STANDING COMMITTEE ON HUMAN SERVICES

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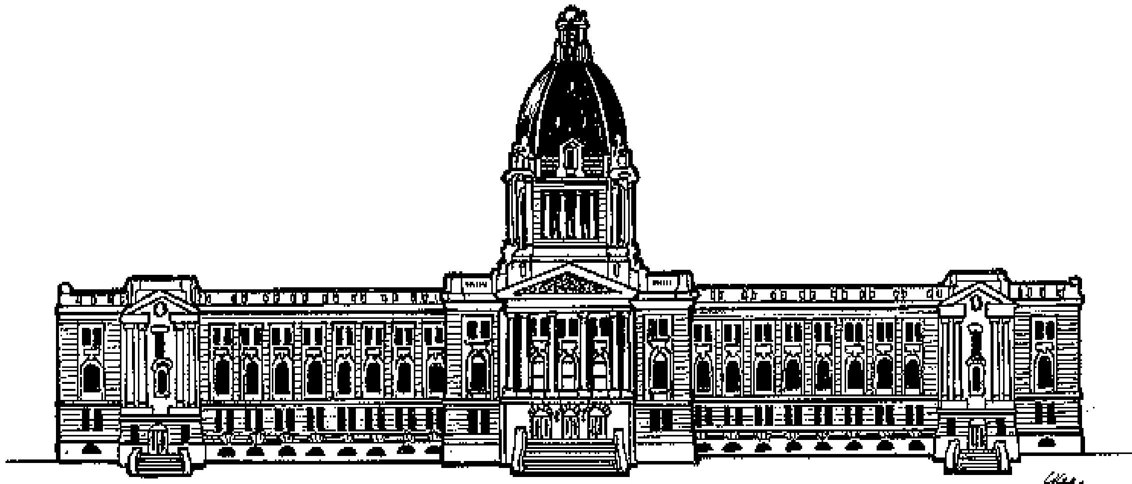

Legislative Assembly of Saskatchewan

Twenty-sixth Legislature

STANDING COMMITTEE ON HUMAN SERVICES

Mr. Greg Ottenbreit, Chair
Yorkton

Mr. Cam Broten, Deputy Chair
Saskatoon Massey Place

Ms. Doreen Eagles
Estevan

Mr. Glen Hart
Last Mountain-Touchwood

Ms. Judy Junor
Saskatoon Eastview

Ms. Christine Tell
Regina Wascana Plains

Mr. Gordon Wyant
Saskatoon Northwest

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[The committee met at 18:59.]

General Revenue Fund
Health
Vote 32

Subvote (HE01)

The Chair: — Good evening, ladies and gentlemen. Seeing as it is now 7 o'clock, the chosen hour for our committee meeting to begin, I'll call this committee meeting to order. I'd like to welcome you to the deliberations of the Standing Committee on Human Services. The members of the Human Services Committee are, to my left, Ms. Judy Junor, and substituting tonight for Mr. Cam Broten is Mr. Len Taylor. On my right is Mr. Glen Hart, Mr. Gord Wyant, substituting for Ms. Doreen Eagles is Ms. Nadine Wilson, and Ms. Christine Tell.

Tonight, committee members, we're looking at the main and supplementary estimates for the Ministry of Health, vote 32, central management and services (HE01) outlined on page 87 of the Estimates booklet on page 5 and on page 5 of the Supplementary Estimates booklet.

Mr. Minister, I'd invite you to make any opening comments, introduce your officials with you tonight, and I'd also ask officials the first time to the mike to introduce yourselves for the purposes of Hansard. So, Mr. Minister.

Hon. Mr. McMorris: — Thank you, Mr. Chair. What I'll do is I'll introduce the officials that we have kind of seated here and maybe the row behind, and then make just a few, just a few opening comments, not nearly as long as the last time we were together, but just a few opening comments.

So seated on my left is of course Dan Florizone, the deputy minister of Health. And on my right is Max Hendricks, the associate deputy minister of Health. Behind me is Lauren Donnelly, the assistant deputy minister of Health; and to my right is Ted Warawa, executive director of financial services branch. There are a number of other officials with us tonight, and I want to thank them for being here for the duration of the estimates that we have. So those are the officials, and as they come up, we'll ensure that we introduce ourselves so the committee knows who and where we're from.

Just a few comments from the last time that we met because there have been some significant, I wouldn't say changes, but developments as we've moved forward as far as the Ministry of Health. We have completed the health quality summit, which was a very successful summit put on by a number of organizations — the Health Quality Council, SAHO [Saskatchewan Association of Health Organizations], and the Ministry of Health — which brought in speakers from across North America. And it was very, very well received.

There has also been the introduction of the STARS [shock trauma air rescue service] program, and the funding of the PotashCorp regarding the operations, especially in Saskatoon, that were very positive, as well as just recently the addition of funding through the Children's Hospital Foundation by Mosaic — a significant donation on Friday by Mosaic toward the children's hospital. So a number of huge donations from corporations towards a number of programs that we are working on as a provincial government.

And as well as furthering the quality improvement agenda, the lean process that saw where we're at and celebrated some of the initiatives that we've put forward through the Ministry of Health, but also how that plays into what other jurisdictions, high performing jurisdictions are doing and realizing that we're definitely on the right track. More work to do, but definitely on the right track. So really in the last I think probably a month since we have met, some significant developments within the Ministry of Health and the health delivery within our province.

So those are the remarks I have, and I'd be more than willing to answer any questions that the committee may have.

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

Ms. Junor: — I'd like to start off tonight with questions around the autism strategy. There's been a lot of parents very concerned about where the action plan that was, I think it was submitted in '08. And a lot of parents, in particular SaskFEAT [Saskatchewan Families for Effective Autism Treatment] which is an organization of parents that have autistic children, were on the provincial autism advisory committee that put the recommendations forward. And they, I think it was October of '08 or '09, and they really don't see much has happened with this report and its recommendations. They are still really concerned. They know there's been money added in two budgets, but they have not seen this reach their children, and they're quite concerned about the status of the report. And then I have some really specific questions.

Hon. Mr. McMorris: — Okay. I'll just take a minute here before. I just want to get kind of the global numbers.

So just regarding the autism file which has been, you know, a very active file in the last three and a half years but for a long time prior to that, we see the numbers increasing. And part of that is through better testing and better acknowledgment of the syndrome. And what we have done over the last three and a half years is increase the funding quite significantly. In fact if you combine the funding over the last three and a half years, it's over $6.5 million invested in autism and trying to make sure that parents and, most importantly, children get the services that they need through the regional health authorities.

Another $1 million in this year's budget — and that's what we're talking about, so I'll try and stay to that — another $1 million into this year's budget dealing with specifically autism and not other, you know, putting it into a program that delivers other programs. So we've invested significantly, and part of that is hiring more professionals to ensure that people, parents that have children with autism can access services that they need. And that started with the plan put forward by SaskFEAT which . . . I shouldn't say put forward by SaskFEAT, but they were part of the overall committee that looked at a long-term plan to address better services delivered to families and especially children with autism.

So from an investment perspective only, the ministry and the

Government of Saskatchewan over the last three and a half years have gone a very long way. In fact if you look back to the previous investment prior to 2007, it was $500,000. If you look over the last three and a half years of our government, it is 6.5 million — a significant investment. I know that's three years compared to one, but you could take any one year of our government and you'd see a huge increase in investment to try and make sure that we have the proper professionals to deal with this.

The report talks about, I believe it was about 32 more professionals. And I'm going to let Roger get into the detail between consultants and other professionals that could deliver services here in Saskatchewan. I think the struggle that we always have is when there had been no programming in the province before . . . or I shouldn't say no, but little programming in the province before. It's one thing to say, invest a lot of money. It's another thing to make sure that you can, through investing money, ensure that the professionals are there. There is no province that are saying we have way too many people that can deal with autism. That's just not the reality across Western Canada especially.

So as we put more money in, we have to train more. We have to bring people up to speed so that they can deliver the services. But the difference is, is that the money is being invested, and we're trying to attract those health care professionals in order to deliver the services that parents and the children need. And I know some of the money is towards professional people to deliver the services. Others are around respite services. Others are around camps through the summer. Some of that investment goes into that which is all part of the overall program. But as far as the finer detail, I think I'll let Roger go through where so many of those funds have gone.

Mr. Carriere: — Roger Carriere, executive director of community care branch. The minister indicated in the first phase of the autism strategy, there were additional consultants hired. There was funding for 15 autism consultants and 18 support workers. The last we heard, all of those positions were filled except for perhaps one.

And the consultants were there to assist parents in making . . . to draw up a care plan and to assist the parents in getting supports that they require. The support workers were to actually work with the families in providing support to those with autism.

Last year in the additional 2.5 million, there was 1.3 million given to Saskatoon Health Region and 1.1 million given to Regina Qu'Appelle to again hire some additional supports for autism. And then this year there is 1 million: 100,000 of that is going to go towards additional diagnostic support in the hiring of a psychologist, really split between Saskatoon and Regina; and then the other 900,000 will go to additional rehab workers such as occupational therapists, speech language pathologists, and psychologists.

Ms. Junor: — Just a few points. Going back to the minister was speaking of when the money was put in, and he said pre-'07 there was $500,000 for autism treatment or therapies, and after that the Sask Party put the rest of the money in. But the '07-08 budget had a $3 million influx or input of money for autism and then has built on that. But the parents are still wondering, what has happened to the money?

The consultants and the therapists that you're talking about, Mr. Carriere, when I was travelling around Saskatchewan last summer I was asking health districts, and they said they had them but they don't any more. They're maintaining the vacancy. This was one particular one, they're maintaining that vacancy.

[19:15]

And also from parents that have talked to me, the consultants . . . There's not a standard for credentials for the consultants. And one of the real problems is that the consultants can have a master's in anything. And there is apparently, from what is told to me, one consultant who has a master's in computer sciences. So you can see that parents are not very happy with the type of service that these consultants will be able to deliver for their children. They're even wondering . . . I think every health district had, they thought had a consultant hired, but they want to know how many have them now, and where are they and what are they. What are their credentials? Because that is a real concern about the credentials of the consultants.

Saskatchewan is still called an autism wasteland. So whatever money we have, we still don't appear to be making a mark with it, and that is certainly reinforced by the parents who come and talk about what is needed for their children. There is of course a push back of parents who have lost EAs [educational assistant] in the classroom that looked after their children or helped them in the classrooms in a hands-on way, but the big concern is what happened to the report and what happened to the recommendations and how slow it has been and how the consultants have so few requirements for a basic credential.

And also even, I think, when it started the thought or the concept was to hire consultants and train them on the job. Well that's a high degree of frustration also for parents that this is not an on-the-job type of thing like an apprenticeship. They need consultants who are trained in the specific areas that will be able to meet the needs of autistic children.

Hon. Mr. McMorris: — You know, I can answer a couple of those questions. Currently there are 14.5 full-time equivalencies of the 15 autism spectrum disorder consultants. So 14.5 of the 15 are working; 17.5 FTEs [full-time equivalent] of the 18 support workers providing services throughout the province are there. There's one health region that has experienced recruitment difficulties, filling a point five consultant and a point five support worker in early 2011. One southern health region experienced one FTE consultant vacancy over the summer of 2010; however, that position was filled in November of 2010. So we aren't maybe fully staffed, but we're at 14.5 of 15 consultants, 17.5 of 18 support workers.

Regarding the master's degree, in as far as what that master's degree has to be in, and you were saying computer science, I believe or whatever, which . . . But of the master's degree in human service, must be in the human services field such as speech-language pathology, psychology, and social work, and experience work with autism spectrum disorder population. Those are the prerequisites and the . . . I shouldn't say

prerequisites, but what these support workers and consultants need to have their master's degree in.

So I would be interested to know, you know, the parents and their stories because certainly they're not saying it for the good of their health. I mean they're finding their children aren't receiving the appropriate services. I will say though that I know there is a degree of frustration with the parents and there is a degree of frustration as far as the Minister of Health, in myself, in that we've hired 14.5 and 17.5 — that's 32 full-time equivalents — into this field in the last three and a half years that weren't there before.

And you know, so we're working on it and we're trying to make sure that parents and their children receive the appropriate services, but when you start with very few in that field that can deal with those children and some very difficult cases, it takes time. And I know there's some frustration there. But what I would say to the parents is that we're working on it. There's more money to hire the professionals. There's more professionals being hired, and it all plays in with the overall program and a report that was done previously that had many of the stakeholders involved. Unfortunately it doesn't change overnight, but I would say in the last three and a half years the hiring process, the money invested, has gone a long ways and I think it will prove much better results as we move forward.

Will there be parents that are frustrated with the delivery model? And I know there will be. Some parents believe that the money, instead of going through the health regions to hire these professionals, should be given directly to the families to hire their own professionals to do the work for their children. That's certainly, you know, an argument that will be out there and I've heard it. I've talked to many of the parents that . . . I've talked to, I shouldn't say many, I've talked to a few parents that have felt that way.

I've also talked to many parents that have had better service for their children because there are more people working within the health region that have expertise in this area, albeit within a very short time frame, over the last two and a half, three years.

Ms. Junor: — One specific concern from a parent is that the cognitive disability strategy, the funding that's coming to her family from this, from this strategy, is going to be cut. She's been told that her application would only be renewed for three months due to changes that would be happening soon. She has two pages of questions about what will that mean for her family. Perhaps you can just tell me on an overview what you envision happening to this cognitive disability strategy funding, how the changes are envisioned or what changes are envisioned.

Hon. Mr. McMorris: — You obviously have some detail there of an individual family and the concerns that they're raising. I don't know, you know, the context. What I would say, just from the little bit that you have mentioned, is it sounds like it's more, it's related more through the Social Services flexible funding program that's, that they could apply to and receive funding from, more than through the autism programming that we do through the Ministry of Health.

Ms. Junor: — So these questions would be better asked to the Minister of Social Services? Because the parents who are coming have a concern about the fragmentation of the services already between Education and Health, and now we'll add a third player in, who will fob them off on to answer their questions.

One of their concerns was that Health uses the IABA [Institute for Applied Behavior Analysis] people from Los Angeles for training, and Education uses the Autism Partnership people, also from Los Angeles. And when the previous minister was in . . . When Minister Krawetz was in the portfolio, there was a pilot project in a northern school division that was, I think, fairly successful. But when the new minister came, they're going to start all over again.

So there's a high degree of frustration with adding . . . I think now if they hear this committee tonight and hear yet another department that has a hand in this that they need to talk to, there needs to be a way, if we're going to provide autism services for children in this province, that there is a coordination of these services between the departments. And I think it looks to me as if Health is going to need to take the lead since the advisory committee was struck by Health. And that's another concern the parents have. That committee has not met since the spring of '08 or '09. I guess it was '09 because the report was out in October of '09. They're concerned about that also. But coordinating the services would be, I think, paramount at this point.

