STANDING COMMITTEE ON HUMAN SERVICES

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STANDING COMMITTEE ON HUMAN SERVICES

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Mr. Derek Meyers
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Mr. Hugh Nerlien
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Ms. Alana Ross
Prince Albert Northcote

[The committee met at 15:21.]

The Chair: — All right. Good afternoon, everyone. Welcome to the Standing Committee on Human Services. My name is Ken Cheveldayoff. I will serve as the Chair of the committee meeting this afternoon. Committee members are Ms. Meara Conway, and substituting in for her today will be Ms. Vicki Mowat; Mr. Ryan Domotor is a committee member; Mr. Muhammad Fiaz; Mr. Derek Meyers; Mr. Hugh Nerlien; and Ms. Alana Ross. Ms. Mowat has informed me that the Leader of the Opposition, Mr. Meili, will be participating at certain points today as well.

General Revenue Fund
Health
Vote 32

Subvote (HE01)

The Chair: — Today the committee will be considering the estimates and supplementary estimates no. 2 for the Ministry of Health. We will now begin with vote 32, Health, central management and services, subvote (HE01). Minister, please introduce your officials and make your opening remarks. Thank you.

Hon. Mr. Merriman: — Thank you, Mr. Chair. We have Max Hendricks, my deputy minister. We have a plethora of a group here, and I'll get them to introduce themselves as they come up to the microphone.

The Chair: — Very good. Ms. Mowat, the floor is yours.

Ms. Mowat: — Thank you, Mr. Chair, and to everyone who is joining us today. We're in for a long haul in this committee today and tonight. So yeah, appreciate the effort that that takes, and the time away from typical duties to do this important work.

Leading off with some questions on the costs and how much is coming in as well, specifically relating to how much money we've received from the federal government as it pertains to health care, I didn't see that clearly indicated in the Estimates book. But how much are we receiving this year in federal transfer payments?

Hon. Mr. Merriman: — Thanks very much for the question. The easy answer would be, not enough. The federal government does not fund the health care agreements with the provinces, including Saskatchewan, to the tune that they should be. And I know the premiers are working on this as part of a larger $28 billion package for all provinces.

But what I can tell you is, what does come from the federal government directly to the Ministry of Health is home and community care and mental health and addictions for $37,220,000. We have the ICIP [Investing in Canada Infrastructure Program] ventilation program for $6.333 million. We have the SAA [Saskatchewan Air Ambulance] Health Canada for First Nations is $1.436 million. We have eHealth for Panorama which is $1 million. We have the dementia project for the Canadian Chronic Disease Surveillance System for $221,545. We have STARS [Shock Trauma Air Rescue Service] Health Canada, First Nations, which is $190,000. And we have the Smokers' Helpline of $100,000 — for a total of $46,501,045.

Ms. Mowat: — So 46 million is the total number of dollars that we are receiving from the federal government in the upcoming budget?

Hon. Mr. Merriman: — 46.5 million and change, but that's what comes directly to the Ministry of Health.

Ms. Mowat: — Okay. I'm confused by the caveat at the end. Is there any additional federal funding that comes to the Ministry of Health, not included in that 46 million?

Hon. Mr. Merriman: — There would be additional dollars that go into the Ministry of Finance and then is transferred out to the Ministry of Health, which would be an additional $1.2 million . . . oh sorry, 1.2 billion. Sorry.

Ms. Mowat: — It's like, this is sounding very low.

Hon. Mr. Merriman: — Yeah, it did when I first said it.

Ms. Mowat: — Okay. So 1.2 billion, that's the overall sort of federal transfer payment that's more broad. And then the other money is the specific targeted funding?

Hon. Mr. Merriman: — Correct. That would be program-designated funding, so yeah.

Ms. Mowat: — Okay. And "hear, hear" on not enough. Certainly appreciate that. How do those dollars compare to this last fiscal year? Are we seeing more? Less? About the same?

Hon. Mr. Merriman: — Sorry, I've got to make a correction there. I was reading the wrong end of . . . I was reading the former one. It's actually $1.39 billion is what we're receiving in '22-23. There's a lot of programs that make up an additional $37 million, which is our 10-year Health Accord agreement. We did receive money in the 2020-2021 budget of $218 million for COVID-related issues that are carried forward into some of the other years that we're still working through.

Ms. Mowat: — How much of that money remains? So you're saying that money is still . . . some of that federal money is still there?

Hon. Mr. Merriman: — Sorry, that's out of the 218?

Ms. Mowat: — For COVID, yeah.

Hon. Mr. Merriman: — The $218.1 million goes into general revenue and then the general revenue allocates it to us. So it's part of that money that we were talking about last night. The money that we had spent on COVID came out of that. So there isn't any dollars set that are left in that, but it did go into the general revenue and it has been spent, with also excess from adding in from the province for the COVID relief.

[15:30]

Ms. Mowat: — Okay, so it's been spent.

Hon. Mr. Merriman: — Yes.

Ms. Mowat: — My understanding is that there are no strings attached to these dollars. This money can be spent how the ministry feels it wants to. Is there . . . I'm seeing a face from the deputy minister. Can you clarify if any of these targeted dollars are going to be spent in areas that they are not designated to be spent by the federal government?

Hon. Mr. Merriman: — Yeah, when the federal government gives us this money, it was designated for specific things in and around COVID. So we've spent those dollars in and around. We have to report back to the federal government on what we spent on COVID out of that money that they have allocated, no different than we have to with other dollars that we receive that are program-specific from the federal government. So if it's designated, then we have to report back to them on what that money was spent on.

Ms. Mowat: — Thank you. So that would be encapsulated by the . . . Is it 37 million for targeted programs? That's the list you started with, that the federal government is providing for this upcoming fiscal year?

Hon. Mr. Merriman: — Yeah, there is a targeted amount that we do have from the federal government, which is about that $37 million. It's specific for like mental health, home care infrastructure, virtual care, Smokers' Helpline, some of the other items that I just went through. That's what that is, and we have to report back specifically what we spent on that. We do not report back specifically on the Canada Health Transfer dollar of the $1.39 billion. That just goes into general health care.

Ms. Mowat: — Okay, thank you. And that reporting back is not made public, right?

Hon. Mr. Merriman: — I don't think it's made public from our end. It may be made public from the federal government's perspective through their parliamentary budget office. I'm not sure on that, but we do report back exactly what we spent, that dollar amount. Whether the federal government reports it out, I guess that's up to them.

Ms. Mowat: — And so none of this, these dollars that we've talked about so far don't include the anticipated, recently announced $62 million for surgeries?

Hon. Mr. Merriman: — That would be correct, yes, because that came in after our budget was finalized, so it would not be in here.

Ms. Mowat: — Okay. Do you want to go ahead with some questions?

Mr. Meili: — Just on that matter, the matter of 62 million, the minister said a couple of days ago that that would be on top of the 21 million that has been committed. Can we maybe just get a bit of clarification on where the minister sees that 62 million? Will the promised 21 come out of that? Will this be an addition? Will that 62 million entirely be spent on reducing surgical wait times?

Hon. Mr. Merriman: — Because this wasn't included in our budgetary process and it wasn't something that we certainly got a heads-up . . . And we do appreciate it from the federal government and make sure that . . . acknowledge that. It wasn't part of our budgetary process and we weren't sure initially what strings that had or where it had to go. We're hearing from the federal government that this is money that could be spent in any way for capacity for surgical backlog, which is good.

What we need to do is be able to figure out where those dollars are going to go into our surgical plan of . . . It's just over $620 million is our full surgical plan. We had $20 million allocated in 2020, which we didn't get to, and that carried forward into 2021. We also had $21.6 million where we had allocated that this year for our surgical catch-up, which was our surgical plan that was brought in in the fall to do an additional 7,000 surgeries. We're going to have to sit down and figure out exactly where this money is going to go.

We are going to front-end load our surgical capacity as much as we possibly can in this fiscal year so we can get as many surgeries done as possible. We will be allocating that $62 million, but there is a process that we have to go through internally to be able to make sure that that is part of our overall package. So we will make sure that that is going to backfill a lot of the surgical procedures that we're going be able to do in this fiscal year.

Mr. Meili: — The minister said something today at SUMA [Saskatchewan Urban Municipalities Association] that I thought was interesting. He said that having more private care would save us money. And that just got me wondering exactly what . . . one, how that works. Because it doesn't appear to be the experience in other sectors or other jurisdictions.

But maybe more generally, what is the plan regarding added private capacity? How much public dollars will flow into that? To whom will those public dollars flow? How does the minister envision this rolling out?

Hon. Mr. Merriman: — Thank you. When privately run clinics that are publicly funded were brought into Saskatchewan, we did do quite of an extensive analysis on the costs of what the private facility was doing, comparing a surgery to an exact same surgery that was done in the public system. That went through a process, an arbitration process. It was brought forward to the union and to the management to be able to say, this is the cost-effectiveness of doing things within the private sector.

The cost can vary from, depending on the procedure, to a maybe five per cent savings to as much as a 30 or 40 per cent savings depending on the procedure, depending on what exactly it is they're doing, how many of them they can do at a certain amount of time, and what their cost is on that.

But there is savings. There certainly is. This has been proven that there are savings. As far as the dollars that are being allocated from our budget, we've got an RFI [request for information] right now that we're going to turn once that's done to be able to find out who can do all of these surgeries. We're going to get an RFP [request for proposal] done and make sure that we can get these surgeries done.

But I'll just put also on the record that we have had over 120,000 surgeries that have been completed through private clinics that

were publicly funded in Saskatchewan. This is an asset that we have in our province, and this is an asset that we are going to use to make sure that we can catch up on our facilities. We've had great success with these private clinics that are publicly funded. We've had positive feedback from the people that went to these clinics, so we're going to continue utilizing them as much as we can. And I think everybody in Saskatchewan wants us to utilize all of our surgical capacity.

And maybe I'll just get Mark just to go through the process of when it was done from the arbitration process.

Mr. Wyatt: — Hi. I'm Mark Wyatt, assistant deputy minister. So the process that we went through was related to contracting out provisions, specifically in the CUPE [Canadian Union of Public Employees] agreement in Regina. And so that contract did require us to demonstrate that there were financial savings that would be attained by delivering a service through a private clinic, a publicly funded private clinic as opposed to having those same procedures done within the public system. So there was a cross-comparison that was undertaken looking at the cost of providing those same procedures that were contracted out, or at that time proposed to be contracted out, against what was in the RFP results that we received at that time.

And for all of the procedures that were included in the RFP and that we were intending to contract out, it was demonstrated that the costs were less work providing them through the private contract than had we done them through, at the time, the Regina Qu'Appelle Health Region.

And so the original contracts that we issued all demonstrated . . . we were able to demonstrate that those would be done at a lower cost than having them done through the public sector. And just noting that these were incremental procedures, we weren't reducing the number of surgeries that were done in the hospitals at the time. These were incremental surgical volumes that were part of the original surgical initiative helping to build the capacity through the private sector.

Mr. Meili: — Just for clarification, and pardon me if I missed this. This is a look back at what was done and the savings in that? Or this is a current look at what's proposed and the likely savings based on the current estimate?

Mr. Wyatt: — What I'm describing is going back to a previous experience where we did go through that arbitration process to demonstrate that there are financial savings. We haven't yet determined what procedures, what volumes might be contracted out in the year ahead. We've issued a request for information to identify opportunities with vendors to provide different types of surgical services, either directly delivering surgeries or potentially providing supportive therapies, home care, that sort of thing.

So we've gone out to the market to identify what possible services could be made available and we're in the process of developing an RFP that would specifically identify what the procedures will be that are contracted out in the coming year or years.

[15:45]

Mr. Meili: — Okay. Thank you for that. One of the concerns around this, especially if we're talking about large volumes . . . And we already are facing a shortage of health care staff in a large number of areas through the Health Authority. We've seen the recent example of MRI [magnetic resonance imaging] hours being reduced in Saskatoon and leadership there relating that directly to losing staff from the public system to the private, user-pay in this case, system. Is part of that analysis going forward the health human resource impact of having a scaling up of the private facilities offering care?

Hon. Mr. Merriman: — Just a clarifying question. This information about the MRI, where was that, like, documented or brought forward? Because that's something that I have not heard yet.

Mr. Meili: — That was publicly shared by radiologists in the group who were observing that they were losing staff to the private operations, and that that reduction in staff led directly to a reduction in hours at RUH [Royal University Hospital].

Hon. Mr. Merriman: — I guess to answer your question, this is a — again just checking with a couple of other officials — this is new information to us that there was somebody complaining about the public system being drawn on by the private system. And they're not having enough . . . They're not in competition with each other, and I want to make sure that that's clear.

