# STANDING COMMITTEE ON HUMAN SERVICES

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**STANDING COMMITTEE ON HUMAN SERVICES**

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Saskatoon Willowgrove

Ms. Meara Conway, Deputy Chair
Regina Elphinstone-Centre

Mr. Ryan Domotor
Cut Knife-Turtleford

Mr. Muhammad Fiaz
Regina Pasqua

Mr. Derek Meyers
Regina Walsh Acres

Mr. Hugh Nerlien
Kelvington-Wadena

Ms. Alana Ross
Prince Albert Northcote

[The committee met at 17:16.]

**The Chair**: — Well good afternoon, committee members. My name is Ken Cheveldayoff. I'm the MLA [Member of the Legislative Assembly] for Saskatoon Willowgrove and the Chair of the Committee on Human Services. Joining us today, Ms. Meara Conway will be substituted for by Ms. Vicki Mowat. Mr. Ryan Domotor is here, Mr. Muhammad Fiaz, Mr. Derek Meyers, Mr. Hugh Nerlien, and substituting for Ms. Alana Ross will be Mr. Greg Ottenbreit.

We'll begin today's meeting with the tabling of documents. I'd like to table the following documents: HUS 10-29, Ministry of Health: Responses to questions raised at the April 14th and April 15th, 2021 meetings. Also tabling today will be . . . I'll table document HUS 11-29, Ministry of Social Services: Responses to questions raised at the April 26th, 2021 meeting.

**Bill No. 48 — *The Public Health (Safe Access to Hospitals) Amendment Act, 2021***

**Clause 1**

**The Chair**: — This afternoon we will be considering Bill No. 48, *The Public Health (Safe Access to Hospitals) Amendment Act, 2021*, clause 1, short title. Minister Merriman is here with officials. Minister Hindley is here as well. I would ask that officials please state their names before speaking at the microphone. As a reminder, please don't touch the microphones. The Hansard operator will turn on your microphone when you are speaking to the committee.

I believe we're beginning with Minister Merriman. Minister Merriman, I'll turn the chair over to you. Please introduce your officials and make your opening remarks.

**Hon. Mr. Merriman**: — Thank you very much, Mr. Chair, and thank the committee for convening tonight. Very much appreciated. I'm going to touch on a few things here, Mr. Chair, on where we're going. I have my deputy minister, Max Hendricks; I have Billie-Jo Morrissette; Mark Wyatt; my chief of staff, Morgan Bradshaw; and we have some other officials available for any very specific questions.

Mr. Chair, the reason for bringing Bill 48 forward is an unfortunate situation where we have to create some areas around our hospitals to protect our patients, our health care workers, and the families that are visiting those patients. This is very specific to in and around COVID-19. We do have some areas that we want to make sure that our health care staff is certainly protected in those situations. And we're very committed to the current COVID response within the COVID-19 pandemic in ensuring that our public health legislation is appropriate effective into the future.

We're proposing a couple of amendments to *The Public Health Act, 1994*. This legislation will allow safe zones around Saskatchewan's 67 provincial, regional, and district community hospitals including all of our affiliated hospitals. This measure will help protect the public, patients, and health care providers from any harassment. Patients within our health care services deserve to be able to have access to hospitals in a safe manner without interference or intimidation, particularly during this challenging pandemic. These access zones will make hospital environments safer for all people within our health care system. The 50-metre safe access zone will prevent sidewalk protests close to hospitals and stop people from blocking any access to the specific hospitals.

I'd like to note that the provisions allow residents to continue to have lawful and attend lawful peaceful protests held outside the access zones, and we have made an exemption for demonstrating for labour disputes. The Ministry of Health and the Saskatchewan Health Authority and others will be able to enforce the access zone by way of injunction.

Further to that, we have also included in this non-traditional immunizers, which will be able to obviously move the COVID vaccine in and around the province but certainly get the injections into people's arms, Mr. Chair. We will continue to do that now that we have 5- to 11-year-olds approved from Health Canada. We're starting those vaccinations tomorrow morning, which is very exciting news. And we will also be looking at using these non-traditional immunizers for our booster shots.

So with that, I would be happy to answer any questions from the committee.

**The Chair**: — All right, thank you, Minister Merriman. Minister Hindley, did you have any opening remarks? No? Okay, thank you. Ms. Mowat, the floor is yours.

