STANDING COMMITTEE ON HUMAN SERVICES

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STANDING COMMITTEE ON HUMAN SERVICES

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[The committee met at 15:00.]

The Chair: — Good afternoon, ladies and gentlemen. Seeing it's now past 3 o'clock, the hour for our committee meeting to begin, we'll call the Human Services Committee meeting to order. I'd like to welcome everybody here and at home to the deliberations on the Standing Committee on Human Services today. Our members in attendance today are committee member, Mr. Glen Hart, Minister Jim Reiter, Ms. Doreen Eagles, and substituting for Ms. Joceline Schriemer is Ms. Laura Ross. And on the opposition side, voting members, Mr. Cam Broten, Ms. Judy Junor, and sitting in as well is Mr. David Forbes.

General Revenue Fund
Health
Vote 32

Subvote (HE01)

The Chair: — As outlined in the agenda, we'll be considering estimates for the Ministry of Health, vote 32, central management and services, subvote (HE01) outlined on page 89 of the Estimates booklet. Mr. Minister, would you care to introduce your officials and make any brief opening comments you wish.

Hon. Mr. McMorris: — Thank you, Mr. Chair. I won't have any opening comments. I had those a couple of meetings ago, and we're, I guess, five and a half hours into it, so opening comments probably aren't appropriate. I will introduce my officials. On my left is Deputy Minister Dan Florizone and to my right is Max Hendricks, assistant deputy minister. Over to my left shoulder here is Louise Greenberg. Next to her is Duncan Fisher. Next to Duncan is Ted Warawa, and next to Ted is Lauren Donnelly. I have a number of officials that are seated behind me that will, if they come up to the table, will introduce themselves at that time.

The Chair: — That, Mr. Minister, does help with Hansard. So with that we'll open the floor to questions. Ms. Junor.

Ms. Junor: — I know we left off on drugs, but I think I'd like to just move to something that's of interest particularly to people with disabilities but also now to people and families who have autism or autism spectrum disorder, and that is individualized funding.

And I was one of the ministers who brought in individualized funding, and the intent was always to improve the quality of life and improve the independence of people living with disabilities. And I understand from people who have criticized the program that it is extremely difficult to get to. And it's interesting that it is housed with home care, which I think is its major problem, other than the fact that it's extremely onerous to fill out all the forms. That's the criticism I've had from people who have two degrees, cannot figure out how to fill out the forms for their family member. And so it's something that it's almost like we've put a roadblock in front of people so that we don't actually have to do this.

So I would like to know, how much money is in individualized funding? How many people are actually accessing it? And how many people are turned down?

[15:15]

Hon. Mr. McMorris: — The issue around individualized funding, I think you started by talking about autism, and then you went into the program being run through home care, regarding individualized funding that would be run through home care. We have about 90 individuals that are on individualized funding right now. I don't have an exact dollar figure because it is kind of in the global funding that goes to a health region, and then health regions break that up and put it into the various programs that they offer within their health region.

There is a waiting list. There are a number of people waiting. I don't have that exact number. I had the opportunity just about two weeks ago, I guess it was, roughly about two weeks ago, to meet with a number of individuals that are on individualized funding and certainly heard their concerns and part of it was waiting to get on individualized funding. They felt they had to wait longer than what they thought was proper, and I would agree I guess.

So there are a number of concerns, not only the wait times but just some other issues around forms that they had to fill out. So what we're going to do is we're putting together a working group with a number of people that were in the building that day with the concerns on individualized funding. We're putting together a working group to see if we can work through some of the irritants, I guess would be the best word to use, regarding this program, partly, you know, to expand the program, look at expanding, partly is to look at some of the irritants of the program for people that are actually in the program right now.

Ms. Junor: — Thank you. I would like to see how many people are on the waiting list, if Mr. Carriere could get that for us. And I also would like a comment from you, Mr. Minister, on your thoughts on taking it out of home care — is that the most appropriate place for it to be? — being as this is dealing with people with disabilities and it is not something that is considered to be purely health care. It's more fostering independence.

And I think having it through home care, it really puts in global funding it. It puts it in . . . Home care will ration it because they have a global budget, and that will not be the program that I think home care would focus on. It's not, with no disrespect to home care, that's not their focus. And I know having had the conversations early on and putting actually the individualized funding program together that there was a fair amount of resistance to it. So it isn't something that I think is being . . . It isn't being run for the patient first. Absolutely not. That would be my view. And I would really like to see it taken out of home care and put somewhere more appropriately.

And right now to access the individualized funding, people with intellectual disabilities are not able to do that, and that's why I want to comment here on autism. Patients and families with autism really want to see the individualized funding model expanded for them to access services that they feel are more

appropriate. It's not anything to do with home care services. It would be more the spirit of the individualized funding model that you give people money that would be earmarked for their care and let them choose what is most appropriate for their care. And families and parents with children with autism are very, very vocal on the fact that they're not getting what they need from sort of the cookie cutter model of autism services. And I know there's been some money put into autism spectrum disorder, and hopefully we'll see some more programming in communities where people need it and that target certain individuals.

But that is one thing I haven't heard any comment on, is the individualized funding and what your thoughts are on that and your thoughts on moving it out of home care.

Hon. Mr. McMorris: — I'll start with the issue around home care and, you know, whether it should be located in home care. I'd be interested in your thoughts on where you think it should be then if it's not in home care. Or could it be just a stand-alone program that's not run out of home care, but just run through a health region as a stand-alone program, I guess, is another option.

Yes, it's tough to know where it should fit because there are some concerns. And that was certainly the concern of the group, is they didn't feel it fit very well in home care, that it gets eaten up by home care and the demands of home care. So I mean it's certainly something that we can look at, if it should be located somewhere else. I just don't know where it would fit, I mean, because there certainly is a large element of home care to it, although the person can hire who they want, and how important that is that they have the same person day in and day out as opposed to sometimes with home care, you know, the personnel and professionals may vary from visit to visit.

On the piece around autism and individualized funding, part of the problem is if we were to individualize the 3 million prior and now the extra 2.5 — $5.5 million — to all the families that have children that have autism spectrum disorder, that pool would get broke down to some pretty small amounts, I think. It is felt that we would get a better usage of our money if we keep it and hire the health care professionals that we need — even though there's a shortage across Canada, to try and attract those health care professionals that we need — and then people with children with autism can access those individuals once we hire them.

You know, there's different models across Canada. Some are better received, but certainly everybody tends to look towards Alberta and what they do. But this is the route that we've gone right now. And part of it was through the action plan, the suggestions through the action plan, so that's why we're following through on that route. This extra 2.5 million, though, is on top of the 3 million that we had put in annually. And there is, you know, there is still some talk around how that will be spent exactly.

Ms. Junor: — I think my problem is that there are families that need to have something done for them right now. And they don't fit the model that is out there with the behavioural therapists and all the people that are being hired following the review that was done in '09, or no, '08 I think it was. These children are falling through the cracks, and I think we need to have some way to have those children . . . one in particular I'm thinking of who is harming herself as we decide whether she belongs under Education or under Health. And I've sent a letter to the minister on this particular case, both him and the Minister of Education. And basically the answer is, send them back to the district to talk to the same people who are failing them at the moment.

So there needs to be a better way to address that. I mean this child is harming herself. And it's serious enough that I think we should stop looking at who should . . . like trying to pass her around like a hot potato, and she meanwhile is doing herself damage. And the school doesn't seem to be able to meet her needs, nor does the health system, but both are saying the other one is responsible. And I think there needs to be a way to fix this because I don't think putting $5.5 million into a bunch of professionals and then seeing this child damaged is where we want to go.

And so I would like to be assured that there's going to be a way to fix problems that don't actually have to fit the program, and that people who don't fit the program — because none of these children have the same either symptoms or part of the spectrum disorder; they're really not the same — they need to have some flexibility in their care. And we need to be able to address that with some degree of flexibility. And I don't see that at the moment. And I'm afraid that we get locked into hiring a certain kind of professional, locked into a program that we forget that these children need something different.

You're nodding?

Hon. Mr. McMorris: — That's more of a statement, I believe.

Ms. Junor: — I want to know that you agree that there should be some way to fix this because I've written you a letter and I've written the other minister a letter. And I didn't get an answer other than send the parents back into the gerbil wheel — like around and round they go. And the child continues to harm herself. And we've just abandoned the family and the child.

And so to talk about an autism strategy and talk about new money, that's all fine. But meanwhile I know this case is out there that's harmful, and we don't seem to be able to be nimble enough to fix it, which I don't think is a very good commentary on our ability to address a problem.

And I don't know if I should try again with another letter after we've had this conversation. And I don't think that . . . It isn't a good enough answer to say she should go back to the same people who are failing her right now and try and fit in there, or try and have them fix it, because they aren't fixing it. And so we need to do something else.

And I don't see . . . There is somewhere of an ultimate responsibility that we stop handing it off to those people who are spinning their wheels out there. We need to fix it by some other intervention.

Hon. Mr. McMorris: — We're not familiar with the exact case, but I tell you, if you would like to pass that information along to us, we'll have the ministry follow up right away and

just see where the system is breaking down.

I know there are always some issues. I mean Education puts money into this area. Social Services has the cognitive disorder strategy. And we put money in. So there's three, you know, there's really three different areas. And sometimes maybe the hand-offs aren't that clean. This sounds like one of them. So if you would like to get us the information, we'll have the ministry check into it as soon as possible, this week for sure.

Ms. Junor: — I just resend the letter to you again?

Hon. Mr. McMorris: — Sure. If you have the information right now you can hand it to me, and I'll certainly pass it on to the officials.

Ms. Junor: — Okay. I have it upstairs, but I'll get it to you as soon as I possibly can.

Just before we leave individualized funding, I want to know, the number you said that were on, 90 people that are on it, is there a limit to how many people can be on it? Or is it dictated by the amount of money they need to . . . district allots for it? And is that number 90? Is that number, has it gone up or down in the last year?

Hon. Mr. McMorris: — Just regarding individualized funding again. The question was, how many people can be on individualized funding? That's really determined by a health region. As they go through their budget, they have, as you had mentioned, a global budget, for example home care, and then they break that off into the different programs. Some will go to individualized funding and then, you know, how many can that hold?

As I said, the number on individualized funding right now is 90, which the number is up. I do know that from the meeting — I just don't know the exact numbers — that the number of people waiting has dropped down. There's not as many people waiting this past year as what was waiting maybe two or three years ago. I don't have those numbers here, but we'll get those numbers to you as soon as we have . . . Yes.