When we look at our human resource plan, we have to build our human resource plan for all of the human resource needs within our health care across the board. We need to make sure that we have the right people in the right place. They work in conjunction with each other, but they're not competitive with each other. I'm not sure about that specific one. We'll have to look into that if that came out of the radiology leadership. The SHA [Saskatchewan Health Authority] is telling me that they have not heard this, so this is new information. So we'll make sure that we're looking into that.

But this speaks to exactly what we were talking about — we've talked about it in question period, we've talked about it at SARM [Saskatchewan Association of Rural Municipalities] and SUMA — is our HR [human resources] overall strategy with Advanced Education to recruit, retrain, train people, retain them within our system to be able to make sure that they can perform these surgeries and perform these procedures. Whether that is in a public SHA hospital or whether that is in a publicly funded, privately run facility, we have to make sure that we have the full complement of people to be able to do both of those, to have both of those systems operating at capacity so we can get the people of Saskatchewan the surgeries that they need.

Mr. Meili: — Thank you, and certainly happy to table the memo regarding the reduction in services. In terms of the description of why that was, one of the radiologists from the group was on social media describing what had gone on, also in conversation with physician colleagues. That was made quite clear, and I think it is a nice sentiment that they wouldn't compete, but it's not been the reality borne out in other jurisdictions when you've had added parallel private care. Simply put, if you're doing more procedures, you need more health care providers. We will absolutely need to be looking at what the impact on health human resources would be, given the current dire state of that field.

I'm going to continue on in the vein of imaging and other methods, in particular of screening. In general what we saw was, over the last couple of years, was a big decrease in the amount of primary care happening — in particular, screening. And one thing that concerns me greatly is the decrease in the number, either through delay or pure cancellation, of cancer screening, in particular for soft tissue cancers such as colon, breast cancer, or cervical cancer, as well as prostate cancer. These are conditions that, if caught early, can be treated better, saving lives, reducing mortality and morbidity.

So I guess what I'd like to know is, compared to previous years, in the last two years by how much was the number of, for example, colonoscopies, fecal occult blood tests, Pap smears, mammography, etc., reduced? So how much did that go down? And has any analysis been done based on our standard rate of capture of early diagnosis, of how many early diagnoses would've been missed and what the potential impact of that would've been?

Hon. Mr. Merriman: — Well we have to keep things in perspective of what happened in the last couple of years. There was obviously surgeries across the board that were . . . that delayed. There was also treatments that were delayed and we've been very much working through that process. I think drawing a comparison of stuff that was challenged in the last couple of years isn't a typical snapshot of what's happening in our province.

I can go through some of the information on the dollar amounts for the Cancer Agency, and we have individuals here that can certainly talk about the specifics of some of the stuff that you've referenced there. But we have to keep in mind that there were procedures — we've been very upfront about that — there were procedures that were delayed and there were procedures that were cancelled. So looking back at the last two years isn't going to be typical of what's happening within the Saskatchewan Cancer Agency.

Mr. Meili: — No, that's absolutely right. It wouldn't be typical. But quantifying what the impact of the last two years is, is really important.

Hon. Mr. Merriman: — Understood. And I can tell you what . . . we have had a $204 million going towards cancer. It's a 7.6 million or 3.9 per cent increase in that. We've also covered a wide variety of drugs within the Cancer Agency as well, so we're expanding that.

Obviously we've got some catch-up, but I also want to make sure that it's on the record that we did all cancer emergency surgeries that were needed in, during the pandemic. Those were all done. And I've talked to many people that are battling cancer and they said that their treatment was minimally interrupted during the pandemic, but there still were some challenges. But I'll get some more details on those specific ones that you were asking about.

Just wondering, can I get a copy of that letter? I don't know where it went. Are we going to get a copy? Thank you.

Mr. Hendricks: — Max Hendricks, deputy minister. So in 2020, at the beginning of the pandemic when I think, you know, the slowdowns were pretty pervasive across the health care system, that was a period of time when we saw not only reduced referrals but there was, I think, some measure of reduction in screening services. So we have two-year numbers, a comparison of two years, over two years.

And so from April 2019 to March 2020, there were 90,287 cervical cancer screenings. In the period the following year, there were 65,705. Similarly — sorry, that was a one-year period — in colorectal cancer. A two-year period, April 2018 to March 2020, there were 152,727. And by comparison, from April 2018 to March 2021, there were 137,625. From April 2019 to March 2020 there were 35,677 breast cancer screenings done. And from April 2020 to March 2021 there were 20,356. So there have been a reduction of screenings. However, these numbers are kind of indicative of what happened in 2020. And in '21, screenings resumed at the normal pace.

I've had several conversations at the deputy table about the impact of the, particularly the initial waves of the pandemic on cancer care. And obviously it's an issue. People were not seeing family physicians as frequently, so weren't being screened. That sort of thing. Or referred for some of these exams. Some patients chose not to attend regular screening programs. And so there are several factors.

And during that period we were fortunate in that the Cancer Agency in Saskatchewan didn't reduce its treatment programming, so its chemotherapy. Similarly, cancer surgeries were maintained during that period. So we acknowledge that, not unlike surgery, this is an area where there's some catch-up to do from, particularly from the earlier phase of the pandemic.

Mr. Meili: — Thank you very much for that information. And obviously that's, as we've missed those screenings, trying to catch up on those. And we may see some misdiagnoses that show up as more serious cases as a result. And of course, added cost.

I want to shift gears a little bit here and talk a bit about the Saskatchewan Health Authority and the leadership there. We've asked a number of times in question period and didn't ever get a clear answer. So I wonder if the minister could tell us why Mr. Livingstone chose to leave his position as the CEO [chief executive officer] of the SHA.

[16:00]

Hon. Mr. Merriman: — Thanks. I'm just looking at the memo that you submitted to the Table for everybody. I'm not seeing anything in here where it talks about anything to do with private facilities.

Mr. Meili: — No, as I said, that's not . . . The memo outlines the reduction in service. It was the radiologists and neuroradiologists themselves who pointed out, both on social media and in conversation with medical colleagues, that that was directly related to the loss of staff to the private facilities.

Hon. Mr. Merriman: — Understood. But I mean there's a process if there's a concern with what's happening within the private. Social media isn't the way to correct a problem. There is . . .

Mr. Meili: — We find our information the way we find it. It's

not like you're going to tell us.

Hon. Mr. Merriman: — I'm not disputing the information. You told me that there was a document here that was talking about the reduction of hours due to private MRIs. That's not in this document. So this document is just saying that there was reduced hours for a certain amount of time. It has nothing to do with the private clinics. So I'm not sure what you're . . .

Mr. Meili: — You misunderstood me, Minister.

Hon. Mr. Merriman: — Well, or you misexplained or you . . . The question wasn't clear.

Mr. Meili: — Well great, we'll look back at *Hansard*. But what I said, and I'll repeat, the services were reduced. We know that from the letter. We know that they were reduced because of the staffing issues. Well, it says staffing issues. We know that that's related to the loss to private care from the radiologists involved.

The point of this is it's a concern that we may see more staff leaking out of the public system into private. The proper health human resource strategy's not in place.

Hon. Mr. Merriman: — Sorry, just for clarification, so is the member saying that we should be responding and running our health care system via Twitter?

Mr. Meili: — No, the member's not saying anything that stupid. Let us continue. The question was about . . . a question we've asked a number of times, which is why Scott Livingstone left his position as CEO of the SHA. You know, we've heard a bunch of information about that, often through sources like social media; that's how information gets out. But we'd love for the minister to tell us himself what went on there. Why did the CEO leave the Health Authority?

Hon. Mr. Merriman: — I just also wanted to get on the record here that we do have two NAIT [Northern Alberta Institute of Technology] MRI students that will be joining us in June.

And again I'm not seeing the correlation of a memo that says reduction of hours equals private MRIs equals Twitter. I've learned a long time ago that Twitter is a very different place, and I don't necessarily have to respond to everything that happens on Twitter. And I would caution the member not to believe everything that's on Twitter either.

As far as Mr. Livingstone, he left his position. We have Mr. Will in that position, who is doing an outstanding job. We appreciate him. We've also had many other people to be able to step up into different positions, not just in the recent months but over the duration of the pandemic. And we really appreciate Mr. Livingstone, his work that he did in creating the Sask Health Authority in the last five years, and creating it from . . . that was multiple different health authorities into one. And we very much appreciate this.

This is a HR issue. And again, and I'm going to also reiterate, Mr. Livingstone leaving has nothing to do with the 2022-2023 budget because there is no line item in here. So I wish we could stick to the budget.

Mr. Meili: — Well I expect that we're hiring a new SHA CEO, so obviously that has financial implications. And then, of course, there's the question of whether or not any money went to Mr. Livingstone upon his departure. So perhaps the minister could tell us whether or not a non-disclosure agreement was signed and what the amount was for that non-disclosure agreement.

Hon. Mr. Merriman: — Yeah, thanks again. This is an HR issue that was brought up to the board. The board has dealt with it. I appreciate the board's work on this. The board informed me that Mr. Livingstone was departing the SHA at that point in time. I wished him, through the board Chair, the best of luck, and thanked him, via the board Chair if they were able to connect, for his work. I've said it publicly in this Chamber many times. I've answered it in the media. And again this has nothing to do with the 2022-23 budget.

Mr. Meili: — Thank you, Minister. The question, of course, was the NDA [non-disclosure agreement]. How much was the NDA for? Was an NDA signed? Obviously that has budgetary implications.

Hon. Mr. Merriman: — It doesn't have any budgetary implications in the 2022-23 budget. Again this is an HR issue. I know the member is very . . . has been asking lots of questions about this. This is something that transpired months ago. We have a . . . I'm sorry, I'm not sure what's funny, Mr. Meili. I'm trying to answer your question.

Mr. Meili: — Yeah. No, you're not, but continue.

Hon. Mr. Merriman: — Well . . .

The Chair: — Well I think I'm going to intervene here and remind members that my job is to ensure that we have a cordial, respectful, and productive atmosphere here. I see this deviating a bit. I remind members that's what we're here for. And we are here for the financial estimates of the vote. So I can go on to read further rules later, if necessary, but I think I'll stop there and ask that we have that cordial, respectful, and productive atmosphere here.

Please continue with the questioning.

Mr. Meili: — Thank you, Mr. Chair. Of course we want to make sure that the questions are relevant to estimates, relevant to vote 1 of estimates which is relevant to the health care budget. Obviously which is also relevant to the performance of the health care system, its management, its direction. To quote the *House of Commons Procedure and Practice*, third edition, the discussion on a vote 1 of this type is wide-ranging. Questions on departmental policy are directed to the responsible minister. Questions of a more technical or administrative nature may be referred through the minister to developmental officials . . . departmental officials.

I can dig more into the rules, but the point is we will only be — and I assure you this — only be asking questions that are relevant to the management of the health system and, you know, obviously that has implications, budgetary implications, as well.

The Chair: — All right, Mr. Meili, if you're going to quote procedure I just feel necessary at this time . . . On April 14th,

2010 Speaker Toth stated that rule 19(3) anticipates a minister will provide a response, but a response can be to decline or take notice of that. So just so everyone's clear. In similar circumstances, for the record, a minister may orally decline to take a question. So it is the minister's prerogative but I'm hopeful, again, that we can keep it pertinent to the estimates and that the questions will be answered satisfactorily for all in the room. Thank you.

Mr. Meili: — I appreciate that, Mr. Chair, and I thank you for that. That's really helpful. So I guess the question is, is the minister declining to answer the question of why the SHA CEO left? Is that his decision at this time?

Hon. Mr. Merriman: — I did not decline. I answered the question. I'm finding it curious that you're debating the Chair. I also think it's interesting that you're quoting the House of Commons because this is not the House of Commons. This is the Legislative Assembly of Saskatchewan. So when you're in the House of Commons, there can be debate that's happening in the House of Commons but we have different rules. Speaker Toth. I did answer the question. I have answered the question in this Chamber many times. I have answered it in the media many times. Just because you don't like the answer does not mean that I didn't answer the question.

Mr. Meili: — Let us ask the question again, and I'm certainly not debating the Chair. I really appreciated his intervention there.

The question that I have is, was an NDA offered to Mr. Livingstone? And if so, how much was the value of that?

Hon. Mr. Merriman: — Maybe I want to explain the structure because I'm not sure if the member understands the structure. There is the minister's office. There is the ministry's office, which is run by Max Hendricks sitting beside me. Then there is the SHA that Mr. Will is the interim CEO right now, where Mr. Livingstone held that position, that reports in to the board.

