before we consider the main estimates for Ministry of Education at 7 o'clock tonight. So I'll now entertain a motion to adjourn. Ms. Schriemer, motion to adjourn. This committee now stands adjourned until 7 o'clock this evening.

[The committee adjourned at 12:02.]