**Ms. Mowat**: — Thank you, Mr. Chair, and I'd like to thank the ministers, the deputy minister, and officials for being present tonight.

I think we have been on the record with the opposition in being supportive in theory of the legislation. Certainly we don't think that health care workers should be targeted, especially considering the tremendous work that they've done during the fourth wave.

And ultimately these policy decisions rest at the feet of elected officials, and this is what we've signed up for, like it or not. So certainly support the notion that protests should not be happening at hospitals, that health care workers should not be bearing the burden of these protests, and you know, work to support this in the ways that we can.

In speaking with stakeholders around this legislation, a few questions have come up, so I will be putting some questions to the minister around some of the finer details of what the implications are of these legislative changes. And I think one of the first questions I have is around consultation, particularly as we look at the provisions around codifying non-traditional immunizers, what the consultation process has looked like. And I'll background this by saying that I heard from a number of individuals that when this legislation was being prepared, they received about a day's notice in the consultation process and felt very time-crunched to be able to provide thoughtful remarks in that period of time.

**Hon. Mr. Merriman**: — Thank you very much for the question. I'll touch on it a little bit and then I'll get my deputy minister or

Billie-Jo to be able to comment on it.

The consultation with the non-traditional immunizers certainly has been happening over the last little while. This is a role that has been happening since the beginning of the pandemic where we've had to move people into positions where they weren't traditionally there. It's not a new process, but formalizing it is. And I understand that this was done very quickly, but with the pandemic we've had to react very quickly on a ton of different situations.

We wanted to make sure that . . . Some protests were not just happening but they were escalating in a very concerning way for our health care workers. We saw them being confronted. I heard from health care workers directly that this was like a slap in the face to them on the protesting side of things. On the immunization side of things, this is something that we've been continually doing since the beginning of the pandemic. We need these individuals there for our booster shots. But also now that we're eligible to do another 112,000 individuals, we need these people there. So it has been happening since our vaccination started January . . . we got into full force in January of this year.

And I don't know, Max, if you had any other comments on that?

**Mr. Hendricks**: — Yeah, so the ability to have non-traditional immunizers was included in *The Disease Control Regulations*, and that would have expired on January 1st, 2022. And just given the pediatric vaccination program as well as the possibilities for the need for boosters, we need these personnel to extend beyond that. We felt that going the route of the Act was advantageous to health care providers, and that it provided them with some measure of liability protection that they would have beyond *The Disease Control Regulations*.

And so you know, as the minister said, this is something that's been in place for quite a while. We used it in the first wave of the vaccinations. It just strengthens this piece. And to be clear, this doesn't give them carte blanche to do any vaccination any time. It has to be something that's actually approved for them to do. And so this is very related to our COVID vaccination rollout as well as influenza as well.

**Ms. Mowat**: — Thank you for providing some background on that as well. So I think you spoke to the rationale behind requiring legislation and that it's primarily related to liability. Is that what the rationale is beyond say renewing the regulations?

**Mr. Hendricks**: — Yeah, I think that, you know, there are a couple of reasons, one of which is in the regulations, we felt that there was the potential for issues with respect . . . when you have non-traditional vaccinators. It just strengthened it as recognizing them as being public health vaccinators because the Act specifically outlines the folks that can do that. So this now just expands that list. And so we felt that that was a prudent measure to take.

**Ms. Mowat**: — In terms of the non-traditional immunizers, I think that folks want to get a picture of what this actually looks like. So how are they deemed appropriate? Who makes that decision? What does the training look like? You know, can you give a picture of what that process looks like?

**Hon. Mr. Merriman**: — Sure maybe I'll start. From the public's perspective, you wouldn't know whether you're getting a traditional immunizer or not, especially when we were doing mass immunization at the drive-through clinics. I certainly didn't know, didn't ask. I trusted the person there was able to be able to do that. Probably a lot of us were done by non-traditional immunizers, so certainly we thank them for that role.

As far as the training process, there was training that was done from traditional immunizers that were able to show them exactly how to do this. These are people that were very familiar with giving injections. But there is obviously a protocol that goes along with any type of vaccination injection. Max, maybe you can touch on maybe a little bit of the training.