Hon. Mr. McMorris: — What I will kind of start out with and then allow either Dan or Roger to carry it further is that, you know, when . . . And you raise a very good point is that people, you know, parents and children sometimes feel that they get left in between one ministry to the next ministry or get passed over to the next ministry. And that's, I guess, exactly what you said is that . . . [inaudible] . . . tell them to go to the next ministry.

Our government, through the leadership of the Premier and a committee struck through cabinet, which is the committee on children and youth, brings together a number of the ministries that deal in this area. It brings together Health, Social Services, Education, Advanced Education and Training, Justice, First Nations ministry, as well as Corrections and Public Safety. So those six ministries are working together to make sure that we have kind of a seamless process, that a person doesn't go to one ministry, get rejected, then go to the next ministry and to the next ministry and kind of do the, you know, the continual phone the next people, phone the next people. We're working together to try and have a coordinated strategy towards children and health services throughout the province, autism being one of them.

And so that's where the ministry is at, and that's where we put more money into autism from the Ministry of Health to deal with this very issue. I think what I would do is maybe turn it over to Roger to explain a little bit more about the committee, the work that we're doing and some of the initiatives that will be coming forward.

Mr. Carriere: — The autism strategy funds that were provided this year were the result of what was called a government-wide enterprise budget where the ministries worked together, the ministries that the minister mentioned, to come up with a plan

for '11-12 and to look at what future plans may be beyond that. There was a consultation last fall with families of individuals with autism, and as well there was a broader reference group comprised of a large group of stakeholders, including SaskFEAT, to look at the go-forward plans.

Because services don't just occur in one ministry but do occur across ministries, the fact that several ministries have been involved in providing supports has been there for many years and the current work is trying to do a better job of coordinating those supports across ministries. As mentioned, the flexible funding pool that's managed by Social Services, while they manage those supports, work regarding that part of the strategy is contributed by many different ministries.

And one of the actions for '11-12 was that the Ministry of Health and Social Services would work together to look at ways in which that cognitive disability strategy can be more effective for families in the province.

Ms. Junor: — I'm going to read a few of the questions. They're quite detailed and they have a lot of detail with each question. And then I'm going to have a copy made for all three of you, I think, so that you can answer them with a little more detail.

But just to give you a flavour, there's a question about school and daycare hours going to be totalled into what the government considers to be therapy hours. There's been talk that the above items are going to be used to say that the child is still receiving therapy. And, well, this parent says while school is a good place to generalize skills being worked on and socialization with others, it is not therapy. And so she said her son does not even have a full-time aid.

So these questions I think are valid, and there's a huge concern about the income testing portion of cognitive disability strategy. I'm not sure if that's done right now. Is that what happens now? It's income testing to receive funding from the cognitive disability strategy?

[19:30]

Hon. Mr. McMorris: — I guess what I would say to that — and Roger can comment further if he so chooses — but is that any of the services that are delivered through the Ministry of Health, which are delivered through the health regions, there is no income testing for those fees.

If you're talking about the flexible funding program that is offered through Social Services, then you'd have to talk to Social Services about the delivery of those programs. We don't have any . . . I mean they're a program that's delivered through Social Services. Even though we're working to integrate, you know, all the programs and understand so that it's a kind of . . . a person isn't falling through the cracks is that . . . The people that are applying for those programs through Social Services have to follow along with the Social Services policies and procedures to apply for those funds.

Ms. Junor: — So back to the committee that the Premier has mandated, would this be something you would bring there, or is up to me to ask the questions of the minister or the parents to go and ask the minister? Or is this something that we would see as a work product from this committee that you're on, that you would actually do it there instead of leaving it to either myself or parents to find their way through this?

I think I can answer my own question, because the parent does say that CDS [cognitive disabilities strategy] funding, she thinks the change that should be made is to remove the income testing. So I gather it is there. But she also supplied for me a court case from Prince Edward Island . . . not a court case, a human rights panel. And children were the . . . or parents on behalf of their children challenged the use of income testing in the delivery of services and said it discriminates against their children. And they won on that issue. So if we are doing that here, regardless of which ministry is leading on it, we are open to a human rights challenge that obviously has been sustained in other provinces. So I'll also give that to you.

And I think parents who are listening tonight will be happy to hear the . . . especially the . . . I think there's six questions on this. There's five questions which you can give to the committee through the Chair, I would assume, and I'll have the questions copied and given to you. Do you want to be referred to the case in Prince Edward Island or do you actually want a copy of it?

Hon. Mr. McMorris: — Mr. Chair, we'll let Dan . . .

Mr. Florizone: — My name is Dan Florizone, deputy minister of Health. What I would like to do on behalf of the Ministry of Health, Ministry of Education, and Ministry of Social Services, and any other ministry that might be involved in these important questions that are being raised by this parent or these parents, is I'd be pleased to take the lead on coordinating the response to the letter seeking clarification.

One of the reasons for us working closely together around autism, as well as around a number of other areas for improvement initiatives like FASD [fetal alcohol spectrum disorder], that's another example, is that we feel it's really important that we think and act as one, respond in a far more coordinated way. Because on the receiving end of these services it's very difficult for families to encounter different silos, different ministries, the hand-offs that occur between ministries. So what I would like to commit to you is that I'll take the lead on finding the answers to those questions and providing you with a consolidated response by coordinating with those other ministries in terms of their responsibilities. And perhaps we can use this as a way of continuing to work close, more closely together.

Ms. Junor: — Thank you. And my question about the PEI [Prince Edward Island] human rights panel?

Mr. Florizone: — I don't have the full background on that, but I'd be pleased to look at that . . . [inaudible interjection] . . . Absolutely. I'll be pleased to respond to that as well. Thank you.

Ms. Junor: — Okay, thank you.

Hon. Mr. McMorris: — If I could just . . . And I'll respond to that too, if I could just . . . So it was the Human Rights

Commission, through PEI, that determined that income testing was not acceptable through the delivery of services of health care. And I'm just wondering because you're asking the question is, like is that, is that not acceptable to you? Are you agreeing with that?

Ms. Junor: — I'm asking you that.

Hon. Mr. McMorris: — No, but I'm asking you. I mean we already have that in many, many different aspects in the health care system . . . [inaudible interjection] . . . We have . . . No, but we have income testing in many, many different aspects of the health care system, i.e., especially long-term care.

Ms. Junor: — This is about children specifically. This was about the children and I think it's . . . Well I'll read you the . . . "The use of income testing in the delivery of services under the DSP [which is what they called it] discriminates against the . . . [names of children] on the grounds of age." So you might want to have a look at this.

Anyway, this what the parents are saying. This is open for a human rights challenge. So they have, they have provided this and have looked at that as a basis for their . . . what they consider to be perhaps something in the future that they will do.

They've also provided me with briefing notes by the Autism Society of Canada and a call to action by the Autism Society of Canada directed at the federal government for a Canadian autism strategy which would set up national standards and, I think, coordinate. Maybe some of the things we talk about in Saskatchewan that we may be reinventing or maybe trying to do on our own might be better served by a national strategy. So the question I have is, what will you do as the Minister of Health to pressure the federal government to actually look at a national, a Canadian autism strategy?

Hon. Mr. McMorris: — What I can answer just generally is that we're not quite sure who that federal government is going to be, as we speak. But assuming, regardless of which government it is, whether it's a majority or a coalition or a minority government, we continue to lobby the federal government on a number of fronts and a national program for autism and autism delivery would be one that we would absolutely lobby the government for.

Having said that though, and I think, you know, you will know this, it's not necessarily . . . And not that an overarching program federally isn't important. It's very important. But what the parents want and what the children want are services delivered on the ground. And that isn't a federal responsibility; that is a provincial responsibility. Now the federal government can help us — and through a provincial strategy, through funding and through other initiatives, help — but it always eventually gets down to who do we have providing the services in the province? Do we have enough health care professionals providing those services in the province? And that's our responsibility through the health regions. So not that I'm discounting any federal strategy. I think they're important and we will lobby the federal government for assistance in many different levels, including a strategy for autism.

We've got a pretty good road plan right now in Saskatchewan that we're working on. We're making sure we have those health care professionals that we need. We're continuing to increase funding to increase the delivery of autism services within Saskatchewan, which is our responsibility to deliver those services. We're continuing to do that on a yearly basis for sure as we increase funding budget over budget. Not to say that there isn't a federal overarching strategy important. It boils down to what we're delivering and what we have on the ground to make sure those services are provided.

Health is only one aspect of the overall delivery of autism services. There's Education. There's Social Services, as we've already mentioned. So it's an overarching strategy on autism, not a ministerial overarching strategy. It needs to be done in conjunction with other ministries.

Ms. Junor: — I just want to read a bit from Autism Society of Canada, which represents autism groups across Canada in all the provinces and territories, and they say that both the United States and the United Kingdom have legislation to support national strategies for autism. And the Autism Society of Canada does call on the Government of Canada to act, that Canada must have a Canadian autism strategy, and recognizing the federal government must work with the provinces and look at best practices.

And they do mention that coast-to-coast dealing with ASD [autism spectrum disorder] is inconsistent. And so I think they would take some heart that you will work to pressure the federal government — regardless of which government it is. It doesn't really matter. I think the issue is these children need care, and the earlier the better. So I think that parents who are watching tonight would be happy to hear that. I'm going to also give you copies of that which they gave me. They passed them out in the federal campaign, so I'll pass them out to you as well. And those are my questions on autism for this evening.

I'll move on now to OCATS [Ovarian Cancer Awareness & Treatment in Saskatchewan], the ovarian cancer people. There's been a fair amount of — how am I going to say it? — there's been a fair amount of concern about the gyne-oncology treatment for women in this province, and it started with Betsy Brydon, a gyne-oncologist, leaving a couple of years ago. Maybe it's a couple. Maybe it's only one, seems like longer. And there were concerns about the difference in the program in Regina and Saskatoon, where in Saskatoon the oncologists were supported, the gyne-oncologists were supported within the hospital setting or within the cancer clinic setting, whereas in Regina they were not.

I've actually met with OCATS, the organization that supports ovarian cancer treatment, and these are women who have survived ovarian cancer or are living with ovarian cancer and have really many concerns about the program or the lack of progress with the program. So I met with a gyne-oncologist from Regina, and she was . . . It was quite interesting to talk to her. She presented a plan in '07 for what she would see should be a gyne-oncology program in Saskatchewan basically. Was kind of led to believe that would never work — it had to be separate between Saskatoon and Regina — but nothing else was ever said to her. And she is still working in Regina without any clear idea of what she can do and what this program can do.

And so there's such a high level of frustration among women, that I think — and I've spoken to the deputy about this — that they really don't need any more meetings. They really don't need to come to the legislature any more. You just have to get in there and fix this. And I think there's a fair amount of commitment with the new CEO [chief executive officer] of the Cancer Agency. I don't know what the College of Medicine, how they feel, but there needs to be some work done. And there needs to be a lead taken on it.

And I think meeting with OCATS again and again is not going to . . . They've done that for years, and it has done nothing for them. They need somebody to actually fix this and get two units up — one in Saskatoon and one in Regina.

[19:45]

Hon. Mr. McMorris: — So this is a problem that's been ongoing, or an issue — I shouldn't say problem — but an issue that's been ongoing for a while because it kind of crosses a few borders. It's health region to health region; also the Cancer Agency is involved, as well as the Ministry of Health.

We've been working on this diligently since 2009. We're very close to a alternate funding formula that will even out the pay structure from health region to health region, because I think that's what you had mentioned, that there are discrepancies between health region to health region. So we're very close to coming together with a final agreement that will address some of those concerns if for example one gyne-oncologist would compare to Saskatoon and there's a discrepancy. We're getting closer on that.

There is an advisory committee that's been working on this, and I'm going to let Deb Jordan get into the details of what has been happening with that advisory committee and the work that it's been doing. It met on March 14th, but there is . . . She can get into the detail of the deliberations.

Ms. Jordan: — Good evening. I'm Deb Jordan, and I'm the executive director of acute and emergency services with the Ministry of Health. So as Minister McMorris indicated, one of the key aspects of bringing stability to the gynecologic oncology program was ensuring consistent and stable compensation for the four gynecologic oncologists who are currently practising in the province. And I might note that the complement of four is the first time in some time that there has been a full complement of four gynecologic oncologists practising in the province. So having that alternate funding plan in place for the four specialists will be key, and that is nearing completion.

The Saskatchewan Cancer Agency also struck a gynecologic oncology program advisory committee, and that committee is being chaired by Dr. Colum Smith, who is the VP [vice-president] of medical affairs for the Saskatchewan Cancer Agency. And the program advisory committee had its first meeting on March the 14th, and its next meeting will be Monday, May the 9th.

Key, after stabilizing the arrangements for physician services and specialist services in gynecologic oncology, is moving ahead with some consistent and shared aspects of a gynecologic oncology program in the province. So notwithstanding the negotiations that were taking place with respect to the alternate funding arrangement, representatives from the Cancer Agency, the Ministry of Health, and the gynecologic oncologists have been working for example on clinical referral guidelines to help guide family physicians and primary care providers to ensure that women receive the appropriate referral from their primary care provider either to a general gynecologist or, where felt necessary through the clinical guidelines that have been developed, to a gynecologic oncologist.

Another key aspect of what the Cancer Agency would like to move forward with in the '11-12 fiscal year for gynecologic oncology patients is a single entry point so that women in the province, regardless of where they reside, once they're referred by their family physician or primary care provider that they have timely access to one of the two sites, either Regina or Saskatoon, for their review and for their care.

So those are just a couple of examples of some of the items that are priority to move forward through the advisory committee this year.

Ms. Junor: — Thank you. I understand the funding discrepancies is one thing, but I also understood from Dr. Brydon's point of view it was the physical space and the way she was left to practise. She had to rent her own space, hire her own staff, where in Saskatoon it was done differently. So with the different funding arrangement, is that going to be the standard then, that practice in Regina will be the same as in Saskatoon within the Cancer Agency or within one of the hospitals?

Ms. Jordan: — It's my understanding that as part of the discussion of the alternate funding arrangement that those types of considerations about office overhead and so forth have also been considered as part of the discussion.

Ms. Junor: — Which means . . . [inaudible] . . . it will be the same in Regina as Saskatoon?

Ms. Jordan: — It's been addressed to the satisfaction of the four gynecologic oncologists who are currently in practice.

Ms. Junor: — Now the satisfaction level, I guess I would wonder because I met this gyne-oncologist just before Easter. So unless something has happened during the Easter break, she was not a very happy specialist.