Ms. Junor: — Now you're saying that there's not as many people waiting. Has the number actually gone down, or have people given up?

Hon. Mr. McMorris: — Well that's . . . We don't know that for sure, I mean. And there'll be some of that. That was again what we heard from the group that we talked to, that some people will get frustrated waiting to be on individualized funding and then simply take their name off the list. That may be the case. Other cases are . . . As I said, we have 90. We've taken some off the list by putting them into the individualized funding program.

Ms. Junor: — So the working group that you were talking about that's going to look at the irritants, do you have a timetable for that? And will it be something that we'll be able to see?

Hon. Mr. McMorris: — Yes. You know, we met with them a couple of weeks ago. And so I'm sure I'll be, you know, brought up to speed from the ministry. We haven't talked since. But I'll be brought up to speed, I would think, in the next couple of weeks as to where we're at, when the first meeting is, and that type of information. We don't have a schedule as to the next meeting will be in two weeks or whatever. The ministry's working on that right now. But we do have the contacts into the community from our recent meeting and had assured them that we'd be back in touch with them to work on some of these irritants.

[15:30]

Ms. Junor: — So could they anticipate that it would be something that would be fixed by the fall or in X number of months? Is that sort of the message you're giving them?

Hon. Mr. McMorris: — Well maybe I'd hesitate to use the term fixed. There are a number of issues, and part of the issue is on funding in the health regions. As far as their home care budget, you know, they would say, well maybe we'd put more on if we put a bunch more into home care, put more people on to individualized funding.

So you know, that will, I think that will be an ongoing concern whether we can meet the demand that there is out there for individualized funding, whether we'll be able to meet that demand. So when you say fixed, I don't know if I can say that in three months we'll fix it all. But we'll certainly deal with some of the issues and have a better understanding.

The funding piece is just one side of it. There are a number of other concerns that were raised by some of these clients, I guess, or individuals, that aren't necessarily money issues as much as they are procedural issues. Some of those I would hope that we could have, you know, depending on what the fix is, have some of those issues fixed. But as far as fixing the overall, all the demands or concerns or . . . That's a tough one to pin down on.

Ms. Junor: — I think it would go a long way to fixing many of the irritants to take it out of home care. So I'm assuming that the working group will come with that same message since you've already heard it too. So I look forward to seeing the progress of that, and I'm hoping to see some change because the program was actually . . . The intent of the program was very good. And finally after negotiating through many roadblocks, got it up and running, and then pretty much home care has put the brakes on it almost everywhere, which is a shame. It's a real shame.

So thank you very much for that. I'm going to move on, back to the drugs program that I was on, I think, when we left last time. And we had talked about basically the reviews of the drugs and that sort of thing.

But I do have some particular questions. And one of them is following up on something I talked about two years ago, and that was the ovarian cancer drug, Paclitaxel. And at the time we had a bit of toing and froing about that because you couldn't tell me if the price of Paclitaxel was down or up because it would somehow infringe on whatever you call it — corporate . . . whatever it is when you bid on things.

But now we're back to Biolyse Pharma calling again and actually having quite a letter actually to you, Mr. Minister, about their concerns with SAHO [Saskatchewan Association of Health Organizations] and the purchasing process that SAHO used for this particular drug, from this particular company. And they have made some serious allegations actually.

The letter is March 10th, to you from Biolyse and it involves when the RFP [request for proposal] came up again for Paclitaxel and the process that SAHO is using. Now if I remember from the previous conversation, I thought the Cancer Agency was doing the purchasing at that point, but it appears they're now dealing with SAHO, which we'll talk about in another area of my questioning. But it does seem like there was some serious problems of how SAHO treated their . . . I don't know if you want me to read it or not, or do you have it? Somebody has it with them. And particularly . . .

Hon. Mr. McMorris: — Yes, we would have it. Sure.

Ms. Junor: — You'd have it? And I'd like you to comment on the allegations that they're making actually. They appended a fair amount of information, plus they were pretty darn clear on how this all worked and how it worked before and how SAHO has somehow really done some damage with this process that they have. And I'd like to know where the process came from. When did SAHO start buying this? And what are you going to do with Biolyse?

Because at the time I think we ended this conversation, you assured me that we were getting Paclitaxel at the very lowest price. Biolyse is saying they were the lowest bidder and they were refused. And so they were refused on other points, and they refute every one of those other points, so they're considering actually a legal challenge on this. So I would like you to explain that to me.

Hon. Mr. McMorris: — Regarding this issue and it has . . . I do remember it being raised in the past. I guess first of all, we'll just comment generally on SAHO and their process. You know, they feel it's a fair and competitive process. There's always certainly companies that may disagree, and this would be one case. For the most part I don't think we get a lot of complaints in the process that SAHO uses, but in this case this company is concerned. If they are threatening legal action or moving into legal action, it really wouldn't be appropriate for me to get into the details of the RFP that SAHO uses. It wouldn't be appropriate for me to start commenting on that if there is a legal action, by the sounds of it, being threatened.

Ms. Junor: — I actually don't think that we could say that at this point. I don't think this should stop you. There isn't anything that said they're actually doing it. They're actually considering all their options because this process was in their opinion so flawed. And I don't think that should . . . Their remarks in here shouldn't in any way lead you to think that there's a court challenge right now that would stop any commentary on it. Or I think you could actually stop the court challenge, if there's one coming, if you would look at the letter and address some of the issues that they have mentioned.

They were certainly disadvantaged in several ways from some of the criteria that didn't take into account the actual production of Paclitaxel by this company and how they've been doing it for 20 years and servicing Saskatchewan and Manitoba. And now all of a sudden, with the lowest bid, they're not awarded the contract.

Hon. Mr. McMorris: — I believe in the past they've had some concerns with the company. Again I'm not going to get into that detail of those concerns because not only have you mentioned that this company is threatening or talking about legal action; they have threatened SAHO itself and through the ministry that they will be taking legal action. So I'm not going to get into the details as to why SAHO has rejected their tender, their bid. That would be something for SAHO and the company to work out.

What I will say though is that, you know, SAHO has a fair and a strong tendering RFP process. There are always going to be some disputes, I guess. It's not real common but there will be some disputes. They have filed a formal complaint outlining the RFP document. I believe that formal complaint goes to SAHO, mind you, but they have filed a formal complaint. And I guess if they want to take it to the next level which they are threatening, that would be legal action. And again I don't want to jeopardize the position of SAHO by getting into the debate as to why SAHO has rejected and not approved because it's on more than just pricing. There'd be, you know, more decision points than just the pricing point.

Ms. Junor: — They're quite clear on all of those points actually in the letter to you, and actually refute every one of them. Some of them they can't meet because that's the sole drug that they provide, so they don't go out and do a lot of education on a drug they've been providing for 20 years, for example, to the same customer. So that is somehow not considered to be fair competition. But my question is then . . . I'll go more general: when did SAHO become responsible for this procurement process? I thought I understood last time you were saying it was the Cancer Agency for this drug, but I could be wrong.

Hon. Mr. McMorris: — The issue around purchasing of drugs, the Cancer Agency does purchase some of their own drugs. The majority of the purchasing for the Cancer Agency is done through SAHO. This particular drug would go through SAHO. It had been moved from the Cancer Agency over to SAHO a number of years ago. We're just going to track down the exact year. We're thinking around 2004, but we'll track down the exact year that it transferred from the Cancer Agency no longer purchasing but for SAHO to purchase on behalf of the Cancer Agency.

Ms. Junor: — So the comment generally is then SAHO's process for purchasing drugs, and they do this, that Biolyse has been the provider of this drug for both Manitoba and Saskatchewan. So not providing it to Saskatchewan, does that jeopardize Manitoba as well? We're in some kind of an arrangement with Manitoba?

Hon. Mr. McMorris: — I think probably the general answer is that . . . I mean we don't direct SAHO to joint purchase or not. They work with, you know, other organizations and come up with some joint purchasing deals at times. And as far as jeopardizing, we can certainly inquire with SAHO a little bit more around this drug as to whether it is . . . We think it is a

joint purchase arrangement SAHO has with Manitoba on this drug but, you know, we can certainly check into that and confirm. But that's what we feel right now.

The other piece around SAHO and the RFP, as with most contracts, it isn't just purely a pricing issue. There are a number of other factors that are considered, and pricing is but one of many other factors that are considered before a particular company is awarded the contract. And so yet as I say, you know, there will be some concern, but for the most part it has been a very fair and we think reasonable RFP process.

Ms. Junor: — I just want to put one example on the record from the letter because it goes to the reasonableness of this, the revelation that the pricing of a federally regulated drug is allocated . . . They only got 15 points out of 100 for purchasing a federally regulated drug in the overall evaluation. And Manitoba and Saskatchewan can request and supply only products that have been approved by Health Canada. So they have no choice but to do a federally regulated one. And they got 15 points out of 100, somehow penalized for something they have no control over.

So there's many of those in this letter which would probably be very good for someone to tell you about because they have some significant questions about the fairness and transparency that I'm hoping that we pay attention to because it does not sound like this is something that's winnable from the government's point of view. So I don't see why we would open ourselves up to this.

And given that I've had this conversation already about Paclitaxel, and there was doubts raised at that time, to hear it come back again, I want to dig because I think there's something wrong here.

[15:45]

I don't know what's wrong with Biolyse, why someone has something against them when they seem to have been the lowest provider, the lowest cost provider of this drug and seem to have no other reason for not giving it to them. It makes you wonder why we've gone this far to annoy such a major pharmaceutical company. Why would we have done this? I don't understand.

Hon. Mr. McMorris: — I think, you know, as I said earlier, that they've threatened legal action. And you know, we hope it doesn't come to that. So I don't want to get into the exact detail of . . . And we don't have — I don't, certainly I don't have — whether we would even have the information to determine why somebody would get 15 out of 100. You know, that's more detail than what we're prepared to answer as well as the whole issue around the legal challenge perhaps.

I think it's, as with most of the cases or situations that we receive, we receive one side of it, and you've received a couple of letters from this company. They have grave concerns, and, you know, they're certainly putting their points forward. And you know, until a person has more information, it's tough to dispute them.

What I could offer is, if you would like, we could certainly have SAHO meet with you to go through their whole RFP process. You know, I will guarantee you that it isn't a personal vendetta of SAHO and this company to say, we're not going to have this company. There is rationale for the decisions that SAHO makes. So you know, it would have to be on a general term if SAHO was to talk to you, not necessarily particulars regarding this drug and the decision, but they could certainly walk you through the RFP process and how they award points to determine who would be the winner of any particular RFP, if that would be helpful for the member opposite. Sure.

