STANDING COMMITTEE ON HUMAN SERVICES

Hansard Verbatim Report

No. 50 – December 6, 2010

Legislative Assembly of Saskatchewan

Twenty-sixth Legislature

STANDING COMMITTEE ON HUMAN SERVICES

Mr. Greg Ottenbreit, Chair
Yorkton

Mr. Cam Broten, Deputy Chair
Saskatoon Massey Place

Ms. Doreen Eagles
Estevan

Mr. Glen Hart
Last Mountain-Touchwood

Ms. Judy Junor
Saskatoon Eastview

Ms. Christine Tell
Regina Wascana Plains

Mr. Gordon Wyant
Saskatoon Northwest

Published under the authority of The Honourable Don Toth, Speaker

[The committee met at 19:00.]

The Chair: — Good evening, committee members and everyone at home. Seeing as it is now 7 o'clock, the agreed upon hour for our committee meeting to begin, I'll call the committee meeting to order.

I would like to welcome you all to the deliberations of the Standing Committee on Human Services this Monday evening. On the agenda this evening we will be considering the supp estimates for the Ministry of Education and Health.

First off I would like to introduce the members of the committee. With us on the opposition we have committee Vice-Chair Mr. Cam Broten, and substituting for Ms. Judy Junor is Ms. Pat Atkinson. On the government side we have Mr. Glen Hart, Ms. Doreen Eagles, Ms. Christine Tell, and Mr. Gord Wyant, and I am Chair Greg Ottenbreit.

Committee members, tonight I wish to table the following documents: HUS 63/26 to 69/26 inclusively, committee regulations from 2005 to 2010.

General Revenue Fund
Supplementary Estimates — November
Education
Vote 5

Subvotes (ED03) and (ED04)

The Chair: — Committee members, we are now to look at the estimates for Education, vote 5 outlined on page 12 of your Supplementary Estimates. Ms. Minister, would you like to introduce your officials and make an opening statement? And before you do, I will just ask all officials as you come to the mike for the first time, if you'd just reintroduce yourself for the purposes of Hansard. So with that, Ms. Minister.

Hon. Ms. Harpauer: — Thank you, Mr. Chair. And I am pleased to be here today with the ministry officials to speak about the supplementary estimates for the Ministry of Education. With me today are, to my right is Audrey Roadhouse, deputy minister of Education. On my left is Darren McKee, assistant deputy minister; and Helen Horsman, the assistant deputy minister. Behind me I have Cheryl Senecal, assistant deputy minister; Dawn Court, the director of financial planning and management; Sonya Leib, the senior financial manager of financial planning and management; and Clint Repski, the director of education finance and facilities.

Tonight we will discuss four primary areas of pressure the ministry is currently facing, which include the 2009 property tax backfill in the amount of $7.03 million; Lloydminster property tax backfill of $800,000; the school operating K to 12 [kindergarten to grade 12] initiatives of $667,000; and the teachers' extended health care plan in the amount of $877,000. So this represents an increase of $9.38 million or an increase of point zero seven one per cent over the original budget of 1 billion, 313.13 million. I would be pleased to answer any questions you may have.

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

Ms. Atkinson: — Thank you, Minister, and welcome to your officials. There's some clarification that I would really appreciate if it would be possible. This particular supplementary estimate calls for $9.38 million in additional revenue, but there's also a change on the capital asset acquisition on page 8 of 1.72 million. And when you go to page 7, there's a revised estimate of 1.144822 billion, and then there's the revised capital asset of 1.72 million, revised amortization of capital assets of 1 million, and then the number changes; it's reduced by about 720,000. And I wonder if you could explain that to me.

Hon. Ms. Harpauer: — Thank you. I'm going to have Audrey Roadhouse, the deputy minister, answer this question.

Ms. Roadhouse: — The 1.72 million was appropriated to us, and it had to do with the move for accountability assessment in records.

Ms. Atkinson: — Can you elaborate a little more? Thank you.

Ms. Roadhouse: — Well I do know that — and I might need the Finance officials to elaborate a bit more — but they were originally moved because of the nursing program, and then we were given the space. Now they've moved to a new location. So this was appropriated to us for that move. Because they were — I'll call it displaced — and so then this was to compensate us for that move for them.

Ms. Atkinson: — Okay. So one division in the ministry had to move out of space that was taken over by the nursing program. And they moved elsewhere, and so there's an additional 1.7 million to accommodate. Okay.

Now then there's the revised amortization of capital assets of a million. Can you explain that?

Ms. Roadhouse: — The net impact is 720 and that's the difference between the appropriated amount and amortization.

Ms. Atkinson: — Okay, got it. So that explains the 720. Okay, I understand. Thank you very much.

So the ministry is asking for 8.503 million, plus 877 million. Is that correct? 877,000 — sorry — thousand. I think you'd like that, yes. We could really do learning and care, I agree. We just about got one over on them. As I understand it some of that is to backfill property taxes. Can you elaborate a bit on that?

Hon. Ms. Harpauer: — Yes. We're requesting, for the backfill of property taxes, we're requesting 7.036 million which is a reconciliation of education property taxes for the 2009 taxation year. These additional funds were required because the actual amount of education property tax revenues received by the school divisions in 2009 was less than what was estimated.

The ministry has identified a number of reasons why the tax estimated was higher than the actual levy, and they include such things . . . Because of course this is the first year where the school divisions didn't apply the levy themselves, so we were estimating what the tax revenue would be in order to do the school divisions' budgets.

So things that would cause discrepancies in estimates were such things as unpaid taxes because we're going to estimate as if they're all going to be paid. The difference is if someone pays early, there is a discount for early paid taxes. So again there's no way to know in advance what type of revenues there were.

There also was a miscalculation on the commercial side of the taxes because the final assessed value of the commercial property for 2009 was $434 million lower than what was estimated. And there was a slight error in calculating the different tiers in the commercial property because commercial property are assessed or levied with three different tiers.

So those were the main areas where there was discrepancies in the calculations, keeping in mind that in 2009 the calculations were extremely complicated. They were done manually, and for 2009 the first three months there was a property tax credit, then the levy was applied for the additional nine months. So there was a number of calculations that needed to be done in a short period of time. So that was the discrepancies that we saw.

Ms. Atkinson: — Okay. So of the 7.836 million, 7.036 was due to the need to backfill property taxes directed to the school divisions. What was the remainder of the money, where about 800,000 . . . was that used for some other?

Hon. Ms. Harpauer: — The 800,000 was to address the anomaly of Lloydminster. Lloydminster of course is a border city, and it falls under *The Lloydminster Charter* which is unique to that particular city. So it was dealt with somewhat separately because the assessment in Lloydminster is an Alberta assessment and yet it is Saskatchewan that applies the levy. So while we're in transition and we're working with the city, we're working with Alberta. Both education ministries and municipal ministries and the city of Lloydminster are all working together to get a better solution.

[19:15]

But in the interim, Alberta would put forward what the amount of money that they felt they needed for their students, Saskatchewan submitted the amount of money they felt they needed for their students, and a blended mill rate then was applied to Lloydminster because it is a different assessment than the rest of Saskatchewan.

So that blended mill rate didn't quite fit the need of what that particular school division had in previous budgets. So this was to address that shortfall so that they wouldn't be seeing a dramatic decrease in their budget. And as I said, the ministries of Education, Municipal Affairs, as well as the city of Lloydminster are working and we're meeting and talking about a solution going forward of how to address the anomaly.

The other very different thing that happens in Lloydminster is that 74 per cent of the tax revenues from the properties is collected from the Saskatchewan properties. Sixty-two per cent of the children . . . Or I'm sorry, 74 per cent of the tax revenues are collected from Alberta properties, but only 62 per cent of the children are Albertan children.

So we need to, again working with Alberta, come with a formula unique to Lloydminster that will address that difficulty. Because by the charter of the city of Lloydminster, the assessment must be the same across the city. The mill rate must be the same across the city using Alberta mill rate . . . or Alberta assessment, Saskatchewan mill rates, but yet it isn't equal, the number of children to the amount of money that will be collected from mill rates. So we're coming with rather a unique formula that will apply to Lloydminster. For this year till that formula can take place, we feel that they were short about $800,000.

Ms. Atkinson: — Okay. So basically the $7.836 million, vast majority of it was to backfill property taxes and the rest of it was to deal with Lloydminster.

Hon. Ms. Harpauer: — That's correct.

Ms. Atkinson: — There was no other school operating funds that went to anything else?

Hon. Ms. Harpauer: — No. That would be correct.

Ms. Atkinson: — Okay. So then we have $667,000 for school operating K to 12 initiatives.

Hon. Ms. Harpauer: — Yes.

Ms. Atkinson: — Can you run me through what those initiatives were?

Hon. Ms. Harpauer: — The $667,000, in essence it's not new money. It's a transfer of money because the Ministry of Tourism, Parks, Culture and Sport used to have the live satellite network through SCN [Saskatchewan Communications Network]. So this is transferring those funds now to the Ministry of Education, and we're paying SaskTel for that service.

Ms. Atkinson: — Okay. So there was a transfer out of Culture and Rec.

Hon. Ms. Harpauer: — Yes.

Ms. Atkinson: — At one stage SCN was over in Education, if I remember. But anyway . . . Okay. And then the teachers' extended health benefits?