One of the things that really was concerning her, and it also concerns OCATS . . . And I think I'll just say OCATS is the Ovarian Cancer Awareness & Treatment in Saskatchewan — and that's the group that creates collaborative care for gynecological cancer — just for people who are watching and don't get the acronym so at least put it out there once.

The care for women with gyne cancers is still under the arm of obstetrics, and that's a huge concern. And I understand that the chief of obstetrics in Regina is going to be in charge of gyne-oncology when he retires. Will you comment on that?

Ms. Jordan: — I'm not aware of what the Regina Qu'Appelle Health Region's plans are with respect to the physician that

you've identified, but the department has typically always been a combined department of obstetrics and gynecology.

Ms. Junor: — That's the concern of this gyne-oncologist. That is not the optimal situation for women with gyne cancers. General gynecologists, as you mentioned, need a different type of awareness or different type of education to recognize the different cancers and get women into the right diagnoses and the right referrals for treatments and the right treatments. So I think that was certainly her concern, and it's certainly a concern of OCATS.

So I don't really think that your answer about that's always how it has been done is something that's going to work. And I would like to see a different commitment, that this should be something that is considered to be a specialty on its own and not left to the obstetricians and gynecologists to run the program. And I don't know why Regina would be in control of it, the Regina Health District, if we're looking at a collaborative model about how women would best be served with gyne cancers. I think it would be in everyone's best interests to have everyone come and talk about a new model rather than presume someone has control over it in the old way.

Hon. Mr. McMorris: — I'll just mention that, you know, I guess in the past is that the health regions are responsible for delivery of health care in their areas. If people are concerned with the delivery and the combination of services in a particular area and those are being voiced through you and perhaps by a gyne-oncologist or some patients, then those concerns obviously should be taken up with the regional health authority. Even though we're looking at a uniform funding model as far as alternate . . . [inaudible] . . . that doesn't take away from the responsibility of the health regions to deliver that service in groups or individually, however they choose to deliver those services.

Those concerns certainly will be voiced with the Regina Qu'Appelle Health Region; if it's the Saskatoon Health Region, how they deliver those services. But eventually it's the health region itself that determines what groups are blocked together under a specific head. That's the way it has been done under previous governments. That's the way it's been done under us. That doesn't mean that it can't change if the health region so chooses to make that change. If you're expecting us to say to the health region what should be put together and what shouldn't be put together, then that's a complete shift from what has been done before and really taking away from the expertise that the health region has in delivering those services.

Ms. Junor: — I would better see it as a role of the advisory committee to advise the health districts to have a standard of care for gyne-oncology that would put it under its own specialist and not leave it under obstetrics. And I think that could be the role of the advisory committee because the health district will do what the health district has done.

And I think the advisory committee has an opportunity to say, if we're redesigning the program or if we're changing the program in a way that will better meet the needs of women in Saskatchewan that have ovarian cancers or gynecological cancers, this would be the opportunity to do it properly. And if you have an advisory committee, I would think that it would come through there, and that would be your opportunity to have the health district change the way they do things. And I think they would probably be open to that because I've spoken to Dwight Nelson as well, that I think that there is a willingness to fix this problem that OCATS brings up quite often and quite clearly that they have a concern. They're acting on behalf of women who have these cancers and who are not being served properly.

Meanwhile everybody talks about more meetings and, you know, two months between each meeting. And I understand that women from Saskatoon are travelling to Regina for extended periods of brachytherapy, which is radiation for cervical cancer, and one of the machines is broken. So there's apparently going to be an announcement about this in a couple of months, but why is that?

Hon. Mr. McMorris: — I mean obviously we have been working through some of the issues raised by individuals and making sure that we have all the professionals involved. That's why we have an advisory group to advise health regions into the future as to the next direction. There has been a meeting on March 14th. The next meeting is in May to continue on.

I will say that OCATS is one voice of many that are part of the advisory group as we move forward. To take one person's or one lobby and say this is the way it should be delivered within a health region would not be responsible. That's why you put together an advisory group to look at how the services are delivered. You let that group do their work and come forward with recommendations. Then the health region, if they so choose to move forward on those recommendations, that's their responsibility.

But what we have done is coordinate an advisory group to look at this and to see where improvements can be made, not just on a knee-jerk reaction to a lobby, but to an advisory group that has all the interested parties together to look at how we can improve services for women of our province.

Ms. Junor: — I don't think this is just the lobby group. This is the gyne-oncologist I spoke to. She was quite clear that this has been going on since '07 in her case, and she's brought forward many of these issues. She is clearly frustrated.

And I think it is now 2011. And how long do you think women should wait for this program? While they wait, as OCATS very clearly says, while we wait and meet and talk and decide, women are dying. And I understand their frustration. So I think, I understand you don't want to take the advice of a lobby group, but for heaven's sakes, a gyne-oncologist is telling us this. And you don't believe me, go talk to them then. And I think this is totally unacceptable to have it for four years and to have OCATS keep coming here and saying the same thing, and now the gyne-oncologists are even speaking up. We really need to do something faster than this, and I don't see any reason why we can't. You've got people on advisory committee; you've got money; then you should be able to fix it.

[20:00]

Hon. Mr. McMorris: — What I would say is that work is being done and we're looking for solutions as we move

forward. You can understand that we don't want to react to a lobby group, nor would it be appropriate to react to one gyne-oncologist certainly, and I don't know which one that you have been talking to. I wish you would put that on the record. That would certainly clear things up because what I will say is that we get lobbied at times by a specific specialist on a specific issue, but when you look at it in the whole delivery of the service, it may not be best for all patients. So we have to take into consideration all the providers of a service.

You know, I find it very interesting that you would say that because, for example, a lobby group has mentioned it and a specialist has mentioned it, we should move on that. And if that's your, if that's, you know, your position, then that's what we should do and it shouldn't take so long because people are dying.

I can tell you, as an opposition critic, we had lobbyists regarding Avastin and we had specialists regarding Avastin and we had the Canadian Cancer Agency and the Saskatchewan Cancer Agency say this is a standard of treatment, and it wasn't moved on by the previous government.

So what we are doing in this case is looking at all interested parties through advisory committee to make sure that the moves that we make into the future aren't a knee-jerk reaction to a lobby group or a specific specialist, but takes into consideration all those working in the field.

Ms. Junor: — I'm pretty sure four years isn't much of a knee-jerk reaction. And I'm assuming if I give you the doctor's name, nothing will happen to her because she spoke to me. Right. Her name is Dr. Maryam Al-Hayki. Do you want the spelling?

Hon. Mr. McMorris: — No, we have it.

Ms. Junor: — Okay. And I'm assuming that she's quite anxious to have things dealt with. So I think four years is probably long enough to have this going on. And I understand how things may or may not have been done in the past, but that isn't an excuse for you not to do anything on this. Doesn't work . . .

Hon. Mr. McMorris: — I'll tell you what. We'll be very . . . You know, we'll be looking forward to talking to the specialist and making sure we have her input. I do know that you've quoted Dr. Shoker before, and those quotes weren't quite accurate. So we'll be very interested in talking to this specialist to make sure that what you say she is saying is accurate.

Ms. Junor: — By all means talk to her. And for Dr. Shoker, he was pretty much told to shut up. He was told not to speak again, to get himself a lawyer, and it wasn't by me. So by all means talk to Dr. Al-Hayki.

Hon. Mr. McMorris: — I'm advised that you quoted Dr. Shoker in the House of what he said. We talked to him, and he wrote a letter saying unequivocally, that is not what I said. You had said in the House, "I quote, this is what Dr. Shoker said." We talked to him, and he wrote a letter. And we have the letter saying, that is not at all what I said.

Ms. Junor: — Well this is not the time to argue about Dr. Shoker. This is an OCATS question. And Dr. Shoker, I've said, has told us he was told not to say another word because he needs a lawyer. So that's unfortunate that people would feel that they cannot speak up and say things that are particular to the profession. And there'll be another one. There's a dentist that's going to speak up, and I hope nothing happens to him either. But he's willing to speak for himself and say directly, where Dr. Shoker was intimidated.

The Chair: — Ms. Junor.

Ms. Junor: — Yes.

The Chair: — I'll ask the minister if he'd like to respond to that before we continue.

Hon. Mr. McMorris: — You know, I mean I'll just go back to the specific incident where a phone call was made by you to Dr. Shoker. You come into the House, and you quote him and you said, "and I quote." So we sent the quote back to him and he said he said nothing of the sort. So you know, I'm not saying that this gyne-oncologist doesn't have some concerns. We will want to make sure that we talk to this physician as we would talk to any other physician to make sure that they are being represented properly.

The Chair: — Ms. Junor. Ms. Junor.

Ms. Junor: — Yes.

The Chair: — I'm more than happy to let conversation go back and forth between you and the minister as long as it stays respectful, just in the interest of time. But if it does get a bit contentious, we'll have everything go through the Chair.

Ms. Junor: — I'm done with that. I'm ready to move on to my next issue. I'm not the one carrying this on.

My next one is, my next issue is the SMA [Saskatchewan Medical Association] contract. There has been some major concerns raised with me that the contract has very, has quite a few in fact substantial clauses in it that are not costed. And I'm not interested in talking about, do doctors merit an increase or should we pay them? I'm interested in what we are paying them. I think the public deserves to know what this will cost, and there are many uncosted items in the contract, as we have seen. So many of the questions I have are particular to some of the issues in there, in the contract, that are just mentioned but with not a cost attached to them.

We heard, at least from the media reports, that the contract was 11 per cent. I have seen the fees increases mentioned as 13.62 over four years and so I'm interested in what is the total cost of all retroactive payments, for my first question.

Hon. Mr. McMorris: — What we will do is I'll have Max respond to this. This has been a contract that was outstanding for a number of years. We were able to come, finally decide on a four-year contract which is certainly very, very positive. You know, we have a huge issue with recruitment and retention into this province. This has been an issue for a very, very long time. We've taken a number of initiatives regarding the recruitment

and retention of physicians, be it increasing the number of medical seats, increasing the number of residency positions, starting a recruitment agency. I can go on and on about the efforts that we have undertaken over the last three and a half years to ensure that we have the proper complement of physicians in the province.

One of those, you know, whether we agree with it or not, one of those recruitment and retention pieces is a solid contract. I will just kind of reference back to where we're at, where we started with the nurses in this province and other health care providers but in particularly nurses. We were able to come together with a four-year contract that saw their pay be competitive with Western Canada, below Alberta but competitive with Western Canada. And you can see the results that we have seen in this province because we've been able to retain our graduates and recruit from outside and then retain those, be it the Philippine nurses or many others.

So we've gone a long ways in increasing the number of nurses in this province through many initiatives, including a solid contract. I believe that this contract, as we move forward, will be solid as far as recruitment and retention along with all the other programs that we've put into place regarding physician recruitment and retention. It definitely is an issue. What we've seen over the last three and a half years is an increase in physicians, not always where we want them to be, be it in a Kamsack or a Spiritwood or many other communities that are short of physicians. But we have seen an increase overall in the physician complement within the province. I believe the contract which Max will speak more in depth on as far as the total cost will be just one more piece in not only attracting physicians to our province, but also retaining.

I think for the first time in a very, very long time, health care professionals as well as many other professionals across the board are looking to Saskatchewan first as a place to go, not last because we were at the bottom of the pay scale in many areas, as well as we weren't as receptive and inviting as we should have been. I think those attitudes have certainly turned around and this contract, I believe, will be very solid when we look at the recruitment and retention of physicians well into the future.

As far as the specifics, I'll let Max talk about that.

Mr. Hendricks: — Okay. Max Hendricks, associate deputy minister. This is a four-year agreement spanning from April 1st, 2009 to March 31st, 2013. For the fee-for-service agreement, it provides $105 million over four years, of which 55 million is for general market increases, 33 million is for program funding, including special programs that reward full scope of practice, rural practice, patient-focused care, chronic disease management, and improved after-hours access.

Seventeen million is for new items and increases to after-hours premiums and surcharges. There'll be a new items, a fund available to add new codes basically to the standard practice, as well as premiums and surcharges. In all, this agreement provides an 11 per cent general fee increase over the term, plus a 2 per cent market increase in year 2, and 9 per cent for programs. And I'm not sure of anything that's uncosted in this agreement.

Ms. Junor: — So 13 to . . . So that's 24 per cent? Is that what we're saying, 24 per cent?

Mr. Hendricks: — 13 plus 9 — 22 per cent.

Ms. Junor: — And what about the 2 you said for something?

Mr. Hendricks: — 11 per cent fee increase plus 2.

Ms. Junor: — Oh and then . . . Okay. So 22 per cent. And so my first question was, what was the total cost of all retroactive payments?

Mr. Hendricks: — The total retroactive costs for fee-for-service physicians . . . And I say specifically fee-for-service because we provide the same level of funding for non-fee-for-service physicians. For fee-for-service physicians, the total amount was $42.5 million over the first two years. That would have been paid retroactively.

Ms. Junor: — Is that reflected in this current budget somewhere?

Mr. Hendricks: — Yes.

Ms. Junor: — Where is that?

Mr. Hendricks: — Okay. Within the current budget, the amounts for fee-for-service bargaining, because we hadn't concluded the agreement at the time the budget was being developed, some of the money appears in the fee-for-service subprogram, and some appears in the non-fee-for-service subprogram. And of course that's to some extent to protect the mandate from being exposed during contract negotiations, which is common practice in collective bargaining.

Ms. Junor: — So where would I see this in the book?

Mr. Hendricks: — Under medical services and medical education (HEO6), under the subprogram fee-for-service and non-fee-for-service.

Ms. Junor: — And is that the 7 million increase, and the 56 million increase? I've got 7 million in the medical services fee-for-service increase, and in medical services non-fee-for-service about 56 million. That's 63 million in this budget.

[20:15]

Hon. Mr. McMorris: — Okay, I think Max is ready.

Mr. Hendricks: — So in terms of the estimates display, where you will see the funding is in '11-12. There's $19.7 million in regional target programs under (HE03) and $36.65 million in (HE06) under non-fee-for-service physician stabilization.

Ms. Junor: — So what were you telling me about medical services and fee-for-services under (HE06)?

Mr. Hendricks: — If you look under medical services, non-fee-for-service, there's a budget line for '11-12 which has 192.088 million.

Ms. Junor: — Right.

Mr. Hendricks: — And of that amount, 35.65 million for a total. The SMA agreement, including extending that to non-fee-for-service bargaining, is included in there. And then in (HE03) on the previous page, under regional targeted programs and services, which is $120.035 million, there is $19.7 million included for a total of $61 million.

Ms. Junor: — And so what was the 42 million over two years you were telling me? Was that . . .

Mr. Hendricks: — Forty-two million is for fee-for-service physicians. And then everything that we negotiate for fee-for-service physicians, we apply that to non-fee-for-service physicians as well. So that $42 million is the amount that's applicable to fee-for-service physicians; 61 million is the amount, in total, including non-fee-for-service physicians.