**Mr. Hendricks**: — So the current immunizers that we're most familiar with are obviously public health nurses, but as well physicians, nurse practitioners, pharmacists, and a couple of others that do this routinely. And they take several modules of training in order to be able to provide that, or it's required that they do that. For each of these additional immunizers we did require them to take additional training. It's laid out. There's certain modules in the vaccination program, some of which are necessary for influenza and the COVID vaccinations. And so that was set out, and I can go through that in detail if you like, what was required.

**Ms. Mowat**: — I think in terms of just getting a general sense. So I'm assuming that different modules were required for different professions, based on their backgrounds. And is there any practical component to that training? Or is it, you know, something that they would take online?

**Mr. Hendricks**: — So it is different. So for physicians, nurse practitioners, and pharmacists, they're required to register for what's called EPIC [education program for immunization competencies] and take four modules: vaccine development and evaluation; storage and handling of immunization agents; adverse events following immunization; and overcoming hesitancy. Obviously in each of those cases, they would have had practical experience during their practicum and during their practice.

[17:30]

And in the case of new vaccine providers and those that have already been trained to administer influenza seasonal vaccination, we followed an approach similar to that which was used in British Columbia and had an expanded module range.

So they were required to take module 1, the immune system and vaccines; module 3, vaccine development and evaluation; module 7, storage and handling of immunization agents; administration of immunizing agents; adverse events following immunization; legal and ethical aspects of immunization; and overcoming hesitancy. And then after which they do have a certificate.

They would have practical experience, some experience in giving vaccines, intramuscular. Like this isn't intravenous. So it's just a stick in the arm; it's a little bit easier. And so, yeah, I think everybody is trained to do this work.

**Ms. Mowat**: — Thank you. You'd mentioned British Columbia. I wonder how what we are doing here compares to other jurisdictions, if non-traditional immunizers are being employed in other jurisdictions as well, and what that jurisdictional scan looks like.

**Mr. Hendricks**: — Yeah, so Quebec has enacted a ministerial order to allow a broader range of health care providers than we have even contemplated within our Act. So they allow pharmacists, respiratory therapists, midwives, medical students and residents like we are proposing, students enrolled in the last year of college program of studies leading to a diploma giving access to a permit to practise as a professional respiratory therapist, third- and fourth-year midwifery students, nursing students, and third- and fourth-year pharmacy students.

In Quebec as well, every other person other than nurses, pharmacists, and respiratory therapists who is also authored to administer the vaccine must first have undergone a training assessment similar to what we've required. And they, like us, a nurse, pharmacist, or respiratory therapist or midwife must be present to respond in a case of emergencies. Obviously we don't have all those classes.

Manitoba is in discussions, or has had discussions regarding training of non-clinical immunizers to administer the COVID-19 and we've contacted them for more information. It's being done in several jurisdictions. We only have information on a few.

**Ms. Mowat**: — Thank you. And that information is helpful. In terms of — there is quite an extensive list, as you referenced — of folks that are non-traditional immunizers in the regulations right now, I wonder if we have seen all of these professions involved in the campaign, if you have that level of detail, and whether there's going to be any change from this list moving into the legislation. So can we expect sort of a similar . . . Is it just that the regulation is going to be the same in the legislation as it was in the regs?

**Hon. Mr. Merriman**: — I don't think that there's any real plans for changes. The bulk of the immunization is . . . We still have booster shots and obviously the 5 to 11, and if there's a recommended booster shot for everybody across the board, we would do that.

But we wouldn't need to expand the list as far as I know, just because we have the bulk of two shots . . . I think we're at 81 per cent of eligible people. The bulk of them have been done, two shots. So we're still getting some first-time people coming in for that, but the bulk of them would be done, so I don't foresee any new positions coming on unless there is something very specific that changes. But as I've learned in COVID, it's evolving always on a daily basis. But I don't foresee anything, no.

**Mr. Hendricks**: — Yeah, no. I agree with the minister that, you know, if we look at the experience so far, as of the summer, the SHA [Saskatchewan Health Authority] had used medical and nursing students, by far the most — over 400 were utilized; former licensed nurses, so these were people that had just recently retired; and then EMS [emergency medical services] personnel, over 483 participated. As well there are over 69 pharmacy technicians and pharmacy students who did participate.