Hon. Ms. Harpauer: — Yes. The Ministry of Education makes payments to the teachers' extended health plan in accordance with article 15.4 of the provincial collective bargaining agreement. The calculation of the payments is based on the teachers' salaries as of January of each year, which is compiled and reported in the school finance report. The school finance report was not finalized and available for use to calculate the payments required for the 2010-11 fiscal year until the budget was set. So this resulted in a budget shortfall because we didn't have the numbers available. And I believe my deputy minister knows why those numbers weren't available as they usually are. So I will get Audrey Roadhouse to just explain why they weren't.

Ms. Roadhouse: — They were moving to a new database and there were some technology issues. So it took a little longer than usual.

Ms. Atkinson: — So is this the first time that we've asked for, or there's been a request for supplementary estimates? Is it, for extended health? Or has this happened in the past?

Hon. Ms. Harpauer: — I don't know for sure, but I would guess because of this little anomaly of them changing the system probably this is, if not the first, one of the first times.

Ms. Atkinson: — I think it may have happened in the past.

Hon. Ms. Harpauer: — Yes.

Ms. Atkinson: — Yes, okay. So teachers' extended health, the amount of money that the province puts in on behalf of teachers, this is based upon teachers' salaries, is it?

Hon. Ms. Harpauer: — Yes it is.

Ms. Atkinson: — Okay. And so when, for planning purposes, when the ministry is putting together its budget ask, how do they go about determining what extended health plan benefits should be? What numbers do you use?

Hon. Ms. Harpauer: — We use the salaries as of January of each year. So January becomes the salaries that we do our provincial contribution calculation on.

Ms. Atkinson: — Okay. And is that becoming more problematic given that there are many, many boomers are starting to retire? You have younger teachers, and so the data that you're using is not as sturdy as it used to be when you had a fairly consistent group of people. And with retirements and new people coming in, is it more of a moving target in terms of determining what wages will be?

Hon. Ms. Harpauer: — Right. I'm going to defer to the officials because of course I'm not doing those calculations, but you could quite likely be right. I'll get Ms. Roadhouse to answer.

Ms. Roadhouse: — You know that teachers do those teacher profiles and it goes into the database, and that's really where they collect that information. And then they use that as of January and then do a calculation at an effective rate of 2.1 per cent.

Ms. Atkinson: — Okay, so just in terms of, for the purposes of discussion, when you're determining this in January, but teacher salary increases happen in September, right? And the school year is from September, right? Okay, right. And we're now giving them grants from January or the year has changed. So how do you reconcile that?

Ms. Roadhouse: — Well January is used to get the number of the salary, and I'm going to assume that January is used because it gives that opportunity from September to December to make sure that that information is in there and it's right. As you know, it takes a while to get those profiles in there and validated and so forth, and so it would be around making sure that you've got your number, your salary number. And by January, as you know, any increments would have been given because they would have come in the fall. Right?

Ms. Atkinson: — Okay. And this is under pensions, but at one stage there would be times when you would estimate that pensions and benefits would be a particular number, but if people didn't retire then you would have a surplus, and so money would be given back to Finance. Are we getting any better at that?

Ms. Roadhouse: — We are getting better at it. Quite a bit better, actually. Through the last, I'll say two to three years since, as you've expressed, there have been some challenges in trying to get that data and people retiring and bringing a lot of money into the plan which then means it's counterintuitive. Right? But it means when more money comes in you actually need to draw down less and so forth. And so the last few years, they've put a lot more emphasis on how to calculate that and receive some assistance and so forth.

Ms. Atkinson: — So I didn't look at Public Accounts for last year, but was there money . . . Did we underestimate, overestimate, or were you bang on? Do you know?

Ms. Roadhouse: — We might have to get more information for you, but the TSC [Teachers' Superannuation Commission] was actually under, and the STRP [Saskatchewan teachers retirement plan] was over, and it kind of just offset each other. I don't think it was anywhere near the . . . I think I'm recalling what you're talking about. It was like 60 million or something, right? Yes. Yes. No, this was just an over, under.

Ms. Atkinson: — Mr. Chair, those are all my questions for this evening.

The Chair: — Okay, thank you, Ms. Atkinson. Any further questions? Seeing none, we'll go with a vote for vote 5, Education, on page 12 of your Supplementary Estimate book. Pre-K to 12 Education, subvote (ED03) in the amount of $8,503,000. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Teachers' pension and benefits (ED04) in the amount of $877,000. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Education, vote 5 in the amount of 9,380,000. I'll now ask a member to move the following resolution:

> Resolved that there be granted to Her Majesty for the 12 months ending March 31st, 2011, the following sums for Education in the amount of $9,380,000.

Mr. Hart: — Agreed.

The Chair: — Mr. Hart. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried.

[Vote 5 agreed to.]

The Chair: — Thank you committee members. Ms. Minister,

have you any final comments?

Hon. Ms. Harpauer: — Thank you very much, Mr. Chair. I would like to thank the committee for meeting with us tonight and for Ms. Atkinson for her questions. I would also like to thank the officials for their support on these estimates and for coming out this evening to be able to answer those questions on my behalf when I don't know the answers.

The Chair: — Any further comments? Thank you, Ms. Minister, and thank you . . . Ms. Atkinson.

Ms. Atkinson: — I'll thank the minister and all of her officials. Thank you for being here. Thanks.

The Chair: — Thank you, and thank you ladies and gentlemen at home. We will now recess until we can facilitate a change for Health estimates later on this evening.

[The committee recessed for a period of time.]

General Revenue Fund
Supplementary Estimates — November
Health
Vote 32

Subvotes (HE04) and (HE03)

The Chair: — Welcome back, everyone at home and committee members, and welcome to the Minister of Health and his officials. I will direct committee members to the work before us. We are now looking at the estimates for Health, vote 32, subvotes (HE04) and (HE03) as outlined on page 13 of our Supplementary Estimates booklet.

I will invite the minister to make some opening comments and introduce the officials. I will just remind officials, when you come to the microphones for the first time just to restate your name for the purposes of Hansard. And committee members have all been introduced prior; however joining us is Ms. Judy Junor for this segment with Health.

So with that, Mr. Minister, I welcome your comments.

Hon. Mr. McMorris: — Good evening, and thank you for the opportunity to present details of the Ministry of Health's supplementary estimates and answer any questions that you may have.

First I will introduce my officials. Sitting to my left is Deputy Minister Dan Florizone and to my right is Max Hendricks. Behind me, over my right shoulder, is Ted Warawa and also behind me is Duncan Fisher.

Before I get into the specific dollars, I'd like to provide you some context to my remarks. Our government is committed to a publicly funded, publicly administered health care system. The Ministry of Health has met many of its mandate commitments, and we will continue to deliver on government's plans to secure the future.

We have completed the Patient First Review, improved cancer screening and prevention through the HPV [human papilloma virus] immunization program, and enhanced the drug plan by capping costs for children. We have recruited more doctors, hired more nurses, reduced wait times for surgeries, and providing more long-term care spaces. We're helping seniors, people struggling with addictions and mental illness, and people with autism and fetal alcohol spectrum disorder.

We are working with all health care partners to make the changes needed to strengthen and sustain our health care system into the future. Above all we are putting the needs of the patient and their families first.

Having provided this context, I now would like to discuss why we are here tonight. The supplementary estimates and mid-year financial results show a $202.6 million overexpenditure for the Ministry of Health's $4.2 billion budget. Most of this year's overexpenditure, 195 million, goes towards the children's hospital, fulfilling a promise for this initiative. Mr. Chair, the children's hospital, adjacent to the Royal University Hospital, will deliver integrated services to meet the health care needs for our province's children and ensure that quality and safety of care are provided.

We believe this facility will enhance children, patient care, and assist in the recruitment and retention of pediatric health care providers and other staff members. Planning is ongoing, including using lean processes to ensure the building layout will be efficient and barriers to teamwork and communication are reduced or removed among health providers and with patients and their families. Members of the public are involved in planning to ensure the needs of patients and their families are a key consideration in the design of the new building.

We expect construction to begin in 2012 and the facility to be open in the late 2015. Mr. Chair, things are well in hand on this significant capital project as well as numerous other projects in the health system.

Mr. Chair, a further 5.05 million of the overexpenditure is for the multiple sclerosis or MS clinical trial funding. We are committed to advancing the science in MS diagnosis and treatment by supporting our researchers in their work to better care for our patients. The allocation includes 50,000 paid to the Saskatchewan Health Research Foundation, or SHRF, for administrative costs in managing the process, and up to 5 million for clinical trials.

Mr. Chair, when we announced this exciting news back in October, the research foundation outlined a three-step process for moving forward on the call for MS clinical trials. The first step was for the research foundation to form an expert advisory panel to assist in developing criteria for a call for research proposals and in overseeing the selection process.

The eight-member panel has been established. It is chaired by Dr. Gordon McKay, a professor emeritus at the University of Saskatchewan who has served as a professor of pharmacy and associate dean of Graduate Studies and Research. His research expertise is in the area of . . . What is it? Neuropathic . . . Antipsychotic drugs and . . . How do you pronounce that one? Neuroleptic drugs. Thank you to all that helped.

And the call for clinical trials is expected to be announced

before Christmas. The expert advisory panel will assess all proposals submitted to SHRF in response to the call and provide its funding recommendations in early spring 2011. SHRF expects to announce the outcome of the competition in April of 2011. The clinical trials are expected to begin in spring 2011; however, this will depend upon the successful research team's plans and timelines. Many Saskatchewan people are impacted by multiple sclerosis. We are very pleased to be moving towards, moving forward on this file.