Ms. Junor: — That's over two years, or is that in this year's budget only?

Mr. Hendricks: — That's in this year's budget.

Ms. Junor: — So the 42.5 over two years, what was that about? Sixty million is in this year's budget, so is this because it's being compounded?

Mr. Hendricks: — So in our previous year's budgets, we actually built in funding based on assumed mandate increases. So in '09-10, we built in $19.84 million, and in '10-11 we built in 47.31. And then the budget in '11-12 paid $55.35 million for the . . . So that's three years of the agreement. The total cost: $122.5 million.

Ms. Junor: — And is that included in the 22 per cent total?

Mr. Hendricks: — Yes.

Ms. Junor: — Is that all of it, or is that just the retro?

Mr. Hendricks: — No.

Ms. Junor: — This is all the services, the total cost of retroactivity up to the signing of the contract is 60 million?

Mr. Hendricks: — Yes, for the first two years of the agreement. But we're now in the third year of the agreement, right?

Ms. Junor: — This is now the active part because it's been signed. This is no longer retroactivity.

Mr. Hendricks: — Exactly.

Ms. Junor: — Right. And so the retroactivity, cost of the retroactivity, was costed into the 22 per cent. It's not in the 13, and it's not in the 9. Where is it?

Mr. Hendricks: — The cost of the retroactivity is included in that, yes.

Ms. Junor: — Right. Is it included in the 13?

Mr. Hendricks: — It's included in both because we're paying . . . Sorry, it is the fees in the 11 and the 2 that I mentioned because we're paying the fee increases in the first two years of the agreement, and those are the retroactive components. So to answer your question more clearly: 3 per cent fee increase in April 1, 2009, and then 3 per cent fee increase plus a market adjustment of 2 per cent for a total of 5 per cent April 1, 2010. Total retroactive: 8 per cent.

Ms. Junor: — So since I'm on this page under (HE03) and when you mentioned regional targeted programs, I notice that there's about $100 million less in '11-12 then there was in '10-11. What accounts for that $100 million drop in targeted programs and services?

Mr. Hendricks: — So as I mentioned in my earlier statements, when we are engaged in negotiations with health unions, oftentimes as we are trying to forecast for budget and include amounts within our budget, we will put it into a program where it's not clearly identifiable for the purposes of trying to contain our mandate based on our forecast. And so in regional targeted programs when we settle with the providers in the last year, we actually begin distributing that money and putting it into the regional base budget. So the money would've been a movement from regional targeted to all the regional base budgets.

Ms. Junor: — And that shows up then in their budgets?

Mr. Hendricks: — Yes.

Ms. Junor: — Okay, so back to the contract itself. And you did mention that there, as far as you know, there are no items that are uncosted?

Mr. Hendricks: — No.

Ms. Junor: — So all the various things in the contract that don't have a cost, with the committee being currently established to determine the allocation and management of the funding, GP [general practitioner], specialists, another committee currently being established and chronic disease management, all these things — long-term retention fund, continuing medical education, after-hours premium — all those things are costed into the 22 per cent in some way?

Mr. Hendricks: — That's accurate. To be very clear, within those programs, while at the time of initially arriving at agreement, we agreed to broad project parameters, but the specific funding amount attached to those programs was agreed to. So the program parameters have to conform to the actual funding available.

So I'll give you an example. For full-service family physicians, we did analysis on who would qualify for that program, what it would cost to provide a 10 per cent premium to those physicians providing that service, and then we said that there's $7.7 million available for that fund. Now in the event that as we go and refine the program criteria, regardless, any refinement has to be kept within that $7.7 million. Now with that one program there is the potential, and it's something that we actually would welcome, is that if more physicians do actually qualify for full-service family physician practice, the costs of that program could escalate. And that was well known. And so

we do, we do know that. So right now we have about a third or slightly more of our physicians, family physicians that would qualify for that. Other than that, every program is a hard dollar amount. So I think, I think as a province that would be a welcome expense, to have more physicians providing a broad range, a full spectrum of care.

Ms. Junor: — So the last piece of the contract or the highlights of the contract that I have talks about the agreement, including a commitment to establish non-fee-for-service bargaining rights for the SMA. And the ministry and the SMA are going to establish the overall concept and articulate the process which . . . The work was supposed to be finalized by March 31st. Can you tell me where that is?

Mr. Hendricks: — I would love to say that it was finalized. We're still working with the SMA. I would say we are 95 per cent there. We're having, not disagreements, but we're trying to actually get this right in terms of where we're going with this non-fee-for-service arrangement. The goal is to have the final agreement signed probably late, sometime late this week or early next week, which does have an appendices that deals with non-fee-for-service bargaining.

As you can imagine, this is really complex because we're moving upwards of 30 per cent of our physicians into a different stream of bargaining which they've not been included to and allowing the SMA to be their representative agency. So in terms of where we're going with primary health care redesign and a number of other alternate funding mechanisms, it's important that we get it right. And from the SMA's position it's important that they get it right too. So there have been a lot of discussions. I think we're down to really the short strokes in terms of reaching an agreement on this.

Ms. Junor: — So does this then have unspecified costs attached to it?

Mr. Hendricks: — What we have done is we have said that over the course of this agreement, and it's based on funding predictability, is that we're going to include five specialty groups in the initial tranche. So they're ones that we know a lot about: psychiatry, emergency medicine, pathology, medical health officers, and primary health care. And so the idea would be that we would go through and evaluate their compensation grids in comparison to comparable benchmarks in other provinces similar to what we do for all bargaining. If an adjustment were required, we would have to do that. We think in most cases it would be unlikely because these are specialties that already do have established grids. Then we will begin a process by which we prioritize new specialties that enter the non-fee-for-service model.

So if we were woefully behind in a certain specialty, there could be costs attached to it. I don't know that yet. I think that given what we know about where we stand in Canada relative to other provinces in terms of our payment schedule and that sort of thing, we're near the top of the heap. So I would assume we would be pretty good.

Ms. Junor: — So will this then be the long-awaited template? Will it include a template for fee-for-service docs that work . . . I'm thinking of how long it's taken to get that template for fee-for-service doctors working in primary health care, which has been a decade.

Mr. Hendricks: — Non-fee-for-service doctors?

Ms. Junor: — Non-fee-for-service.

Mr. Hendricks: — Yes, this will also include a model contract for non-fee-for-service doctors. We have been using one. It's not one that's been formally agreed to, but most regions have adopted the one that was again very close to having an agreement reached with the SMA, so this is part and parcel to that. So the difference here is that you would have an agreement that covers all specialties.

Ms. Junor: — So that this is what we used to call a template that was being worked on for so long, and it now will be able to be used in a lot of the specialties in a lot of the sites.

So when we're talking about this contract, I know that the sensitivity was around reopeners. But from the people I've had look at what is here, they have significant concerns about what costs are open-ended and not . . . The expenditures are not committed to because of the compounding because of the unknown aspect of the retroactive. I'm hoping that clears up what we've talked about tonight about the retroactivity and where in the budgets this all is. There is a significant concern about some of the issues in here, or the parts of the contract that appear to have an open-ended or unattached money to them. But you have said that all of these do have money attached to them. All have been included in the 22 per cent, and all will show up in the budgets as you have demonstrated.

Mr. Hendricks: — Yes, I just reviewed the detailed contract this morning, and each specific program has a dollar amount attached to it. As I said, the only one to my knowledge where there could be any variability would be on the full-service family practice fees if more physicians did qualify for that program, which we would see as a positive expenditure. It was designed with that in mind to entice physicians to take on a full scope of practice.

Ms. Junor: — And so these committees that are being established to determine the allocation and management of all the funding in the various points that are in here or parts of this contract, is that the normal way that this has been done before?

Mr. Hendricks: — There have been committees. We've had . . . For several years, we've had committees for the emergency room coverage program, the specialist emergency coverage program, rural and remote practice, specialist recruitment and retention committee. So there have been several committees. What's unique about this agreement is that it actually I think from a provincial perspective derives a lot of value in terms of the quality piece, the chronic disease management, the full-service family piece. And these are all new things. There are additional complexities in the fee-for-service arrangement that we have in this province and so you need committees to work out how those will actually work and to monitor them as they go along.

So there is precedent for this. We will have more committees now. But I think it's really good because we're actually

engaging the doctors and talking about quality of care issues now.

[20:30]

Ms. Junor: — So when I look at the full-service family physician item and the breakdown of the premiums by location or type of hospital, when it says 10 per cent in a community hospital or an ER [emergency room] centre, 5 per cent in a regional centre, does this mean that that physician will get 10 per cent of an increase? Is that what it means? Or is that also what's included in the total of 22? Or is this above and beyond that?

Mr. Hendricks: — So when I . . .

Ms. Junor: — Individual physicians in these categories, will they receive more than the 20? I guess . . . [inaudible] . . . physicians will get 13, right?

Mr. Hendricks: — Yes. So, no. The way that the fee-for-service allocation works is that we provide general fee increases to the SMA and they have various groups that split these increases up amongst the specialties, based on their assessment of where these specialties lie in terms of their compensation relative to other jurisdictions and relative to each other.

So to say that every physician will get a 13 per cent pay increase would be incorrect. It will vary significantly by specialty. One thing that is clear though, that a physician who provides full-service family practice in a rural area will receive a 10 per cent premium on all of their earnings. So we've specified that in the agreement.

Ms. Junor: — So how is that costed then to the agreement?

Mr. Hendricks: — So that agreement, when I said that there was 11 per cent for general fee increases, 2 per cent for market, and then 9 per cent for programs, that is included in the programs piece.

Ms. Junor: — So all of these changes to those different locations or a physician's work would fall under the 9 per cent, any of their increases?

Mr. Hendricks: — So a family physician under this agreement will, particularly a rural family physician, because very early on in the negotiations we said our key priority was addressing rural family physician issues, and they will receive a favourable increase in this agreement compared with other specialties.

Ms. Junor: — And so there's also a comment in here that complete details of what constitutes a full-service family physician and the associated payments are currently being finalized. What does that mean?

Mr. Hendricks: — What we did was we defined, we came up with a set of parameters, so probably there are about seven of them — won't get them right off the top of my head — but it was prenatal care, postnatal care. And we're talking about is a group of physicians, physicians doing obstetrics, still maintaining long-term care, that association with long-term care, doing well-baby care in office, full assessments, and that sort of thing.

There are about seven different services which we specifically identified. We went through our data and looked at what physicians currently provide or physician groups provide — that range of service — and identified the number that would qualify under the program. So in terms of negotiation, I don't think that there'll be much. I think that we've pretty . . . You know, we worked this out as a committee in advance of signing the agreement. Now we would just be tweaking it in terms of exactly, you know, does physician X qualify, does physician Y. There might be some minor program changes, but it does have to live within the $7.5 million that's been provided for that program if the current number of physicians that qualify remain the same.

Ms. Junor: — And when you talk about additional funding and continuing medical education that's going to be in the next budget or in the next year, 2012-13, that is also included in the total cost of the contract and the total percentage of increase. That would be one of the 9 per cent program increases?

Mr. Hendricks: — Yes. There's $1 million for continuing medical education in '12-13.

Ms. Junor: — And the emergency room coverage program also, is that . . . Because there's retroactive payments and then there's different increases. So this is also, is this also considered a program in the 9 per cent? Would that also be considered in there?

Mr. Hendricks: — So those amounts are included in the program funding, so it currently has a base of 24.6 million. It will increase by 5.8 million in '10-11, 5.9 million in '11-12, and 4.7 million for a total of 16.3 million over the course of the agreement.

Ms. Junor: — And the other one that I'm looking at is the after-hours premiums are going to be increasing by 50 per cent in October of 2010, so obviously that's retroactive, and then again in April of 2012 an additional 50 per cent. There are some physicians who are going to receive a lot of money, right?

Mr. Hendricks: — Yes.

Ms. Junor: — And it will be uneven as it has been before in other years. It's not evenly applied to . . . It's what you do and where you do it basically because you can't say all doctors are getting . . . They're all getting a base increase of 11 per cent, right? And then all the other increases that come with this, like after-hours premiums, surcharges, and all those other things fall into the 9 per cent.

Mr. Hendricks: — Premiums and surcharges fall into the 11 per cent and so premiums and surcharges will increase by $3.73 million in '10-11. So as you know, it's retroactive to October 1st, 2010. Half a year, it will increase by a further 4.23 million in '11-12, 7.47 million in '12-13. But in terms of retroactivity, it will be physicians that actually did provide those after-hours and out-of-hours call premiums, so we're rewarding after-hours work and trying to incent that, which I think, you know, in terms of the situation in rural Saskatchewan where we've had

physicians working after hours and on weekends and stuff, it rewards that work. So yes, some physicians will receive significant retro payments.

Ms. Junor: — So the total cost of the contract, the increase in the contract in percentages is one thing, but it would depend then, if you've added an increase to the fee structure, it would depend then on how many activities a doctor does for the total cost of increase. So you can't actually put a total cost on the contract until you find out your year-over-year or year-by-year how many doctors are practising in what setting and doing how many procedures, right?

Mr. Hendricks: — Yes, we can. What we do is the retroactive piece, right. We pay basically 3 per cent in the first year and then the 3 plus 2 market in the second year. Based on just their gross earnings, all physicians, they get that equally because that's retroactive. Going forward, the SMA, when they divide up the funds amongst themselves to the various specialty areas, they have to live within the basket of funds. So if there's actually an increase in one area, in for example '11-12, they'll have to diminish in another area to offset that. So the total cost of the agreement cannot exceed what the ministry has agreed to or they have to actually lower the percentage in the next year.

Ms. Junor: — So then somebody who . . . Say an orthopedic surgeon is doing too many hip replacements and has overshot the number. Then does that stop the hip replacements from being done or from him doing any more because he has to stay within the budget?

Mr. Hendricks: — No. So I'll just use hypothetical numbers here. Say that the fee code for hip replacements was to increase by 3 per cent and 3 per cent, right, over the last two years of the agreement and the total number of hip replacements overshot the budget basically. There are a couple of decisions he has to make: either decide to reallocate internally to orthopedics and give them a more favourable settlement in the last year because this is decided on a year-by-year basis, or instead of 3 per cent in the last year they might get 2.5 to deal with that increase in services. So there are a couple of ways that the estimate would balance that.

Ms. Junor: — The services themselves will not be rationed or cut back. It would be an allocation from somewhere else that might have to be . . .

Mr. Hendricks: — From within that pool of funds.

Ms. Junor: — But something else would have to give up something?