And then obviously one of the biggest challenges have been in the North, where, you know, kind of some of these allowances for those other professions that you see have helped the immunization program up there, for example dental therapists, who would be used to giving needles. And so it's a really important part of their vaccine strategy in the North, and that's why the list is a little bit more expansive.

**Ms. Mowat**: — I was wondering if rural and remote areas were contemplated the most in this type of situation. And so I guess one of the questions is around, you know, why we don't have public health capacity to spearhead more of these vaccine clinics. You know traditionally, when you think about the role of public health, they have had a very strong role in immunization campaigns. And I know that . . . yeah I guess that is the question there.

**Hon. Mr. Merriman**: — Sorry, just for clarification on the question, why isn't public health . . . Sorry, I didn't catch . . .

**Ms. Mowat**: — So certainly if we're looking on a go-forward basis . . .

**Hon. Mr. Merriman**: — Oh, okay.

**Ms. Mowat**: — We're not talking about COVID anymore. We know that this legislation can be applied to future campaigns and any communicable disease, which, you know, we have vaccines for. I would say that the alternative to bringing in non-traditional immunizers would be to beef up public health to make sure that there is the prevention side, the education side, you know, all of the other pieces that fall into the health care journey, especially as it applies to immunizations. So just wondering if anything was contemplated on that front.

**Hon. Mr. Merriman**: — Well it's certainly something that we're working on as building back on our health care system to make sure that those . . . hopefully we will not have anything like we've had in the past 18 months that we have to deal with. But we want to be able to have that flexibility that if something does come around. This is part of the learning process of what we have learned from COVID and how we can be more prepared next time around that we do have a piece of legislation, if this is needed, that we can react very quickly, and we don't have to go through a very quick process in this Chamber as well as consultation and that.

It doesn't mean that this document is not a living document. I mean it can have some adaptations if we need to in the future. But I want to be able to have this piece of legislation here that if myself or whoever is the Health minister into the future has another tool in their tool box to be able to pull out if need be. Hopefully it'll never be needed again, but we want to be prepared for the next come around.

**Ms. Mowat**: — Thanks. In terms of the process for utilizing non-traditional immunizers, if say a vaccine clinic is popping up in a community, is the attempt to go to seek out immunizers through the SHA first and then move on to additional professions later? Or what does that process look like?

**Hon. Mr. Merriman**: — I think we would obviously use in-house first. We would always look at that possibility. But

depending on the timing of it, when a vaccine comes in, how fast those have to be distributed, we might need to pull in our other resources which this would be one. But we always look at in-house first, and we were doing that right from the beginning.

But because of the timing of the vaccines arriving over the last year, it was very challenging, so we would have very little vaccines and then we would have a large amount. So we had to have the workforce to be able to ebb and flow with the vaccines that were being procured by the federal government. So that created . . . Hopefully if there is a mass vaccination program again, the procurement and that flow of vaccines would be steady because it would be much easier.

We had lots of times where we had scheduled workforces because we were ready for a vaccine drop and it never came, and it would be two or three days later and then we'd have to adjust our workforce again. So that had a huge impact on what we were able to do as far as our vaccinations.

So it has that ebb and flow. So when you have that ebb and flow coming from something that isn't controlled by the provincial government or the Ministry of Health or the SHA, we have to react to that. So that's why there may be a need for it in the future, but we'll always go in-house first like we did before.

**Ms. Mowat**: — I see here . . . And we certainly heard about their issues related to the patient experience as well, you know. There were many situations where clinics were cancelled. People weren't notified. Like, I know there were a lot of people that were having to react quickly and move accordingly in those situations. Going forward, we . . . And the use of the non-traditional immunizers.

I'm curious about how the ministry envisions utilizing this legislation. In a perfect world, let's imagine COVID is over; it's a beautiful utopia that seems so distant right now. You know, is there . . . It's built into this legislation that non-traditional immunizers can be used on future campaigns. Is that something that the ministry is planning to use often as a last resort? How is this being contemplated?

**Hon. Mr. Merriman**: — I wouldn't see it as often, but it's a safety net that we do have and that's how I am looking at this, and in speaking to the officials, that this is just like another layer that we have if we ever have to do something like this again. But again, if there is a different circumstance where there is a different virus and we need to do something in a different way, that would require a ministerial direction for that to change over and do something else. If it was another virus we would have to do that.