[20:00]

Mr. Chair, the final component of the Ministry of Health's estimates overexpenditure reflects 2.5 million for additional physicians and surgeons. These include vascular surgeons, intensive care unit physicians, and gynecological oncologist physicians.

Attracting and keeping health care providers is a top priority for our government. It's why we've established a physician recruitment agency headed up by Mr. Ed Mantler. Physicians play a key role in delivering quality care in our province. We will continue to work with health regions to retain and recruit key health care providers.

I provided you with details of the overexpenditure of the ministry's 2010-2011 budget. I'm here with my senior staff to answer any questions on those three areas: children's hospital, the MS clinical trials, or the extra 2.5 that's gone into physician and surgeon recruitment and retention.

So I'd be more than glad to answer any questions.

The Chair: — Thank you, Mr. Minister. With that we'll entertain questions. Ms. Junor.

Ms. Junor: — I want to start with the extra money for the physician-related costs. You said 2.5. Is that for the agency or is that for actual recruitment of physicians like you said, vascular and the gyne-oncologists?

Mr. Hendricks: — That's for actual physicians. It's $1.1 million for vascular surgery, 1.1 million for intensive care, and 300,000 for obstetrical gynecology.

Ms. Junor: — So do you actually have physicians for these positions?

Mr. Hendricks: — They're actually recruiting into them. The intensive care physicians was to adjust their payment rate so that they'd be similar to Regina. But we're adding an additional vascular surgeon in Regina and an additional vascular surgeon in Saskatoon with those resources.

Ms. Junor: — Is the additional vascular surgeon in Saskatoon going into the kidney transplant program?

Mr. Hendricks: — There was a review of the kidney transplant program, and basically what came out of that review is that they believe that vascular surgery can participate, but shouldn't be the backbone of the transplant program. So we had a situation with just their day-to-day work where they were being overwhelmed so we felt that moving from three to four surgeons was appropriate.

Ms. Junor: — So was that a yes? There is another vascular surgeon going into Saskatoon, but not to be the backbone?

Mr. Hendricks: — Most vascular surgeons don't provide, as you know, transplant services any more. We actually go to specific transplant surgeons. So it's unlikely that this new vascular surgeon will actually participate in the transplant program.

Ms. Junor: — He or she is going into Regina, did you say?

Mr. Hendricks: — There is one to Regina and one to Saskatoon.

Ms. Junor: — Okay. And the gyne-oncologists, is there more than one?

Mr. Hendricks: — Yes. We've historically had four in the province. This will add an additional half an FTE [full-time equivalent] and will also provide some compensation adjustments. When we looked across Canada, we weren't as competitive probably as we needed to be to actively recruit these folks. So we are hoping that we can recruit some replacements and add an additional half FTE.

Ms. Junor: — I understand from the patients with gyne cancer, OCATS [Ovarian Cancer Awareness & Treatment in Saskatchewan] that all the gyne-oncologists have been lost out of Regina. Is that the case?

Mr. Hendricks: — Well one of the things that we're trying to do is move to a provincial program. So we did have a doctor, a physician, that recently retired, so we're challenged. And we're trying to recruit additional resources to Regina, but trying to establish it as a provincial program to share resources between the two cities.

Ms. Junor: — So what will that do for the women in Regina that now have nobody to go to when it's a provincial program?

Mr. Hendricks: — I think once we have four and a half physicians in place, it will strengthen the service and we'll actually improve access for women who have gynecological cancer.

Ms. Junor: — So there are some still in Regina? I thought they were gone.

Mr. Hendricks: — Okay. So we have one physician in Regina that is doing a limited scope of practice. We have another that is on leave and we have one that's in Saskatoon undergoing an assessment with the plan being that that physician will return to Regina when they've completed that assessment.

Ms. Junor: — So at the moment, women with gynecological cancer are going where?

Mr. Hendricks: — Saskatoon.

Ms. Junor: — Okay. And that's been going on for how long?

Mr. Hendricks: — Since the beginning of September.

Ms. Junor: — And is there compensation for people who have to travel outside of Regina because there is no service? Are they getting compensation for having to go to Saskatoon?

Mr. Hendricks: — No, out-of-province travel costs are not compensated.

Ms. Junor: — Out of the city.

Mr. Hendricks: — Oh, out of the city?

Ms. Junor: — Yes.

Mr. Hendricks: — No.

Ms. Junor: — Yes, because they are travelling from Regina to Saskatoon . . .

Mr. Hendricks: — No. Sorry.

Ms. Junor: — Because there is nobody here in this program. There was a fair amount of warning that this program was falling apart in Regina and it just got let go, as far as I could tell.

There was a fair amount of to-ing and fro-ing with Dr. Brydon and around the whole issue of her leaving and why she was leaving, because she wasn't supported and there was only her left. And I think that was pretty concerning for the women that have come to the legislature and talked about what there is, what there isn't for women with ovarian cancer in particular.

So nothing was done to really stop Dr. Brydon from leaving. And I don't know what this provincial program will do for women in Regina. I'm not exactly sure what type of program you are building up with it. What are you looking for? To make it a provincial program, what does that mean?

Mr. Hendricks: — Well what we are doing is we are adding additional resources so that, with a provincial program ensuring resources between Regina and Saskatoon and having an additional half FTE, we'll have more gynecological oncologists. Also, as I mentioned, we are adjusting their compensation with the hope that we will be able to attract more.

Ms. Junor: — Thank you. I would like to now turn to your MS funding. As you can see, there are several people who have come in that actually have MS and are interested in hearing these questions and the answers to them tonight.

Looking at the website for the research foundation, I was reading today that there is nothing going to happen with the proposals until at least April of 2011. And you are asking for the 5 million now in supplementary estimates. Can you tell me why?

Hon. Mr. McMorris: — The reason why the 5 million, which is unique to any other province in Canada . . . The process that we're going through and the fact that we've agreed to move forward on the clinical trials is unique. No other province has moved in this direction. There's been a couple of provinces talk of some other processes, Newfoundland tracking people that have been overseas for liberation treatment.

But the 5 million is asked for now. We have worked with the SHRF, the research foundation. They've put in place an expert committee that will be . . . has the call for proposals going out immediately or very shortly. As those proposals come back, and if there are some that meet the criteria — which I'm sure there will be — and we can have the clinical trials up and running before April, although that is the targeted date, if we can have the clinical trials up and running before April, the money will be there to move it forward.

Ms. Junor: — I think it's pretty clear on SHRF's website that there is no chance of that. Their goal is to have a process in place for proceeding with clinical trials in the spring of 2011. So they're telling people that there's no list or requirement for patients to register their interest. Your own doctor will have no information, so don't bother phoning there, and watch for updates and announcements in the spring of 2011. So I don't think they're anticipating to be moving forward any quicker than the spring of 2011. It certainly doesn't seem like it in all the pages that they've got on their website. This is the message they're giving to people.

Hon. Mr. McMorris: — Well I think the message that is being given by moving the $5 million into SHRF so that when the proposals come forward, and if they can expedite it and start clinical trials earlier, the money is there. There is not much use saying that we're going to start clinical trials and, oh, we'll maybe put it in next year's budget. The money is being asked for now, being moved, so that if clinical trials can start earlier, not only is our commitment there in word but it's also there financially.

Ms. Junor: — Now you have the 5 million where? Like it's a promise, and I know that if nothing happens before the end of the budget year, the $5 million can't be just carried over. The auditor won't let you do that. So what will you do with it?

Mr. Florizone: — What I've done, on behalf of the minister, is written to SHRF and made arrangements that the funding will transfer to SHRF as soon as supplemental estimates have been considered and if they're approved.

Ms. Junor: — So after tonight, if we approve these supplementary estimates, SHRF will get the money in trust?

Mr. Florizone: — That's right. It'll go through. And the commitment I've made, based on obviously the assumption — and we'll wait for the decision, but — is that the funding would flow to SHRF so that they have the dollars in their account.

Ms. Junor: — So now with the trials that are being proposed or what I can gather what they'll be looking at, there's no mention about having the diagnosis or any diagnostic capacity here in Saskatchewan in place ahead of the research proposal for trials which wouldn't, in my opinion . . . I don't know that much about it, but it wouldn't seem to be a big investment or a big undertaking to offer the diagnosis in Saskatchewan ahead of the clinical trial research process which, I would assume, would need to have patients that would qualify for the liberation therapy.

So they all are going to have to go through a diagnosis or diagnostic process and now are basically, some of them are going to BC [British Columbia] and paying $2,500 for a diagnosis, or out to Ontario. And as I understand it, it's an ultrasound Doppler. And another one of the ways of diagnosing this is a piece of software that's either purchased for the MRI [magnetic resonance imaging] or we have it already, I'm not sure which.

So first of all can you tell me, have you contemplated moving the diagnosis ahead of the process that we're waiting for spring for? And do we have the capacity within the province to actually do diagnosis the two ways that I have suggested or others that you may know of, ahead of the trials?

Hon. Mr. McMorris: — So part of the $5 million is for that very thing, to cover the costs of any of the diagnostic imaging, extra blood work equipment, that type of thing. That's part of the $5 million, 5.05, and the zero five was put towards the health, to SHRF for their advisory board expenses. So part of the $5 million is to cover those extra costs for diagnostic imaging.

Ms. Junor: — So back to my question then about, do we have that capacity here in the province? Do we have to purchase anything new, or do we have the equipment and the professionals to do the testing? Do we have that capacity here already?