Ms. Junor: — Yes. I would definitely want to go and talk to SAHO, and I could do that after we're done in this session. I could probably arrange to do that through your office, Mr. Minister. Would that be possible?

Hon. Mr. McMorris: — Sure. Yes, we will.

Ms. Junor: — Before we leave the drug questions, I want to ask some particular drug questions because I've got so many letters on particular questions. And one is about the, about vaccinations in general. They're not eligible for . . . I don't know if all of them are not, but some of them are not eligible for exceptional drug status. That includes the vaccination for shingles, which many seniors are being advised to get. And it's $174 a shot. And they can qualify. So they're being advised to get it, and Health Canada has approved it, but we're not covering it provincially. And we're telling seniors they should get it. So I'm wondering what's our position on that one right at the moment.

Hon. Mr. McMorris: — What I'll do is I'll let Rick go through this. He has a far better understanding so I'll let Rick answer it.

Mr. Trimp: — I'm Rick Trimp. I'm executive director of population health branch. When we establish immunizations across the province, we establish those through expert advice that we are given on a national basis. The national body will make recommendations on a cohort size, an appropriate age group that at that time the science suggests. The varicella vaccine is for a specific age group and that age group does not include seniors when it was introduced. We review our immunizations annually and more often as required and will receive information from the national body on immunizations.

Ms. Junor: — You have no intentions of covering this for seniors?

Mr. Trimp: — The information that we have right now: no, it's not covered for seniors. If a senior wishes to procure the vaccine it is available through pharmacies.

Ms. Junor: — I know. It's $174. That's what the problem was. Okay. Thank you then.

My next question is about another particular question. It's about children who have PKU, phenylketonuria, and this is a generic metabolic disorder and can result in severe mental retardation if there is not a special diet begun in early infancy. And all babies are tested for this in the nurseries, as far as I can remember.

There are 16 types of formulas covered through Sask Health. In contrast, the province of Ontario currently covers 60 types of

formula for the treatment for PKU, and the current plan, people are lobbying to have the current plan expanded to include all of the current formula options. And this is again where people can choose what is best for them so the patient can have access to the formula which best suits their individual dietary needs based on a prescription from their dietician and/or a metabolic specialist. And Saskatchewan remains one of three provinces in Canada that does not provide any coverage of medical low-protein foods. And the cost would be fairly small, providing these foods for children and adults with PKU and similar disorders.

So there certainly seems to be a fairly decent argument for the fact that there's only 20 children and maybe a handful of adults currently living in Saskatchewan with this condition that would need this low-protein food. It wouldn't cost the provincial health plan very much money. But it does contrast to how much it does cost people to go into institutionalized care that don't have the correct diet and the correct supplement.

So if you're putting people in long-term care or special education services, we're definitely seeing the long-term costs. So the upfront costs would, I think, be a good investment. Can you comment on that, please.

Hon. Mr. McMorris: — Regarding PKU, I had the opportunity to oh, I don't know, maybe less than a year ago, meet with a family up in Saskatoon that had a son that — I believe it's an enzyme deficiency — that had this enzyme deficiency. And they were kind of going through some of the problems and concerns they had. And so from that I had asked the ministry to kind of review the program and do an interprovincial comparison as to what is done here compared to other provinces. Now we know that we cover 100 per cent of the — what would you call it? — formula, I guess, compared to other provinces. But there are variations.

And so I've just been informed that the ministry will be coming back within . . . quite soon with, you know, their comparison — how we shape up and where we can make some improvements — because definitely we can make some improvements.

I do know that after meeting with the family and raising the concerns again back with the ministry, we were able to expand what we do offer. Is it as much as other provinces? No, but that's the interprovincial comparisons that the ministry is working on right now and will be reporting back to me in the near future.

Ms. Junor: — Thank you. I have a question. This has come from seniors who are telling me that if they have a prescription for two to three months — the prescription is given for two to three months supply — they can only get 50 tablets per prescription. So they have to come back each time and pay the dispensing fee. We need to fix that. And I know it's been long-standing so you don't have to lecture me about the 16 years it's been there.

[16:00]

Hon. Mr. McMorris: — This issue is really negotiated through the Pharmacists Association. They can charge a dispensing fee for every . . . up to 34 days, I guess they can, and so a dispensing fee for each 34-day set. Some pharmacists choose to do that. Other pharmacists will choose to dispense for perhaps two months. They can dispense up to three months if they so choose. It's the pharmacist's decision and, you know, it's not necessarily government's decision.

I guess we could say that they can't, but that is negotiated through the Pharmacists Association to be able to charge a dispensing fee every 34-day period. And as I say, then that kind of falls on the pharmacists themselves as to whether they so choose to do that.

Ms. Junor: — So it's an individual choice as well. If you went to a different pharmacy you might get a different . . . Can you not fix that? Can it not be . . . I mean, why would we want seniors out shopping to get the best deal? I mean that's not very fair. They don't have transportation. They're going to have to phone around and ask to be put on . . . if you what something, press 1; if you want something else, press 2. I think they should be able to have a uniform policy that they can expect from their pharmacy — when they go, that they get this — and not have to go shopping around looking for the best deal.

Hon. Mr. McMorris: — Well that policy is every 34 days. The pharmacist can charge a dispensing fee for up to a 34-day prescription. That's the policy. If pharmacists want to forgo that dispensing fee and dispense for two months, that's their decision. We could enforce it that nobody cannot . . . can waive that fee. That would be a concern I would think.

Ms. Junor: — So the policy is negotiated with the pharmacy association? So you could change that policy at that level if you wanted to have this conversation with the Pharmacists Association and see if they could come up with something that would be fairer to seniors.

Hon. Mr. McMorris: — I'll just talk to the officials.

Just a couple of points regarding seniors and the drug plan. Of course we're all aware that they're able to get their prescriptions at $15 which is a very fair, you know, is a real benefit for seniors at the $15 per-prescription fee because many are far more than that. You know, so there's quite a savings there.

The pharmacists' contract is up. There's another year left in the pharmacists' contract, I guess. We could revisit it at that time, but I don't know quite what the solution would be. Because — and I'm just going to round the number — if they receive $9 for a dispensing fee and we're going to tell them that they have to fill a prescription for three months for $9, they're not going to go for that.

So what do we . . . I mean, we have to change the whole structure. Do we then say, you know, if you're going to multi-month — if it's going to be two or three months — if it's three months, you get instead of $27 you get $25 for a dispensing fee? Because, you know, that's how they make their money, the pharmacists. So if we're going to follow along with that and negotiate something like that, it would change the whole structure of the way pharmacists are reimbursed.

Ms. Junor: — I think it's confusing to people to get a prescription written for three months and not have it being able

to be filled for three months. So that's where the problem is — not only the money and the inconvenience of going back each time but the prescription itself has led the person to assume that they could have the whole prescription filled since it says for two to three months supply. That's where their confusion is.

So is it with the SMA [Saskatchewan Medical Association] that the doctor shouldn't be writing prescriptions for that length of time? Is it with the pharmacists so they should have a better process of filling them, maybe more than 34 at a time? I don't know where the arbitrary number of 34 came from. And maybe it is all about money. Then I guess it is a contract discussion.

So anyways, I just want you to have that comment because I think seniors are really starting to question that, and I don't know where exactly they should turn their ire to. If it's a policy change, then perhaps you can affect it. And if it's something that the SMA needs to know, perhaps we can call them. But maybe you could do what you can with whatever negotiations you have coming up with the pharmacists and throw it in and see if they have any solutions, would be probably a good start, I guess.

One more question under the drug questions is I'm assuming you've probably got a letter, a lobbying letter from the nurse practitioners. Actually they're wanting Health Canada to move forward with legislation involving the prescribing of controlled drugs and substances by nurse practitioners. And I'm wondering, what's your position on that?

Hon. Mr. McMorris: — I think what we'll do is I'm going to have Kevin Wilson just cover off the statement or respond to a statement that was made near the end regarding the number of months that a pharmacist would fill a script for. He'll have some . . . I think there needs to be some clarification around that. And then I'll tackle the nurse practitioner piece once Kevin is done.

Mr. Wilson: — So if the prescription was for a 90-day supply, the reason that the . . . Under the payment policy the pharmacist would charge, may dispense a 34-day supply for one dispensing fee. So they could actually dispense the full 90-day supply unless it was for some professional reason that they would choose not to. So that could be dispensed. It may be though that they would also charge a fee for each portion of that that was a 34-day supply. So there could be a larger payment, but the actual dispensing of the 90 days would be within their judgment. We wouldn't restrict that from a payment policy perspective.

Ms. Junor: — I think it was mostly the money. I don't think it's the fact that they don't get it as much as the fact they have to pay three times to get what was prescribed originally. Thank you.

Hon. Mr. McMorris: — Regarding the nurse practitioner piece and the ability to prescribe, you're correct that it is at the national level, that the federal government would have to change legislation to allow that. We are in favour of that. We are in favour of expanding the scope for nurse practitioners, as I think most provinces are. But the federal government has to do that work around consultation and making sure that all the associations such as the Saskatchewan Registered Nurses' Association is aware of that.

So we're waiting. We're waiting . . . I guess the federal government knows our position on it and we're waiting for the federal government to move on that to allow it to happen across Canada, because it wouldn't be individual provinces. It would be a national change.

Ms. Junor: — Thank you. I'd like to move now to the kidney transplant program, and could you give me an update on the progress of reinstating, give the committee an update on the progress for reinstating the program in Saskatoon.

Hon. Mr. McMorris: — What I'll do is I'll let Duncan Fisher respond. And he'll respond kind of maybe even more generally or with more information than even what you're asking for because there's really kind of three parts: the patients, where we're at with the patients that are lined up with a donor; also then the program, where the program is at; as well as the recruitment piece on making sure that we have the proper complement that ensures a long-lasting program as opposed to where we were at before the program was shut down. Duncan.

Mr. Fisher: — In terms of the patients, probably the update that I can provide is around the people who are waiting for the living donor transplant. There were five people that didn't have a date for the transplant. One of those people I believe has been dropped off the list due to the donor kidney not being appropriate for the transplant. Two of the remaining four people have received a date in Edmonton. And we're working with Winnipeg and Edmonton to get the final two people dates.