Mr. Hendricks: — The rate of increase in pay for specific services might change in different specialties. So they might reallocate from another pay code in orthopedics to maintain the payment schedule cost of the hip replacement. There's a whole bunch of shifting around. They deal with hundreds and hundreds of codes to balance this off, and it literally finishes to within 100 or $200,000 of the total.

Ms. Junor: — And I think I'm going to change . . . You said we were going to break, Mr. Chair, at about quarter to nine, you thought? I'm going to do some more general questions to take us to that time.

I just had . . . I was at SUN's [Saskatchewan Union of Nurses] annual meeting, the Saskatchewan Union of Nurses annual meeting, and I got some of their literature and their comments on some of the issues that affect nurses. And I know that the minister's very proud of the fact that he has reached his target of hiring nurses. But it was interesting to hear how the nurses think of this. And one of their comments is the government claims that their target of hiring 800 nurses has been met and makes no reference to further retention and recruitment initiatives or strategies. While the targets through the SUN-government partnership are 91 per cent completed, we still know there are vacancies. The lack of attention paid to retention and recruitment strategies beyond the hiring of 800 nurses is disconcerting to SUN. Without strategies in place, how does the government plan to address the vacancies? Which is a good question.

Hon. Mr. McMorris: — I think what we'll do is Max has one clarification on a point that he'd made, and then I will answer the member's question.

Mr. Hendricks: — Just on your question about the increased number of hip replacements affecting the allocation or the amount that they get, we did away with utilization sharing in this province several agreements ago. So if there is a natural increase in the number of hip utilizations based on population growth or something, that's not put back on to the SMA. The ministry actually does fund increased volumes due to increased utilization.

Hon. Mr. McMorris: — Just further to the member's question regarding the Saskatchewan Union of Nurses annual convention — which I had the opportunity to speak at, and overall I think went very, very well; and of course we had ministry staff there for the whole, I guess it was two and a half days — attitude, I would say, overall was very, very positive. A few irritants here and there, but overall very, very positive compared to the very first Saskatchewan Union of Nurses annual convention that I was able to address back in Prince Albert after, you know, shortly after our first year or within our first year of government. A marked change in the attitude, I would say, of the nursing community within the province. I think that stems from a lot of issues, and I could certainly go on at length with that.

But regarding the recruitment and retention issue and the Saskatchewan Union of Nurses and government partnership that we have put together, of course we've met the 800 nurses target well in advance, a year in advance of when we said we would. It was interesting to know that the member opposite said that we've kind of, I think she said we've met 91 per cent of the targets or what we had initiated, you know, and we have another year left to meet the rest of the targets — not a bad percentage after three and a half years of setting forward what we want to do and getting to 91 per cent. The member opposite looked like she was reading from a document from SUN. I'd be very interested if you would table that so we can go through those as we move through the night. But overall very, very positive.

[20:45]

What I will say is that regarding nurse recruitment and retention, it was a priority in 2007-2008, and it's still a priority for our government in 2011. It's not just with our government, but regional health authorities have committees set up on the local level for recruitment and retention with Saskatchewan Union of Nurses committees within the local level. Because we have 12 health regions and a cancer agency, but 12 health regions that have different needs and different cultures, I think it's very important that we maintain those relationships on the local level, and that has continued to be that way. We put money in through the nurse partnership agreement — not all of that has been spent — to cover off the costs of these committees working on the local level to ensure that we retain nurses that we've recruited and we recruit more. We've done a very good job in really all over Saskatchewan but in rural Saskatchewan, and part of that is through these committees on the local level between local health regions, regional health authorities, and the local Saskatchewan Union of Nurses committee.

I would say that one other thing that will be ongoing as far as the retention and recruitment of our registered nurses — a little bit like what we've just gone through in the conversation with the SMA — is a very competitive contract that still has another year and a bit to go before it expires that will put us among the leaders in Western Canada, as with the SMA. We are no longer looked at as probably the province to leave as far as nursing graduate students. We're the looked at . . . at the place to be at.

I've had the opportunity over the last couple of years to attend a couple of the graduating ceremonies at SIAST [Saskatchewan Institute of Applied Science and Technology]. One, just two weeks ago, where we were in the room on whichever floor it was, the 10th floor of SIAST, where the nursing graduates would, after a few speeches would then stand and talk about their experience through the years that they spent taking their education, where they spent their training in the different health regions.

And each time I've gone, I've been amazed at how many are looking at Saskatchewan first. In fact the last time I was there . . . two times ago, everyone was staying in Saskatchewan except for two. One — and this is a blessing and a curse — met a RCMP [Royal Canadian Mounted Police] recruit who was stationed outside the province, so she was following that recruit outside the province, but wanted to make sure that she could hopefully get back to Saskatchewan. And the other nurse was looking at some international opportunity. So only two out of that group were moving out of the province. The last group that I was at, when we went around the room and each individual nurse talked about where her training was at, her experience, and where she would be working, 100 per cent of those graduates were staying in Saskatchewan.

So you know, there is always more work to do. And we will never take for granted the successes that we've had because there is more work to do. We're still on a strong track. We are still retaining more nurses than we ever have in the province in previous years. We have a strong contract that are keeping nurses in the workforce longer than some nurses expected to stay in the workforce. We have for the first time, as the SRNA [Saskatchewan Registered Nurses' Association] said, you know, 10,000 nurses registered through the SRNA — huge advancements on that front.

So I would say overall, notwithstanding some areas where certain nurses will be concerned with the delivery of programs or other issues within the facility, the nursing community that I saw three years ago through the first annual general meeting that I spoke to, to the last annual general meeting which you attended in Saskatoon, was a marked difference.

And that comes from a number of things. First of all, listening to their concerns and reacting which I believe our government has done, putting their concerns first. Releasing Time to Care on many different wards has been very, very positive and, you know, talking to nurses that I have had the blessing to talk to when I visit some of those wards have said that just this program in and of itself has changed their attitude, has allowed them to stay working for another couple of years because the whole attitude of the workplace, the whole attitude of management listening to their concerns and implementing those concerns because the best ideas to problems definitely comes from the front line. That is happening through Releasing Time to Care.

So there are many, many aspects, and it's not just one program but many programs that would see a change in attitude and a change in really the nursing recruitment and retention results of this government over the last three and a half years. I don't think you can point to any one thing, but there is a broad range of programs that have seen a marked difference from when our government came to power.

The Chair: — Thank you, Mr. Minister. With that we'll take a brief recess and return in approximately five or ten minutes and reconvene.

[The committee recessed for a period of time.]

The Chair: — Good evening ladies and gentlemen. We're reconvening a committee meeting with Human Services Committee with Health estimates and supplementary estimates, vote 32, of the central management services (HE01) and on page 87 of the Estimates booklet, on 5 for the Supplementary Estimates book. Ms. Junor, you like to continue questioning the minister.

Ms. Junor: — Thank you. We left off discussing some of the comments that SUN has put out in a one-pager that I have had the Chair copy and has passed out, I believe. The heading that I was reading and the comment I first started off with, the heading is "How does the 2011-12 provincial budget affect SUN members?" And one of the other things that they brought up . . . And as the minister pointed out, I was at the meeting, and I was there when he gave his speech.

The few irritants that the minister was speaking about, one of them was — which I think is an unfortunate categorization of the comments that were at the mike — one of the main comments was about the nursery situation in RUH [Royal University Hospital] which mirrors the concerns here at RGH [Regina General Hospital] where the baby died here not so long ago. And the nurse who spoke was quite eloquent in her comments and in her suggestions, and she certainly mentioned that the unit was ready to open the nursery to a better or more flexible use. This I believe was a Thursday and, as she said, they were ready to do this on a Monday. And I'd like some

comments from the minister about what's happened in Saskatoon about those comments.

Hon. Mr. McMorris: — Yes it was. I remember, you know, vividly the nurse standing up and certainly a very positive response to her question as to the issue around a nursery and care of newborns in that area, and a very positive response for that nurse. And I remember my response saying that, you know, the health regions are always looking to improve services. And through the work that we've done through Releasing Time to Care and making sure that management realizes that some of the best solutions come from nurses, I think that there'll be a dialogue and continue to be a dialogue as there always is between nurses and management and all health care providers to improve services.

It is an interesting issue because the standard of care, the care regarding infants across Canada, it has been standardized. And what we have been doing is following along with that standardization of care both in Regina Qu'Appelle as well as in Saskatoon, and as has every other major jurisdiction. Not to say that there can't be some room for improvement, there certainly can be.

What I will say is that I've had the opportunity . . . as again on Friday when we were at the announcement of Mosaic putting in $4 million to the children's hospital through the Children's Hospital Foundation, it was very interesting. After that announcement I had a number of nurses that work on that very unit that came up to me and talked to me after and said that, you know, certainly there are concerns there, but let's not just throw out everything that we've improved on and moved on. I realize that, you know, at the Saskatchewan Union of Nurses that was one concern of a particular nurse and maybe speaking on behalf of some other nurses. I also know through talking to nurses that work on that unit that they're quite happy overall with the delivery of care in that area, not to say that there isn't some room for improvement.

So I'd hate to again just react on one person's question at a Saskatchewan Union of Nurses annual meeting. That wouldn't be my responsibility. Again it's the responsibility of health regions to deliver health care in their area. But when you look at what is being done across Canada, this is the model of care that all health regions and provinces are moving to; we have as well. And although there are concerns by a specific nurse or a group of specific nurses, there is also a counter to that, when again that I have met with and spoke to some other nurses that felt that the care that they were delivering was very positive and wanted to make sure that we didn't back away from the standard of care that is delivered across Canada.

Ms. Junor: — I don't think, listening to the nurse at the mike, that that was at all what she was proposing. I think that given the . . . And I'm sure the minister remembers that I'm an obstetrical nurse so I've seen the rooming-in standard come through into the standard of care over the years and now has come to a point where it is definitely the norm with no reliance, barely any reliance, as far as I can tell from two units, no access to the normal nursery.

So what nurses are saying and have been saying for a while, it's particularly in RGH — I was interested to hear it from RUH as well — that this is a time to actually review some of the things we're doing and see if there could be some improvements. Given the fact that a baby died, it would be, I think, prudent to do that. And I don't think anybody has suggested that we throw out the whole program at all. I don't think anybody's ever said that.

And I think that what the nurse at the mike was saying that there is, there is room, there is staff. It would take nothing except a change in perhaps how policy is applied, so that there is some flexibility. And I believe there is conversations happening already in Regina around the same issue. So I'm hoping that the Saskatoon one will have some attention paid to it as well. I'm not sure if the concerns that were provided at the mike come to the CEO of the health region — I'm not sure if they do that or not — but I'm sure that the nurses will be able to do that in their own way.

Another couple of the bullets on this page, one in particular, when the minister mentioned irritants, another person at the mike stood up and asked about the minister's commitment to medicare, a publicly funded, publicly administered, etc.. And it was interesting. When you finished your speech, not a single hand clapped. And so it doesn't surprise me that the bullet on here says:

> The provincial budget has an underlying tone of privatization as it refers to group purchasing, third party services such as using private surgical and diagnostic clinics to reduce wait-lists, and smaller and more efficient public services. Such references jeopardize the publicly accessible and delivered health care that Saskatchewan has pioneered.

So I think that there was, I think from what I heard — I missed the joke — but from what I heard, there wasn't much buy-in from the people in the audience. They didn't believe it, given . . . You can say what you did at the mike, but given what you're doing, it's actually reaching people and it's convincing them of something totally opposite.

Hon. Mr. McMorris: — Well I guess our, our reflections on what happened at the Saskatchewan Union of Nurses annual meeting may vary certainly quite a bit. What I will say is that when those concerns are raised, Lynn Digney Davis, our chief nursing officer for the province, was attending the whole conference and registers those concerns and they're carried to the health region. The health region would be aware of concerns raised by the Saskatchewan Union of Nurses at that, you know, the questions that were raised. There was certainly the issue around maternity, and there was a couple of issues around mental health and North Battleford for sure. I'm sure you'll be asking questions on that in a little while.

But what I would say is that I remember it a little differently, that when I left the podium, I think you said there was absolutely no clapping. Oh, that's not what you said?

Ms. Junor: — When you answered the question on privatization, gave the party's position, not a single soul clapped.

Hon. Mr. McMorris: — But I would say though when I left

the stage, there was a comfortable round of applause, a polite round of applause when I left the stage, and certainly a lot of compliments after. But I think what I was most taken with, standing at the front delivering the remarks that I delivered, were the amount of people nodding their head in agreement when I was talking about finally we've taken the nurse shortage seriously. We have finally increased the number of training seats in this province by our commitment of 300, so that we train more of our own instead of expecting solely on recruiting from outside, not solely but highly on recruiting outside the province and even outside the country.

Very many people nodding when I was going through many different remarks, including the issue around people that have been waiting up to three years for a hip and knee replacement, which is completely unacceptable, and how we needed to reduce those wait times. And how we are reducing those wait times is certainly not on the shoulders of a private clinic or a third party deliverer at all. I mean we are looking at all the possible options through our surgical care initiative that is safer, smarter, sooner, and the changes that we have to make.

And I saw a lot of very positive responses, a lot of head nodding to say that yes, to have the longest wait-lists in Canada is unacceptable. Something needed to be done. It starts with the proper complement of health care professionals. And that's what we've been working on certainly over the first couple of years, three years, of our mandate, as we move in through the Patient First Review and the surgical care initiative ensuring that we have a stronger deliverer of those services.

I can tell you that the people that I've talked to that have, the odd person that I've talked to that have been through the third party deliverer or a clinic that's helping us reduce those wait times, they are extremely happy to have their procedure done. And people that are waiting are seeing their wait time shortened. I mean, people waiting 18 months or longer have been reduced by over 60 per cent; people waiting 12 months or longer have been reduced by over 27 per cent over the last recent, last couple of years. Some huge, huge inroads on some of the longest waiting lists in Canada. What I sensed, and you know I could stand to be corrected, is that when a person comes in to the health care system now, not waiting three years but waiting less than 18 months — cut by 60 per cent — their attitude towards the health care professionals certainly has changed because when they were waiting three years it was very, very difficult.

So I know not all people within that room, the Saskatchewan Union of Nurses, would be happy with a third party deliverer to try and knock down the wait-lists, but what I do know is after going through the Patient First Review and looking at the system through the patient's eyes as opposed to the provider's eyes, we got a different glimpse of the system and those are the recommendations that we've been moving on.

Ms. Junor: — I have a couple of more questions about the lean project and shared services, and I'm wondering, has there been . . . Can you define what shared services is and where the project is in the different regions or in the regions?

[21:15]

Hon. Mr. McMorris: — Well again, just going back to perhaps my previous answer which identified and talked to the Patient First Review that was conducted in the province, the only one of its kind in Canada. And certainly after the quality improvement summit that took place last week, a week and a half ago, and some of the really positive feedback that stemmed from that, that looked at the system, again differently through the patient's eyes.