Hon. Mr. McMorris: — Yes, for the most part we believe we do. This is a priority for our government, and we believe that we have the capacity within the province. Of course we have moved to, I believe, a third scanner in Regina that will be handled through a third party contract, through a public system — again no queue jumping. But we're working on the capacity within the province.

Ms. Junor: — That's the MRI piece. What about the Doppler, the ultrasound?

[20:15]

Mr. Florizone: — Thank you. As you're aware, there are seven diagnostic trials under way right now across North America. Those studies are examining diagnosis, looking at the various equipment and looking at, according to Zamboni's study, the use of Doppler ultrasound. Zamboni was very specific about his procedure and has taken issue with the use of other modalities. Some of the difficulty and the controversy is that with ultrasound it's been intimated that by pushing down on the actual unit, you could create the kind of blockage that you're looking for.

What we're very interested in is having the science inform the next steps. So certainly the early findings within those diagnostic studies will inform the submissions. The reason for the timing of this interventional study is the fact that more and more information is coming forward with those seven studies in terms of some of the early findings. You'll note that Saskatoon has been involved through Dr. Knox, through that clinic, in one of those diagnostic studies.

Ms. Junor: — So I think there's a fair amount of frustration in the community of people who have MS, that you've committed to the trials but they're still a long way off for people, and they still are going for diagnosis to other provinces. And BC is the first one that comes to mind, but I think I've also read that Ontario has got the Doppler. They bought it and they're using it.

So my question would be, why then wouldn't we get in on the diagnostic trials as well since we've already committed ourselves to the research trials which is going to have to include the diagnosis? So why wouldn't we do that if we had the capacity here already?

Mr. Florizone: — We are.

Hon. Mr. McMorris: — We are part of . . .

Ms. Junor: — So people are being diagnosed now in Saskatchewan?

Hon. Mr. McMorris: — No, no. The diagnostic trials, through Katherine Knox in combination with UBC [University of British Columbia], are already being conducted. We are one of the few provinces that are involved in this. There are seven through North America, I believe. Saskatchewan is involved in one of them. And I . . . Okay, I'll just leave it at that for now.

Ms. Junor: — Actually that's . . . I know that one, but I want to talk about people here that I don't . . . I don't hear who Dr. Knox is using or who BC is using. Are they using patients from Saskatchewan in their trials?

Mr. Florizone: — That's correct.

Ms. Junor: — So how many people would be from Saskatchewan that would have that option? And how do they get the option?

Mr. Florizone: — I'm sorry I don't have that number in front of me, but we certainly can get back to you. Dr. Knox has been very specific in her study design with UBC on how many Saskatchewan patients would be involved in that diagnostic study.

Ms. Junor: — See my understanding is . . . And like I said I don't know all the details, but my understanding is this isn't widely available to MS patients in Saskatchewan. It's a very select few. And so my question is, on their behalf, is that there should be a wider diagnostic trial going on that is specific to Saskatchewan.

If we're already into the clinical trial promise, we've committed ourselves. So why would we not open up the diagnostic trial to better meet the needs of people in Saskatchewan? Because they're already, people are travelling away to Germany to have the diagnosis and then the procedure. They're travelling out to other countries. They're travelling to BC and probably Ontario. So if we're already committed, we're on that path, we're already committed in part of the study in BC, why wouldn't we actually do some more diagnostic trials here ahead of the research trials since this funding is in there already and the commitment's made?

Mr. Florizone: — Thank you. What we're committed to is the science. We're committed to making sure that the scientific community is ready to move to intervention because it's really the intervention — first diagnosis, then intervention — that I understand patients seek. We are obviously following the scientific community in terms of the staging and the important work that's going on right now. We're looking forward to, obviously through the Health Research Foundation to a number of proposals. There is no limitation in terms of those proposals being from scientists within this province, so we look forward to a range of proposals that include diagnosis and intervention that may involve researchers across the country.

Ms. Junor: — In this study that we're participating in with Dr. Knox in BC, are the people from Saskatchewan having to travel to BC to be diagnosed?

Mr. Florizone: — I'm sorry, I don't have the answer on the volumes that are being done locally versus any requirements for travel. Again that would be contained within the study design, which we'd be pleased to share with you. I just don't have a copy of it in front of me.

Ms. Junor: — So in that study design which you will share with me, we will have those answers? We will know how many people from Saskatchewan are getting an opportunity and whether they're having that opportunity here or in BC?

Mr. Florizone: — Well we'll have more detail in terms of the random selection, the establishment of the selection of candidates, so you will have as much specificity as we have with respect to the study design.

Ms. Junor: — And I think if I recall the conversation around the liberation therapy at first, when it was first started or first noticed worldwide, I don't think Dr. Knox was a big supporter of it. And I know the research community hasn't come willingly to this point. And so Dr. Knox's diagnosis and her diagnostic trials, it's not in conjunction with this clinical trial. It's that she was doing this on her own before, was she not?

Mr. Florizone: — She was doing this under a joint funding venture between the MS Society and the national research foundation, CIHR [Canadian Institutes of Health Research]. To suggest that she's not supportive, I couldn't speak on behalf of Dr. Knox. She certainly has been supportive at every phase that we've talked to or that I've talked to her directly. Now that's not to say that she'll be necessarily involved or submitting a proposal. That time will tell in terms of the local Health Research Foundation and the submissions that they do receive. Again we've set no condition on the research foundation that they need to select Saskatchewan researchers. The partnerships, though, are very, very important where possible.

Ms. Junor: — And I can't say . . . I have not spoken to Dr. Knox either, so I can't say what she feels. I'm only going by what I saw of her on TV, frankly, and she wasn't that keen on doing this, as I don't think anybody's surprised that the MS foundation or society wasn't either.

So I think there's some, there's certainly some difference of opinion from people who actually have MS and from the research community, which has been pretty widely shared. And the frustration of people that have MS, you can tell that it's very high because they're not waiting for this. They're going off and spending their own money to do it. And so that's why I think it seems like something that could be done sooner is the diagnosis, which would at least alleviate that cost from people who actually . . . The ones I've heard have done the diagnosis first, like in BC, and then picked the place they're going to go to have the liberation therapy. Or people who go to Germany, for example, and have it all in one piece. And if you go over to Germany, pay your money to go over there, have the diagnosis, and then you're found not to be a candidate, then you have wasted a fair amount of money. So it would be a good idea to have the diagnostic screening here.

And I know there's been some worry that the research projects will not necessarily pick people from all of Saskatchewan. If the research project is in Saskatoon where it is likely to be because of all the concentration of MS research there already in the university, in the synchrotron, people are worried that they will not get into the clinical trials and that the clinical trials will only be for a select few. So the many, many, many people who have MS will not benefit from this in time to help a lot of them. A lot of them could be better served by having this happen quicker for them. So I understand the science and I understand all that, but I do understand that if I had MS, I'd want a faster solution.

Hon. Mr. McMorris: — I was interested when you said that you weren't surprised that the MS Society was not in favour of clinical trials. I don't know where you . . . Pretty much any person that I've talked to is very surprised that the MS Society is siding on the fact that they shouldn't be moving forward with clinical trials. I don't know where you got your information from, but people that I've talked to are quite surprised that the MS Society hasn't been certainly more supportive of the fact that some provinces like ours would like to move forward with clinical trials.

I certainly understand the position that many MS patients find themselves in. I've had the opportunity to talk to many, many MS patients, some who have been overseas, to Costa Rica, and some that have remained here and are deciding to wait until the clinical trials are conducted.

What I would say in . . . You know, we wish we could have done it sooner, and it could be done and conducted quicker. What I will say is that no other province has taken the lead like Saskatchewan has. The Premier came out, and it wasn't without some, certainly some people doubting and questioning our leadership. We feel it is the very least that we can do to show leadership in this front. No other province has.

The health research foundation, Canadian health research foundation came out opposed. The MS Society has come out opposed. But our government has decided that we're going to continue to move ahead with the clinical trials to help in the future, to help either support the liberation treatment because it's proven through science, or in the case that the science isn't there, that will help people make their decisions if they still so choose to go overseas or out of the country.

The fact though, that the science has to be done. There is no question that it would be irresponsible for any government to move forward and plan on covering such a procedure without

taking the lead from the research community. You can say that, you know, you're hearing rumours that it's going to be from Saskatoon only because that's where the research is being done. There's just no basis to that whatsoever.

The expert panel has been put together. There has been no — as of yet, but that will change in the near future — proposals come forward from the research community. We will not be directing those research proposals whatsoever. It comes from the scientific community. They know what they need in order to either prove or disprove this treatment as it moves forward.

But what I will say again is that we in Saskatchewan are the only province that has stepped forward and said we will fund, not only said but put money behind the fact that we'll fund clinic trials.

Ms. Junor: — I'm a bit confused. You started off saying that you don't know where I've heard that the MS Society was against clinical trials, and you finished off by saying the MS Society was opposed to clinical trials.

Hon. Mr. McMorris: — You said you were surprised that they were against the clinical trials, is what you said.

Ms. Junor: — No. I said I was surprised that they were not supportive of the liberation therapy, not the clinical trials. But you say that they are opposed. They were opposed to the clinical trials.

And I think you should not be dismissing people's concerns about how the clinical trials will be done, dismissing them as rumours. They're legitimate concerns that people have that they won't get into the trials, that there will be a selection process that will be restrictive and that may not include them. And I think that they're legitimate concerns, and they're not just rumours. They're what people are saying that these are their worries. So I think that we have to be careful that we're not minimizing their concerns.