In terms of the program, as the minister has stated, we're trying to work with the health region to get the program up and running within three to four months. To do that, Saskatoon has taken steps to initiate a review of the program to ensure that whatever model is put in place in the long term is sustainable. And so that review will kick off I believe it's in the near future.

[16:15]

We want to make sure that in terms of the messaging regarding the program, that it's not lost that what is not happening here are the living donor transplants. Those are being referred out while the program is down.

There are a couple of very important components of the program that continue to operate. The first is the post-operative patients, people that have had recently a kidney transplant or are living with a kidney transplant. That portion of the program is still going, and they still receive their necessary follow-up care from the nephrologist in Saskatoon.

And the cadaveric transplant that the program was doing, there are no organs that are being donated or harvested in Saskatchewan going to waste. Those organs, if they are available and match to a Saskatchewan patient on the cadaveric list, those people are being sent to Edmonton for those surgeries on an emergent basis.

And in terms of recruitment, Saskatoon has begun steps to begin the recruitment for a transplant surgeon to come in and help be part of the interim solution for the transplant program

and getting it up and running. And they are also considering recruiting some locum physicians on a longer term locum basis to come in and aid the transplant program, as I said, getting it up on an interim basis.

Ms. Junor: — Can I ask . . . We can't talk about this as three to four months any more because we're already a month in. So it would be now two to three months we're looking at. We're sort of looking at a July date for this? And my other question is, there was last I heard 106 people waiting on the list. How many are now waiting on the list? Excluding I guess, the living donor ones that you've already mentioned how they're being taken care of. What's the other waiting list like?

Hon. Mr. McMorris: — Again we'll have Deb Jordan respond to the particulars on the number of people waiting and some of those particulars.

Ms. Jordan: — Good afternoon. As the minister said, I'm Deb Jordan, executive director of acute and emergency services. The vast majority of patients who are on the transplant list in Saskatchewan are waiting for a donation from a deceased donor. As Duncan has just referenced, those patients who have been fully worked up and their living donor has as well, and are medically stable and ready for transplant, arrangements have either been made or, for the two patients, are in the process of being made and will be made very shortly.

So I think one of the things that's important to bear in mind is again, with the vast majority of people on the list — approximately 100 — the vast majority of those are waiting for a donation from a deceased donor. There are some other patients who are in process of being worked up for compatibility with a living donor.

Ms. Junor: — So thank you. My question was how many people were on the list, and you said 100.

Ms. Jordan: — Approximately 100. There are some patients who, while they are on a list for a possible donation from a deceased donor, are also in the process of being worked up for the possibility of a living donor. So that's an option as well.

Ms. Junor: — So we've expanded our sharing of the program or taking people out of the province to now Winnipeg, did you say?

Ms. Jordan: — Winnipeg is being explored as a possibility. The commitment and undertaking was for those patients who have a living donor, that arrangements would be made as quickly as possible for them. And so in order to explore what possibilities existed sooner rather than later, we've also had some discussions with Winnipeg in addition to those that have occurred with Edmonton.

Ms. Junor: — Thank you. Now how many . . . I think we heard 12 had gone so far to Edmonton since the program here was shut down in July. How many now? And do we anticipate ramping that up so we can move this 100 people down?

Ms. Jordan: — Twelve patients have gone to Edmonton. Nine of those were patients who had received an emergency transplant from a deceased donor, and three are living donors. There are two patients: one who is a living donor donation who is booked for later this month; another who, for their own particular circumstance, wanted a date in the summer.

And we have, I think as Duncan had indicated, a standing arrangement that if a donation from a deceased donor becomes available at any time, and there's a match for a Saskatchewan person on the transplant list, they go immediately.

Ms. Junor: — Basically we're almost at a standstill cutting down anybody on that 100 list because we are moving those emergent ones in with the living donors. But Edmonton isn't ramping up the ability to take any more off the 100 that are sitting waiting?

Ms. Jordan: — Just to clarify, the majority of the 100 are patients who are waiting for an organ from a deceased donor. Some may also be in the process of trying to identify a living donor who would be prepared to donate, but they remain on a list for a deceased donation as well.

Ms. Junor: — Thank you. I understand that. I am still trying to get to, how can we move our 100 list faster? So we're waiting for the cadaveric, the transplants, but we also . . . My question then, are we waiting for that from all across Canada, or are we waiting for only from Saskatchewan?

Are Saskatchewan people, I guess, in the same lineup as the ones in Edmonton? Is Edmonton taking them as they are in a meshed list, or are we waiting for somebody in Saskatchewan to be a donor, and then Edmonton will do us?

Ms. Jordan: — Maybe to just take a step back. The process when there's a deceased donor, the first look for a match would be on the provincial list. And if there is a match, that patient and that organ are moved immediately to Edmonton.

As is the case all of the time, if there is not a match available on the provincial list, then that organ and the information with respect to the organ is made available to other provinces to see if there's a match with anyone on their list. The window, however, for the transport of the organ is three to four hours, so it's a very tight window.

Ms. Junor: — I just have a little bit of confusion about how we could be doing 31 or 32 when we had our own transplant program, and now we can only do 12, when we're looking at still the same pool of cadaveric or live donors. What is causing our people to be backed up?

Ms. Jordan: — Perhaps just some information on numbers of organ donors in the province. In any given year there are between 9 to 15 donors for organs in the province. And then of course, as I had mentioned earlier, there may be some potential of an organ that becomes available in another province that is identified as a match for a Saskatchewan patient. So when we look at the 9 to 15 in a typical year, and thus far in 2010 we've had two donors.

Ms. Junor: — So when we heard that the program had done 30-some, that was an exceptional year?

Ms. Jordan: — I can provide in a typical year, and we can go

back over the past few years. In 2007 there were 29 transplants that were done. In 2008 there were 35. Again, it varies a little bit from year to year depending on the number of donations that come through from deceased donors, and as well the number of living donors who are identified who go through the assessment and are a suitable match for a living donor donation.

Ms. Junor: — So you did '07 and '08? You gave me the numbers for '07 and '08? And '09 as well.

Ms. Jordan: — Correct. '09 is 21.

Ms. Junor: — And so far this year we've done how many?

Ms. Jordan: — Five.

Ms. Junor: — And all have been done in Edmonton.

Ms. Jordan: — Yes.

Ms. Junor: — All right. I think that's it for the kidney transplant program. I'd like to just move into another topic which is Aboriginal health. I know my colleague from Cumberland was here the other night and asking some questions, but I have in my hand an OC [order in council] that talks about the Aboriginal Health Transition Fund, an agreement with the federal government. And there's a fair amount of money has come this year and other years — I think since '08 and '09 and then this year — and I would like to know what's being done with that money.

I see in the OC many initiatives, projects, none of which I have seen planned for or know that there's . . . I'd like to know if there's a plan for these. The projects have been . . . I don't know when they started, but I would like to know things like the northern health strategy, project no. 1. There's several projects, including one in Cumberland, Cumberland House healthy community, that I would like to know what exactly is happening with these. And there's another one, project no. 4, which talks about a transition to a multidisciplinary primary care maternal-child health program, with All Nations' Healing Hospital. And I'm wondering, since we had a fair amount of conversation this week about midwives, how is that fitting in there? And all of the projects — 10, 12 of them, 14 of them — I would like to know what's the plan for them, how they're funded and what's their goal and what's their reporting mechanism and what's the evaluation of them?

Hon. Mr. McMorris: — Thank you for that question. I'm going to allow Louise Greenberg to go through it. This is her area, and she has information on pretty much all of the programs that you had mentioned. So I'll allow Louise to answer.

Ms. Greenberg: — Thank you, Minister. Ms. Junor, I was looking for some of my background materials so you may have to repeat a part of your question. But I have background on each of the projects and can provide further information if you require. The OC you would have been talking about is for the Métis Nation of Saskatchewan?

Ms. Junor: — The OC is a fairly lengthy one and I received it April 6th. It's the approval of the terms of the amending agreements substantially in the form of the amending Aboriginal Health Transition Fund contribution agreement. And there are all the plans attached to it that I think would be interesting to see where they are, what they're doing. And there's several, I imagine, goals or objectives under them, or at least points under them, but I haven't seen anything that talks about success or a plan or whatever is happening.

Ms. Greenberg: — Part of the way we've had to work when the federal government, they provide the funding, and every time we've had to make changes to the whole funding pool. We started off with roughly $8.8 million three years ago for this funding, and not all the funding was spent for each fiscal year. So we were able to carry forward some of the dollars to the following fiscal year. Every time we had to carry forward the money to the following fiscal year, we had to redo the funding agreement and do a new OC because of the carry-over effect which was a little bit onerous on the part, I guess, of the amount of paper work that had to be done.

Each of the projects — there is, I believe, 15 of them in total — they all have a plan and they've been . . . Initially they were all evaluated by a working group that was set up within the province that included representatives from U of S [University of Saskatchewan], U of R [University of Regina], and other individuals who had a research background to evaluate the project, and to also evaluate whether or not they'd be able to achieve the results in the prescribed amount of time and also were worthy enough of being funded. The projects are all this year doing an evaluation that's part of the criteria in being awarded the funding. They have an evaluation process that's going on right now. On our website, there's actually a description. On the Health website there's a description of each of the projects which gives some background on the funding that's being directed for each of the individual 15.

[16:30]

The one that you . . . pertained I believe to the All Nations' Healing Hospital and that was for the maternal, child . . . They're doing a pilot to inquire the best way to deal with maternal and pregnant mothers at the All Nations' Healing Hospital. So it's a bit of a pilot project. They have funding for that.

We also have pilot projects going on in P.A. [Prince Albert]. It's a joint project with the P.A. Grand Council and the Prince Albert Health Authority, and looking at how to better improve chronic disease management. We've got several projects going on with Eagle Moon Health Office. It's part of the Regina Qu'Appelle Health Region. And that project is doing a number of things, looking at how to better improve home care services to both Métis and First Nations and also looking how to provide culturally sensitive projects.

There was money. You mentioned the northern health strategy. The northern health strategy actually started back in about 2002, 2003. There was another program that funded it previous to the Aboriginal Health Transition Fund. But they've been funded on a yearly basis of about $500,000 a year and have identified a number of priorities, some of it dealing with coordination, some of it dealing with trying to work with the . . . I believe there is 13 partners that are involved in the northern

health strategy. Their priorities have included oral dental health. They have included dealing with perinatal issues. They've also done work on health human resources and labour market development in the North.