But again, we would always go in-house first, and we would have to find that balance with pulling too many people out of in-house and not reducing services or programs within the SHA. So we would try to find that balance if we had to pull a certain amount of people out and we had to bring some non-traditional immunizers in to be able to balance that to make sure that our programs and services . . . We would certainly have a look at it at that time, but always in-house first.

**Ms. Mowat**: — Thank you. You've mentioned the flu a couple of times. And is this something that is being contemplated for use within a regular flu season?

**Hon. Mr. Merriman**: — I wouldn't see it within a traditional flu season because the volume just isn't there. I stand corrected, but I think our flu uptake is in and around 30 to 32 per cent traditionally across the board. Is that . . .

**Mr. Hendricks**: — A little bit higher than that.

**Hon. Mr. Merriman**: — A little bit higher than that? Okay, that's a little bit better than that. So we're not seeing the volumes this year.

Now that people are more aware of vaccines, the flu vaccine is going out very well. But again, I don't think we would use that, just because it doesn't have the peaks and valleys. Our flu vaccine arrives in a very steady flow. There is no peaks and valleys. It all comes in in two or three shipments that I'm aware of. So I don't think we would use this for that, unless — which would probably be a good thing if we got up to 90 per cent uptake on our flu vaccines, you know — and there was some problems with shipments and delivery, we might have to look at this, but not typically.

**Ms. Mowat**: — Thank you. I think those are the questions I have around the non-traditional immunizers.

In terms of the hospital protests, there is a very specific definition of hospital that is provided here. My read of that is that other facilities that the SHA owns and manages are not included, that other clinics wouldn't be included, including temporary pop-up vaccination clinics. So I'm wondering if you can speak to how that definition was determined and why it doesn't include other sites of vaccination.

**Hon. Mr. Merriman**: — I think it was, the determination was the main focus of the protests that we were seeing and blocking access, specifically in Regina, but at other locations. We wanted to make sure that we had our 67, as I identified earlier, our 67 hospitals.

[17:45]

There is the non-traditional pop-up clinics, the drive-throughs, and that. We haven't seen it, and this is again the main thrust of this is to protect our health care workers.

Now those health care workers are obviously, not all of them are within the hospital walls. There's lots of outreach programs and that. So to get into that would be very challenging, but we would work with local law enforcement if there was some aggressive protesting at a specific . . . or if it was a mobile clinic and there was a specific problem in a specific community, we would just relocate to make sure it's safe. But again the main thrust of this is to protect our health care workers, the patients, and the people coming in to visit them.

And we're also looking at potentially . . . I know the Minister of Education is considering, you know, what they need to do within the school system, because we will have . . . that will be, probably our second-largest immunization areas outside of pharmacies will be in the schools. So we want to make sure that that is protected as well.

**Ms. Mowat**: — Certainly. Can you speak to how the, I think it's 50 metres parcel of land language was determined?

**Hon. Mr. Merriman**: — Well what we wanted to do was create . . . The safe access was the main concern and the access points in restricting that. We looked at a lot of our hospital facilities and tried to determine . . . Like I'll give you two real examples. There's the Royal University Hospital in Saskatoon which has a ton of space in and around it. The Regina General doesn't. So we had to create kind of . . .

The 50 metre was decided that that would be a reasonable distance for everybody to be able to access the hospital. You're not right on top. You're not necessarily on the property line, which was another topic of discussion. It was to create a safe space so nobody could protest within that specific area. So as we have so many different hospitals and so many different layouts of the hospitals right in the core, like in Regina, we wanted to make it that it had that functionality to it but it also created a safe area.

**Ms. Mowat**: — What does that look like if the parking lot is a little further away? It's, you know, a notorious patient experience finding parking from afar and making your way all the way to the hospital.

**Hon. Mr. Merriman**: — Yes. Well most of our major centres, and certainly there is parking available and that. But sometimes people have to park . . . I know at the City Hospital in Saskatoon, most people park . . . There is a parkade there but a lot of people do park on the street out there. So I guess it would depend on the timing of when you're coming at that. But the problem is, is where do you stop? Like you want to be able to protect that safe environment and create a perimeter there, but there's going to be, with 67 hospitals, there's going to be 67 different scenarios on that. So again, the overall thrust was to create a safe area within that, that was reasonable for the hospital, functional for the hospital. But if there is somebody that wants to express their . . . or protest, they have the opportunity to do that, just not inside that 50 metres.