And there's such a large community of people who have MS that there is going to be limitation to how many people actually get in and have this done. So everybody really wants to know that it's very fair, that it's very transparent, and that it's very accountable.

And I understand the science, and so does everyone else, but I think they also understand that they want it to be fair and that they want to have a chance to have it done. So I'm hoping that all our . . . And I'm assuming that the research foundation will have research proposals from a wide variety of people, but I still think there is a concern that it will be a small cohort and that there may not be that many people captured by it. Because it's a research project; it'll be going on for a while. And I think there's people who would like to see something happen sooner because it's happening sooner in other places. Not a question; a comment. Oh, Pat has a question.

Ms. Atkinson: — Thank you. We're talking about the MS and clinical trials. Can you indicate to us what you believe the clinical trials are going to do? Are the clinical trials going to look at liberation therapy?

Mr. Florizone: — The very specific condition set upon the Health Research Foundation is that they utilize the Zamboni treatment, the liberation treatment very specifically. So those are the proposals that they seek.

[20:30]

Ms. Atkinson: — And you believe that there are research scientists in the province that are going to do the liberation treatment? They're going to come forward with a proposal to do liberation treatment and have a clinical trial?

Mr. Florizone: — The call went out right across the country. An expression, verbally, of interest certainly has been received. What we need is a very formalized method through the scientific community, through an expert panel, to be able to judge the merits of the proposals. So the expression of interest is certainly there. We're in no position to judge the merit or the scientific basis for those proposals. That's why we rely on the Health Research Foundation and their expert panel.

Ms. Atkinson: — So the proposals have gone out across the country, but are the clinical trials going to be done here in Saskatchewan with Saskatchewan people?

Mr. Florizone: — That is correct. The condition that we've set out, a second condition, is that this involve Saskatchewan residents. If other jurisdictions indicate interest in joining this clinical trial, they're certainly welcome. The extent of that partnership would be based on the contribution towards the cost of the clinical trial. So our expectation has been quite clear that the funding provided from Saskatchewan is for clinical trials involving Saskatchewan residents.

Ms. Atkinson: — One of the issues that's been brought to my attention is that if you go elsewhere to have the treatment done, the liberation treatment done, and you come back to Saskatchewan, there are neurologists that won't deal with you any more or basically they fire their patient, as I understand it. And there's really no place, no central place for people who've had the treatment to go and just indicate that they've had the treatment. And I'm wondering if you're looking at a registry of some kind as part of this system that we're into.

Hon. Mr. McMorris: — Certainly that's where Newfoundland has gone, is they've started a registry, taking names of people that have come back. It's our understanding for the most part as far as just pure science is concerned, those anecdotes don't help in the science a whole lot. I mean it's certainly . . . I've talked to a few, quite a few that have been and have come back, and their stories are compelling. But does that advance the science? Not so terribly much.

I have, you know, when I've talked to the MS Society I thought that would be a great avenue for their society, to start a registry to keep track of people that have travelled overseas or out of the country to receive this treatment. As of yet they don't feel that that's their role, and so be it. I don't think it's really the role of government because I don't know what it provides us other than a sounding board for people that have had the treatment.

Ms. Atkinson: — I guess I was thinking that it might be important for government to know who in our province has

received the liberation treatment, where they live, where they went, any complications — maybe there are; maybe there aren't — who their physician is, who their neurologist is if they have one, just to see if there are any difficulties six months, one year, two years down the road. Because you spoke earlier, Minister, about science and I'm just wondering if it would be prudent — as we're waiting for these trials, and we have people who are already going — would it prudent of us to do an electronic record of some kind to keep track of people who've gone, just to see? The scientists might be interested if there is any aftermath six months, one year, two years down the road. Just a thought.

Hon. Mr. McMorris: — One of the concerns I think from again and from the scientific community, is there are so many variables as to where they have gone, the procedure that's done, any of the diagnostics, the measuring after, whether it's placebo or not placebo. There's just so many variables that until, you know, we feel comfortable with the scientific community studying all of that, knowing all that information as opposed to a person just putting their experience on a website, I don't know how that advances it.

I mean it's very interesting reading. And I've read a number of letters of people that have been away. And I've had the opportunity to meet with a number of individuals that have been away, and it's extremely interesting and compelling. I am not a researcher by any stretch of the imagination and that's kind of . . . You know, the problem is that I don't know if it advances the science even though it becomes compelling and interesting to listen to and perhaps even interesting to track. I don't know though where the benefit is for government with this information.

Ms. Atkinson: — Well I guess I'd like to argue that there is a benefit for government. And because it's going to be some time as we make our way through these clinical trials, if we get there to clinical trials, and it may take some time to get to the actual clinical trials where we are doing liberation treatment in the province of Saskatchewan. And yet we have citizens that are spending money going outside of the country, and they are coming back with this treatment. And I just think from a scientific point of view . . . And I'm not talking about all the stories. I'm just talking about the physical effects of this treatment on the body.

And I'm just wondering if it doesn't make some sense to have a database of some kind — where they went, who their physician is — because, you know, there's some suggestion that there could be complications later. I think we should track that as part of the science. And I'm just wondering if any thinking has gone on about the notion of a registry from just in terms of the science that we are trying to address.

Mr. Florizone: — There was, and thank you for raising it. There was considerable discussion at the scientific panel nationally about establishing such a method. The purpose, the thought was exactly as you described, to be able to not only track but to use that evidence in formulating whether or not this is successful or not. Now I was just an observer. I was not a participant at the round table, but I can tell you that they rejected the notion on the basis of its lack of scientific credibility. Having said that, I do understand the other secondary uses that you've described.

The one thing that we were deeply concerned . . . Actually there are a couple of things that we're deeply concerned with, based on just seeing the media reports that have occurred, one having to do with patients that are refused follow-up treatment. And I can say that, on behalf of the ministry and the minister himself, we've been in conversation with physicians, with the SMA [Saskatchewan Medical Association], and it's been quite clear that that at least has not been reported to us as an issue in Saskatchewan. Now if that is a problem, we certainly need to address it and address it immediately. And we've got the commitment of the physician leadership to do that.

The second issue is one of embarking on a trip anywhere across the globe for treatment based on the hope that it may resolve a clinical issue like MS. We would very strongly urge that patients seek advice, and even if they ignore that advice, seek the advice of their family physician, and if they're seeing a specialist, their specialist as well.

One of the recent reports of a death that occurred involved a stent. And it's crystal clear right now, in terms of the researchers that we've talked to and the clinicians that we've talked to, that stenting veins, given the current technology, is not acceptable. So even though there's recidivity, even though veins have an elasticity and may actually return — sorry, the lack of elasticity, they may not . . . No, it's elasticity. They'll return to the same size. Stenting may be seen as a solution to it, but stents were always viewed as and designed for arteries, not for veins. And the real problem with clots or throwing a stent resulting in disability or death is a deep, deep concern.

As we look at other countries and the clinical practices, the problems with diagnosis, misdiagnosis, intervention, post-operative complications, these are all real issues. So you could imagine returning back from a country with a stent in a vein and what problems that may pose, not only for the patient, but for the clinician who's providing follow-up care. They may never have seen a stent in a vein.

Ms. Atkinson: — I think this is where I think we need to have some form of registry because I think we need to know . . . And we all know people who have gone to Germany, Bulgaria, Costa Rica, Mexico, Poland. People are going and they're spending their money. Fundraisers are going on across the province to assist people in going. Then they come back and they come back with great hope.

But I was struck by this, the death in Ontario. And I thought, you know, I think we might need to have some form of registry here so that we know what did the person get. Was it a stent? Was it a balloon? You know, what exactly was it? Because we need to monitor this so that we can alert . . . If there are problems that are showing up in our health system, then we can alert people. Because there are a lot of people that believe that this is going to give them some relief.

And, you know, some people believe it is and others aren't so sure, but we have people that are going off to get this procedure done. And I'm wondering, does it make some sense from a public policy point of view just, if there are difficulties, to alert the public because we're tracking it.

Hon. Mr. McMorris: — I think, as with every situation and case and certainly the fatality from the gentleman from Ontario, there are many variables that go into it and what was covered and the exact shape of the person when he went a second time. And all the details aren't necessarily put across the media. What is put across the media is someone went for the treatment and passed away, due to . . . But we don't have all the information; the media hasn't covered it. And in this situation, I think that's very much the case.

I think it's, for most people that have looked at this for any length of time realize that about a third, not a lot of effect; a third, some effect; and a third, a lot — really noticeable. We can study it more. It may change those numbers a little bit. It's subjective. They're reporting on their own, you know, so there's just a whole lot of variables. And as I say, it's a person self-reporting as opposed to being studied.

So that information is interesting and could be somewhat important. We've had this discussion ourselves as to whether we wanted to do it. I just don't know if it's the responsibility of a ministry as much as it is . . . I really believe it's the responsibility of a society, meaning the MS Society, that would look into this for their members.

Ms. Atkinson: — Well, Minister, not all people who have MS belong to the MS Society. The MS Society, as I understand, is skeptical about the treatment.

These are people who are going off and getting the treatment. We have a government that's committed to doing clinical trials with the liberation treatment. We have people coming back to Saskatchewan having received this treatment, and there is no place for them to go in terms of alerting people that they've had this treatment in terms of a central kind of body — not to make judgment, just to track.