The board is the one that makes the decision on whether they are accepting, whether they are hiring somebody. That is the board's decision, not my decision and not the deputy minister's decision. There is a separation there from the board. So these are questions that are HR matters that the board dealt with and advised me on.

I'm not sure, and like I said, just because you're not getting the answer that you would like does not mean I'm not answering the question. I am answering the question to the best of my ability, but I think you just see the whole ministry and everybody from the front-line health care workers to the ministry all in this same area, which is not the way it operates. This is not how our health system operates.

The CEO, the interim CEO, Andrew Will who's sitting over there, does not report in to me. He reports in to the board. So that's how the structure is. So you're asking me for information that I don't have.

Mr. Meili: — So you're unaware of whether or not there was an NDA or what the amount was? I mean I'm . . .

Hon. Mr. Merriman: — Obviously you didn't listen to what I said.

Mr. Meili: — Certainly interested in which pot it might have come out of. But was an NDA offered, and what was the value?

Hon. Mr. Merriman: — I've answered this question already. Thank you.

Mr. Meili: — Minister, you have not answered the question. You have chosen not to, and let the record show that the minister was not willing to say whether or not the outgoing CEO had received a non-disclosure agreement, regardless of which pot it might have come out of.

There is another element to this that does have a direct impact on this budget, which is the position — I've forgotten the terminology — vice-president, enterprise initiatives support. Can you tell me what the job description is for a vice-president, enterprise initiatives support, and what the value of that position is?

Hon. Mr. Merriman: — Thank you. And I guess I'll start off by backing up a little bit. Since the beginning of this pandemic, we've been able to . . . or had the opportunity of seconding people all over government. We've seconded people from the public service. We've even seconded people from the Crowns to be able to assist us in various ways.

I remember when the pandemic started and I was in Social Services, my chief of staff and one of my ADMs [assistant deputy minister] was seconded over to Health to be able to assist because we needed people with a very specific set of skills to be able to help out. Now that just wasn't at the senior level; that was also all the way down that we were moving people around with our emergency order, with their letters of understanding with the unions to be able to put key people in key positions.

The specific position that you're talking about, I'll just go through some points here. This is a short-term and again a seconded position from an individual to Ministry of Health that fulfills a role. This position was announced by the Saskatchewan Health Authority and it is a temporary position. Position's being filled by a very capable and experienced woman that has a history of providing sound and strong leadership as president and CEO of the Saskatchewan Housing Corporation, assistant deputy minister of housing and disability within Social Services, assistant deputy minister within the Ministry of Finance, and also the chairperson of the Public Service Commission. This is a very capable person that we have seconded into a position to be able to help out with the SHA on a temporary term.

It is very, very disturbing that you have a capable woman in a very good position that had to get dragged through the media because of who she was associated with in the past, and nobody was looking at the qualification to this individual. This individual I've had the privilege of working with is an amazing woman that helps out and is in a position to be able to help us in the short term.

[16:15]

This is not a permanent position. This is something that we needed to be able to help out while we were working through COVID-19 and now into our transition of getting our health care facilities back to where they were.

Mr. Meili: — Thank you, Minister. The question was on the dollar value for this position and its job description.

Hon. Mr. Merriman: — What I can tell you is the job description, as I did indicate, is to help us transition through COVID-19 in the last six months but also be able to work on our strategy. This is something that you've identified in question period, that we need more people in our health care facilities. This is something that this individual has a background with, certainly working with the Public Service Commission, working within Social Services, working in Finance.

This is a very capable individual that is able to bring her set of skills to be able to help recruit, retain individuals into our SHA. She works directly for the interim CEO and will continue to do that duty. And again it's frustrating that somebody, a public servant like this, is getting dragged into the political arena.

Mr. Meili: — Minister, I haven't mentioned anyone's name. I don't understand what you're referring to in terms of that attempt to indicate that we're somehow saying anything bad about a public servant. I'm asking you questions . . .

Hon. Mr. Merriman: — You called her out by position.

Mr. Meili: — I'm asking. . .

Hon. Mr. Merriman: — There's only one of those positions in the Health Authority, so you are identifying the individual by the only position that is out there. And you have identified the individual in the media and in this House. So don't say that you haven't, please, because you have, Mr. Meili.

Mr. Meili: — The question . . .

The Chair: — I'll remind both members to put their questioning through the Chair, please, and answers as well.

Mr. Meili: — Thank you, Mr. Chair. The question remains. We don't have a . . . There is a position, and this is an unusual position. You spoke of secondments in other parts of the health system. I don't know if there are other examples — maybe there are and you could tell me — but of secondments that were done against the will of the senior leadership within that department. That's an unusual situation. It's also an unusual situation to have a new vice-president position that is not tendered, that we have no idea of what the cost was, and that we don't have a job description. So I will repeat. Can we have something more than a "to help us with COVID" description of what this job actually entails and what the cost is?

Hon. Mr. Merriman: — Mr. Meili, in answering your question, this individual, as I have said, has been able to help out in multiple areas bringing her wealth of resources to our . . . And I identified at the beginning of this that we had people, my chief of staff and ADM, we've had people moving all over our system to be able to backfill key positions to deal with an unprecedented pandemic. We needed highly skilled people to be able to be seconded into various areas. I'm not sure what the concern is on people being seconded into areas. We had hundreds of people seconded into hundreds of different positions. We had nurses and we had vaccinators that were in different positions.

You seem to be focusing in on one position. Also the statement of that this was against senior leadership, if you could provide me some documentation on that, I would certainly appreciate it. Or did you get that from Twitter as well? Because I'm not seeing any documentation on your assumptions that you're making out here again in the general public. You're making some assumptions that are not validated by any facts.

So again we've had hundreds of people, maybe even a thousand people, I'm not sure, moving around the system to be able to backfill in various areas. I'm not sure why this one individual is being singled out. I'm not sure if it's because that she has all this. I'm not sure it's because she's a woman in a powerful position. I'm not sure what it is. But I am disappointed and I think that this line of questioning, again, has very little to do with the budget. And I think I've explained this a couple of times. And again, maybe you don't like the answer, but this is exactly what had happened.

We have people moving all around to deal with this. And we've kept some people on because we need those individuals to help us with transition of things that the general public and yourself, Mr. Meili, have asked us to be able to backfill. You stood up in this House today talking about backfilling positions in rural Saskatchewan. This is one of those things that this individual will be helping us out with. So we need to have those skilled people in the skilled positions to be able to help us out on a short-term basis.

Mr. Meili: — What was the cost of the position?

Hon. Mr. Merriman: — She would be receiving the same payroll support as any other vice-president within the Saskatchewan Health Authority. There's a pay range there. I'm not sure of the pay range again, but she would be paid very similar to other individuals at that position, no different than other areas of government.

Mr. Meili: — Are the officials aware of what that pay range is for us?

Hon. Mr. Merriman: — The pay range for the vice-president for the SHA?

Mr. Meili: — Yes.

Hon. Mr. Merriman: — Thank you. The pay range can be found at the saho.ca website. All of our VP [vice-president] information is labelled out there as to what those pay ranges are. It is all in the public view and can be found with a quick Google search.

Mr. Meili: — Well that's very nice. I will ask Google since the minister doesn't want to share. The question though is . . . I think the question remains. And the minister asserted that somehow this is information that, or a discussion that isn't in the public interest or in the public realm.

But the fact of the matter is, it's been widely reported on that the departure of the SHA CEO was directly related to the minister's decision to force in someone of his own choosing. And if that isn't the case, if that isn't the case, I think the people of Saskatchewan deserve to know why . . . If that, which is the story that's been reported and is, you know, understood by the public

right now, if that isn't the case, then what was?

Hon. Mr. Merriman: — As I've said before, we had hundreds of people. Assumptions that are made online or on Twitter or . . . I haven't seen anything documented from senior leadership within the SHA that said that, or the board, so not privy to that information. You can make all the assumptions you want.

But again I'll remind the member that we're here to talk about the 2022-2023 budget. We can continue to do this for the next six hours if the member wishes, but I have a lot of officials here that have prepared a lot of time to talk about the budget. If the member wants to rehash question period from six months ago, I guess that's your prerogative. But we have officials here to be able to answer some information about this budget.

And I would think that this budget of $6.44 billion invested for the people of Saskatchewan is something that is significant and should be talked about, because there are a lot of great stories in here within this budget that our surgical list, our human resources, our Cancer Agency, mental health and addictions, all of these things that the people of Saskatchewan are very interested in and very supportive in on how we can make sure that our health care system is back on track.

And like I said, if you want to rehash question period from six months ago, that's your prerogative. But it has nothing to do with this budget.

Mr. Meili: — Minister, yeah, and I understand the minister isn't going to answer this, but it is of concern. We lost Mr. Livingstone from that role. And no shade upon anyone following in his footsteps, but it's a concern. We lost Dr. Tootoosis from the board. We lost Dr. Wasko from the exec. So to see that level of departure from senior leadership at a time like this is certainly concerning.

And it's been brought to my attention, and I'd just like to confirm whether or not this is the case. Has Paul Babyn, Dr. Paul Babyn, also stepped down from his role as a physician executive, and Dr. Tonita from the Saskatchewan Cancer Agency? Have those two individuals left those roles or are they still in those roles?

Hon. Mr. Merriman: — Thanks for the question. With an organization of 40,000-plus individuals, there is always turnover. There will always be turnover. There is retirements. There are people moving on to other positions within our system, within other systems. I've always been a very big supporter of people moving into positions if it's going to enhance their skill set. And if somebody decides to move into a different position in a different province, then our job is to replace that individual.

We've had a lot of people retire. There's a lot of assumptions that are being made about people and why they're leaving. The individuals that you just identified, I was told both of them have retired. So when people retire we wish them the best of luck. We thank them for their service, and we allow them to enjoy their retirement. We do not try to take their retirement and torque it into something else.

Other people leave for other opportunities. Some people retire. With an organization of 44,000 individuals, there's always going to be turnover. And when we have turnover, we try to do strategic planning to make sure that we have a succession plan. There have been some people that have moved on and have been critical of the system, and I accept that criticism.

Again, Mr. Meili, I don't think this is funny. You ask me serious questions and then you sit there and laugh like this is some comedy routine. This is a very serious subject about our budget, and I don't appreciate you being disrespectful to myself or to my officials by laughing. I don't laugh at your answers or your questions, so I'd appreciate it if you would be . . .

The Chair: — Okay. I'm stepping in as well. I remind the members of the committee: cordial, respectful, and productive atmosphere. I'd ask the member to proceed with a different line of questioning. The member has the opportunity tomorrow in question period for 25 minutes to pursue some of these answers, but let's bring things back to the estimates before us here today.

Mr. Meili: — Thank you, Mr. Chair, and I simply would say one . . . We see the minister laugh at questions all the time. It's a common thing that he does in another part of this job. And the truth of the matter is the questions that are being asked . . . We're asking you questions. You seem to be feeling like they shouldn't be asked, that it's somehow unfair or you're not okay to ask about departures. But when we have a serious number of people leaving the Health Authority, people in leadership . . .

You know, physician numbers are down significantly, three out of five nurses talking about leaving the profession. There are questions that need to be asked. And I appreciate the confirmation regarding the head of the Sask cancer association and Dr. Babyn. I think it is important for people to have a sense of what's going on.

[16:30]

One of the concerns I have — and after this I'll hand it over to my colleague — at this point are there any physicians on the board or executive . . . or pardon me. I know there are on the executive. Any physicians on the board? We lost a number of senior physicians on the executive. What's going to be done to make sure we bring in the leaders within that particular field to make sure that their guidance is used in directing these next stages?

Hon. Mr. Merriman: — Sorry, which board are you referring to? There's several within the health regions.

Mr. Meili: — Sorry?

Hon. Mr. Merriman: — What board?

Mr. Meili: — I'm referring to the SHA board. Thank you.

Hon. Mr. Merriman: — What board, sorry? Be specific. I would say that we have a very good complement on our board. We have physician executives that advise our board. We have a Chair who was a Chair of SGI [Saskatchewan Government Insurance] for years. We brought in specific individuals that had some specific background.

One of them was a leader within the community in mental health and addictions, on Minister Hindley's side of things, to be able to

advise at a board level about mental health and addictions and with some real-life experience. We've also brought in former Chief Reg Bellerose, who is a pillar in this community. We are making sure that we have a good complement and a very diverse board.

As far as Dr. Tootoosis leaving, yes, absolutely I was thankful that she was able to serve in her position but understand that she had to refocus on other things and very much appreciate that. It's not somebody that we can just turn around and replace very quickly. But we're always looking for new opportunities and board members, not just to serve on the SHA but on all of our boards, and make sure that we have a good, diverse board that represents not just the people that they are governing but also the community.