Tony Dagnone that did a great job on the Patient First Review made a number of recommendations. One of those was again of course the surgical care initiative that we've been working on. Another area was around shared services. We have 12 health regions that have their own responsibilities, but should they operate in isolation? And the Patient First Review, through Tony Dagnone's again leadership, looked at that a little differently and said we need to re-evaluate how we coordinate the services from health region to health region.

And so the shared services organization has been set up, again stemming from the Patient First Review recommendations. It's been doing its work over the last couple, over the last year or so, and I think what I'll do is I'll let my deputy minister, Dan Florizone, who knows it very, very well and especially knows the lean concepts which shared services is kind of working towards, knows that file extremely well, so I'll allow Dan Florizone, my deputy minister, to comment on those areas.

Mr. Florizone: — Thank you, Minister, and thank you, Chair. In terms of shared services, when Mr. Commissioner Dagnone made his recommendation, the CEOs of the regional health authorities, the CEO of the Cancer Agency, and SAHO formed together some working groups to be able to look at shared services opportunities. The Ministry of Health had worked with these groups and in fact had not only committed to moving shared services forward, but also to setting some targets around savings.

In the first year, a lot of the savings that were achieved were achieved through group purchasing and in fact you've heard many words on the new West and the New West Partnership. Part of the work that has been done over the course of the last year has been through a national purchasing organization that is also used by Alberta and BC [British Columbia], HealthPRO. And what SAHO has done is looked at their contracts for the group purchase of supplies, and in phase 1 has been able to achieve better pricing through national purchasing organization and through those partnerships with Alberta and BC.

Now I should say that the New West Partnership has been about more than just simply, from a health shared services perspective, than simply shared services through regional health authorities. We've been working across Western Canada at pricing on pharmaceuticals, at cancer drugs, but most certainly we're looking right now at supplies. And there is an interest across all Western regional health authorities to look at the possibility of group purchasing on equipment.

The target set was $5 million for this past fiscal year, and for this next fiscal year we've set an additional target of $5 million in savings province wide through shared services initiatives.

Now I mentioned group purchasing. There are also some

changes that are being made in back office functions. Now this is being done in stepwise fashion. They've gone through and taken a look at certain contracts that are held. For instance looked at they'd be getting better pricing on mobile devices and rates through SaskTel. They've looked at SGI [Saskatchewan Government Insurance] and insurance rates and other providers of insurance. So it's really around the spirit of thinking and acting as one.

There are a number of other areas that they will continue to look at. And the work that they're going through right now is an analysis of whether more savings could be achieved by consolidating administrative functions, looking at anything from telephones and telecommunications right through to legal and those types of services that you wouldn't normally staff in a region or would normally be referred to as administration. How could we, and should we, do it in a different way by thinking and acting as one?

Ms. Junor: — So the $5 million that's targeted to be saved, will that be put into other programs or will it be just taken off the budget of the health district?

Mr. Florizone: — We've already removed it from the budget of the health regions. And in fact the targets that have been set almost come up to about a 1 per cent reduction from what we'd refer to as a status quo.

Now I want to be clear here: status quo funding is not the same as the previous year. It's the level of funding that would be necessary to fund cost escalation, collective agreements, and would reflect population growth. It would be the kind of funding that would be necessary to continue with the initiatives that have already been approved and adopted in the province.

And what we've done is we've set efficiency targets on the basis of that level of funding. So there is a $5 million reduction that has already been included in the funding allocation to regional health authorities.

Ms. Junor: — So when you talk about the status quo funding, what's the percentage you put on a status quo funding allocation?

Mr. Florizone: — Right now it's approximately point nine of a per cent above what the current allocation is to each of the individual regional health authorities. And I'd have to break that down by RHA [regional health authority].

Now I must say that where we look at world-class health systems, what they've done is they've set targets that would bend the cost curve by 2 per cent. So as we're dealing with the Institute on Health Care Improvement and other world-class organizations, their recommendation to us is to see if we could gather, year after year, 2 per cent efficiency savings in the health system.

So we have set a target that is somewhat less, certainly achievable, and it relates to areas like attendance management, like shared services, areas that are certainly above what is being spent in other jurisdictions, areas that we know could be areas for efficiency gains in the current system.

Ms. Junor: — So the efficiencies, what is the incentive for the health districts to find efficiencies when the savings are just taken off their budgets?

Mr. Florizone: — Well once again we've set a $5 million savings efficiency target, so good on them if they find 10. What we've got is we've got that kind of room to move in terms of, you know, when we're talking $4.5 billion in spending, $5 million where they can achieve these types of system-wide savings through procurement, through use of technology and telephones, through insurance, through group purchasing in certain areas.

The real gold I must say is not, and the real efficiencies are not so much in just simply group purchasing but rather in standardization. In other words, working around consistent protocols that would involve clinicians where the number and the range of supplies and group purchasing that's conducted where we would find consistency not only in this province but a far greater level of consistency across Western Canada. In other words, the range of hips and knees wouldn't be wide and broad and just simply based on the salesman who shows up at the hospital or convinces the particular surgeon, in the case of prosthetics, but rather would be narrowed to best practice, best evidence, and clinical decisions around what we should have on hand and where.

Ms. Junor: — I don't think I heard yet the incentive for the regions to save. I mean, it is all good to find efficiencies. But you're saying, or you said, I thought you said . . . I just heard that Duceppe was defeated, so it's kind of thrown me off my questions. But I think you said, I think you said that the $5 million savings will come off their budget. So to me, I wonder what's the incentive for health regions to save money if nothing can come back into their program enhancements?

Mr. Florizone: — We didn't adjust their budget by 10 million. So what we're saying is 2 per cent is achievable. And what we've done is we've stripped point nine of a per cent out.

Ms. Junor: — So you've taken the money out already.

Mr. Florizone: — Half of what's possible on an ongoing basis. In other words, it is quite clear, based on what we know and the evidence from other jurisdictions, that they could look at efficiencies beyond, above and beyond what we're talking about.

I think it's a fair challenge that you put forward: how do you create and balance the type of incentives necessary to achieve the types of efficiencies? But at the bottom . . . the bottom line with these efficiency targets is the benefit should accrue primarily to the taxpayer, and the best way to achieve that in a health sector is to be able to bend the cost curve, bend the funding curve right out of the gates. There's no lack of interest in spending in other areas. We need to be very clear what the priorities are and very guarded against just simply a ballooning and continued ballooning of health care costs.

Ms. Junor: — So from what I can gather, that the only incentive to save is that you will meet your budget target set by the department.

Mr. Florizone: — One of the areas that I think we've been highly successful with as a ministry is working very closely with the regional health authorities and the Cancer Agency. In fact many of the targets that have been set, we've been working with the regions and the Cancer Agency on these targets.

I'm very pleased to say that all regions and the Cancer Agency are on target to balance their budgets this past year. We'll certainly wait for the audited financial statements before we declare that that is a victory, but given the fact that there were significant challenges and there continue to be very strong focuses on efficiencies, we have been able to achieve certain ends.

Now there is, there's certainly a bit of, more than a bit of pride in being able to set a target and to achieve it. The incentive piece, the regions still can go beyond the targets we've set. Many of them have. Many of them have achieved savings beyond that, and they have full freedom and flexibility to redirect and reinvest those savings.

Hon. Mr. McMorris: — And I just want to kind of follow up to the line of questioning. I find it interesting when you would look at it like, why would health regions want to find savings? And I would put it the other way: why wouldn't they? I mean, why wouldn't . . . You don't have to pay somebody an incentive to find . . . An issue, for example, insurance where you could save, you know, combined, a couple million dollars. That shouldn't be incentivized. That should be what health regions are doing.

Health regions should look at their budget and say, where can we find savings? How can we be more efficient? As opposed to looking at their budget and saying, well we can always spend more, and there's no use looking for efficiencies or savings. That isn't . . . I don't believe that's the mindset of the health boards across the province, and I don't believe it's the mindset of the CEOs and management around the province.

I think there has been enough in the media over the last number of years when health budgets are hitting 42 and 43 per cent of the overall provincial budget that sustainability is a major issue. It has been a major issue for a number of years. And what we have done is, through the Ministry of Health and through shared services, is say, where are those efficiencies? It's about time we start looking for those.

And what I have heard from health regions is, well we're not going . . . What I haven't heard from health regions is, unless you pay us more, we're not going to look for efficiencies. In other words, they don't have to be incentivized. They are looking for efficiencies because they realize that at some point, whether it's 42 per cent, whether it's 44 per cent, whether it's 50 per cent, you can no longer go on spending as if it's sustainable into the future until you look at the processes that you have in place. And health regions have been excellent. I will say all 12 health regions and the Cancer Agency have been very good over the last year to look for efficiencies.

[21:30]

You have said many, many times that we underfunded health regions. I don't believe we did. All health regions have come in at a balance. So far health regions and the Cancer Agency are coming in at a balanced basis because they realize how important it is to keep those costs under control and look for efficiencies wherever it is in the health care system, and they don't have to be paid to do it. They do it because they need to do it and they want to do it.

Ms. Junor: — Yes, Pollyanna. I have one more question and then I want to turn it over to my colleague from North Battleford to, as you mentioned, get into the mental health questions and the North Battleford hospital questions.

My last question in this series is about SAHO itself. I don't see in the budget . . . Where is it displayed what SAHO gets from the department?

Hon. Mr. McMorris: — So I'll allow Max to go through the SAHO piece.

Mr. Hendricks: — So the funding for SAHO is included under provincial targeted programs and services, which is under (HE04), provincial programs. So of that $51 million in '11-12, the grant from the ministry to SAHO is $2.672 million. Now the majority of SAHO's funding actually comes through health regions. The ministry's agreement with SAHO relates primarily to labour relations.

Ms. Junor: — Primarily. What else do they do for the ministry?

Mr. Hendricks: — They do a couple of human resource-type reports, just minor little contracts, that sort of thing. But the large bulk of that is labour relations.

Ms. Junor: — Mr. Chair, I'll let my colleague from North Battleford ask some questions.

The Chair: — Mr. Taylor.

Mr. Taylor: — Thanks very much. Just as we're sitting here, there's a federal election going on around us. And I notice the BlackBerrys and iPods have been pretty actively watched throughout the evening. I think the numbers are indicating a change in circumstances around the country, and we may be seeing if the numbers hold a majority Conservative government.

There are a number of issues that have been on the federal-provincial table for a while, not the least of which is national pharmacare program, increased support for Health Infoway, the electronic health record. I'm just wondering, in your opinion, Minister, what does a majority Conservative government mean to a national pharmacare program or electronic health record support that the provincial, territorial, and federal ministers have been discussing for some time?

Hon. Mr. McMorris: — Yes. Thank you for the question. I think that's been preoccupying a lot of people, and perhaps our viewership is not nearly as high as it would normally be, which is probably a good thing.

What I would say is that the question overall is how does what looks like a Conservative majority government impact some of the issues that have been on the table regarding health care and

have been on the table for quite a long time? And you would know that very well as a former Health minister, is that . . . The first thing I will say about the election results, if they stand the way they look right now, is some stability. We won't have to worry about going to the polls over the next four years or in the next year or the next two years. So we can plan perhaps a little bit longer than the next budget or the next non-confidence vote, which was always kind of weighing in the back of any FPT [federal-provincial-territorial] negotiations as we went forward. It was hard to get the federal government to commit to any long term when they weren't sure they were long term. So I think if nothing else, what it will do is certainly add some confidence and some consistency as we move forward.

Having said that, there's a provincial election coming along so I don't know how much continuity there is through the next negotiated talks because of course there's a provincial election and the results remain to be seen there. But I think it is positive for provinces to have some consistency as we move forward.

Regarding the pharmacare program, that has been talked about for many, many years. It's not that it is dead, but I can tell you after being at three of the last FPT meetings — or has it been four? It's been three — FPT meetings, it comes up. But it has really kind of died away. There are been many other issues that have kind of overridden that one just because the federal government has more or less completely walked away from it. So we've decided that we need to start looking at a program to find efficiencies with drug purchasing, not only within our own jurisdiction, but working with provinces around us. And the deputy minister talked about some of that through joint purchasing with Western provinces.

I would say that a national pharmacare program, although it makes sense to us provincially, hasn't made sense to any of the federal governments prior to the Conservative government and during the Conservative government. So it can be raised at another FPT. But quite frankly what was talked about more, regarding the drugs purchasing and the drug plans of provinces, was the issue around generic drugs and that whole piece and how we work with our pharmacist community to make sure that, you know, their professional fees are honoured but we get a cut in some of the generic drugs. That has been a bigger conversation piece at the FPT meetings than a national pharmacare program. Not that it's off the agenda completely, but I can tell you that it's probably taken a number of steps back as other issues regarding the drug programs within the provinces have kind of moved forward and taken the spotlight and the discussion process.

It will be interesting as we move forward, watch very, very closely what the various parties were saying on health care, what the Conservatives were saying as far as trying to attract more physicians to rural Canada and what they would do in that vein.

I was also very interested to see what now the new Opposition Leader had to say on health care, and how he said within the first 100 days we'd have 1,000 more doctors working in Canada, and just very interested to know kind of where that comes from and how he would have, if he became the prime minister of Canada, how he would ever accomplish that. Now that he is the Leader of the Opposition, he'll have more opportunity to explain his views on how that could have been done.

I don't know how you would just snap your fingers and within the first 100 days increase the physician complement across Canada without a couple things. Number one, I would think changing the, you know, the qualifications through the College of Physicians and Surgeons in provinces. I mean we have standards that foreign grads have to meet. It's not that we have 1,000 physicians graduating from Saskatchewan or Canada that are looking for work. They all have work, so we're utilizing all those physicians. Perhaps we can attract others from other jurisdictions, but there is an evaluation process they need to go through. And to just simply say we could increase the number of physicians by 1,000 within the first 100 days, I'd be very interested to know how that will be played out. Of course it wasn't necessarily fleshed out very much through the general election, but as the Opposition Leader now, we'll be very interested to see how that plays out as we move forward.

As well as we're going to be very interested to know what the Conservatives have in mind when they say they're going to give more incentive towards attracting into rural Saskatchewan or rural Canada because we also know that, you know, the docs are paid through a contract. If they're going to top some of that up to incentivize — I've never used that word so often as I have tonight — but incentivize physicians to move to rural Canada, you know, we're going to certainly follow through on the promises that were made during the campaign, both through government and through opposition.

I forget the other piece that you mentioned though. You mentioned the drug plan and . . .

Mr. Taylor: — Electronic health records.

Hon. Mr. McMorris: — And the electronic health records. That's, you know, that's an area that certainly the federal government needs to continue to play a larger role.