And so I think it's my view, from a public policy point of view I think we need to as the government, the state, know who's gone. Where did they go? Who was their physician? What kind of procedure did they have? And if there are problems, I know Health Canada alerts the public if there are problems. You know, maybe we could alert the public in a proper way.

But I'll leave that to you. I would . . . This was raised with me. It's been raised by people not only who have MS but also people who are physicians. And so I said I would raise it with you at some moment. So I have. Thank you.

[20:45]

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

Ms. Junor: — Back to the actual clinical trials and the actual doing of them. If the stent is not acceptable in a vein, then how does the research community anticipate doing the liberation therapy? If the diagnosis is that the vein is blocked or the veins are blocked, then what, if we're not going to ask for or accept the stenting?

Mr. Florizone: — Zamboni himself was quite clear that the procedure itself shouldn't . . . That the use of stents, he didn't recommend. Angioplasty was the approach that was taken. Part of the clinical study is not only to view what the short-term effects might be but also the long-term effects. There was some indication in the research community that there may be an effect where this intervention needs to be redone or repeated at an interval, say every year or so. So that's part of the study, to be able to look at the longer term impact of angioplasty in a vein.

Ms. Junor: — So again, not my area of expertise; I'm obstetrics. So angioplasty is not a new process. So we would have people that could do it here? And where could it be done? So if the clinical trials say we're going to do, we're going to go ahead with the liberation therapy but that is going to involve angioplasty, not stents. So who would be doing it and where would we do it?

Mr. Florizone: — Our current angio rooms would be the logical choice. Right now with respect to the study, it would be up to the study design, the team that would be putting the proposals together. We certainly have factored in and certainly recognized not only the diagnostic cost but the cost of the angio, angioplasty that would be incurred.

Ms. Junor: — So for interest, what's the cost of an angioplasty?

Mr. Florizone: — It would be an estimate only. As you are aware, we don't track these individual costs similar to what you could see in the US. [United States] So this estimate would be about $2,500 per procedure.

Ms. Junor: — So would the cost of the angioplasty be the biggest cost that's incurred in the clinical trails?

Mr. Florizone: — Once again, it depends. It'd likely be one of the most significant costs, but it also depends on the diagnostic approach. Doppler ultrasound is relatively inexpensive when considering the cost of CT [computerized tomography] or MRI. Again it may be you would have to look at the clinical costs in addition to the facility costs, but that likely is the most expensive portion.

Ms. Junor: — And the MRI, I have understood that it's a piece of equipment software that's added to the existing MRI. Like an MRV [magnetic resonance venography], I've heard. Is that what it is? We would have to buy a piece of software?

Mr. Florizone: — I do apologize. I'm not sure on the specific equipment that may be proposed. And I guess we are looking forward to the response of the health research foundation, the proposals that are put forward based on the science of the day and the technology that might be required.

Ms. Junor: — I'm kind of interested in the expediency of the process, so if we have to have equipment in place it would be good to know. You can't just go and buy an MRI at Walmart. I think it takes a while to get them here. And whether you need to get a new one because of the capacity that's needed to put the software on it, I don't know that, or whether the software itself is fairly expensive and needs to be preordered for many months. So in the interest of how fast the clinical trails could get going once the research proposal is accepted, that's why I'm kind of interested in having our ducks in a row, so to speak, ahead of time.

I understand the staffing too. I'd like to know what kind of staffing you'd need to move this forward?

Hon. Mr. McMorris: — I think we're waiting on the research community to put forward proposals. There have been certainly some expressions of interest, but until a formalized proposal comes forward I think a lot of these questions are premature. You can't answer the question of, you know, whether you need to buy a specific piece of equipment for an MRI if the MRI isn't the diagnostic tool that the research community is putting forward.

And you could extrapolate that the same with staffing. We need, that's the $5 million we are talking about today is to move to SHRF so that they can start down the process and attract proposals that will start to identify that. It would be premature for me to say what a researcher needs as far as the size because we don't know the size of the research project. As far as numbers of patients, that hasn't been determined; that will be determined through the research community. The research community is working on that, will be putting proposals forward. We can then identify the specific costs whether it be staffing or whatever type equipment may be needed.

Ms. Junor: — How many MS patients are in Saskatchewan?

Hon. Mr. McMorris: — The projection is about 3,500.

Ms. Junor: — 3,500. So I'm assuming — when you're talking about you can't predict what the researchers will want to have or how they'll want to do it — in other countries that are doing this already, the equipment that they're using would likely be what we would be looking at, not inventing something new, I would assume. So we can anticipate somewhat, if they're using MRVs in Germany, and that's the best place you can go to get it, or BC has got whatever they've got, that doesn't seem that we should be just totally ignoring the progress that's been made in those countries or that province.

Hon. Mr. McMorris: — We're waiting for a proposal from the research community that will identify what the researchers particularly need as far as scope and size of the clinical trial and equipment needed. I think what we can say is that they've got a full commitment of our government that we will move on this as quickly as possible. We're obviously committed, as we're moving $5 million forward right now to show the research community this isn't just talk. We're there to fund it. And when their proposal comes forward, we'll be there to make sure that they have the proper resources, be it equipment or human.

Ms. Junor: — Thank you. I think I've heard that answer enough. So I think I'm pretty much done with my questions.

The Chair: — Ms. Atkinson.

Ms. Atkinson: — Minister, do you think that we will have the ability to diagnose MS patients and the clinical trials will have started by next fall?

Hon. Mr. McMorris: — Yes.

Ms. Atkinson: — You do. So you think we'll have the equipment in place so we can diagnose patients and then we'll start the clinical trials by next fall.

Hon. Mr. McMorris: — That certainly is definitely the hope of our government. Again we have to wait on the research community. They're the experts in the field. They know how to conduct a research project that will stand the test of its peers. I mean it doesn't help to just expedite it and it not stand peer review. That needs to be done. Otherwise this is a waste of time. I believe that we can be up and running in that time. I hope that we can be up and running in that time. There has certainly been a lot of attention but again it will be up to the research community as we move forward. I believe we will be though.

Ms. Atkinson: — So by the next election, November 2011, we'll have clinical trials on the way and we'll be diagnosing people.

Hon. Mr. McMorris: — You know, I can honestly say that this timeline has absolutely nothing to do with any other timeline that the member opposite may be implying. I would hope that we have clinical trials up and running by the next Grey Cup too. That's a pretty important timeline.

Ms. Atkinson: — November 2011.

Hon. Mr. McMorris: — It's whichever one you want to gauge it to.

Ms. Atkinson: — Right. Okay. Thanks.

The Chair: — Ms. Junor.

Ms. Junor: — Thank you. And thank you for the people who came to listen to the questions that have MS. And welcome to the committee, which is what this committee is actually for, so you can come and hear this. So very happy to have had you here tonight.

I'm going to move into a different line of questioning on the children's hospital in Saskatoon and I do want to talk about . . . It's hard to know where to begin. The initial hospital proposal, I understand, was for a fair amount of square footage and beds and design and services. Has that changed at all with the money that's been put in now? Because that money is 195 million and I know it doesn't cover parking; it doesn't cover equipment. Has there been any changes to the actual proposal for the structure of services and beds and square footage? Has that changed?

Hon. Mr. McMorris: — So this is asking for 195 million. It's important to know that 5 million went to the health region already, to make up the total commitment of our government of $200 million for the children's hospital. The design is based on the 2007 design work that was done.

That being said, we've asked the health region to go back and look at those designs through the lens of lean processing, which may change the square footage, may change the design somewhat to make it as efficient, run as efficiently as possible, as I said in my opening remarks. So there may be some change of that magnitude, but it would be a change that would implement the concepts of lean into the design and construction of the new facility.

Ms. Junor: — For the benefit of those thousands of people watching the committee tonight, can you tell them and me what the lean design, for example, would do?

Hon. Mr. McMorris: — I have a person that would be more than glad to explain the principles and concepts of lean design, a person that certainly introduced it in his health region when he was a CEO [chief executive officer], and into government. So I'm going to turn it over to my deputy minister, who is more than well versed on the lean concepts.

Mr. Florizone: — So as one example, and I'll use the example of ambulatory care services, we've witnessed facilities that have been designed to have the patient go to one room and have the providers travel in as opposed to the patient having to travel from room to room to room. Part of the difficulties, as you're well aware, are difficulties where there are hand-offs. So the concept would be around patient centredness, being able to bring the services to the patient as opposed to having the patient travel around the building trying to sort through what diagnostic lab or other services might be available.

Some of these designs have been taken to the point that where they're in-patient care areas, the design of the room is very, very functional. It would be a way of establishing a standard room where linens and items can be delivered from the outside from the corridors and passed through into the room without someone necessarily interrupting care.

There also is some talk about the new design of beds, where the beds are actually wired for sound and have medical gases and all of the connections within the beds themselves. So rather than the design being built in and rigid, it offers flexibility. And the same room that's designed for an ambulatory service, for instance, could be used on those peak hours for emergency services or other clinical uses. So it's about flexibility and it's about patient centredness.

Ms. Junor: — It isn't though. When you're saying that services come to the patient, you're talking diagnostic. You're not talking about having X-rays coming to the room as a routine, are you? You're still going to have an X-ray department for the complicated diagnoses that are done there, and not have the portable chest X-ray and all that stuff that used to be done come into these rooms as a new routine?