We've also had pilots at the Saskatoon Health Region with CUMFI which is the Central Urban Métis Federation, I believe — I'm getting the acronyms mixed up — but it's the Métis organization, the Saskatoon Health Region, and also the Kinistin First Nation, and trying to look at ways to improve services to both Métis and First Nations in the Saskatoon Health Region and looking at opportunities for joint partnership.

There have been some other projects, and if you name them, I could give you some details on them.

Ms. Junor: — What I would actually like is since most of this in this OC, most of the projects are described by their objectives and their scope under this initiative, what I would like — unless it's on the website — where each project is and what it is doing. I would like to see that.

Ms. Greenberg: — I could provide you with some background. Most of the projects they do have to wrap up this year. This is the final year of funding. I could provide some update. We have some material on that. The evaluation though is being done this year. So the evaluation on how successful the project was will not be available till the end of this fiscal year.

Ms. Junor: — I'm interested in the evaluation, but at the moment I would really like to know, under each project, where it is and what is actually happening under each one. So when I look at northern health strategy when it says, increase access to mental health and addiction services, that's of keen interest to many people in the North and especially my two colleagues from the North. So I would like to know under each project what is being done, where, and any other information you can provide on the projects, and I'll wait for the evaluation when it's available.

Ms. Greenberg: — For each of the projects, we have a project description, and we have deliverable, so we could do that. One of the things that the northern health strategy did do last year was organize a forum dealing with youth suicide and they had, actually they had to turn people away. It was held in Prince Albert and had quite a large group of people interested in . . . [inaudible interjection] . . . Yes.

Ms. Junor: — Yes, I had that report, thanks. Could I ask a question in particular? And this is from the All Nations' Healing Hospital. I just wonder, it says, manage low-risk deliveries. How many deliveries does that hospital have a year?

Ms. Greenberg: — I'd have to find that information. I don't . . .

Ms. Junor: — I'd be interested in having that information actually. And while you're doing it, it would probably be good to have an overview of the province — how many deliveries there are wherever they are — because we'll probably going to be having a conversation about midwifery, and that will feed into that conversation when we get there, which won't be today. But thank you. That's my questions. I'm curious. I cut out an advertisement — I guess it was Saskatoon Health Region — there's a Cameco Chair in Aboriginal health, and I think there's some connection with the government. I know there's a connection with the health district. Do you have a direct connection with it? Because I think it's Cameco is going to fund it, it sounds like. But there's a fair amount of things that could be probably attached with some of the things we're doing, and I imagine that's what their focus might be. Do we have a relationship with Cameco with this?

Ms. Greenberg: — Not, not directly through the ministry, but it would be through the health region and also through U of S. There is also the Saskatchewan Health Research Foundation has been, as one of its strategic priority areas, is focused on Aboriginal health research and may have some ties in, though SHRF [Saskatchewan Health Research Foundation] doesn't give direct funding to the Cameco Research Chair.

Ms. Junor: — Before I leave Aboriginal health, and I didn't actually . . . It's probably in here somewhere. But what are we doing with our diabetes strategy provincially?

Ms. Greenberg: — Oh sorry, could you repeat the question? I found actually how many children are delivered at All Nations' Healing Hospital.

Ms. Junor: — You could just add it to how many are everywhere. How many, it doesn't actually say . . . Now I lost the question. Maybe *Hansard* will have to give it to us . . .

A Member: — Diabetes.

Ms. Junor: — Oh yes, thank you. Our diabetes strategy.

Ms. Greenberg: — For the First Nations?

Ms. Junor: — For the province.

Ms. Greenberg: — I have the answer for you though, to go back to newborns.

Ms. Junor: — Deliveries, yes.

Ms. Greenberg: — In 2008, 2009 there was a total of newborns, well I have here newborns 13,995 . . . [inaudible interjection] . . . No, that's total. For Fort Qu'Appelle there was three.

Ms. Junor: — Three? Okay then, another question. I thought there had to be a certain amount to maintain your accreditation for delivery, for having deliveries.

Ms. Greenberg: — I think some of these deliveries aren't planned.

Hon. Mr. McMorris: — If I could just comment that these were just emergency deliveries. So I think the feeling is, with a program there'd be many more deliveries in the hospital because of the young population around Fort Qu'Appelle.

Ms. Junor: — Okay. That's a very good idea actually. And the diabetes strategy. Thanks.

Ms. Magnusson: — My name's Donna Magnusson. I'm the executive director for primary health services branch. On the diabetes question, Ms. Junor, the province actually funds about $650,000 for programs, services throughout the province. A hundred thousand of that actually goes to the three northern RHAs [regional health authority], and the three CEOs or chief executive officers have gotten together and they've formulated a plan based on population, based on-reserve, off-reserve. So they've divided the money between the three regions and Cumberland House is actually included in that.

The remaining $500,000 goes to the other regions. Saskatoon and Regina each receive about $60,000 each and the rest about $47,000 per year. And then $50,000 is actually retained by the ministry for the development of provincial programs, services like information booklets or ongoing teaching and resource materials.

Ms. Junor: — So have we seen a decrease in the rates of diabetes in the province?

Ms. Magnusson: — We're just actually, we're updating the figures because there were some comments a couple of weeks ago when they did the program from the Regina Food Bank. So we're just looking at those. What we think is that there may be a slight decrease in the incidence of diabetes, but we need to confirm that.

Ms. Junor: — Do we still have a breakdown in the Aboriginal or First Nations population as compared to the non-Aboriginal?

Ms. Magnusson: — Yes we do, and the Aboriginal rate is about three times higher than what we would see in the rest of the population.

Ms. Junor: — In the monies that you were mentioning, the allocations, is there a dedicated or a focus on Aboriginal . . . We were originally, years ago talking about an Aboriginal centre of excellence and having diabetes being a focus of that centre of excellence. We didn't actually get there. But do we have a focus on Aboriginal diabetes or Aboriginal health?

Ms. Magnusson: — You're probably referring to the project that was supposed to be in Saskatoon associated with the Muskeg Lake project. And that project didn't proceed, but what we have done is we had in preparation for that, actually we had provided the Saskatoon Regional Health Authority with the funding to actually put the staffing in place. And even though the project itself didn't proceed, we've left that funding there.

And they've changed the name of the project. They call it Aim 4 Health and its focus is really on Métis and First Nations people, primarily first of all within Saskatoon and then those that have to come to Saskatoon — and a lot of those are actually from northern Saskatchewan — to get their services.

And then the third group that they're targeting are immigrants and refugees because we're seeing a fair bit of undiagnosed diabetes in that group as well. So it's targeted to hire Aboriginal people as much as possible, and be culturally sensitive to both Aboriginal and immigrant needs.

Ms. Junor: — Thank you. I'd like to move into long-term care, the discussion about long-term care. And I noticed when I asked a written question, I received how many long-term care beds are in each region. And overall I see a loss of 115 beds in the system in long-term care, and I'm wondering . . . I know I also have the corresponding waiting times. So we don't have a great deal of . . . We still have a fair amount of wait times in certain areas, and we have lost 115 beds. I'm wondering what we're going to be doing about that.

Hon. Mr. McMorris: — The numbers that you would have received wouldn't necessarily be the actual bed count because what we do is go on population on the number of citizens that we have in long-term care. There could be a slight decrease in the number of beds, physical beds as some health regions or some facilities will move from a double room into a single room. So that may be a reduction, but it certainly wouldn't account for the 115, the number that you had mentioned. What that number is is based on the number of people actually in long-term care facilities, the number of citizens in long-term care facilities and not the physical bed.

Ms. Junor: — So when I asked the question how many long-term care beds were in each of the 13 health regions, I have the chart that says number of long-term care beds per region. You're actually telling me that this isn't the number of beds, this is actually people? So then the whole, my whole question, the point has been missed. I wanted to know the capacity in the system, and I assumed this was it.

[16:45]

Hon. Mr. McMorris: — There are roughly about 8,600 beds, but we can . . . just one second here. I'll just get Roger Carriere to kind of fill in some more of the detail on those numbers which you have, I guess, totalled at the bottom of each column.

Mr. Carriere: — Calculating that number of beds is sometimes not as clean as it might appear in surface. Regions report to us each year the number of beds they have in operation. As mentioned earlier, some have converted some double rooms to singles. However, also regions have what they call flex beds. Sometimes they're used for various purposes and sometimes if, particularly at that point in time, there's a long-term care resident in that bed, they'll count it as a long-term care bed, but at another point it might be used for another purpose. So it does create some variation in the number of beds that regions report.

It was similar the other day when Mr. Vermette was talking about the beds in La Ronge, and we had a difference of two beds. And when we looked into that, it was because the number I had used was actually including two beds on the acute care side of the facility that were being used on a temporary basis for long-term care. So you do get some of that fluctuation due to that.

Ms. Junor: — So you could not tell me what each district has for long-term care beds, excluding anything they use for respite or flex? That's what I want to know. How many long-term care beds are in the system? And that was the clean answer I asked for, and that's what I assumed I got. And that's where I got my 115 beds less in '09.

Mr. Florizone: — The number you received is accurate. What

we were trying to do is explain the variation from year to year. And that number is the clean number for those long-term care beds that were reported to us by regional health authorities. So these are beds that are actively being used for long-term care.

Ms. Junor: — Thank you. Then my question is, Saskatoon is down 23 beds and their wait time has gone up significantly. It's now 55 days, up from 39 last year or in '09. That's the data you have given me, is 55. The wait time is 55, over 55 days from 39, almost 40 days in '08. And they've gone down 23 beds.

Regina appears to be stable at the same amount of beds and just slightly up for wait times. And I'd like to know what the difference is, why the difference is.

Mr. Florizone: — Well there are a couple of factors that enter into this. And most certainly Saskatoon, we've heard with respect to some of the analysis that they've done locally, they have a need for more by way of long-term care. What they've done is trended out their population, and their population continues to age. There's a bit of a maldistribution. They have higher proportions of long-term care beds in their rural areas than their urban centre.

One of the difficulties that Saskatoon was encountering was that they had almost 60 people who were in hospital waiting placement. And you'll see them reflected on the wait-list. Those 60 people were in acute care beds.

One of the key challenges in long-term care — and I know, I know that you're very familiar with this — is that it's one thing to have a certain number of beds. But what you need in order to match the need is, where a patient presents or a resident presents as requiring long-term care, you need an empty bed. And one of the things that Saskatoon has been lacking historically is to have that kind of flexible bed, that kind of environment where you'd be able to admit immediately into not quite respite but it's more of a convalescent-type care or a transition-type care where then placement or a discharge home could take place.