They've put money into Infoway. Not all that money has been spent. You know, I think there has been some concern with the expenditure in light of what was going on in Ontario, and that really has slowed up the spending.

Having said that though, I know we here in Saskatchewan are continuing to, want to move forward with electronic health records and want to rely on the federal government as a partner in that. We continue to push that. I can tell you that every province across Canada at the FPT level will raise that issue and push the federal minister on that issue. I know that happened in Newfoundland this past year. And continue to say that we need to move this file forward not only through the responsibility of provincial governments but also through a national program such as Infoway.

So we'll continue to lobby specifically on the health medical records. I think there is much more ground to be gained in that one than there is in the national pharmacare program. Not having given up on it completely, but when you're looking at where can we move the agenda forward, definitely I think on the electronic health records or Infoway is an area that we can certainly push because there is buy-in across Canada and there

is buy-in by the federal government on that program. We just need to continue to lobby and work harder on that program.

Mr. Taylor: — All right. Thank you very much, Minister. And I'm sure you have pictures of files in dumpsters that would help to support the argument at the federal table to indicate that electronic health records have many advantages.

To my significant questions that both you and my colleague have alluded to, Saskatchewan Hospital, just a simple question: what's the status of Saskatchewan Hospital? What's in the planning stages?

Hon. Mr. McMorris: — It's been raised a number of times. It's been raised for 40 years probably. It's 100 years old, a little over 100 years old, and we know the life expectancy of any building in Saskatchewan. And once it gets up to, you know, 40 or 50 or 60 years, people look at replacement. So it's been talked about for very, very many years. Of course the older it gets, perhaps a little more conversation around it. I've said different times that I've had the opportunity to tour it a couple times and know first-hand the shape that it's in and would be the first to say that something needs to be done there absolutely. I can tell you that around the government table, the caucus table, and cabinet table, it's been raised many, many times, and we realize it's a priority.

We first are working on the 13 long-term care facilities that we've put into place because having toured a number of those, realize that there was an infrastructure deficit definitely across Saskatchewan. I think you could probably say that across most provinces that developed a lot through the '50s and '60s, '40s, '50s, and '60s, and certainly Saskatchewan has. So we've worked on trying to improve the living conditions for a number of our seniors in the province, 13 long-term care facilities are all moving ahead now. Changing the formula from 65/35 to 80/20 certainly will see all of those projects move forward. We're very positive about that. We're very happy about that.

Having said that those are moving forward, we have to look at the next initiatives. The Moose Jaw Hospital, we've put money in this year's budget to move that one ahead. And as we move forward, I would say that the provincial hospital in North Battleford is very, very high on the priority list, if not number one, and I would hope to move on that as quickly as we possibly can.

[21:45]

Having said that, I also want to clear up a couple of things that have been said through the media and I think misconstrued maybe on any statements that I have, whether it's I have made or other members, have taken those statements out of context. I will say that the North Battleford hospital, the provincial hospital, has been in North Battleford for 100 years. The community is very receptive to that facility. The community is pushing for that facility. There has never been an intention of our government to move that facility to any other jurisdiction, even though some would like to muse about that and be in the media and try and have it reported as an issue that way. I'll clear up the issue right now. Our government has never looked at a rebuild of that facility in any other jurisdiction, other than land that has already been looked at and allotted for that particular facility.

So let's make sure we're all clear on that as we leave here sooner or later tonight, that we're all clear on where the provincial hospital will be located once it's rebuilt. There has never been — never been — conversation by this provincial government to move it off of the site that it's in. We need to look at that site and redevelopment of that facility. It's very high on the priority list, and as we move forward, hopefully more announcements can be made.

But I will make one more statement regarding the North Battleford hospital, in that we will not be making an announcement on the provincial hospital in North Battleford until we can fund the provincial hospital in North Battleford.

It would be very easy for me as a Minister of Health, three years ago, under pressure to say, we are going to build a new provincial hospital in North Battleford. And the year after say, we're going to build a new provincial hospital in North Battleford. And the year after make that announcement — no money behind it — and continue to make that announcement, not only through the three and a half years that I have been the Minister of Health but make it again just before an election. Let that election pass and let it roll through four more years and another election saying, we're still going to build that hospital, and no money has been put towards it.

You won't hear that from our government. Humboldt has heard it. Preeceville has heard it. There have been a number of places, communities that have heard it. In fact as recently as Friday, I was in Saskatoon at the children's hospital and interesting to hear the former Chair of the children's hospital foundation talking about the promises that were made to their foundation year in and year out about a children's hospital, but never any money behind it. So as we make announcements towards whatever facility is going to be made next, there'll be cash and money to follow along.

There was a leaflet put out not very long ago about the children's hospital — that it was cancelled, that it was scrapped — by the opposition party. Nothing could have been further from the truth. The money is there and it's moving forward. In fact a number of comments to say that, how could have that been so misleading that the children's hospital was going to be scrapped? And it was sent to every mailbox in Saskatoon. Absolutely incorrect because the money is there, and that facility is moving ahead.

So when we make an announcement, and I hope it's very soon because it is an extremely important facility for the health care of our people in the province, when we make the announcement, we won't make it and then expect to start construction eight years later.

Mr. Taylor: — The minister answered a number of questions that I was going to raise, but he also brought forward a number of issues that I wasn't going to raise that I feel now an obligation to raise.

The comment about funding the long-term care facilities. The minister was in front of this committee just a couple of weeks ago, April 4th as a matter of fact, in which he indicated that the

13 long-term care facilities are actually unfunded. The funding for the long-term care facilities don't appear in the budget. He may have an idea that those facilities are going to be funded, but they depend on the communities coming forward with the funding. They depend on the agreements being put in place between the department, the ministry, and the communities, and the funding in that particular year for those projects to move ahead. He has announced 13 long-term care facilities unfunded, and then he tells me that he'll never do that — very inconsistent.

And I'm not going to argue about Sask Hospital. I think it is appropriate that you can announce your plans. You can begin the process of trying to develop those plans, but the project isn't formally announced until the funding is available and brought forward in the budget. The Provincial Auditor supports that. The Minister of Finance supports that, and that's the way it's been for years.

The bottom line is if we look at the four years between 2003 and 2007, the average income of the province was around $7 billion. The average income of the province from 2007 to today is roughly $10 billion a year. There was $28 billion available in the four years between 2003 and '07 for governments to make priority decisions. There's $40 billion available for governments on decisions between '07 and '11. That means there's a $12 billion difference in income available to your government, Minister, than there was to my government. And yet we can't find the funding for not just Sask Hospital but a number of health facilities. In fact during your term, can you name from the General Revenue Fund any new long-term care or acute care beds that you've actually funded?

The health capital for new projects has virtually been non-existent since this government was elected in '04. There's been a continuation of a number of projects that were started in '06 and '07 but virtually nothing new out there. Moose Jaw Hospital's important. Sask Hospital, North Battleford is important. And there are other projects out there that have been on the drawing board for some time, not the least of which would be Green Lake or Cumberland health centre, a number of things like that.

But my question really is, the minister announced there was some funding for planning in Moose Jaw. He announced that there was some planning for North Battleford. And in fact the new planning documents have now been completed. He asked for rescoping of Sask Hospital. That material is now complete. It's in the minister's hands. And when I asked earlier about what's the plans, the minister did not indicate the status of the minister's review of the rescoped plans that have been brought forward by Prairie North Regional Health Authority. Can the minister indicate what the status of that review of the new plan is? And can he indicate if there are any challenges that the new plan is presenting?

Hon. Mr. McMorris: — I guess I'll first comment on the fact that you're referring to the issue that our government hasn't put anything into capital over the last three and a half years.

Mr. Taylor: — Just lots of renovation money.

Hon. Mr. McMorris: — We've put in lots of renovation money, exactly. In the first budget year, we put $100 million into renovations because these facilities that we were left through the VFA report that was done by your government showed huge deficiencies. And there's more to be done, absolutely more to be done.

But I know making some of those announcements, being in Saskatoon at St. Paul's when the chillers were replaced and how happy those people were. The maintenance people just think that they could maybe get a holiday during the summer because they kept breaking down all the time in the summer, which would shut the facility down or at least the operating room.

So we put $100 million in the first year into repairs of facilities, which was a record amount that had ever gone into facility repairs. We have put $200 million into a children's hospital. We have put over $80 million into long-term care. We have put well over $150 million into the Academic Health Sciences facility so that we can maintain a College of Medicine and make sure we have the appropriate space to train the health care professionals. I know that's not necessarily the delivery of health care, but it contributes to the delivery of health care.

I can go on certainly about Humboldt which we broke the ground on and paid for through our government, through funding through our government. Preeceville was another one. Oliver Lodge is another one. So to say that we have put nothing into capital in the last three and half years is very inaccurate. I would say it's probably anywhere between 5 to $600 million, depending on what you want to add in and how you want to slice it, in the last three and a half years to capital repairs or to the construction of capital facilities. Thirteen long-term care facilities are, some have gone . . . One has gone to tender. Others will be going throughout the summer. Six hundred more beds that are up to standard.

So you know, I won't, I can't sit here and take the assertion that we haven't put anything into capital in three and a half years. That's just not accurate. And I don't know if you feel that $100 million into repairs is not helping the capital situation of our facilities because it most definitely is. So we've put a lot in the last three and a half years. Some will argue we could do more.

You were using the point of what the average earnings were of people when your government was in place, compared to what the average earnings are now. And certainly we are blessed to be in a province that's doing extremely well. That's why over 40, probably 44 per cent of the provincial debt has been paid down. That's why we've seen some of the most historic tax relief, personal tax relief — over 90,000 people taken off the income tax rolls. All of those are part of the benefits that we are receiving in the province.

[22:00]

Now I don't know if you would be so bold to say that we shouldn't have paid down debt and we shouldn't have done tax relief, if we should have put all that money into health care facilities. And I might argue with you around the cabinet table because I'm the Health minister. But what is best for the province and has the province benefited from the increase that we have seen over the last three and a half to four years in the fortunes of our province have been turned back in to the

province, be it debt reduction, be it tax reduction, or be it infrastructure spending through highways, through health care, through education, at record levels — record levels. That is what has been done over the last three and a half years.

Mr. Taylor: — Okay. And perhaps the minister could now try to answer my question.

Hon. Mr. McMorris: — Sorry, what was it?

Mr. Taylor: — It had to do with the new proposal, and what stage of review the new proposal is at the moment.

Hon. Mr. McMorris: — Right. I guess I'm sorry, I answered your preamble with my preamble. Now I'll get to the question. Is that the . . . We have put $450,000 to the Prairie North Health Region to look at further scoping and further development of what needs to be done through the provincial hospital in North Battleford. That work has been done. The ministry is in, you know, has received the report as to what is looked at and the size of beds . . . not the size of beds, the number of beds that are needed within the facility. And so it's a matter of moving that forward and making sure again that we have the cash to put behind it when we announce what we want to do there.

I could announce this is what we're going to do and then not fund it. And that's just not fair to the community. It's not fair to the community of North Battleford. It certainly isn't fair to the mental health community to stand up and say, here is the report; this is what it's going to be, and we're going to build you a new hospital but not until 2020. We can't do that. When we stand up and say, here is the report; here is what needs to be done there, but better yet here is the cash to go behind it so that we can construct that facility, that's when we'll make the announcement.

Mr. Taylor: — At the same time, the minister or ministerial officials asked Prairie North to, when they were doing the rescoping, to look beyond Sask Hospital, to take a look at mental health services generally across the province. Prairie North did that in their review, and they brought forward a proposal that contains not just the rebuilding of Saskatchewan Hospital in North Battleford — certainly shows it as the core piece to a Saskatchewan mental health strategy — but also indicates a community component, a community residential component. The proposal doesn't exactly, the summary documents that I've seen don't exactly show where that community component fits in terms of administrative and carry forward activity. Currently that sort of activity is managed by community-based organizations through Social Services and other ministries.

That's why I'm asking where in the review this proposal is because it's beyond just building Saskatchewan Hospital. Are the various ministers talking about the proposal as a package? Is this new rescoping that the minister asked for and a provincial review slowing down the process of finding funds to build the new Saskatchewan Hospital? Because for all intents and purposes, the core facility number of beds hasn't changed a great deal, the delivery of services hasn't changed a great deal except to package itself with the community component.

Hon. Mr. McMorris: — We'll let Max answer this question.

Mr. Hendricks: — So in the context of looking at the construction of a new facility in North Battleford, obviously one of the things that you would want to do is look more broadly at how we deliver acute mental health services within the province. And so one of the things that this review did was they said in some cases it might be more appropriate to treat or to provide care for individuals with mental illnesses closer to home. So they talk about residential beds that are closer to their families. They talk about step-down beds to help them to return to the community, so the notion being that not everybody belongs in a very acute facility like Saskatchewan Hospital, North Battleford.

And you know, no decisions have been made on that programming recommendation. And you know, it does have its merits. I wouldn't say that it's slowing down a decision on the core facility. Obviously there would be some impact in terms of the design of the facility and exactly how many beds there would be needed, but I wouldn't say it's slowing it down. I think that, you know, we have the report. It's being evaluated, and as the minister said, when the capital dollars are available, then that's when a decision will be made.

Mr. Taylor: — Okay. Thank you very much. I will read briefly from the document that was prepared for the ministry, the executive summary. There's two pieces that I wanted to read. So this is from Prairie North's document:

> Saskatchewan Hospital North Battleford's current capacity is 178 beds. The facility presently operates with 156 beds, 25 of which are for forensic patients. The wait-list to enter Saskatchewan Hospital North Battleford is ongoing, and insufficient community residential options exist to discharge out of Saskatchewan Hospital North Battleford.

And then towards the end of the report, the conclusion states:

> Individuals struggling with long-term psychiatric illness and are high complex needs are amongst the most vulnerable members of our society. Their needs often go unexpressed by virtue of the individual's limitations. Their voices are among the most difficult to hear. It falls to us all to listen, reflect, and act to address their needs across the entire continuum of mental health care and service by providing appropriate facilities and programs with appropriate resources and supports that other segments of society have come to expect. The provincial strategy proposed in this report, with replacement of Saskatchewan Hospital North Battleford at its core, puts the needs of these patients first.

The minister may recognize some of the department's mantra words there — patient first. Very important in the way Prairie North put this together.

The proposal talks about new Saskatchewan Hospital beds — 188. That's simply 10 beds above the current capacity and doesn't take into account the full development of forensic activity that was there previously. And then there's a community residential option of about 120. Is there any reason at all why the actual work, the development of the structural work and the development of a costing plan for the core facility

— Saskatchewan Hospital, North Battleford — can't be done while the overall strategy of community beds is being reviewed?