Mr. Florizone: — As you're aware, the use of, probably the predominant use of testing in that setting in terms of services coming to the patient would likely be more the laboratory side. Point-of-care testing, while it has been viewed historically as expensive on a cost per test basis, when you look at the convenience to the provider and the patient in terms of getting that diagnosis sooner rather than batching and having people stay prolonged periods of time, it's been shown that these type of point-of-care, real-time testing that can occur right at the bedside translate to much swifter flow for patients through to the type of care that they receive and ultimately to their discharge.

Ms. Junor: — But you're mostly talking about lab, not X-ray.

Mr. Florizone: — That's right. That's right. So some services obviously remain fixed in place — CT, MRI — but the most used and kind of a regularized service, that would be brought to the bedside. Rather than having the patient travel, those services would be brought to the patient.

[21:00]

Ms. Junor: — I'm mostly familiar with the lab people coming to the bedside already, so what is different about this? What type of services would they be coming now for?

Mr. Florizone: — I'm sorry. There are . . . And again we could follow many, many patients through ambulatory care. It's unlikely that the lab at all times is coming to the bedside, or the physician is coming to the bedside, or the nurse or the physiotherapist. What often happens on these routine visits for ambulatory care is that the patient and their family are travelling throughout the facility, given a little map in terms of trying to monitor their routes. We've walked the footsteps that patients walk throughout our ill-constructed and ill-conceived facilities. I can tell you that this design flips it on its head and allows us to provide the services where literally the patient is there, a room with a view, and the services come to the patient when and as needed.

The terminology is that the patient pulls the service as opposed to waiting, waiting, walking, going from one waiting room to the next.

Ms. Junor: — So looking at the children's and youth health services that are going to be in this facility, I see pediatric ambulatory services and that's about all that's ambulatory, other than child protection and maybe mental health services. So a lot of them are the actual nephrology, you know, plastic surgery, ortho, stuff like that, and all the things that are needed in there plus obstetrics. So I'm not sure exactly how much that will make a difference, but I understand where you're coming from with it.

Mr. Florizone: — I've used it only as a single example. What we know from the experience throughout North America is that you could reduce the space needs by somewhere around 30 per cent, which means far less walking distance for staff, most and foremost far less walking distance for patients. These methodologies apply throughout the care whether it's in-patient care, outpatient care, emergency services, or operating procedures.

Ms. Junor: — So now the beds that we have in the system or the capacity we have in the system for obstetrics and pediatrics, will that be increased, the same, or decreased?

Mr. Hendricks: — So the total number of beds, acute care beds, NICU [neonatal intensive care unit], PICU [pediatric intensive care unit], will be increased from 137 to approximately 164. We're . . .

Ms. Junor: — So it's been increased?

Mr. Hendricks: — Increased. Yes. The number that we were just talking about, ambulatory beds, the number of ambulatory beds will increase from the present 14 to 27, including pediatric emergency.

Ms. Junor: — And otherwise all other services are pretty much the same? Or is that total of everything?

Mr. Hendricks: — That's total . . .

Ms. Junor: — That's the total of everything.

Mr. Hendricks: — Yes, total beds. So NICU's going from 32 to 44, PICU from six to 16, general pediatrics is staying the same, and maternal service is going from 58 to 63.

Ms. Junor: — And what's on maternity? There's going to be ORs [operating room], I would imagine for Caesareans and things like that, that would be self-contained in a unit?

Mr. Hendricks: — Yes. The idea is that you would collocate all those things to reduce movement.

Ms. Junor: — And pediatric surgery will be done in dedicated ORs as well?

Mr. Florizone: — Again we need to, as we work through this, we'll do what makes sense. Right now the concept is dedicated pediatrics ORs. But depending on the context and the design, it may make sense to share some of those operating room spaces. Whenever you dedicate, you run the risk that it may go . . . You may end up with downtime and not be optimally used.

Ms. Junor: — You know, there's still people who have approached me and said that we really don't need this. They are still talking about it as a children's hospital, and I don't think we've been clear enough to talk about it as a tower or a pavilion or something that's attached to a hospital. It's not a free-standing children's hospital. So there are still a few — quite a few people, actually — who are questioning why we need this as a children's hospital. I think it would be good to actually explain that tonight for the record, that what it is actually is a tower or a pavilion.

Mr. Florizone: — As a tower . . . I mean historically what we've looked at is it being defined as a hospital. It is a hospital within the hospital in terms of its design, taking advantage of the campus, the other services, and synergies that exist. Many people who are for instance looking at it and saying, well do we really need a stand-alone hospital, perhaps don't understand the fact that what we're doing is we're really renewing a lot of the pediatric services, in fact most of the institutional pediatric services within the city, and those services are tertiary for the province. So the concept itself is to really renew, to revise, to redesign. And it's important to get this right.

Ms. Junor: — So I think . . . And I don't think people very, they don't talk very much about it being a women and children's hospital either. I don't think there's much emphasis being put on the fact that maternity is going to be moving into here and all of its aspects of the maternal care. So there'll be, you know, pre and postnatal, and all that stuff will be in there and the assessment units and all that.

And I think that that's a good idea for people to know that this is, as well as you're saying, replacing all the existing services that are scattered around because there never has been a good centralization of maternal services, which was supposed to happen in the early '90s with City Hospital to begin with. It never did happen. And so this is I think catching us up almost two decades later. So I think that those are the arguments I use anyways because this was supposed to be done at the City Hospital.

But another thing that people are quite concerned, and I attended public meetings in Saskatoon so I heard a lot of this — the parking. People are very concerned about the parking up there, and I know that the parking is not included in the 195 or the 200 million total. So can you give us some idea of what the parking situation, how it will be handled?

Mr. Hendricks: — So we've asked the consultants or the architects who are working on the project to come up with several proposals for parking because, as you said, it's very space limited. And the current plan is actually that the facility would be located where the parking lot is right now, which needs to be redone anyways. But we're going to look at a number of options and whether that will be financed through the government and the Saskatoon Regional Health Authority, what options exist. They're working with the university because apparently the university has excess space as well. So a number of options are being looked at.

Ms. Junor: — The worst one I heard is that there will be off-site parking and buses will bring people to the facility. Is that still in the mix?

Mr. Hendricks: — That's one. We haven't looked at the options yet, but that, as I understand it, was one of the options that is being looked at, yes.

Ms. Junor: — [Inaudible] . . . most people that would be working or visiting these facilities. And the cost, you said, there's options for the cost because it's not included in the 200 million.

Mr. Hendricks: — Right. And so it depends on how much they're able to lever the existing space at the university. You know, obviously going off-site, as you mentioned, and bussing people in would be lower cost than building a multi-level parkade. So all of these are going to be balanced. And you also have to look at the revenue projections over the long-term for the region and how that balances out and do the cost benefit of it. So until I see those options I don't, you know, sort of want to comment about where we would actually go.

Ms. Junor: — But there will be, there would be some expectation on the district's part or the region's part to have some cost sharing and some money from the government to support the parking.

Mr. Hendricks: — Not necessarily. If there's a good business case and the revenues can match up with the cost, they might go to the private sector for the construction and operation of the parkade.

Ms. Junor: — And my other questions which kind of tie in with parking are traffic flow because that's a really very difficult place to get into with . . . I think there's only one road to get in there through the gates or through that . . . off College. So what are the . . . If you're going to start moving roads, that's

another thing that's going to be fairly costly.

Mr. Hendricks: — That's something that I'd have to follow up with you on. I'm not sure what they're planning in terms of traffic flow right now.

Ms. Junor: — So they're going to have to deal with that pretty soon though because if they're going to start construction in 2012, they're going to have to know where everything goes.

Mr. Hendricks: — Correct. Yes, there's a lot of things happening right now. Like even our discussion about the parkade, you have to decide what's going to happen there, you know, where the facility is going to be placed. You have to know where the parkade is going to be placed and what options exist there to determine your traffic flow. So there are some things that are being worked out as we speak.

Ms. Junor: — So there was certainly talk about, around the meetings that I attended, that this 200 million is not nearly the end cost of this facility, that this is going to cost a lot more than that. And there was definitely concern in the public that expressed those concerns at these meetings that this is not . . . The 200 million is just the tower pretty much. And I don't even know, does that include — the 200 million — does that include removing all the services from the other places that they are and renovating or taking down whatever the old places at RUH [Royal University Hospital]? Is that all included in the 200 million, or is that just straight billed cost?

Hon. Mr. McMorris: — The 200 million is for construction of the children's hospital. We realize that there's other itinerant services such as parking and things that will be changing. I think there's some efficiencies that can be found at the time when you're designing the children's hospital and building, that some of those itinerant services can be moved for less cost than if you're doing it solely. Same with the ground floor renovation of RUH. There's some work that needs to be done there, and that can be done at the same time.

So there may be some extra costs over and above what it costs for the construction of the children's hospital, but I think those costs will be offset by the fact that the children's hospital will be constructed.

I think that's one of the reasons why it's important to move the money to the Saskatoon Health Region now. Much of the construction, while it won't start for a year or so down the road, 2012, completing in 2015 . . . There certainly will be some interest gained by the Saskatoon Health Region as a large portion of that money won't be spent for a few years. And so there will be extra revenue that way as well.

Ms. Junor: — Yes, and we're quite familiar with that because we gave the 200 million to the university for the Academic Health Sciences in that very way for that very reason — that they would collect the interest — and happy to see that building going up as quickly as it is.

So I'm assuming that the U of S [University of Saskatchewan] will collect . . . or not the U of S. The health region will collect the interest on this. And yes, there will be money because that's a plan that's been tried and true. And so my . . . [inaudible interjection] . . . Anyway, where was I? You interrupted my flow of thought here.