Ms. Mowat: — Thank you. I think we'll move on to talking about some other costs that the ministry is facing and sort of how we can most intelligently spend our money. So talking about some of the cost savings that we've been able to realize. We know that this is a very significant amount of the provincial budget that we're deliberating on today. And sometimes we get the criticism in opposition of always asking for more money, but I think we need to be doing this as smart as we can and be working smarter about how we do this as well.

One of the persistent themes that I've noticed, having been the critic for Health for a number of years, is the rising cost of drugs. And I know this is something we have spoken about before. I've noted that in this year's budget, there's a variance in the Saskatchewan prescription drug plan, an increase of 5.99 per cent. I don't think that this is atypical. We've seen this type of increase before. I'm certainly not arguing that we should cover less prescription drugs for folks, but I know that there are ways to save money on prescription drugs.

And so of course I'm talking about pharmacare here, an issue that we have discussed many times in this Assembly — more frequently, I would say, before the pandemic with the previous minister — and we've asked about in question period and had petitions and so on. But I think this conversation bears revisiting, considering what's happening with the federal government right now.

We know that the current federal agreement allows for the federal government to work quite slowly toward the goal of covering essential medicines only, after the 2025 election. We also know, anyone who has purchased in bulk or negotiated in sales knows that there is a lot to be gained from that buying power at the federal level. And certainly we've always advocated that this is something we should be pushing at the federal level because they have that ability to have that buying power. Our cost of drugs in Canada is so much higher than it should be, and pharmacare is the unfinished business of medicare. It's one of them anyway.

What have conversations looked like with the federal government on pharmacare? And have you taken a look at the recommendations — they would be a couple of years old now — from the advisory panel on the implementation of national pharmacare?

Hon. Mr. Merriman: — Yeah, maybe I'll just start and then I'll turn it over to my deputy minister, and then I think Mark's going to join us because this is his area of expertise.

There are certainly some synergies with what we want from the federal government and what their pharmacare programs look like. But I've been very adamant, and I know the Minister of SaskBuilds, my predecessor in Health, was adamant that we want to make sure that this is complementing our system. Like we have a very good, robust drug plan in Saskatchewan compared to some other provinces — certainly compared to some Maritime provinces. We want to make sure that the drug plan that is going to be proposed by the federal government and supported by the federal NDP [New Democratic Party], that this is in addition, this is going to be a net benefit for the people of Saskatchewan.

And that's what we really want. And we want to make sure that we're not detracting from anything. There are some areas within medication, there's some drugs that are very, very expensive that we brought forward in this budget that are millions of dollars for treatments. And we want to look at the federal government to be able to help us out with the procurement of that because it is very costly for one individual to receive one medication that might be a couple of million dollars.

So that's an area where I think the federal government could certainly help us out with in making sure that . . . if we do this across provinces. But I know that this is happening at the deputy ministers' table on the bulk buying, and we have been doing that for years in some specific areas.

But I'll turn it over to Max, and then Mark has a lot of information on this. This is something he really thoroughly enjoys.

Mr. Hendricks: — Actually we're very lucky to have Mark, who sits on the pan-Canadian Pharmaceutical Alliance. So you know, I think there are several factors. This is about my third time where the federal government has raised pharmacare at national tables during my tenure in the deputy minister's office, both as a DM [deputy minister] and as associate.

You know I think that . . . And we have reviewed the findings of the Hoskins report in detail. And you know, I think that there are some things that we like in that report and some things that maybe we think would be or could be done differently. I think there are some misunderstandings.

The federal government . . . and the Hoskins report suggested things like bulk buying, and it kind of ignores the fact that for several years, as the minister has said, provinces have been involved in the pan-Canadian Pharmaceutical Alliance. You know, I think when you look at the literature and you see Canadian list prices, you'll see that they're high, but that's not actually the price that we're paying. We have agreements with pharmaceutical companies.

And so this is part of a national strategy. And interestingly, you know, I think there . . . It was interesting several years ago when the federal government asked to become part of our pan-Canadian pricing alliance. So they asked to join us. And so I think that, you know, we as provinces have demonstrated a strong commitment to cost-effectiveness in our provincial drug plans.

One thing about the Saskatchewan drug plan is that, as the

minister said, it is one of the most comprehensive in the country. And we are interested in a plan, in a pharmacare program or something of that like that strengthens our program, not one that doesn't achieve, kind of, the maximum benefit for the people of Saskatchewan.

You know, essential medicines list, typically you might have 400, 450 medications that are your most frequently prescribed medications that might be added to that list. In Canada, where that would probably start is with a lot of medicines that have already fallen into the generic category and therefore generally are lower cost drugs. Also we have to remember that there are a lot of people in Canada that have insurance through a private provider through their employer. You know, there are some issues around essential medicines list, about whether that would shift costs to, in this case, the federal government and to the provinces.

So we need to have those discussions with the federal government. We want to see a program or programs that, you know, kind of address the key issues that the province is facing right now, the biggest being probably expensive drugs for rare diseases. We're having a whole bunch of new drugs that are coming to market every year that are 1 million or $2 million per person. And you know, were you to have a drug for an illness that is prevalent in Saskatchewan that is currently untreatable, it could be a tremendous, tremendous pressure on the province. So you know, that's like one area that federal assistance would be very beneficial.

And so I think, you know, in April I have a meeting with my federal and provincial colleagues to discuss this, amongst other things. And we'll be asking questions about this, about where the federal government intends to go, whether they intend to use the Hoskins framework and just carry that forward or whether there's an opportunity for provinces to weigh in on, you know, I think with some of our concerns, thoughts about where a national program could go. No doubt that a national program would be great, but it's just, you know, I think that because we've invested so much as a province, we may want to see some different things out of that. And I don't know, Mark, if you have anything to add.

Mr. Wyatt: — I can maybe just elaborate a little bit on the pan-Canadian Pharmaceutical Alliance and specifically on the point around bulk buying. The PCPA — that's our acronym for the pan-Canadian Pharmaceutical Alliance — it doesn't bulk buy, but it bulk negotiates. And the result is that all of the provinces and territories basically purchase based on the negotiated price that's been agreed to through the PCPA.

And so you know, when I go back to, you know, the drug plan budget from a decade ago, there was basically how much we expended on drugs and that was the bottom line. Now when we look at our budget for drugs, both within the ministry but also within the Cancer Agency, there's how much we spent on drugs and then we have rebated amounts that come back based on the PCPA-negotiated prices which now are . . . You know, I can tell you it's more than $100 million that we're talking about as a ministry and also tens of millions of dollars for the Cancer Agency.

Writ large across the country, we estimate that the PCPA-negotiated savings on an annual basis is now $2.9 billion and growing. And it's a combination of both savings generated through those brand negotiations, but also we collectively negotiate on behalf of all the provinces, territories, and federal plans for a generic pricing agreement. And so we basically have a framework that determines what the price is for all of the generic drugs sold or compensated through public plans. And with the higher volume drugs, we're now down to basically 10 per cent of the actual brand cost for those products.

So through those generic negotiations we have saved, you know, billions of dollars for Canadians in being able to negotiate that. And I will say, you know, it's a negotiation with the generic manufacturers' association and done in a way that we're trying not to force anybody out of the industry. We're trying to maintain, you know, a Canadian presence in terms of pharmaceutical manufacturing, research, development.

Other countries have gone down the direction of tendering to get the absolute lowest generic price which I think . . . You know, we've taken a different path to negotiate, you know, the lowest price that we can achieve through those negotiations, but in a way that doesn't lead to some of the potential unintended consequences around drug shortages, loss of investment in the pharmaceutical R & D [research and development] and manufacturing in the country.

[16:45]

Ms. Mowat: — Thank you. A very thoughtful response. Certainly we have participated in many of those conversations about coverage for rare diseases, so appreciate that that is driving cost pressure as well.

Ultimately when we're talking about this, certainly we want to make sure that it's going to be cost-effective for the ministry, but the bottom line is access as well. And I did not grow up in an affluent family. We did not have coverage for drugs. You know, I lived as a student without coverage and was happy for the coverage I could cobble together at times. And I am still, you know, a privileged individual in our society. But something as simple as accessing birth control pills was very difficult for myself.

And so I know that these challenges face people every day at the kitchen table when they're talking about drugs. So I appreciate the comments around overall cost savings for the ministry. I know that a lot of people are fortunate enough to have good coverage through their job. I'm one of those people right now that has good coverage through my job and a lot of those things have been negotiated. But at the end of the day, it's also the right thing to do to be able to provide those essential medications.

And you know, this isn't a bleeding-heart appeal. It is just sort of as a reminder that if there can be cost savings realized at the ministry level and we can also help out those folks in Saskatchewan that don't have access to essential medications, it is a win-win. So I'm really encouraged to hear that the ministry is open toward this, to hear the deputy minister saying that it would be great if we had a federal program. You know, I think these are steps in the right direction, so I look forward to continuing dialogue on this.

But unfortunately, we have many different things to chat about

here today. So I will move on to an additional topic here. We're talking about cost savings. I've always taken particular interest in the concept of Choosing Wisely, which I know that there has been some work directed to in the past. I know it's been a very busy couple of years with the pandemic. I've had the opportunity to, you know, attend a conference on this and learn quite a bit about what practices are happening across Canada. I remember that there had been some initiatives in Saskatchewan, but I'm looking for an update on if there's any work that's ongoing, if there are any priorities and opportunities, things like targets that have been set, and whether those have been achieved.

Mr. Wyatt: — Probably the best example that I can give you of, you know, work related to the appropriate use of health resources would be the work that we're undertaking right now around plasma, blood plasma. And it's a topic that I know that Choosing Wisely has been looking at. It's one of the areas overall in terms of, you know, blood expenditures, but also trying to address high costs in health care through the more appropriate use of blood products in the health systems across the country. In Saskatchewan, we've done work in the past around whole blood.

And having said that, we recognize that we had opportunities within immunoglobulin plasma preservation to be able to both save some money but also . . . There are plasma shortages internationally. And so part of this was also brought on in recognition that, you know, there is some risk of potentially running into supply shortages. So we've been working on a . . . through a sort of a task group that's made up of representatives from the Health Authority, physicians, and the ministry, with some focused strategies, trying to look at alternatives to IG [immunoglobulin] use.

And so far, you know, starting to see some good progress in terms of being able to identify alternatives, identify appropriateness criteria, working with physicians around those. And so I would say, you know, in terms of the activity within Saskatchewan right now, there may well be other examples that could come to mind. That's one that I'm part of that I think is very much a good demonstration of kind of the Choosing Wisely philosophy.

Ms. Mowat: — Thank you. That's certainly the only example that I've seen lately as well. So maybe this is a plug to initiate more of those endeavours. And I know that it can be tricky because usually there's physician leadership and study and all of those pieces that are brought in as well. But I think there can be . . . Sorry?

Mr. Hendricks: — Sorry, I can maybe start. So we meet regularly with Choosing Wisely Canada, and I meet with their CEO from time to time. Obviously you don't meet with them every . . . or we haven't met with them recently because of the pandemic as often. But you know, I think that, you know, those discussions will re-engage. Saskatchewan has been a partner in informing their priorities before in terms of Choosing Wisely but, you know, I think in terms of what we've done, we've done some work independently in Saskatchewan in the past around orthopedics. And you know, we will be continuing that work.

And you know, as we go, one of the elements of this surgical backlog and the wait-list that we have now is we need to make sure that the surgeries that we are doing are the ones that we should be doing and that people are properly informed and that we're using our precious HHR [health human resources] resources, our surgeons, and our O.R.s [operating room] appropriately as well as our dollars. And so work will continue there, and Mark can kind of build on that, you know, kind of the work that we're doing on the orthopedic stream.

Mr. Wyatt: — Yeah, just in recognition of the fact that orthopedic in-patients make up such a large part of the surgical backlog, and particularly the in-patient backlog which requires more resources to be able to move through those, through the wait-list, we are creating sort of a model line process to be able to address how we can both increase the number of orthopedic procedures that are done in the province, how we can better distribute them across all of the surgical hospitals in the province.

But another component of that will be, you know, looking at appropriateness of orthopedic procedures and ensuring that, you know, as people are reaching a point where joint replacement is a consideration, you know, that they've explored all of the options for surgery. As Max mentioned, there has been work done in the past related to orthopedic surgery in particular, but we also know that we still have a high rate of orthopedic, you know, total joint replacements for hips, knees per capita in Saskatchewan. So I think there's, you know, definitely an ongoing opportunity to look at appropriateness criteria as one of the ways that we can be able to move through the wait times.