**Ms. Mowat**: — Thank you. What does this legislation mean for non-COVID-related protests? So for example, you know, we've seen pro-life demonstrations outside of hospitals. What does this mean for them?

**Hon. Mr. Merriman**: — There was a labour exemption for our friends at Labour that wanted to do that because we understood that that was a completely different type of protest. As far as the pro-life, or if there's individuals that are out there protesting and that, they would have to adhere to this 50 metres as well. The only exemption that I'm aware of is labour. That was in consultation with our labour friends through the Ministry of Labour.

**Ms. Mowat**: — Thank you. That was my reading of it as well. So this provision has a sunset clause that it will expire after two years, which presumably is when we're hoping to get out of all of this. So I wonder if you can speak to why it needs to have a cap on it. Like why in two years is it going to be acceptable to protest our health care workers but it isn't today, if you take a pretty literal read of the bill?

**Hon. Mr. Merriman**: — Well I wouldn't say it's okay to, I would not say it's okay to protest our health care workers. I would say looking out for two years, we're hoping that certainly the virus is in behind us, and the tensions in and around the virus and the vaccination that seem to have come are in behind us as well, and we can get back to being one whole community.

We're anticipating that two years, it's up to two years. We can draw that back if we need to. But during this time when people are very charged up about polar opposites, which we haven't seen in our health care system or around our health care system before, we wanted to make sure that that was provided during this challenging time of people very much expressing openly their emotions and their frustrations on all sides of this discussion.

**Ms. Mowat**: — Why does there need to be a sunset clause at all?

**Hon. Mr. Merriman**: — Because this is around, this is specifically in and around COVID. That's why. So we're hoping that in two years that, like I said, that COVID is in behind us. And that's why we had that clause on there. It's not that we will not be protecting our health care workers after two years. We will be protecting them.

But we feel that this is specifically in and around COVID so we can make sure that those individuals, in a time that is very emotionally charged, that they are protected to be able to go to and from work, patients are able to flow in and out of our hospitals, and the families visiting. So if this needs to be reviewed a year from now, then we would certainly do that, but right now this is very specific in and around COVID. That's why it has the sunset clause, and for no other reason.

**Ms. Mowat**: — Okay. I wonder if you can speak to the provision around — I guess this is going back a bit to the non-traditional immunizers — but the immunity clause against errors, and sort of what that would protect those individuals from, like if they would have the same amount of protection as other health care professionals.

**Hon. Mr. Merriman**: — Sorry, Ms. Mowat. I just missed the first part of that question.

**Ms. Mowat**: — The immunity clause, like if you can just speak to the rationale. So I'm on 37.1, paragraph (7).

**Mr. Hendricks**: — So as I discussed before, and this refers to section 68, which is when we are appointing a non-traditional immunizer for the purposes of the person appointed as a vaccination provider who is not otherwise employed by the ministry, local health authority, or municipality, it's deemed that that person would be carrying out that on behalf of government. And I'll give you an example. So the College of Medicine, College of Nursing students are not deemed to be necessarily, through any other mechanism, an agent of government, but this allows them for the purposes of liability to be considered as such.

**Ms. Mowat**: — Thank you. In terms of enforcement, I wonder if you could speak to what this looks like on a practical level. So someone is found to be demonstrating at a hospital, what happens next? Whose responsibility is it to, you know, bring in local law enforcement? What does that look like?

**Hon. Mr. Merriman**: — I'll start off. I think it would be the individual manager, whoever's on site or if there was a specific person. I think the first step in this would be education, and saying, there is a 50-metre zone now; I'm not sure if you're aware of this. This legislation hopefully will be passed, and this is the new law out there. Educate them at first, and if at that point the individual or individuals decide to stay there and they are "breaking the law," then we would involve local law enforcement to be able to assist.

We're really hoping that this is not going to happen, that we're not going to have to do this, we don't have people protesting our great health care workers. But if we do have to involve local law enforcement, we certainly could.

**Ms. Mowat**: — So would it be the responsibility of security at the hospital? Like is there a clear plan in place of who is responsible for this?