Using acute care is a highly expensive option to be able to provide such transition, and its programming doesn't have a tendency to be consistent with long-term care standards or appropriateness for long-term care patient needs, resident needs. In other words, putting someone in a gown, taking away their activities of daily living, not allowing them the independence that they might need to recuperate or to at least maximize that independence, that rarely occurs in acute care setting. It certainly can occur in respite settings, in private personal care homes, and in long-term care oriented facilities.

Ms. Junor: — Thank you. I understand in Saskatoon there were high use of acute care beds for long-term care. And I understand from the staff there that 50 — it might be 60 — they said 50 beds, 50 long-term care beds were created or a unit of long-term care that would be awaiting placement. And that was sort of like on site but not in a long-term care facility, but was made into a long-term care unit within a hospital. And instead of saving the acute care beds that this freed up, those beds were closed.

Mr. Florizone: — So in response to that, I just want to be really clear on what Saskatoon Health Region did. And I'm sorry about the number. I should be referring to the exact number, but I do know the number is somewhere between 50 and 60, so we're in the ballpark.

The Ministry of Health supported a short-term action to establish and to provide care to those persons living in acute care. And the real sense here was that we could maybe create in the short term a bit more of an appropriate care model and environment to care for individuals. Now I say short term and I think the confusion is created here when Saskatoon went out and it almost appeared like they did a permanent conversion of acute care beds to long-term care. In our view, the ministry's view, that's not appropriate.

Now we say short term as well because we have more beds coming on board. Oliver Lodge, some of the ability now to create that transition, those units come about because of the additional beds coming online in Saskatoon. So we would want to see acute care preserved for just that, acute care, making sure that we're using our acute care capacity to deal with surgical wait-lists and acute care needs as they're emerging. And we're certainly seeing that trend out as not only increasing, but we have wait-lists and backlogs that need to be dealt with.

We want to make sure that we have adequate capacity for long-term care. The other important factor here is that while we have almost every region someone making a comment about the need for additional beds, we institutionalize at a level that is second from the top in this country, that is the highest as a country among virtually any jurisdiction on the planet. And there are many reasons for this that are culturally defined or historically defined, but where we need to make a break with that is by making appropriate investments in home care and home-based service.

So there is the need to look right across the continuum, to look at home care, to look at private personal care homes, to look at enriched housing, to be able to look at the types of investments that'll be necessary as we move forward. When we start talking about the sustainability of the health care system, these solutions are key to forward-thinking sustainability that's required.

So rather than talk about beds, because a bed built is a bed filled, and anyone who measures need by whether or not we can fill beds, all you need to do is go to the regions that have far greater number of beds. They're all filled. And when the need arises, the bed isn't available.

What we're hearing from the public is that they need the care in the appropriate setting. They need a bed when that's required. But certainly long-term care, at least the long-term care that we deliver should be reserved for those that are frail elderly. We should be able to maintain and maximize independence for people in their own homes for as long as possible.

The other misnomer — and I'm sorry to go on on this, but — the other misnomer is that long-term care is all that long term. We've seen a reduction in length of stay from what used to be measured in years, perhaps five or six or more years. We are now seeing average lengths of stay to be two years and less, and in many cases for new admissions, shorter than a year. So other

options that are community based are certainly a priority for looking at that care continuum. Thank you.

Ms. Junor: — Thank you. I don't think there is anybody in a long-term care bed right now that isn't a frail elderly. I don't know. I haven't visited some of the outlying ones, but I'm certainly hearing reports back from all kinds of nursing and support staff that the acuity in long-term care is very, very high.

So I was in Hafford a couple of weeks ago, and they have five beds that they could use there. And it made me go back and look at all this data about where the beds are and where the wait times are because they said people from Hafford are coming in to, say, St. Joseph's in Saskatoon. So they would be taking up, because there's no beds in Hafford, so they would be taking up space in Saskatoon. They are also going to North Battleford. So they're going into that system and taking up their long-term care beds. And according to the information I received on my tour from various sources, they have five beds that are available to be used that would definitely impact on Saskatoon, cutting down the wait times there and the needs for beds there if those beds were properly utilized in Hafford.

And I believe the Hafford delegation brought this very issue to the SARM [Saskatchewan Association of Rural Municipalities] convention or the SAHO convention. I think it was SARM. And they made a fairly good argument, and so I went out and had a look, and they were right. I mean they have the actual physical space. They have the staff there that could be maximized so that it wouldn't really cost that much more for staffing to put five extra people in that facility. And I think it sounded fairly logical to me when you're putting a strain on Saskatoon and North Battleford who are both in the higher wait times — Saskatoon for sure; North Battleford, it doesn't look like I have that wait time, no data this time. So I think Hafford had a good argument, and I'd like to know your thoughts on that.

Mr. Florizone: — We've actually instructed Saskatoon and in fact all regions who had long-term care residents residing in acute care beds to be creative and innovative, to look at options that included personal care homes, home care, enriched home care. In fact just on the point around the individualized funding, we asked them to look at innovation there as well. One of the areas that we instructed regions to think through and work through was this notion of utilizing rural capacity, in particular where we see facilities in the rural areas that may have vacant beds that could be used for this purpose. Perhaps they have higher bed ratios.

Now it's really, really important that we be sensitive to the patient, to the resident and their family here. We've heard through a number of reviews that have been done, some of the work that's been done by our Legislative Secretary, certainly the Patient First Review, that people wherever possible want to be cared for as close to home as possible. We also have heard that it's traumatic to be moved away from your local community and, in particular, separated from your spouse. So these are pieces of policy and work that really need to be thought through as we have people move out to a rural area on the condition that they might move back. Now I do hear what you're saying. There may be residents from that local area who have . . . [inaudible interjection] . . . Yes, who have family and connections. And the road goes both ways.

[17:00]

So most certainly we need to be able to look at these options. Everything has been on the table with respect to attempting to provide appropriate care for those people that are residing in long-term care. Now I don't have the numbers with me right now, but we actually set targets for regions to work towards improvement in this area. So we have seen a marked reduction in those people that are living in acute care who require long-term care. We're working that through.

Ms. Junor: — I have one question and this is a particular question. As my colleague and I were saying, you know, you're speaking to the choir here. Like we know a lot of this stuff. So I'm actually asking particular questions.

I asked a question, a written question that was submitted to the minister about what were the hours worked per resident per day in long-term care, and the answer was that the ministry doesn't collect these statistics. So they're obviously collected somewhere because I've seen long-term care studies and reports done using that data or those statistics. So if they're not collected by the Ministry of Health, are they collected by the districts or by anybody?

Mr. Florizone: — With respect to hours worked per resident day, we don't collect as a ministry that information. I do know from my previous experience that the regions, the health authorities do measure in this way. They will compare facilities and they'll also look at intensity of care. So they may use MDS [minimum data set], RUGS [resource utilization groupings scores] information to take a look at the intensity of care that's being provided. We however do not look at those forms of ratios.

What you're going to see is we're actually emerging to a different sort of measure and that is how much time is being spent per resident. And to us within the ministry and to regional health authorities, that's a far better measure, given the fact that we're seeing nurses, registered nurses in particular, spending 26 or 28 per cent of their time in a 12-hour shift with the actual patients in acute care and residents in long-term care. So the notion of this measurement is that it's actually patient-focused. Those measures have been taken by front-line workers, and they're taking very concrete steps to reduce the waste, the time spent doing things that may not be adding value to the resident or patient themselves.

Ms. Junor: — Thank you. I think I'm going to leave long-term care because my colleague from Nutana has some questions. And I would have liked to get to just a quick . . . This will be my last question. And I mean it's a fairly big area, but I want a quick update on the physician recruitment strategy.

Hon. Mr. McMorris: — What I'll do is I'll allow Max Hendricks to get into more of the detail. The committee that was named a month or two ago has met a second time as of today and are well on their way to moving in the direction we need them to do, to retain and recruit more of our physicians. And so I'll let Max get into the detail of what they're working on.

Mr. Hendricks: — Okay. The physician recruitment agency is

one piece of the overall physician recruitment strategy. As the minister mentioned, the board has now had two meetings and they're starting to focus in on what the vision, mission, and first objectives of the agency will be. But it's a subset really of what the entire program is about.

We've started a repatriation campaign and have student ambassadors at the College of Medicine actually liaising with the students, medical students and residents, trying to provide them with information. We've done a bit of a social media campaign where we're trying to create the link-ups on Facebook and Twitter that would allow students and residents to communicate with us and tell us their issues, concerns, and communicate with those abroad that might be considering Saskatchewan as a place for potential practice.

One of the issues that we're hearing a lot about from potential applicants to Saskatchewan or physicians interested in coming to Saskatchewan are concerns about the licensure process with the College of . . .

Ms. Junor: — CAPE [clinicians' assessment and professional enhancement].

Mr. Hendricks: — CAPE, with the College of Physicians and Surgeons. And one of the things we're looking at is expediting the assessment process for physician applications and having an expedited assessment process actually located in Saskatchewan. We haven't decided yet whether that will actually continue to use CAPE or we'll have our own type of OSCE [objective structured clinical examination] examination here, but those discussions with the college and with a group of advisers are ongoing. Another thing that we want to do is expedite and have online physician applications to the College of Physicians and Surgeons. Currently it's a lot of back and forthing through paper procedures. So we're trying to take a broad-based approach and look at various ways that we can address this issue.

Ms. Junor: — I said it was my last question, but I have just one more. When I asked questions, written questions about how many physicians were working in Saskatchewan for certain years, the data wasn't available for . . . March 2010 physician supply data is not available until April. So now April's over, so I'd like to know how many physicians were working in Saskatchewan as of March 2010 and how many general practitioners and how many specialists, same dates.

Mr. Hendricks: — If I could provide that information to you after. I don't have the March 31st, 2000 figures.

Ms. Junor: — Okay, then. Now I can turn it over to my colleague from Nutana.

The Chair: — Before I recognize Ms. Atkinson, we started a little bit late, so we'll run the meeting till 5:20 before we wrap up. So, Ms. Atkinson, you have a few minutes.

Ms. Atkinson: — Thank you. Minister, I represent a number of physicians in my constituency who provide physician services through the College of Medicine or provide physician services in our community. And some of them are young physicians and many of them are specialists.