Ms. Mowat: — Thank you. Also in the vein of cost savings, I think it's been five years since the SHA was amalgamated. And I think back in 2017 it was estimated that we would save $18 million due to this amalgamation. What is the current estimate on how much has been saved? And can you speak to which components of amalgamation have not yet been completed? Because I think there are still . . . we're not completely through that process.

Hon. Mr. Merriman: — I think I'll start and then Max can get some of the . . . It is about dollars and cents, but it's also about efficiencies. And I just made a comment to one of my colleagues earlier today, saying I can't imagine what it would have been like running . . . going through the pandemic with multiple health regions. That would have been very challenging because everybody would have been in competition for vaccines, for clinics, for testing facilities. And we would have had all these different districts to be able to manage. And I saw what was happening in Ontario and some of the other provinces where they still have the multiple health regions. And they were running into a lot of challenges with their local CEOs and people getting very frustrated. So there is a dollar value.

Certainly that was identified that there would be some savings on efficiencies, on some senior management and that. But it's not always about the dollars and cents. It's about the efficiencies that we've created, the streamlining that we have done in a lot of our programs and services which, you rightly pointed out, is still evolving. This is still evolving. We're working on that. That's part of our health human resource strategy is to make sure we've got the right people in the right places at the right time. But there is a dollar savings, but the efficiencies that we've created and the better quality of care that we have been able to provide and will continue to provide will certainly outweigh the dollar amount. But Max, I don't know if you have any additional information.

Mr. Hendricks: — Yeah.

Ms. Mowat: — Maybe I'll just . . . Can I just respond to that?

Hon. Mr. Merriman: — Sure, yeah. Absolutely.

Ms. Mowat: — Thank you. Just to respond a little bit to that, certainly I agree that it's not always about cost savings. Looking at a few different ways that we can realize some of that, though, I do remember at the time that there was a lot of emphasis on the cost savings on the ministry's behalf. So that is why I'm bringing it up, and I think it's a fair question.

And on the efficiencies piece, I agree with you. If things have become more efficient as a result of amalgamation, great. But there are also a lot of examples where things have become less efficient and that there have been additional roadblocks created for folks. And you know, I know you can sort of pick and choose your examples for things, but I think about the fact that former health regions are still utilized in a number of different categories. And I know that, you know, folks were still having to submit through their facilities what they thought they would need for COVID, and that that went through their former health region. Like there's still a structure in place that involves the former health regions, so that's sort of what I'm getting at. I know it's not exactly the same.

And things like centralized scheduling, it's been a mess. Like there's no . . . You don't hear back from folks when you request time off. Like we have heard very serious concerns that affect quality of life for workers. You want to talk about retention; like, we've got to keep people around. And keeping people around means, you know, respecting their time off and those pieces, so just a couple comments about efficiency there.

Hon. Mr. Merriman: — And completely understand. It's not a . . . There was an emphasis on the cost savings, but I think what the pandemic highlighted is how we can work together as a centralized unit. And there are still some pressures out there. You've rightly identified them. You're bringing them forward in this Chamber as casework and as people that need to be able to get their health care in a timely manner.

Like I said, it would have been a great challenge to do what some of the other provinces were doing and very separated and with defined borders on . . . We had the ability to be able to . . . people that could get vaccinated anywhere in the province. And that wasn't the case in a lot of provinces. They had to stick to their specific area and get their vaccination in their specific area.

So for sure there's dollar savings that we can look at, but there are some challenges out there. With any time we centralize a system, there are some challenges. There are some of the more rural facilities that we certainly heard, the Minister of Rural and Remote Health and myself heard, said that they're challenged, and we need to be able to backfill that. Whether that's with management, whether that's with operations, capital, we need to be able to do that.

So we want to make sure that we're not just looking at the big structures of Saskatoon, Regina, and Moose Jaw, P.A. [Prince Albert], but we're looking at the smaller health care. Because if we lose the ability to have our smaller health care facilities supporting us, our larger facilities cannot handle that. So we need to be able to make sure we're supporting it across the system. Sorry, Max. I cut you off.

[17:00]

Mr. Hendricks: — Yeah, so when the SHA was created the original, I think, commitment was to save approximately $9 million in senior executive salaries. And that has been achieved. You know, as we go through the organization, and you know, it's a massive undertaking when there are this many people involved, the SHA has kind of been moving from obviously the VP level, which is completed. They've completed the executive director, director level, and they're kind of down at the manager level out in the various areas of the province.

And you know, one of the things that I think is important to remember is, you know, while we've merged our 12 regional health authorities into one provincial health authority, you know, this type of transition — we're almost at five years — took 8, 10 years in Alberta because it's extremely complex. We literally had dozens of different accounting systems, dozens of different scheduling systems. All this has to be brought together, and that is well under way.

And I'm hoping and confident that over the next several months we're going to see some of the real benefits, the non-clinical benefits of amalgamation into a single health authority, from an administrative perspective as we combine those systems.

And so I think that the most important part though, as the minister was saying, is you know, as a deputy managing through the pandemic, I cannot imagine managing 12 regional health authorities to have done what we were able to do during this pandemic, including moving staff around as we needed them, being able to respond, not having budgetary issues between regional health authorities, you know, impede decisions.

And so I think the clinical care of the people of the province, and being able to move patients actually when we needed to, was greatly served by having a single health authority. And so, you know, I don't know if health ever saves money at the end of the day, but you know, in terms of cost avoidance I would say that this amalgamation, that's probably where we'll yield the greatest benefit, just in terms of those efficiencies that we'll never see or be able to quantify.

Ms. Mowat: — Thank you. And thanks for providing a bit of an update on where the process is at. Can we get an update on the IT [information technology] consolidation at eHealth? Is there a service agreement that has been finalized?

Mr. Hendricks: — Discussions are still under way. Work was paused during the pandemic in terms of that integration. And so very recently in the last couple of months we've asked eHealth, the SHA to begin that work again in earnest. It's really important that we complete that. So discussions are still ongoing about that.

Ms. Mowat: — Maybe while I'm in this topic I'll ask another one of my questions about eHealth. It was estimated over a year ago now that eHealth needed $150 million over the next three years to update obsolete and failing equipment. We know that the risk of failure is quite high here. I think the pandemic has also

highlighted the importance of eHealth.

Can you provide an update on whether this is being prioritized or what equipment has been updated and how much money is being dedicated toward this goal? And I'm referring to . . . There was a CBC [Canadian Broadcasting Corporation] News investigation. I think that they had . . . I think it was a minister's briefing note that had been sought through the FOI [freedom of information] process that came out of January of 2021.

Mr. Church: — So we've continued to progress our . . . Oh sorry. Davin Church, eHealth Saskatchewan. We've continued to invest in modernization. Over the last three years we've invested close to 30 million through government-directed funding.

This upcoming year, we'll be investing our total sum of the capital, 7.4 million, into the modernization. We'll continue with investments in other areas, such as our Windows 10 replacement, close to another 7 million there. And then also just a lot of the utilization in health system pressures will go to helping to reduce any pressures on different systems there as well through upgrades and others.

Right now, and as you've referenced to the media report that came out last year related to some materials that were provided to minister, officials, we're at a point where we've invested a significant amount. As we move forward with the SHA and looking at consolidating former clinical systems that were disparate across the province, former health authorities, as we move through those, those will also reduce that amount. So might not be directed through more broader modernization but through other initiatives.

And so we're at a point also where in this upcoming year we'll be doing a reassessment on what that investment over the next period is. And also looking at . . . and the inclusion of that was also these systems need to be maintained. They aren't a once-and-done. So also that evergreening in asset management component, which we know is a focus and we've been working with the Provincial Auditor on as well.

Ms. Mowat: — Thank you. So you said 7 million is going toward basically this area in eHealth in the upcoming year?

Mr. Church: — We have 7.4 in capital funding that was provided, as well as we have operational funding that's been provided to continue to refresh, particularly around Windows 10 and so forth as well. So it'll be probably closer to the 14 to 15 million. So we're still developing our operational budget and allocating that. But through directed funding we'll have the 7.4 as well as a portion of the 3.2 in utilization and health system pressures as well, as well as operating budget that will be invested there. That's been part of our previous year increases.

Ms. Mowat: — Thank you. What's the next clinical system that you're looking at? Like, what are you tackling next?

Mr. Church: — Davin Church, eHealth. Our predominant focus right now has been on contract consolidation from those former regions on the clinical side to at least maintain and get some cost savings through that, through common CPI [consumer price index] indexes that varied across the former regions.

You know, the clinical systems were continuing conversations with the Saskatchewan Health Authority. Certainly those are much more intensive and require a lot of front-line support and input from clinical leaders. And so the past two years, what we've focused on predominantly, contract consolidation of those various contracts with similar vendors or same vendors. We are beginning to have conversations just around what opportunities we have for consolidation of various other clinical systems.

Ms. Mowat: — Thank you. Switching gears a little bit, certainly it seems one of the benefits to amalgamation is the ability to look at big-picture recruiting and retention efforts, human resources. I want to delve into this a little bit in terms of what the new agency is going to look like and some of those pieces.

It certainly seems like there is a tremendous opportunity to centralize recruiting and retention, but as far as I can tell at this point, those efforts have not been centralized. What I hear from community leaders is that each of them works to advocate on behalf of their community with their local representative to identify what their needs are to their rep in the SHA, and then those needs are sort of brought to the bigger table and negotiated and talked about. But each of those . . . I've had these conversations over and over again, and they seem very similar in pockets all across the province. And it does not seem terribly efficient.

Of course I know that the needs are different in different communities and there will be different models that are suggested by local leadership. But can you speak to how this agency — I don't even know if it has a name yet or what it's called — but how we expect recruiting and retention efforts to change?

And you know, I want to believe that this is going to have a significant impact. But I don't know what the dollars are, who the people are, and what the scope of this agency is going to be.

Hon. Mr. Merriman: — I'll maybe just start out. And thanks. It's a very good question and we've got lots of questions about this since we made this announcement. The official name is going to be the Health Care Recruitment Agency of Saskatchewan. That's going to be the umbrella organization that is going to work with . . . And it's not just us working in a silo; it's working with the Minister of Immigration and Career Training. They obviously have contacts in and around the world that we can tap into.

What we are looking for from our Health Authority and from other areas of our health care, not just the SHA but other areas, what is it that we need out there? What are the people we need? What are the positions, short term and long term? And as the Premier was identifying, there is a multi-point plan out there right now to be able to not just recruit people internationally and nationally, but also to retain them, to make sure that they stay here for a long time, they set up roots in our province, and they can call it home, hopefully for generations.

But on top of that, we also have to train internally. There was a lot of talk at SUMA and at SARM on ideas that local areas have done to be able to recruit. There's offering of housing, vehicles, to be able to help out with the recruitment process, to be able to bring specific individuals from across Canada and from around

the world and call Saskatchewan home. As I've said before, we have a great story. We've all chosen to live in this province for a multitude of reasons, and we need to able to show that this province is growing. This province has a lot to offer as far as a work-life balance, and we need to be able to bring those people in and be able to sell Saskatchewan on what it is that we have here that is unique.

Now in saying that, we've got some dollars allocated specifically for recruitment into the Philippines. We had $1.5 million earmarked for incentives, and that would cover anything from travelling costs from somebody — you can imagine the travelling costs from the Philippines to going to Saskatchewan — but also supporting them when they arrive here, to make sure that we can get these individuals. Because as I mentioned before, we're in competition with other provinces and other states to be able to get quality health care workers, so we want to make sure that we have our best offer on the table.

[17:15]

As well as that, we're working with the Minister of Advanced Education, Minister Makowsky, on increasing the number of nursing seats, the number of doctor seats. We're working with the College of Medicine to be able to make sure that we've got enough individuals that are going through our advanced education system. And then once they're through we've got to do a really good job of retaining them here in Saskatchewan, and making sure that they have the opportunity to call Saskatchewan home and they're not getting poached from other provinces. So we've got to make sure we do that.

There's a wide variety of incentives that we can work on. But in also saying that, we have to make sure that we're not just covering our major centres, we're covering rural and remote. Because that's where we're hearing a lot of the challenges at the SARM and SUMA and we're hearing it through our office. And I'm sure you're hearing it through your office as well.

So we've got a lot of work to do, but this is the agency that's going to do it. And as I mentioned at SUMA today in our breakout session, that this agency is no longer . . . is not just Saskdocs. It's not within the SHA. This is a separate . . . that's going to have its own board reporting in to the deputy minister and myself and the Minister of Rural and Remote Health, so we have a better idea of what's happening and how we can be nimble to be able to capture as many people in this market as we can and bring them to Saskatchewan.