Mr. Hendricks: — I think because they're complementary. You know, you refer to a group of individuals that are often referred to as lost souls, people that fall between the cracks that probably don't belong in Saskatchewan Hospital, North Battleford. Sometimes they end up in the North Battleford hospital actually or in Saskatchewan Hospital, North Battleford, but it's not the right care setting for those individuals to actually progress and maybe achieve a better outcome. And the ministry, I think, is very interested in looking how we care for those people that actually do fall between the cracks.

And one of the things that we need to do, because it is complementary, when we look at a less institutionalized mental health care approach, it's obviously necessary to have these residential, intensive residential support beds and these step down mental health care beds in communities because they're complementary. They're the satellites, if you will, to Saskatchewan Hospital in North Battleford that provide for the continuum of care. So I wouldn't say that we want to look at just the core hospital in isolation; it's more of a mental health approach provincially.

Hon. Mr. McMorris: — I think Dan also has a few comments to make.

Mr. Florizone: — So if I do understand the question, and maybe if I could seek clarification, but as I understand what you're saying, while we understand the priority that Sask Hospital, North Battleford is and we're waiting a funding decision and the appropriate timing of that funding decision, is there work that we could be doing now in preparation for that decision so that we're prepared to move perhaps more quickly with construction? Is that at the nub of the question?

Mr. Taylor: — I'll take an answer to that question. Yes.

Mr. Florizone: — Okay. One of the things that I worry about and the ministry worries about is that we would end up blueprinting and preparing a plan that doesn't, you know, it may not be the final plan. There may be more thinking that goes into it. I'm really pleased to say that we've taken the planning about as far as we would like to before we get a funding decision. Usually at this point we're looking at some sense of whether this is affordable and in what time period and then moving on to that next phase obviously of detailing and blueprinting the building.

What you've heard today is certainly an interest . . . You're well aware of the need to be able to replace Sask Hospital, North Battleford. My fear is spending money, investing in blueprinting, and then having potentially that money and that investment go to waste because by the time we get to the approval, something in the environment may have changed. As such I just wanted to clarify that.

Mr. Taylor: — Okay. And I'm glad you did, and I'm glad you brought me forward because now I have to seek further clarification from you. Because my original question was, is this provincial plan slowing down the process? And the answer that I'm hearing from the deputy minister is yes.

Mr. Florizone: — The answer is no. Sorry if it sounded like a yes. It's actually a no. At this point the planning that's been done to date is not slowing anything down. We're at a point right now where the decision is, should we fund? There may be some refinements over time but we're primarily at a point of a decision of, go and when can we move forward to the next phase.

Mr. Taylor: — Okay. I appreciate that. The minister has indicated where he feels this is on the priority list. He says it could be number one. I'm trying not to paraphrase too much here, but it could be number one on the priority list.

So if the deputy minister says we're at the point now where we're at the decision of do we fund, so where is that decision being made? In the Department of Health? At Treasury Board? Department of Finance? If the decision point now is do we fund, because that's what I'm pretty sure I heard the deputy minister say, then whose desk is this sitting on? And what does the community or the minister have to do, with help from the opposition, the mental health community, patients, families, what do they have to do next to move this along so that the decision can be made to fund?

And I say this because the minister's got the letters, I've got the copies of the letters from people across the province who have indicated that the hospital is at a point where we can no longer tolerate the physical circumstances. Up to this point we've managed really well. Even the facility manager was on TV just a couple of weeks ago. She's never commented publicly before, but they're at the point where they can no longer make do with what they've got to work with. And so until a decision is made to fund, we're still four years out from moving into a new facility, regardless of what we're doing in it.

[22:15]

Max, or Mr. Hendricks, talked about the lost souls. Sask Hospital does a lot of work that's related to that, but they have to be there. They may not be institutionalized, but that whole assessment process, it's the only assessment facility in the whole province. You've got 12 regional health authorities and the court system that's sending people to North Battleford for assessments, and where they end up after that is anybody's guess.

But the facility can no longer handle and manage these people humanely. We've got walls that are falling down on staff's heads. We've got documentation now of people falling through stairways. So a decision made today means we've got to put up with this for another four years. A decision made next year means we've got to put up with this for another five years. A decision two years from now means we've got to put up with this for another six years. So whose desk is this on? Who do we have to direct our attentions to so that that decision to fund can be addressed?

Hon. Mr. McMorris: — I will answer that question, and I would think that that member would know where the decision is. He was the minister of Health. He's been around government. He realizes that there are priorities in government,

and when you talk about capital in health care, it is never-ending. There is a lot of capital replacement that needs to be done. And I think you could probably point to a number of facilities, when you were the minister of Health, that just simply needed the decision to fund it to move it ahead. And you know where that decision lies. That lies with the cabinet. It lies with the government. It isn't the ministry that makes that decision to fund it or not fund it. It is with the government that needs to make that decision.

This facility is 100 years old. Absolutely in the last two or three years, there has been a lot of people talk about whether that facility should be . . . not whether it should be; when will it be funded. Just like when I was the opposition critic, that facility needed to be funded. And your government did a report and did a full scoping. And was it moved forward? And why not? Where did the buck stop then? The buck stopped through Treasury Board and cabinet finalization and budgeting. That's where it stopped. Because it was fully scoped a number of years ago under the previous government, and it didn't move forward. So you could say that if we delay the decision one year, now it's five years out. I could say that if the decision would have been made in 2005, it is 12 years out from when the decision could have been made and it could have been funded.

It is a challenge, as you will know when you look at all the capital requirements within a provincial health infrastructure. You know that because your government did the VFA report that talked and looked at every health care facility in this province and what needed to be funded, what needed to be improved. And although we have some very good health care facilities within the province, we have a number of health care facilities that need to be replaced. Whether it's a provincial hospital or long-term care or some of our acute care facilities, we have pressure issues as far as expansion of population that needs to be addressed. All of those need to be addressed.

But you know very well where that decision needs to be made. It's a government and it's through cabinet and it's through Treasury Board and it's through the expenditure of those funds. That's where it's made.

We have worked with the Prairie North Health Region through the ministry and the community to further along the planning because the plans that were made four years ago or five years ago by the previous government, by your government — which, you know, weren't funded and whatever because of economic times — needed to be looked at again. And so we've scoped it out, and we know what needs to be done. It needed to be replaced, I would say, in 2000; it needed to be replaced in 2005; and it needs to be replaced in 2011. We have to make that decision as to putting the money behind it and make sure that moves it forward.

I have heard the concerns from a number of people as I've heard the concerns from a number of people on many different facilities around this province, whether it's long-term care, whether it's some of our acute care settings. There are always concerns brought forward, as you will know, to the Minister of Health, and it's a matter of trying to juggle those and priorize them with the amount of funds that you have to put into capital. We have put an amazing amount of money into capital in the first three years, and I think that's going to continue. And when we have enough to follow this project through, it will be done.

But you know where that decision is made. That decision is made around a cabinet table, because you've sat at one. And it's made through Treasury Board, and I don't know whether you sat at Treasury Board. But those are the processes that help government make those decisions. It's not the health region. It's not the Ministry of Health. It's our decision. We're working on that. We realize that. We've put money into the health region to further scope it because the previous scoping had been done a number of years ago and hadn't been acted on. We've followed through with scoping again. We want to act on it, but before we pull the trigger, we have to make sure the cash is there. And when we pull the trigger, the cash will be there.

Mr. Taylor: — Again I appreciate the minister's answer. I am seeking clarification. The community is very interested in where the project is going, and so the minister has been very helpful in that regard. Every year in government is different. The minister enunciated that quite well. He tends to want to roll things up and compare circumstances today with the circumstances of four or five years ago, and that's fine. But the people in Prairie North Health Region, the people in the mental health community, whether they're professionals, staff, family members, they've been through this a number of times. They know where we're at. They know what was funded before. They know where the studies have been, and now they know that the decision is this government's to move this forward.

And they are looking for — and that's why we're here tonight asking questions — is an understanding of where things are at with this government under these circumstances at this time where every year the province seems to have windfall revenues over budget by the end of the third quarter that previous governments could only wish for. We're seeing additional funds available to this government over budget in each of the years, even the year with the miscalculation on potash revenues. So there are additional revenues that come forward. Governments can make decisions based on the priorities that are being brought forward.

I'm just trying to get a handle on where this decision is at because the minister clarified it earlier, and I'm grateful for his clarification about where the construction would take place. The fact that he indicates that there's no discussion about anything going beyond North Battleford other than the discussion about the community component for additional beds, that's what the community's looking for. He also indicates that the review is under way with regards to the community support. And I understand the decision now is pretty much down to a decision of funding.

I simply ask the minister to communicate as best he can the messages that he's getting from staff and family members and professionals and try to listen to, as Prairie North so adequately put it, the voices that are most difficult to hear, the people who have made Saskatchewan Hospital in North Battleford their home. Because while staff and Prairie North have done a tremendous job of coping with what they've had, waiting for a decision to be made — regardless of which government was in power, they've been waiting for a decision to have been made; they've coped adequately — we're getting to the point now where everybody involved is saying, we can't cope much

longer. We need to move forward.

So I'm not trying to make a speech here. I'm just indicating to the minister to do, please do everything that he can to move this forward to a funded decision. If there are windfall revenues this year, additional revenues, anything over the $100 million mark, ask for it to be earmarked for Sask Hospital in North Battleford, and we can move ahead.

Hon. Mr. McMorris: — Yes, I'll just comment in that, you know, I . . . And you will know this; both of you will know this very well. As the Minister of Health, you do an awful lot of asking. There are a lot of demands and a lot of issues that need to be addressed. And, you know, we're at a record budget of $4.46 billion this fiscal year, an increase of 9 per cent, huge increase. And you know, there's always, you know . . . I deal with it daily, wants for more. And I can tell you that it's not from a lack of asking from my perspective as far as the Minister of Health, as far as moving this project ahead. But it also has to go into, you know, the whole overall spend of government.

And I think the general public have realized for a long time that it isn't really ever the decision necessarily of the health region whether it should be done, or the Ministry of Health. It has been the decision of government for many years, whichever government — and I agree with exactly what you said — whichever government as to whether this facility will be funded and move forward, as it is our responsibility as government to make that decision. But I will heed your words of advice, and I will continue to keep asking because that would be the true statement — not start asking — continue to keep asking to have this facility funded.

Mr. Taylor: — Okay, thank you very much. I see we're winding down the clock here. If my colleague will let me change the subject for a minute for one other area of questions. I think the minister knows, and certainly I know, that the folks within the Ministry of Health know that I value the work that quality of care coordinators do in the entire system. I've always believed that they have one of the most difficult jobs within the health care system. And we've all understood and recognized that communication between patients, families, and professionals is sometimes a very difficult thing. Quality of care coordinators have done a great job of that.

I understand Prairie North is one that regional health authorities are having some difficulty recruiting and retaining quality of care coordinators. Is that correct or is it not? The example is Prairie North has been without a quality of care coordinator at Battlefords Union Hospital for four or five months. It's creating some challenges within the community. And I'd like to see us do whatever we can to facilitate and help ensure that not only is that position filled but that the people who are doing those jobs are feeling respected and cared for.

Hon. Mr. McMorris: — Thank you for that question, and I agree completely with your comments about the extremely valuable work that quality of care coordinators do within the system, not only through the health region but also through the Cancer Agency. They do great work and sometimes in very difficult circumstances, because they're dealing with emotions and families and everything else. So I know that again when I was in opposition, we accessed the great work that quality of care coordinators do throughout the various health regions.

In the Prairie North Health Region right now they have a number of, they have some health quality care coordinators, I believe three. There is a vacancy. I think there was four. And they look after geographic areas. Right now there is maybe a opening in North Battleford.

[22:30]

The health region again is responsible for its staffing and the complement of staffing. I don't think they're hesitant to hire into that position because they don't think the person does the proper job. That's not the reason why that position hasn't been staffed up, because I think all health regions have valued from the work that quality of care coordinators have done.

So the position is open and the health region is looking to fill the position. They still have three quality of care coordinators that . . . I'm not exactly sure how they portioned out their work, whether they're trying to cover some of that area. But we can find out perhaps a little bit more from the Prairie North Health Region regarding that specific vacancy and get back to you on where they're at and what they plan into the future.

But as far as the overall picture of quality of care coordinators, extremely good work for all health regions on the patients' behalf.

Mr. Taylor: — I appreciate the minister's offered to check the circumstances and perhaps get back. As I understand it and it has been for a number of months now, The Battlefords are being serviced by a quality of care coordinator out of Lloydminster. When we're dealing with families in crisis, which is often the work that a quality of care coordinator finds themselves in, that distance is substantial and not just the distance but the access to the bigger hospital, the regional hospital that exists in The Battlefords.

My question was sort of along the lines though of, is this an area where we are finding difficulty province-wide of filling positions? And if not, then I'd simply ask the minister, if the region needs any assistance, I would hope that the . . . If the region needs any assistance, I would hope that the ministry would provide them with whatever assistance they need. That's an important position and we'd all like to see it filled.

Hon. Mr. McMorris: — Okay. Just kind of to quickly answer the question, is that we aren't experiencing difficulty recruiting into these areas even though, and I would agree with you completely, that you deal with families quite often in stress or distress, stressful situations or in distress. When there's positive outcomes, which they quite often receive positive outcomes, I think it has to be at times a very gratifying position to work in because they do help people navigate a system that sometimes isn't as friendly as we all want it to be.

And you know, not to speak on their behalf, but some have been in that position for quite a while and have done, you know, amazing work. So obviously there is great gratification at times helping people navigate the system. We haven't had trouble recruiting into that position so far, and sometimes that also is a sign that the workplace is gratifying, that people, you know, are

willing to fill those roles, generally, you know, sometimes social workers, sometimes nurses. But we'll certainly look into Prairie North and see if we know any more about the situation than what you've mentioned.

Mr. Taylor: — Thank you very much.

Hon. Mr. McMorris: — Just in closing, I would like to thank all the officials that I have to my left and right and certainly behind me for their work. It started fairly early with a briefing this morning to try and get me ready, and they're here to support me tonight. So I want to thank them all for spending the three and a half hours. And now they can go check on the election results because I'm sure none of them knew earlier.

The Chair: — Thank you, Minister McMorris. Ms. Junor, you have some closing comments?

Ms. Junor: — Thank you to the minister and all the officials that came tonight to spend this really exciting night here. And I do look forward to the next . . . I think we have one hour left, so I'll look forward to seeing you all again. And good night.

The Chair: — Thank you, Ms. Junor. Thank you, committee members, and all those watching at home that gave up watching the election for this exciting evening. And thanks to the minister and officials.

I'll ask for a motion to adjourn. Ms. Wilson. This committee meeting stands adjourned.

[The committee adjourned at 22:32.]