They have been waiting for some time — and I've been asked by them to ask this question — they've been waiting for some time to have a new agreement with the Government of Saskatchewan. And I'd be interested in knowing whether or not they're going to have an agreement with the Government of Saskatchewan sooner or is it your strategy — because this is what they believe — that you're waiting to complete your negotiations with the 25,000 allied workers or health workers and health sciences before you enter into a final agreement with them.

And many of them . . . We're now getting towards the end of June, and it's time when people start making their moves. And I'm wondering, are we going to have an agreement sooner or is it going to be after all the other agreements are concluded?

Hon. Mr. McMorris: — You know, the negotiations or the talks aren't slowed down or they're not waiting until the other provider unions settle. First of all, the negotiations aren't through the government. And the residents for example or those physicians that are teaching physicians, it's through the university, the U of S.

If you're talking about the overall SMA agreement, then that is through us. And there's progress being made; we're in talks with them. And actually, you know, I had the opportunity to sit with the president, Dr. Miller from Moose Jaw, a couple of weeks ago, and he was quite happy with the progress that was being made. That was perhaps a bit of a change from when I talked to him a month before. But two weeks ago, he was happy with the progress, and we're working on that.

I don't know when the provider unions will first of all get to vote on their contract or settle on their contract. So I mean that could be drawn out for a year. There's no way that we'll carry on negotiations with the SMA for an extra year just because of the provider unions. Those negotiations are going on, you know, currently and I think they're going quite well. I mean I just don't know any sort of timeline for the provider union group, so it wouldn't be very prudent for us to say, well we're just going to hold off all negotiations until they're done. That could take way too long.

Ms. Atkinson: — Okay. I'm basically talking about people who are in private practice, but there are people in private practice that do provide some teaching services in the College of Medicine. So I'm talking about the SMA. When do you expect to meet again? Because these physicians are waiting to — they're specialists, many of them — they're waiting to have some of their issues addressed. And they're also being recruited and headhunted from other parts of the country.

And when I said we're getting towards the end of June, what I mean by that is we're now in early May, and physicians with young families or school-age families, they start to make their decisions. And they're being headhunted now so they can move in the summertime so that their children can be in a new location in the fall. So I'm wondering, is it probable, possible that we'll see a concluded agreement with physicians before the end of May? And I'm thinking of some pretty highly skilled people, and we do need their services. But they're waiting for the fee, for the fees basically.

Mr. Hendricks: — I think one of the unique things about this round of negotiations and why it's taken some time is that on both sides, from the ministry and also from the physicians, there were a lot of unique programming ideas that we actually sent away to subcommittee to be addressed before reconvening the full MCRC [medical compensation review committee], which is the main negotiating committee.

We've met probably two — over the last month and a half — two times. We're meeting again next week. As you know, they have their representative assembly.

The physicians are very interested in securing an agreement quickly. Will it be by the end of May? I'm not sure. That will depend on what happens over the next couple of weeks. We'll be actually tabling a mandate with the physicians that will outline the specific dollars, and so it's going to be aligning their expectations with the resources.

But one thing I can say is that the way, the approach that's been taken in bargaining is that we are seeking to be competitive with comparable markets. And so when we do look at what we will be looking for as a mandate for physicians, we will be looking at Western Canadian markets. BC [British Columbia] is a place we lose physicians to, Alberta. So we'll take all that into consideration. So I think that any physician that's considering relocating or where they will go should be reassured that Saskatchewan will be competitive.

Ms. Atkinson: — I think, I think when . . . Because it's taken so long and it's taken a very long time, and I think it's taken longer than what many people would consider to be the usual time, there are people that are just sort of getting to the end of their rope. And they're being given some very good offers, and not only in Western Canada but in other jurisdictions as well, other provinces.

So is there some way that someone could signal that, publicly I guess, that it's the intention of the province to be competitive with other jurisdictions? Because the clock is ticking and it's been a very long time in terms of trying to get this settled. Just a question.

Mr. Hendricks: — The minister and myself and Dan next week will be meeting with the board of the SMA. And the minister obviously speaks at the representative assembly, so he'll have that opportunity to send that message then, which is I think already done a couple of times or several times.

Ms. Atkinson: — Well I guess it hasn't been heard. I understand you have to say something 13 times for someone to actually hear it.

My last question has to do with Sunnyside Nursing Home. Sunnyside Nursing Home is a nursing home in the constituency of Saskatoon Nutana and it is run by the Seventh Day Adventists. They are an associate or an affiliate with the Saskatoon Regional Health Authority.

They're in the process of putting together a plan to build an addition to their facility. They are one of the nursing homes in the province where they have two residents in rooms. And I'm wondering if there's been any discussions between the ministry and the Saskatoon Health Region about additional long-term care facilities in the city of Saskatoon given that there are some waiting times, given that there are people in acute care beds and the population is aging?

[17:15]

Hon. Mr. McMorris: — Thank you for that question. I'll just kind of answer it generally in that we're continually talking with all the health regions regarding their needs, and Saskatoon is one of them regarding long-term care. And we touched on it earlier about the need to get some of the people out of the acute care centre. Oliver Lodge will be opening soon which is an addition of 63 beds, which will be great.

But how does that look into the future? Do we have enough beds in Saskatoon? Because generally the two major cities, Regina and Saskatoon, are receiving a lot of population from rural Saskatchewan and quite often an older population. So how does that match up into the future? We know that there is a great demand for more beds in Saskatoon. We've been in discussion with the Saskatoon Health Region to look at options to try and increase the bed count. You know, it's calculated on a, you know, 1,000 people over the age of 75, so many beds per 1,000 people over the age of 75. Every health region varies a little bit on that count. But if you project into the future the demographics and what the needs will be, there certainly will be a need in Saskatoon and Regina for more beds.

Ms. Atkinson: — Minister, on page 25 of the budget summary, there's an indication that Treasury Board organizations which include regional health authorities are . . . that it's the intention of the government to change how we deal with capital, that the intention is to amortize it over a period of years and not to provide grants as projects are announced and built.

Is it the intention of the Ministry of Health to change how we fund special care homes in the province of Saskatchewan, given that there was money that was sent out to the regions and then it was used for other purposes, and we now have various regions waiting for these long-term care beds? But is it the intention of the province to change how we deal with capital and move to amortization over a period of years in order to fund these facilities?

Hon. Mr. McMorris: — I wouldn't say that there is a concerted effort to change the way we fund capital. I mean right now there's many different variations of buildings that are in, you know, whether it's an affiliate, as you've already mentioned, with the one long-term care home in Saskatoon. There's quite a variation from health region to health region regarding how capital is funded, and we're looking at all those options as we move forward, including in Saskatoon.

What are the options that we can explore to ensure that we have, you know, if we an increase of beds, is it the government putting all the money upfront or is there other options, just as we did with, you know, some of the retrofits for facilities on trying to make them more efficient? That's amortized out over years; it's not an upfront capital spend, but it was amortized over years.

So there's, you know, there's a real mix on that through health

region to health region, and even within a certain health region. This was also signalled through the Patient First Review as a, you know, an area to look at, to try and look at other options for capital.

Ms. Atkinson: — So if you look at sort of the behaviour in terms of capital construction, and I'm not talking about retrofits, but capital construction, it has been cash financed. I'm talking about the province's share, I'm not talking what the health regions' share, but the province's share. Is your government looking at changing the notion of cash financing larger builds like nursing homes, hospitals, that kind of thing? And I'm talking about the province's share, I'm not talking about the health regions' share.

Hon. Mr. McMorris: — Or the community share, you mean?

Ms. Atkinson: — Yes.

Hon. Mr. McMorris: — I guess just basically is that we haven't changed any policy as the way capital is funded. It's a pay-as-you-go, just like whether it was the Humboldt facility, so much each year till it's complete. That policy hasn't changed.

Ms. Atkinson: — If I could, Mr. Chair, your government signalled in this spring's budget that they're changing the way they cash finance Treasury Board organizations. That includes regional health authorities and school divisions as well as other Treasury Board Crowns.

So I guess what you've said is that it's not the intention of your government to change the way we cash finance large health projects when it comes to the province's contribution to those projects. We're not going see amortization over 20, 30 years for the nursing homes that will no doubt sometime be, the province will start to construct through the health regions. And I'm not talking about the health regions' share. I'm talking about the province's share.

Mr. Florizone: — Just to clarify. The regional health authorities are not considered Treasury Board Crowns. That statement that was made and embedded around Treasury Board Crowns. The actual regional health services Act excludes regional health authorities and states very clearly that they're not Treasury Board Crowns. However, because of the funding arrangement and the financing arrangement, they certainly are treated in many similar ways to Crown agencies.

So I wanted to just clarify because the actual statement that's made in the budget documents does not, that wasn't an announcement that was intended to apply to regional health authorities. What we do have is we have the Patient First Review that talked about the need to think creatively in innovative ways about financing these facilities. So when it comes to the capital needs, when it comes to the need to explore innovation with respect to financing, this is certainly something that will be explored over the coming several months.

Hon. Mr. McMorris: — Mr. Chair, I have one point too to clarify, of a question regarding SAHO and the purchase of drugs. I had used the term that the company threatened to sue, and that's perhaps too strong. I think probably what I should say is SAHO is aware that there may be a lawsuit. I shouldn't have said that the company had threatened. I don't know that for sure. It was too sharp of a term. Anyway, thank you.

Ms. Atkinson: — For the purposes of clarification, Mr. Chair, on page 25 of the government's budget summary, there is an indication that Treasury Board Crown organizations are changing the way they fund and expense capital in this year's budget. Rather than provide an upfront capital grant, the province will fund the capital as it's amortized. So if you look at the summary once again, under Treasury Board organizations, regional authorities are included. And so what we've been trying to understand from the government in estimates is, is it the intention to change how we cash finance facilities when it comes to education facilities, health region facilities, and so on and so forth? Because we were told by the Gass Commission this wasn't a very good idea, and it's how you add to the long-term debt of the province.

So I'm just wondering, for the purposes of the Ministry of Health and, you know, there's the Health Information Network, so on and so forth, is there an intention on the part of the government to change how we pay for and finance the province's share of capital?

Mr. Florizone: — Once again, just to clarify, and I understand the presentation, but the regional health authorities are not Treasury Board organizations. There may be a display issue with respect to those statements or those financial . . . the estimates. They are not Treasury Board organizations for the purposes of *The Regional Health Services Act*. With respect to policy change, no policy change has been announced to date.