Sorry, Mr. Chair.

The Chair: — Thank you, Mr. Minister. Having reached our agreed time for consideration of these estimates, we will adjourn consideration of the estimates and supplementary estimates no. 2 for the Ministry of Health. The committee will now recess until 6 pm.

[The committee recessed from 17:16 until 18:00.]

The Chair: — Welcome back, committee members. We will now resume consideration of the estimates and supplementary estimates no. 2 for the Ministry of Health. Mr. Love will be substituting in for Meara Conway. Mr. Love, the floor is yours.

Mr. Love: — Thanks, Mr. Chair. And thanks to the ministers, all the officials that are here. It feels like a fuller house than what we had, you know, a year ago when we here. So it's good to see everyone, and thanks to everyone for the work that you do in support of these ministers.

Most of the first section of questions here, I'm going to ask a number of questions related to staffing, just looking for numbers and data. So that's going to be kind of the focus for the first section here. And most of this, as critic for seniors, will be related to, you know, care provided to seniors along the whole continuum.

I want to start talking or asking questions about long-term care specifically. Minister Hindley, if you can tell me how many continuing care aides are currently working in Saskatchewan. If you can give me the total FTE [full-time equivalent] and as well as how many of those are full-time permanent positions.

Hon. Mr. Hindley: — Thank you, Mr. Chair. So in terms of long-term care staffing of full-time equivalent positions for 2020 and 2021, which is the most current stats that we have available, there are 5,118 FTEs for continuing care aides. We don't have a breakdown of permanent and part-time. That's just an overall FTE number that we have that we track.

Mr. Love: — Do you have a number of how many individuals in total contribute to that FTE?

Hon. Mr. Hindley: — Sorry, we don't have that number.

Mr. Love: — Okay, I might come back to another question on that later. Can you let the committee know how many vacancies there currently are for continuing care aides in the province, how many unfilled positions exist province-wide?

Hon. Mr. Hindley: — The number of active job postings as of March 2nd of this year for continuing care aides or assistant CCAs [continuing care aide] is 202.

Mr. Love: — And can you tell me how many of those posted positions are full-time, how many might be part-time or casual? Full-time permanent.

Hon. Mr. Hindley: — Yeah, unfortunately, similar to the other question, we don't have the breakdown of full-time versus part-time and all that available with us.

Mr. Love: — Is that an answer that you can table for the committee?

Hon. Mr. Hindley: — It'll take some time, but we'll try and get that number for you.

Mr. Love: — Okay. So I guess one of the concerns that I have that I'm sure that you're aware of, and it's been discussed in this committee in the past, is the casualization of the long-term care workforce.

Now in this committee in the past when that's been discussed, the response from the government was that the government is moving away from casualization and looking to address recruitment and retainment by moving to . . . and I can't quote on

this obviously right now. But my recollection is that there was a move towards recognizing that to recruit and retain, we need full-time permanent positions that people would be . . . so that was the discussion.

But tonight you're saying that the ministry doesn't track any of those numbers. So I guess my question is, how can we know and how can the committee and people of Saskatchewan know that we're moving towards regularizing full-time permanent work if none of those numbers are tracked?

Hon. Mr. Hindley: — Yeah, it's my understanding we do track them, but we don't have those stats with us here this evening.

Mr. Love: — So going back to my previous question about the 5,118 FTEs. Can you table an answer to the committee detailing how those FTEs are divided between full-time permanent, casual, and part-time?

Hon. Mr. Hindley: — Yeah, we'll have our officials try to break down that information for you. So we'll try to provide that.

Mr. Love: — And commitment to table the answer to that?

Hon. Mr. Hindley: — We'll try and get you the information.

Mr. Love: — Okay. Continuing to look at questions of staffing. I'm wondering if you can tell me how many retirements and resignations there were in the long-term care workforce last year.

Hon. Mr. Hindley: — So the retirement information, we'll try to get that for you. Again, we don't have that at our fingertips right now, so that would take some work from the officials to, sort of, break that number down.

With respect to the question about resignations, that's a bit more tricky to try and pin down because you could have, you know . . . We have thousands of health care workers in the workforce, and so there's constant flux and movement within that, within the staffing. And people leaving for a variety of reasons. As an example, a staff person may decide to leave a job at one facility and move to another one. Perhaps they leave the community, or who knows, right?

So that's a bit more difficult to track and really sort of gauge when it comes to resignations. So that's a hard number to get. But on the retirement number piece, we'll see if we can do a bit of a deeper dive and find that, some figures for you.

Mr. Love: — Yeah. I can understand, Minister, how that is a challenging number to come up with. I'm wondering if you can provide any, you know, anecdotal comments as far as what your sense is on this file of folks in the workforce, as far as if we've seen regular levels of attrition or if that has either been increasing or decreasing through the pandemic.

Hon. Mr. Hindley: — Just, you know, anecdotally you know, it's been . . . I think that we're just chatting here amongst officials, and I think I might have some comments here from the deputy minister or the interim CEO of the SHA just in terms of, you know, what they might be hearing and seeing out there in the system.

We do track overall attrition rates here. And there doesn't seem to be any, at least for, you know, looking at the numbers for . . . and the most recent ones we have for 2020-2021, there doesn't seem to be any changes. Kind of in the ballpark, it looks like, just based on the chart that I'm seeing right now. But again that's just for that particular budget cycle. But I don't know if Max or Andrew might want to speak to this a little bit further.

Mr. Will: — Yeah. Thanks, Minister. Andrew Will, interim CEO of the Saskatchewan Health Authority. You know, I would say certainly throughout our organization we have turnover that normally happens, you know, people that get to retirement age, people that, as was mentioned earlier, churn between facilities. You know, I think certainly the last couple of years has been challenging for our staff. There's no question about that. They've had to do some pretty tough work, and we're really thankful for the work that they've done.

I think you would probably find some examples of where people have decided to retire, but I think you would also see people that might have been eligible that hung in there and stayed in the workplace as well. So as the minister said, the stats show some pretty consistent turnover. So I don't think I would say at this point we've identified a trend either way. They're probably all kinds of different circumstances.

Mr. Love: — Yeah. Thanks, thanks, Andrew, and it's nice to meet you. And you know, and I agree. I think certainly what I'm hearing is that folks who work in long-term care, I think that there are probably lots out there who might be eligible to move on, and they're sticking around.

[18:15]

I think it's fair to say they care about the residents. And they know that this has been a difficult position to recruit and retain, that there's been struggles in the workforce. And they want to make sure that the care's there for the residents. So I appreciate the work that those folks do too and it's good to hear that.

If there's no other comments on this, I'm just going to backtrack for a minute then, and I guess with the news that there's normal attrition rates, you know, we're not seeing any trends. I just want to note that the last time that this committee met, the number of FTEs was 5,054 in CCAs. I'm looking at *Hansard* record from April 14th, 2021. And tonight the number is 5,118. And so I'm wondering how does this represent the government message that 108 new care aides were hired last year as part of the promised — I heard 300 — because those numbers only show a difference of 64?

Hon. Mr. Hindley: — Yeah, no, great question. So last year's budget commitment was funding to hire 108 CCAs, and as of the most recent information I have, the member's correct. We have hired 101 of the 108 CCAs. So 94 per cent of the positions have been hired. And I believe, it's my understanding, that the remaining seven positions are posted right now. So again that was the budget allocation just to fill those 108 spots for last year. And of course there's an additional . . . in this current budget year, there is $6.53 million to adding the next tranche of that.

So 117 is what we're hoping to hire in this current budget year. So we've hired 94 per cent of the CCAs that we had funding to

try and hire in the previous fiscal year, and are at 94 per cent there. Just a little ways to go to finish the rest of those, fill the rest of those spots.

Mr. Love: — So can you help me to understand how that's represented in the numbers? If there's only been an increase of 64 . . . And I realize that there's, you know, people coming and going all the time. You know, this is a point-in-time number. I realize that. But it's significantly different than 101 hires, and especially if we factor in the 202 vacant positions.

Yeah, I guess, Minister, just if we . . . If there should currently be by, you know, the jobs posted, 202 more people already working because those positions are posted. Just wondering if you can help me make sense of this, given the message that the government was successful in hiring all of the promised new positions.

Hon. Mr. Hindley: — Right. And just to clarify, the 5,118 is for 2020 and 2021, not '21-22, right. So the 108 that we funded for last year were for '21-22.

Mr. Love: — Okay. And as far as the 202 vacant positions, would you say that it is the goal of this government to fill as many of those as possible? And then to fulfill this year's promise of 117, that's in addition to the vacant positions?

Hon. Mr. Hindley: — The attention and the commitment that was made during the election was 300 additional continuing care aides over the term, this term. And yes, those are over and above any existing positions or, in this case, vacancies that we might have.

Mr. Love: — Well I guess that the question still remains — and I don't imagine we're going to agree on this — but if there's 202 vacant positions, have you really succeeded at hiring an additional 108?

Hon. Mr. Hindley: — Well we have, because they're new positions that there's been new funding created for, for these positions. So we're expanding the number of continuing care aides that we do have across the province, both in rural locations, home care, long-term care. And these are new positions that didn't exist before this commitment, so it is . . . at the end of the day, it will be more continuing care aides province-wide than what we had before.

Mr. Love: — If the 202 vacant ones are filled.

Hon. Mr. Hindley: — Which we're trying to fill as quickly as we can.

Mr. Love: — Can you tell me how many of the . . . I think I already asked that question, actually, about how many of the posted positions are full-time. I already asked that. I'm going to move on to another question.

Can you tell me, of the new positions that were filled last year, including these 101, how many of them were filled by individuals who weren't already working in long-term care? Are you able to say how many of them were maybe filled by people who didn't move from . . . Or maybe you can tell me how many were filled by folks who moved from casual, part-time into a new full-time position. And how many of them were people who were new to long-term care, essentially showing successful recruitment of new workers into the sector?

Hon. Mr. Hindley: — So some of this information, we just, we don't, you know, track specifically in terms of where an individual may be coming from. It's my understanding when they're hired as CCAs in this system, there's obviously a lot of turnover in that particular area. There's, you know, a number of, a large number of postings on an annual basis when it comes to that. But I'll maybe ask Billie-Jo Morrissette, assistant deputy minister, to comment a bit further.

Ms. Morrissette: — Good evening. Billie-Jo Morrissette, assistant deputy minister with the Ministry of Health. So the minister is right. You know, when we look at CCA vacancies in any given year, you know, we post, I think it's upward, you know, close to 4,000 jobs every year. So there's kind of this continuous churn in the system where people are, you know, they're moving, they're taking on different positions, and it's just because of the size of our system. It's a really, kind of, common thing that happens in the system.

But with respect to your question around how many of the new positions, you know, where are they coming from, we don't, you know, we don't track them. When we hire them, we kind of don't keep the statistics on, you know, where they're coming from. But I think it's fair to say that it's probably a combination. So you will see people come . . . you know, we have in some cases increased the amount of hours in a position to make it full-time, as an example. So you'll see some individuals who are already in the system who would be taking on more hours or taking advantage of that full-time position. So that'd be one circumstance. You probably see people, you know, bidding into those jobs who are already in the system.

But we also do train a lot of CCAs every year. And so there would be a large number of new CCAs coming into the system that we'd expect to be, you know, bidding into those depending on the nature of where they are. But we don't have that information available to us. But I think it would probably be fair to say that it would be a mix.

Mr. Love: — So if somebody moved from, like, somebody was already in the system and they moved from a casual or part-time position as a CCA into a full-time position, would they count as one of the 101 new hires from last year?

Ms. Morrissette: — Yeah. So there would be a scenario where, as an example, we might have had, you know, let's say a 0.6 position, and we used some of the new positions to make a full-time position. So that 0.4 would be part of the new, you know, what we're talking about here in terms of the new positions. So for certain, yes.

Mr. Love: — So in this budget year with the promise of 117, have you already designated which facilities those new jobs or the new FTEs . . . like, I realize from what you're saying it might be actually just bumping up, like, you know, 0.6 to full-time or something like that. But have you already designated which facilities those FTEs will be for? And if so, can you provide a list to the committee of where they're designated for?

Hon. Mr. Hindley: — As of right now we haven't determined, you know, which facilities, which communities . . . We will. We did that with last year's commitments, and there was a comprehensive list of which communities, which facilities, and how many positions, and all that stuff. Yeah, as of this point we haven't done that but we will be making those decisions, I think, in the weeks ahead. And that would be public information there as well.