**Mr. Hendricks**: — SHA security would.

**Hon. Mr. Merriman**: — Yeah. It would be no different than any other security issue dealt with at a hospital. If we have security there, they have a chain of command to be able to inform who and what is happening, whether that be a senior manager. But it would be no different than any other security incident at a hospital, which unfortunately we do have at some, especially in our major centres.

If there is an incident, it can go up through the chain of command. And again the first step would be to try to let everybody know that this is the new rule. And if they still want to protest, then we would involve security, make sure that they know what their limits are. And if they need help from local law enforcement, then we would leave it to their discretion to be able to call those individuals in. But we're really hoping it never escalates to that.

**Ms. Mowat**: — Thank you for that clarity. So it certainly makes sense. In terms of the local security, I know there are several cases where security is privately contracted. What happens? What efforts to educate will there be? Because I'm imagining you can see where I'm going with this. If you have a shift worker who occasionally does shifts at the hospital but goes and does security shifts elsewhere as well, how are we going to make sure that these folks are educated on what the rules are around hospitals?

**Hon. Mr. Merriman**: — My assumption is it would be an internal communication through email, through various portals that the employees would be able to get, if this is the process on how we'd do that.

**Mr. Hendricks**: — Yes. So because these are changes to *The Public Health Act*, *The Public Health Act* prescribes who can enforce certain things. *The Public Health Act* prescribes who can enforce the provisions of that Act, and so in this case, the security details of the health authority.

And what we would hope, you know, if there is a protest, it would be beyond 50 metres and it would be peaceful and not interfering with access or workers around the hospital perimeter. But as the minister said, if this situation were to escalate or there was . . . I think the SHA would make a determination on how most effectively to enforce that, whether it be fines — we have COVID enforcement teams, right? — but most likely in the case if it were one of our larger facilities, that law enforcement would be called. And they're able to enforce this Act and hopefully they could just through persuasion get people to back off, that sort of thing. We're hoping that this isn't something that we'll have to use.

**Ms. Mowat**: — Thank you, and thanks for talking through that a little bit. I know one of the questions that a lot of people have, like a lot of them are on the practical side of, you know, what does this actually mean for folks at the everyday level. So I appreciate you taking some time to go through that as well.

I think that amounts to the substance of my questions here. Overall, you know, we've called for these measures around eliminating protests around hospitals, and I think are certainly supportive of those changes that are being made in the Act here and don't want to stand in the way of making sure that these provisions get brought into place. So with that I will conclude my questions, and thank you for your time.

**Hon. Mr. Merriman**: — Thank you very much for the questions. And I want to thank . . . If you can thank your colleagues for supporting this and moving it through quickly because it is very important, I very much appreciate that. And I know the health care workers that are speaking out to me and you will certainly appreciate that as well. So if you can pass that on to your colleagues, thank you very much for that.

I just want to quickly thank my officials, thank the committee for hearing us today on relatively short notice. And with that I'll conclude my comments, Mr. Chair.

[18:00]

**The Chair**: — Thank you very much, Mr. Minister. Are there any other questions from any other members of the committee? Seeing none, we will proceed to vote on the clauses.

Clause 1, short title, is that agreed?

**Some Hon. Members**: — Agreed.

**The Chair**: — Carried.

[Clause 1 agreed to.]

[Clauses 2 to 8 inclusive agreed to.]

**The Chair**: — Thank you very much, committee members. Her Majesty, by and with the advice and consent of the Legislative Assembly of Saskatchewan, enacts as follows: *The Public Health (Safe Access to Hospitals) Amendment Act, 2021*.

I would ask a member to move that we report Bill 48, *The Public Health (Safe Access to Hospitals) Amendment Act, 2021* without amendment. Mr. Fiaz moves. Is that agreed?

**Some Hon. Members**: — Agreed.

**The Chair**: — Carried. Minister, do you have any closing comments?

**Hon. Mr. Merriman**: — Just to thank the committee for their

time.

**The Chair**: — All right. Ms. Mowat, any closing comments?

**Ms. Mowat**: — No, I'm okay. Thank you. Thank you, everyone.

**The Chair**: — All right, colleagues. That concludes our business for this evening. I would ask for a member to move a motion of adjournment. Mr. Meyers has moved. All agreed?

**Some Hon. Members**: — Agreed.

**The Chair**: — Carried. Committee members, this committee stands adjourned until the call of the Chair. Thank you.

[The committee adjourned at 18:02.]