Oh yes. Since we've had a lot of discussion around the Amicus project and the tendering and the tendering that wasn't done for the original project, I want to assure the public who are watching this and through the *Hansard* of this committee that the processes that will be used for the children's hospital won't be what we've seen for Amicus, that we will see a public . . . the transparency and the accountability to the public, that this will be a process that they can see and understand and have confidence in that it was done as all contracts should be.

Hon. Mr. McMorris: — As with any of the capital construction that a health region is supporting and is . . . funding, I should say. As with all capital projects that health regions are directly funding, that goes through a tender process.

Ms. Junor: — So we lost our way then with Amicus because they weren't directly funding it. Is that what you're saying?

Hon. Mr. McMorris: — The children's hospital will be tendered.

Ms. Junor: — Thank you. And so all the contracts that are leading up to the actual construction then — the architects, the consultants — all of that is a tendered process that we would be able to show the public? And we would be able to see and track it all the way through? And . . . [inaudible interjection] . . . I think, well there's nodding. You probably should say yes for Hansard . . . [inaudible] . . . I'm understanding from the nods that are happening.

So we will be able to see this project. Both the minister and the deputies are saying yes to that question. So the public will be able to see, watch this project as it unfolds and be quite comfortable in knowing that they can watch and judge for themselves how this is working and watch the process of it or the progress of it.

[21:15]

I'm also concerned about a newsletter that the health district sent out in June when they got their budget, and they talked about their capital projects. And they said they've got zero new capital funding, but they're going to look at other sources to fund capital investments because they will probably have to come up with something for this project, I would assume, although perhaps not in this year.

But just, oddly enough, they have said to their people that this newsletter went to that they're going to look at other sources to fund their capital investments, including voice recognition, electronic health record, and medication carts. Truly that's what it says.

So I'm not exactly sure how you look at sources to fund capital investments using voice recognition, electronic health records, and medication carts. Have you heard anything like that from the health district?

Hon. Mr. McMorris: — We have committed $200 million to the children's hospital — 5 million has gone out before; 195 is

going out tonight, hopefully at the completion of the estimates. That is the commitment of our government, to fund a project that we announce as soon as we possibly can, not announce it year over year over year without funding it. So that's the estimates that are in front of us tonight on $195 million for the children's hospital.

Ms. Junor: — You might want to . . . not want to announce that the money's going out the door tonight. You might have somebody waiting outside on the front step for it. I think one of my colleagues has some questions right now.

The Chair: — Further questions? Mr. Broten.

Mr. Broten: — Thank you. Ms. Junor spoke a bit about the services that will be provided in the children's hospital, and I have a few questions to expand on that. There's obviously a great amount of work that's done in a modern health facility, and I'm thinking of some of the other therapies like speech-language pathologists, occupational therapists, audiologists, music therapists, OTs [occupational therapist]. Is the planning that is being done now, do the plans include those types of professions in the operation of the tower or the pavilion as it's called?

Mr. Hendricks: — So the services that are planned for the children's hospital are antepartum labour and delivery, a fetal assessment unit, postpartum care, an NICU, a PICU, in-patient pediatrics, pediatric ambulatory services, maternal ambulatory services, adult and children's emergency services. That's one point that's often missed is actually this will reconstruct the adult emergency at RUH which has to be constructed as part of the new facility to decant into the children's hospital. A pediatric surgical suite . . .

Now inasmuch as in-patient pediatrics is going to be delivered in this new facility, many of those services, support services, and ancillary services that you mentioned will be provided to patients in that setting.

Mr. Broten: — So the new children's hospital, basically what is happening currently with those types of therapies with existing pediatrics in another facility, that will now take place at the new facility?

Mr. Hendricks: — Correct. Yes.

Mr. Broten: — So there would not, within those therapies that I mentioned, there would not be any expansion of services but more or less a relocation from what is happening in one spot now to the new location?

Mr. Hendricks: — Correct. But keeping in mind that the number of beds is being increased in the new facility to recognize our demographic changes and, quite frankly, the number of births and children in Saskatoon.

Mr. Broten: — Okay. That's all right now.

The Chair: — Ms. Atkinson.

Ms. Atkinson: — When services are moved out of RUH over to the children's pavilion, what does the region anticipate doing with the space that's being vacated?

Mr. Hendricks: — I don't believe that there are any firm plans for what's being done with the space. One of the issues that they have to tackle at RUH is how they reorganize their space and renovate it so that, you know, hopefully adopting some lean concepts. But I can't say specifically what those beds and those areas will be used for now.

Ms. Atkinson: — So it's going to be a reconfiguration of the emergency area, as I understand it. There's going to be vacated space at RUH. The main floor is going to be reconfigurated. And I guess I'm curious to know what kinds of services will go into the main floor and the space that's being vacated, given that there's going to be a net increase, of what? 25 000 metres of space? And so I'm curious to know what that may cost.

Mr. Hendricks: — I don't have those estimates with me right now.

Ms. Atkinson: — Are there estimates?

Mr. Hendricks: — [Inaudible] . . . actually.

Ms. Atkinson: — So we're building a new tower at a cost of about $200 million for the tower. It's going to be tendered. And part of that is a new emergency room that will be housed in the new tower, I guess. And then there's all this space that's being vacated in the new part of RUH — when I say new, from the '70s — and we're not sure what might go in there.

Are there any other services that are going to be dislocated in terms of Ellis Hall? Or moved?

Mr. Hendricks: — No. So, no.

Ms. Atkinson: — Those are my questions.

Ms. Junor: — So the new building, which is this one, I gather the emergency, the old emergency, is going to be redone as well. Is that included in the 200 million cost?

Mr. Hendricks: — Yes.

Ms. Junor: — And Ellis Hall isn't going to come down? Is going to stay?

Mr. Hendricks: — I'm not absolutely sure.

Ms. Junor: — But I have heard at some of these public meetings, them talking about all the old hospital, this one in the middle here, or this old one here, no in-patient services will be in there. No acute services will be in there any more. The original, first building, there won't be any acute or in-patient services in that building.

Mr. Hendricks: — As you know, one of the opportunities when you clear up this space that was previously occupied by the pediatrics area and maternal areas in the old hospital, it provides an opportunity to redesign that space and to use it differently.

One of the things that they're trying to take account in the

region as they build this new hospital is those services in the new tower, the children's hospital, to try and locate within the old facility the services that will support the children's hospital. So they're going to be moving stuff around as they redevelop the old part.

Ms. Junor: — So is that included in the 200 million?

Mr. Hendricks: — It's not. No.

Ms. Junor: — That's what's going to be a fair amount of cost, I think. This is what the district was sharing or the region was sharing with the public at the meetings I was at, is that there will be some additional capital costs as they try and fit down the collocations and moving out whatever is in this old part, whether they actually even can use it. She wasn't, Maura Davies wasn't sure. She wasn't sure what would happen. She wasn't sure if they would actually even still retain the old hospital, and even if there were, it would be a possibility of taking it down. There was even those options out there.

So I think given the situation that the district's in and the conversation that was shared in this newsletter in June, that there is no money in the district for capital projects. There is no money there. So when all of this happens, it's going to be interesting to see if the children's hospital goes up here, and then what else can happen with the existing money in the health district with all this other space and all the other things that may or may not have to be moved.

So I think we're anticipating that 200 million is just the bottom in the first tranche of money that's going to have to go out for this project. And I think people were aware of it at the public meetings anyways, that this was by no means the end number.

I think I'm actually done because I don't think I can actually talk any more. So if no one else has any questions, I'm done, Mr. Chair.

The Chair: — Any further questions? Seeing none, we'll move to vote 32, Health, page 13 of your supplementary book. Provincial health services, subvote (HE04), in the amount of $5,050,000. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Regional health services, subvote (HE03) in the amount of 197,500,000. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Health vote 32, the total amount $202,550,000. I will now ask a member to move the following resolution:

> Resolved that there be granted to Her Majesty for the 12 months ending March 31st, 2011, the following sums for Health in the amount of 202,550,000.

Mr. Hart.

Mr. Hart: — Mr. Chair, I so move.

The Chair: — Mr. Hart moves. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried.

[Vote 32 agreed to.]

The Chair: — Thank you committee members and minister and officials. Is there any final comments before we move on for the next business in this meeting? Mr. Minister.

Hon. Mr. McMorris: — I would just like to take a second to first of all thank the opposition for the questions, and even more importantly, thank the Health officials for the answers. So thanks to the officials as well as the opposition.

The Chair: — Ms. Junor.

Ms. Junor: — I also want to thank the minister and his officials for coming tonight and answering the questions that we put to them. Thank you.

The Chair: — Thank you, committee members and minister and officials. And thank everybody at home for watching. We have one more piece of business before the committee is recessed. Committee members, you have before you the draft of the ninth report of the Standing Committee on Human Services. We require a member to move the following motion:

That the ninth report of the Standing Committee on Human Services be adopted and presented to the Assembly.

Ms. Eagles.

Ms. Eagles: — Mr. Chair, I move:

> That the ninth report of the Standing Committee on Human Services be adopted and presented to the Assembly.

The Chair: — Moved by Ms. Eagles. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. I ask for a motion to adjourn. Mr. Wyant.

Mr. Wyant: — I so move.

The Chair: — This committee now stands adjourned.

[The committee adjourned at 21:28.]