Mr. Love: — Can you provide any comments on how those decisions are made? Like, do facilities apply for more staffing? Is it based on a per capita or per resident quota? Like, how will you decide where those 117 — and probably 117 plus the 7 from last year so, you know, 124 — how will you decide where they go?

Ms. Morrissette: — So it's a combination of factors in terms of how we decide where they go. So certainly we would look at the information around, you know, per capita or some of those other metrics that we'd have available to us. But we also do consult with the SHA. So the SHA, you know, we look to them to provide advice around, you know, where that clinical need is. So it's a combination of, you know, what we know around some of the data and around some of the metrics that we have, but as well as kind of consultation and engagement with the SHA and its leadership.

Mr. Love: — Can you tell me how much was spent on overtime pay in long-term care last year and how much is budgeted for this year?

Hon. Mr. Hindley: — Yeah, we don't have it broken down. We just have the overall overtime figures for the health care system. We don't have it broken down by long-term care and acute care.

[18:30]

Mr. Love: — Can the minister comment, then, just even anecdotally on, you know, trends, you know, through our second year of the pandemic in terms of increased costs? I know that we were, back in supplementary estimates, looking at increased cost to the system due to overtime for front-line health care workers. So even anecdotally, Minister, what trends have you seen in the, you know . . . I don't want to put words in your mouth, but over-utilization of overtime pay to ensure that there's folks in buildings caring for residents?

Hon. Mr. Hindley: — I suspect — again this is, you know, not factual by any stretch of the imagination, but just anecdotally — I would suspect that there has been some increases. We know that there's been, you know, significant pressures when it comes to overtime on the acute care side, and I expect that there would be some on the long-term care side.

You know, you mentioned in some of your earlier comments about the great staff that we do have working in long-term care. And I know some of them personally. I've talked to some of them throughout the last couple of years, and how — like any one of us, but particularly in the area of health care — how they've had to adapt and put in long, hard hours, extra hours to provide the care for the residents that they, as you said, care about. And I know that to be true just from the staff that I know that work in long-term care, whether they're nurses or continuing care aides. And I've spoken to personally, I'm sure you have as well, as you've mentioned, that they've gone above and beyond, perhaps what their normal duties may have been before the pandemic.

And then also if you look back, I think, at what we had over the last couple of years in terms of visitation restrictions to limit the spread of COVID-19, and particularly when it came to protecting our seniors and those in long-term care, it unfortunately meant that we had residents that weren't able to leave, in some cases, to visit family.

Or vice versa, have children, nephews, nieces, that sort of thing, come in, friends to come in sometimes and in a roundabout way help with that. They'd come in, and you know, maybe come in for a meal and help out their parent or loved one that's in a care home, or would take them out for a day trip for a Sunday afternoon coffee, that sort of a thing. And you know, that would in an indirect way take some of the pressure of the staff. And they just didn't have that because of the measures over the last couple of years. So because of that I expect that, again anecdotally, that there would have been increased use of overtime in amongst the long-term care as well.

Mr. Love: — Yeah, I think that one of the things that all of us with eyes on the system need to be paying attention to is the effectiveness and the impact of that incredible overtime that many of these workers have been putting in. I'm sure you've heard stories of workers who have gone extended periods of time without being allowed to take vacation time because they were simply needed on the job, being mandated overtime shifts, working just incredible . . . I mean, we know what it's like to work long hours, but when you're doing lifts and toileting and all this work, like it's just incredible respect that I'm sure that we both generate for the folks who've done this.

And I think all of us in the room with eyes on the system, I think that it speaks to the need for increased staff and for the need to treat those workers well and show our full respect, to limit that overtime so that they can stay in the job longer, you know, that we see more folks choosing to stay in the career for a longer amount of time.

Hon. Mr. Hindley: — If I could maybe just add on to that, I agree with the member and his question about . . . And that's why, you know, we've put some commitments towards additional staff. And I think it speaks to the new health human resources agency that was mentioned in the budget and how important that is going to be for us, you know, as a provincial government, as a Ministry of Health in terms of identifying where are our priorities and where do we need to be recruiting and retaining staff in a number of areas. And that includes our long-term care facilities and what do we need to make sure that we're addressing any gaps that might be present when it comes it to, you know, CCAs, nurses, what have you.

And that's why I think, you know, that's one of the benefits that we're confident will come out as a result of this more strategic, more focused health human resources agency that can take a broad look at provincially what we need, and not just in existing facilities but in new facilities as well. We're going to be replacing, and you know, continue to replace and build new facilities when it comes to long-term care across this province, you know. So we're looking at how do we staff the new LTC

[long-term care] in La Ronge and places like Grenfell and Watson and Estevan and those sorts of locations. So you know, here in Regina, an ambitious project to replace 600 long-term care beds in this city, some specialized, some of the standardized beds.

And so I think that's going to be important as we look at the overall health care labour force of this province, not just the immediate needs but what are we looking at medium term, long term. And that's why we have, you know, between this ministry and conversations and discussions with Immigration and Career Training when it comes to things like international recruitment, or Advanced Education and opening up more seats.

And I know I have, personally I have talked to the folks at my regional college in Swift Current about some of the training that they're able to provide and have spoken to them about what the demand has been like over the last number of years and where they see that going. You know, where are they seeing a demand or an increase in demand for certain types of professions when it comes to health care? So we as a government want to make sure that we're supporting that in all those facets.

Mr. Love: — Thanks, Minister. I'm going to move on here to a couple other areas. I'm wondering if you can tell me how many geriatricians are currently on the job today working with older adults in Saskatchewan.

Hon. Mr. Hindley: — So, geriatricians. We have currently in Saskatchewan three Royal College-certified geriatricians practising in the province. I would note though that one of those geriatricians is currently on a one-year leave of absence and expected to return to practice this summer. The other two are currently practising. And according to the information I have here, it looks like two more Royal College-certified geriatricians have been recruited, are expected to start this summer.

In the meantime, there is a general practitioner that's providing some locum geriatric GP [general practitioner] services here in the province. There continues to be, you know, recruitment under way for, you know, some of these spots that aren't filled. And it looks like additionally that in that area that we also have general practitioners with additional training in geriatrics that are providing some clinical geriatric services to patients as well.

But you know, this is an area that's also in fairly high demand, and not a lot that are trained, is my understanding, on an annual basis nationally through the Royal College-certified program. The overall number of specialists we do have practising in the province of course has increased, but we're also focusing on some of these hard-to-recruit specialties such as geriatricians. So it's definitely a challenge there, but we do note that we have some positive news on the horizon here in the months ahead in terms of additional geriatricians coming to soon practise here in Saskatchewan.

Mr. Love: — Well that's better than what I heard it was, to be honest. So the number of having two on the job is more than I was expecting because I had heard kind of anecdotally from those in the system that we had only one practising geriatrician on the job.

So what would be an appropriate or ideal number for a province of, you know, over 1.1 million people as far as the number of . . . You know, does the ministry or the SHA have a goal of when, you know, of how many more you want to recruit? Like what would be an ideal number for a province like Saskatchewan?

Hon. Mr. Hindley: — So I think, you know, the member in his previous answer, I think there was some concern that there was just the one. I'd heard that as well. So anyway, positive news on that front.

Just looking back at what has been stated publicly before, it looks like both the government and the SHA have stated that there's an approximate need for six to seven geriatricians in the province over the next five years. And I don't know how current that is, or when that comment would have been made. In terms of context, I honestly don't know how current or relevant that would be. But I think it's part of some of the . . . This would be one of the areas that we're also looking at in terms of additional recruitment and where, you know, we can help fill in that gap.

I'm not sure, but perhaps the deputy minister might want to make some additional comments just in terms of that overall strategy and where geriatricians might fit in to that.

Mr. Hendricks: — Yeah.

[18:45]

Mr. Love: — If I could just add in one question for the deputy minister before you share. One of the things I'm most interested in is how many geriatricians practising, certified, would we need to also attract — resident doctors — to be able to . . . or potentially, like, through our college and our medical school at the U of S [University of Saskatchewan] to train geriatricians in the province? Do we need to get to a certain level until that's possible? And if you could inform the committee on how this goal might also lead to training people locally.

Mr. Hendricks: — Yeah, well so first maybe dealing with kind of our physician resource planning. Prior to the pandemic, we had started working on developing with all of our, you know, partner agencies a new and updated physician resource strategy for the province. And typically what that would do is it would identify the need for specific specialities based on a physician-to-population ratio. And so for a specific specialty like geriatrics, it might say, X number per, you know, 100,000 population age 65-plus, who are the ones likely to use it.

But as the minister mentioned, there are very few training programs in Saskatchewan or in Canada. In order to establish a training program, you would actually need a group of certified geriatricians that had academic appointments and then we would need to establish a postgraduate program in that area. Saskatchewan doesn't have a postgraduate training program in geriatrics. And you know, I think were we to get to a number, as the minister was talking about, of six or seven and that sort of thing, it becomes a more viable thing to consider that, just given our aging population, whether that would be a priority. We just haven't been there yet.

And you know, across Canada, this isn't something that's completely unique to Saskatchewan. When you look at the physician-to-population ratio of geriatricians, again using a

similar methodology to what I described, Saskatchewan now — with three plus two coming — would be in a favourable position compared to most other provinces or many other provinces. Obviously with one, we wouldn't have been.

But you know, I think we'll see an improvement there. And as I said, when we update that resource plan, we'll have a more definitive idea of where we need to go in terms of recruitment.

Mr. Love: — All right, thank you. I want to turn my attention now to home care. And maybe just off the top, I believe that the budget this year includes a sizable increase in funding for home care. I wonder if you could just give a breakdown of how that will be used and also of any of the new CCA positions. I know last year, I think, it was 90 for long-term care and 18 for home care. I didn't see a similar breakdown this year. So are those 117, will any of those be designated for home care? And is any of this, I think, around $4 million in additional funds for home care focused on staffing? If you can just help me to understand how that extra funding will be used.

Hon. Mr. Hindley: — The funding allotment for continuing care assistants in the budget, so it's $6.53 million in the new budget year for the additional 117 CCAs. The breakdown of that is for long-term care there would be 70 positions, 7-0, and home care would be 47.

And just to touch on a couple other areas there, in addition to the CCA dollar amount is two and a half million dollars for improved access to individualized home care funding, and then an additional $2.25 million for supportive home care services, which can be used so that . . . that can help facilitate seniors remaining in their own home. And a large portion of that would be directly for front-line care, so of that 2.25 million for supportive home care services.

But yeah, for the 117 CCAs, 70 in long-term care and 47 targeted towards home care.

Mr. Love: — Can you inform the committee a little bit more on that 2.25 for supportive home care services? What would be the vehicle for delivery of services? Will there be any expansion, you know, from services previously offered through I believe what the ministry calls, like, homemaking services? What types of services will be offered with those increased dollars?

Hon. Mr. Hindley: — I'll maybe just provide you some opening comments, and then Billie-Jo will get into a bit more detail here in terms of what we'd be looking at. But I think, you know, the numbers kind of hit on what we're trying to accomplish as well.

And it's, you know, these types of supportive services that we want to be able to provide that can truly help seniors stay in their homes as long as they can. And I know that you've heard that. I've heard that from the people that we represent and that contact both of our offices. I think we're meeting with the same groups. And it's a pretty consistent message in terms of what their priorities are, and so that's the goal of this.

And some of this additional funding is to make sure that we're working with seniors and older adults to try to identify, you know, what is it that could potentially be . . . I don't know if barrier's the right term, but something that might present a challenge for them to remain at home, you know, as long as possible if they're not in need of, you know, high levels of health care.

So that's what we're, you know, interested in trying to make sure that we're targeting those dollars to supportive services that can really help keep them at home as long as they possibly can. But maybe, Billie-Jo, you could get into a bit more detail in terms as to what that might look like or what sort of initiatives we might be looking at potentially.

Ms. Morrissette: — Thank you, Minister. Yeah, just a little bit more detail on, you know, the types of services. Really we are, as the minister noted, trying to focus on kind of the front end of the continuum of keeping people home longer.

We know we have pressures in our home care program around some of those services at the kind of front end of the continuum, so things like homemaking, personal care, respite, meal services. This is the area that we'd really like to focus. And you know, that is meant to address some of the pressures in the system there.

And so just, you asked a question about the delivery mechanism, and so we would be looking to use our existing program delivery mechanisms and really increase and enhance the amount of capacity available in those. Where we might put those exactly is a little bit yet to be determined as we work with the SHA and some of our partners around, you know, where we're seeing the need, the greatest need. And we'll target the funding there.