With respect to exploring these options around innovative and creative financing arrangements, the recommendation has been made through the Patient First Review that the minister ought to and the ministry ought to explore those options. That certainly has been put out there and stated. So innovative and creative options with respect to capital financing, the provincial share has been put out there.

Ms. Atkinson: — And, Mr. Chair, what I would say is that we had innovative and creative financing in the '80s which led to the Gass Commission in the early 1990s that strongly, strongly recommended against this kind of innovation and creativity. Thank you very much, Mr. Chair.

The Chair: — Thank you, Ms. Atkinson, Ms. Junor.

Ms. Junor: — I'd like to move, since we've had a little extra time added, I'd like to move to the seniors file. And I just was reading a *Leader-Post* article about drugs from March 19th of 2010, and it just caught my eye that it said the seniors' drug plan allows 95 per cent of Saskatchewan seniors to pay only $15 for covered prescriptions. Is that accurate? Like, 95 per cent seniors fall under the low income . . . or the income cut-off for $15 coverage?

Hon. Mr. McMorris: — You mentioned that it was 95 per cent of the seniors were eligible, and that's correct. Ninety-five per cent of the seniors are eligible. They fit under the cap, or they fit under the cap of $66,697 annual income. And so then because of that, they're eligible for the $15 senior drug plan.

[17:30]

Ms. Junor: — Thank you. Another topic under seniors is the seniors' centres, most of them in rural Saskatchewan. And there's been a real concentrated lobby from seniors that have access to these seniors' centres because of there's going to be so many more closing. They're in danger of closing mostly because of the utility rates and the rent and the upkeep of the facilities.

I visited some of them where they can't afford to turn their heat on, and so the seniors don't come any more. And these were centres that were vital gathering places for seniors who would otherwise be socially isolated. And they used to come and play cards and do various things. Now they can't because they can't pay for the utility rates — the heat and the power and the phones — and they just can't raise the money; 80-year-olds cannot go out and do fundraising. So there has been an ask from the association, the president of the Saskatchewan Seniors Association, to have some government grant money to shore up the centres, but there's been no real, doesn't seem to be a real appetite for this.

It does seem to be fairly short-sighted to let these senior centres close in rural Saskatchewan when it is one of the places that keeps seniors active and independent, and even programs are running, some programs were running through them, like foot care. So it doesn't seem to be unreasonable to try and find a way to keep these open. And the information I have is that 40 to 50 more are in danger of closing over the next year or two, so we have to do something fairly soon.

Hon. Mr. McMorris: — Yes, I am very aware of the issue around the senior centres around the province and especially, as you said, many of them are in rural Saskatchewan. I've certainly been lobbied by the group, the seniors' group that would like to see this . . . I forget the fellow's name from Prince Albert . . .

Ms. Junor: — Len Fellows.

Hon. Mr. McMorris: — Len Fellows, who would like to see this move ahead. The ministry had met with him last week. Both Louise and Roger met with him last week and heard his concerns, you know, and they're legitimate concerns.

Some of these facilities are having a hard time making ends meet, making sure that they can keep the heat and the lights on. Other senior centres are doing quite well, and I can identify a couple of them. One that I'm familiar with, quite familiar with is the one in Fort Qu'Appelle, very active. It does well. It's got a good financial foothold, good financial foundation. They seem to be doing very, very well.

There's many others around the province. I was speaking with a fellow up in Preeceville when we were at the hospital opening there, and he was talking about how they were able to keep their senior drop-in centre, I guess, or senior centre going, but he said it takes work. And it takes, you know, they do some fundraising. They've raised their rates. They put on a lot of activities. They rent their facility out, and they're able to make it work quite well. But it's because they're proactive, and they do a lot of those things to keep it open.

There are seniors' centres that aren't as fortunate, and sometimes that's simply because of population. A lot of the people that were active in that community have either moved away or passed away. The numbers have certainly dropped, and I think that is the biggest challenge for some of these seniors' centres is that the numbers have dropped even though the expenses tend to go up.

There are other examples where seniors' centres, you know, they haven't raised their membership fee for forever. And so then when you look at that then people say, well is it the responsibility of the government then to help subsidize these, to keep them open, if they haven't perhaps been as aggressive as what other communities have? As I said, some of your communities are very aggressive and fund theirs completely, whereas other communities may not have the membership, may not have the activity, may not have the interest in that community to do that. Is it then the responsibility of government?

I understand the need for these facilities because, you're right, it does reduce the . . . It's a social place for seniors to gather in rural Saskatchewan, and in some small communities it may be their only opportunity to talk to other seniors. And so it's a great place for that. The question, the bigger question becomes is it the responsibility of government to make sure that these are open? And does it become the responsibility of Health then to make sure these are open because it is a bit of a social issue, maybe more than it is a health care issue. I'm not sure that it would be necessarily classed as a Health issue. I mean you could look at it as a public policy piece, and where does it fit? I'm not sure it fits under Health.

We certainly have a lot of people coming to our door every day wanting more and more funded. We're not looking for places. But this is one area that, you know, it's not as easy as saying just fund these seniors' centres and then don't worry about the rest because they're doing well. Well what's the incentive then for the rest to continue to raise their rates when, if you just let them lapse, the government will come in and subsidize? You know, there's some problems with that as well.

Ms. Junor: — Basically I'm coming from the point of view that, according to many seniors' groups, that healthy aging can delay and minimize the costs of the health system with chronic diseases and disabilities later in life. So you do have, this is more proactive and preventative when you have a place for seniors to do some healthy aging.

And I think it might be useful to look at some way of assisting them without outright grants so that there isn't a disincentive for people to still have their fundraising and that can do it. But when you're looking at a group of people in a certain community that have basically elderly people, they don't do bake sales and fundraising anymore, nor can they afford membership fee hikes. It would be useful to look at, and I have suggested to see if the districts can run some programs through them so that they end up having a place to gather, but also a place to get information and do some health services like foot care.

So that would be what I think we should look at, trying to use the health centres that are out, or the senior centres that are out

there already, kind of a joint use thing and basically use the strengths of the communities. The ones that have good solid centres that don't have any financial disadvantage or problems, good. But the ones that do maybe benefit from the district running some programs through that would pay rent for them or offer some other incentives, that's just a comment and a suggestion.

I do have a . . . I asked this last year and you told me that this provincial advisory committee on older persons was still up and running and there, and I've not met a senior who knows about it or a seniors' group who is aware of it. What's happened to it?

Hon. Mr. McMorris: — The council that you had mentioned has been disbanded. It's not in operation right now. It hadn't met in about a year, so we disbanded it. We were waiting on . . . well not waiting, but through the Legislative Secretary is going to make some recommendations, and perhaps one of those recommendations will be around a council that will help represent seniors, I guess. Then that will be better informed.

Just one other piece regarding the long-term care . . . not the long-term care, the senior centres is there are some programs through other ministries such as Tourism, Parks and Recreation. The community vitality program, that goes towards facilities. So it doesn't necessarily have to be a Health initiative.

I will say though that — and you had mentioned that maybe the health regions could rent — I do a constituency tour every year in my constituency, and I try and use the drop-in centres. And there isn't a time where I don't at the end of the day say, listen, $20 for the day is not enough. They haven't raised the rates, you know. I mean they charge $20 and I can have the hall for the whole day. That's just, you know, they need to take, to be blunt, they need to take some ownership, and if they have some financial problems, start to look at what they can do to solve some of those problems themselves.

I'm not just saying that we need to just turn our back on them. And I won't use the community, but every year I write a cheque for $100, and every year they, you know, say just $20. You know, they just haven't changed and they need to.

Ms. Junor: — Perhaps then when we have this advisory group reconvened, that they would have some thoughts on how we can actually assist the seniors' centres. Because I think they are a valuable resource and an asset, and I think it would be good to not let them die out, especially in rural Saskatchewan.

My last question, according to the Chair, is I noticed in the resolutions from the Saskatchewan Seniors Association, there was a resolution about covering the costs of drugs for the treatment of macular degeneration. And I thought we already did that. Have you seen the resolution? And they seem to be under the misunderstanding that there isn't coverage. They're asking to lobby the government to include drug therapies for macular degeneration in the formulary and aids for macular degeneration in its aids to the independent living program.

Hon. Mr. McMorris: — You know, I think probably what you should do is go back to the group and just say their lobby has been successful because it is covered.

Ms. Junor: — Thank you. Oh I think that'd be wonderful. I think I can do that. Thank you, Mr. Chair.

The Chair: — Thank you, Ms. Junor, and Mr. Broten. I understand the committee is ready for the vote. So with that we'll call the vote 32, Health, general management and services subvote (HE01) in the amount of 15,344,000. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Provincial health services, subvote (HE04) in the amount of 182,930,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Regional health services, subvote (HE03) in the amount of 2,906,744,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Early childhood development, subvote (HE10) in the amount of $10,608,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Medical services and medical education programs, subvote (HE06) in the amount of 703,420,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Drug plan and extended benefits, subvote (HE08) in the amount of $382,658,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Provincial infrastructure project, subvote (HE05) in the amount of $250,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. No vote is needed on this one; it's for informational purposes only. Amortization of capital assets in the amount of $1,582,000.

Health, vote 32, in the total amount of $4,201,955,000. I will now need a member to move a motion to the following:

> Resolved that there be granted to Her Majesty for the 12 months ending March 31, 2011, the following sums for Health in the amount of $4,201,955,000.

So we'll need a motion from one of the committee members. Mr. Hart. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried.

[Vote 32 agreed to.]

The Chair: — That will conclude today's committee meeting. Thank you to all of the committee members, the minister, and

officials for staying to this extended hour. And thank you to committee members for working hard to get this vote through for the Ministry of Health. Ms. Junor, any closing comments?

Ms. Junor: — I'd like to thank the minister and his officials for their time for the, I think it's eight hours, eight and a half hours. And I look forward to more hours next year.

The Chair: — Thank you very much. And, Mr. Minister, any closing comments?

Hon. Mr. McMorris: — Yes, I'd just like to also thank the officials for being here. They were ready for yesterday, but they were here for today as well. And so thank you all of you for changing your schedules, but more importantly for the great advice that I'm given on a daily basis. I, you know, I guess we get to see it for eight and a half hours here today, but I get to see it every day, and I just want to thank them all for all their help and support.

The Chair: — Thank you very much, and again thanks to the officials for this change in the schedules and such. I really appreciate it. With that I'll need a motion to adjourn. Mr. Reiter. This meeting now stands adjourned.

[The committee adjourned at 17:42.]