Mr. Love: — Maybe looking for some more numbers and data here then, along the same line. Looking at home care, and I'm looking at questions asked in previous committees and just looking for a long-term comparison. I'm wondering if you can provide for 2021-22 the hours of care provided under each of the following categories: acute care; long-term supportive care; rehabilitation; maintenance; and palliative care, end of life. Like within home care. And if you don't have those for '21-22, then for 2020-21 and including 2019-20.

Ms. Morrissette: — All right. So we do have some data with us around units of service in a number of the categories you asked. Not all of them, so I'll maybe give you the ones that we have and then we can endeavour to get the others to you.

[19:00]

So for the first one would be units of service for palliative. And I think you asked for '19-20 and '20-21. We don't have '21-22 yet. So the units of service in palliative for '19-20 are 106,967; '20-21 would be 84,604. I move on to acute services, so that would be things like nursing in some of that higher level of care. In '19-20 the units of service for acute services would be 239,638, and for '20-21 would be 223,458.

And the last one that I have with me tonight would be the supportive unit. So that's what we were just discussing, some of the meal services, personal care, those kinds of things. So '19-20 would be 1,024,074; '20-21, 880,842. And so yeah, those are the numbers. And for some of the rehab and therapy numbers that you requested, we just don't have those on hand tonight.

Mr. Love: — Okay. Thank you for that. Do you also track or can

you communicate what the overall expenditure is for each category?

Hon. Mr. Hindley: — Don't have just the specific breakdown by category. But what we can report just based on the information we have is for home care-based service expenditures for 2020-2021. That fiscal year the amount was $205,893,231 in home care-based service expenditures for 2020-2021.

Mr. Love: — Okay. So again just staying under the umbrella of home care, I'm wondering . . . So you know, I had a look at the SHA home care policy documents and it says that primary home care services include assessment, case management, coordination, nursing, homemaking that includes personal care, respite, home management, and meal service. Can we get a breakdown of the hours of care for those kinds of . . . Is that something that you track, like as far as in each of those areas of care? And in particular I'm interested in homemaking and meal service.

Ms. Morrissette: — All right. So for the meal units of service for '20-21, we've got 249,667. And for the homemaking units of service for '20-21, we have 761,752 units.

Mr. Love: — That's for 2020-21?

Ms. Morrissette: — Correct.

Mr. Love: — Do you also have the numbers from the previous year, for '19-20?

Ms. Morrissette: — I do. So back to meal units of service, for '19-20, 250,284. And then over to homemaking units for '19-20, 866,786.

Mr. Love: — So I'm just curious. Like with that there's a bit of drop in most of these numbers from '19-20 to '20-21. Is that pandemic related? Is that redeployment-of-staff related? Any comments that you can provide to enlighten on the change in the care provided to Saskatchewan citizens?

Hon. Mr. Hindley: — Yeah, and the reason for the drop is precisely that. It's, you know, pandemic-related redeployments and trying to protect, you know, the most important services, nursing for example, wherever possible and when looking to redeploy a staff for COVID response and support. And that's what's impacted the numbers between '19-20 and '20-21.

Mr. Love: — Can I also ask for the nursing numbers, as far as the units of care for nursing in home care in those two years?

Ms. Morrissette: — All right. So for just nursing-specific units for . . . I'll give you both '19-20 and '20-21. So for '19-20, 471,089 units. For '20-21, 430,571.

Mr. Love: — So I'm just curious here for my own understanding. Like the redeployment of nursing from home care kind of makes sense, like being deployed to other sectors of health care. But what kind of redeployment was experienced in the areas of like homemaking, home management, and meal service? Like where would those folks have been deployed to, or you know, even kind of anecdotal comments as we saw quite a big decline there.

And maybe some of this also had to do with, like you know, safety like entering somebody's home and knowing how the virus spreads, that there would have been challenges there but obviously wanting to make sure that care is provided for people in their homes while still doing it in a safe way. If you can just help me understand. You know, the nursing makes a bit more sense. But again, for the meal service and homemaking, what would that redeployment have looked like?

Hon. Mr. Hindley: — So a couple of things. Just to go back to the home care numbers again, part of the reason for the drop likely as well — again this is probably anecdotal, but there would be some facts behind it though as well — I think is we obviously would have had fewer surgeries taking place over the last couple of years, understandably, just due to COVID and the redirection of resources and where the priorities were for the health care system. So in effect, by having fewer surgeries being completed and particularly, you know, that would also include seniors and older adults, so therefore there would be less of a demand on home care services. So that would make some sense for part of the reason in the drop of home care just in terms of the stats that we track there.

And additionally to that too I think also — again this is anecdotal but I think there's probably some, you know, facts behind it as well — you would have had, in the case of, say, elderly parents or family members, you would have greater availability of family members to be able to come in. Perhaps they weren't working; you know, they were working from home, not working at their jobs or whatever and therefore had greater availability to be able to support their loved ones that are seniors living on their own. So I think that's a couple of the reasons behind some of the . . . you know, that would contribute to the lower home care numbers.

And then just to the most recent question, in terms of the redeployment of some of these, you know, for example, meal service and homemaking and that area, they would have been asked, you know, if they could become or they would have offered to become part of the labour pool and then used for any number of things, whether it was COVID-19 screening, perhaps helping out at a vaccination clinic, any number of areas where, you know, it was deemed that the SHA needed some additional staff and would have brought those in from the labour pool. It would have been developed throughout the pandemic.

Mr. Love: — Yeah, I understand that. I got one of my vaccinations from a speech-language pathologist, so it happens. She was very nice. So I just want to make sure I've got this right, Minister Hindley. So the total home care expenditure for 2020-21 was 205 million? Can you give me the number for '19-20 as well?

Hon. Mr. Hindley: — Just to reiterate, the number for 2020-2021, 205 million. For the fiscal year of 2019-2020, it was about 204 million — 204,349,765 is the actual number.

Mr. Love: — So just to follow up on that, it's a small increase in overall expenditures but a significant decrease in the units of care across the board. Can you just help me to understand how those numbers align, the small increase in expenditures and the significant drop in units of care?

[19:15]

Hon. Mr. Hindley: — So there were probably a multitude of reasons for the actual increase itself in the expenditures. When you look at the pandemic, one, there would have been negotiated pay increases as per contracts that would still have taken effect, right? And so that would be part of it. And when you go back and look at some of the staff redeployments that would have happened, there's a couple of factors there. And some of this might be overtime-related. That might be part of it when there's, you know, additional hours that have to be put in if staff are redeployed to other areas by the staff that are still behind doing some of these jobs.

And then the other piece to that as well would be, as I understand, when there were staff that would have been redeployed on a short-term basis, they likely would have been charged . . . that salary or pay would have likely been charged still to their home position. So even though they were working in home care typically either in, you know, as you said in terms of examples, whether it's meal service or homemaking, whatever it happens to be, and then they were for a short period of time redeployed as part of the labour pool to COVID screening, vaccination clinic, what have you, but they would be doing that work but still be paid as from their home department, so in home care.

So it would be a combination of a number of those things that I think would add up to where the numbers are, what they show for 2020-2021.

Mr. Love: — Okay. Last little question, then I'll turn it over to my colleague here. Can you report on the number of FTEs in all designations that, you know, that work in home care for both the two years we're discussing, '19-20 and '20-21?

Hon. Mr. Hindley: — Sorry. Yeah, we've done some checking here. We don't have the number of FTEs of designations just for home care. Apparently the reporting system just doesn't record it in that level of detail, so we don't have that. Sorry.

Mr. Love: — Okay. Well then I think that that's going to conclude my questions for the night. I'm going to thank the ministers and the officials here for answering my questions. And I'll see you again, I think on Monday, the next time that I'm here in the committee. And I'm going to turn things over to our Health critic, Vicki Mowat, to resume her questions for the minister and the officials. Thanks so much for your time tonight and I appreciate all of your hard work.

Ms. Mowat: — Thank you so much. So the last time we were chatting, we were talking about short staffing and the recruiting and retention efforts with the new health care recruitment agency of Saskatchewan. So I think there had sort of been a brief conversation about what that organization was going to do. You mentioned the fact that this is going to be a stand-alone agency with its own board. Can you clarify sort of what that structure will look like, as well as what the budget will be, and you know, what the FTEs will be and that sort of thing?

Hon. Mr. Merriman: — Thanks for the question and appreciate that. It will be set up as a treasury board Crown with obviously representatives from the SHA, ministry. When we did this before we had representatives from SARM and SUMA. We'll probably have a makeup where the board is . . . Also if there are areas represented, you know, if there's a health care workers area that should be represented we can look at having that as well.

We just want to make sure that we have a representation of the areas and the people that we're recruiting on this to be able to make sure that it's the most effective board. But it will be set up like a treasury board Crown.

Ms. Mowat: — Okay, so the other questions I had around, you know, if there's initial funding going into this.

Hon. Mr. Merriman: — Yeah, in the budget there was $3.5 million allocated for that. Is that correct? Sorry, $2.4 million allocated for that that will get the structure and be able to do the recruitment that we need.

Ms. Mowat: — Thank you. And is that coming out of the health budget then?

Hon. Mr. Merriman: — It'd be out of the ministry budget, yes. The ministry's budget, yes.

Ms. Mowat: — Okay, and what do we expect the agency to look like? Like you've described a board that would oversee the agency, but you know, how many employees would they have? What would the structure look like?

Mr. Hendricks: — So you may recall when we had Saskdocs, it was a separate treasury board Crown that was tasked with initially recruiting physicians only was its mandate. And it had a board like the minister described. At that time it had a CEO, and then it had a few people that were actual, just recruiters. That's all they did. Their job was to make those connections, travel to recruitment fairs. It had a couple of administrative staff. It was a pretty small agency. And as you know, the minister mentioned at the time when it ceased to operate it had a budget of $2.4 million. One of the things that was taken on by Saskdocs, towards the end of it being put into the SHA, was it took on health careers in Saskatchewan.

So this new agency will have a broader mandate and will be responsible for recruiting all health professionals that are needed. And actually one of the things that we kind of discovered at the end of Saskdocs is there are some efficiencies because there are certain career fairs that they do go to where there are a variety of health care providers. So not just focusing on one provider, you know, they would go maybe looking for a physician and find a nurse or something. You know, that sort of thing. And so it will be doing that.

But our job will be to provide it kind of with an idea of what is needed in the health care system, and it will be very focused on not only recruiting, but also helping recruits kind of integrate into communities. That was kind of part of the successful recipe for Saskdocs, is it really worked on that community end to make the transition successful, but also to, you know, improve the likelihood of retention, trying to kind of match people to the right community.

[19:30]

Ms. Mowat: — Okay. I was going to ask how it would, like what the retention efforts would look like, because most of what I've heard so far is about recruitment. So can you clarify that a little

bit? Because I think retention is a very important part of the bigger picture as well.

Mr. Hendricks: — The agency, you know, I hope you didn't take from my comments that that's all I did, is go to recruitment fairs, but I guess that's what I said. One of their primary areas of focus was actually our own College of Medicine. And during the time of the agency, the retention rate at our own College of Medicine in family medicine went from just under 70 per cent to over 90 per cent. They did not miss a white coat ceremony or any opportunity to interact with residents so that residents in family medicine, or any specialty for that matter, didn't graduate knowing that they didn't have a job opportunity in Saskatchewan.

So that will be something that the agency will emulate, not only with the College of Medicine, but with all of our health professional colleges and with our technical institutes as well, to make sure that there is, you know, no health professional that we educate in this province that doesn't get some sort of connection before they graduate.

Ms. Mowat: — That sounds excellent. In terms of keeping people around, I suppose what I hear you saying is that, if we can make sure that people get teed up with the correct career path that is a good fit for them from the beginning and is sort of what they're looking for in their field, then they're more likely to stick around. Is that the rationale there, in terms of how that leads to retention?

Mr. Hendricks: — Yeah, absolutely. Like, you know, if you recruit somebody into a rural area, it's really important that, for example, you're making it . . . Like what Saskdocs used to do is they used to work very carefully on making sure that community was a match for the physician's spouse as well, as well as their children, that sort of thing, so that they had a better probability of being retained in that community.

They also worked with the community in educating them on what their responsibilities were, you know. And so, you know, a community . . . And one of the things that we hear in rural Saskatchewan is that, you know, docs get tired. It's a 24-7 job, that sort of thing. There is a lot of community demand, and just making sure that the community understands and has reasonable expectations.

And so it worked really well. And having SARM, SUMA engagement on that front was very helpful in terms of going and educating communities on that role as well and hearing their perspective. So as the minister said, having a representative board, getting different perspectives from not only municipal leaders but also from health professionals, I think is critical here.

Hon. Mr. Merriman: — And maybe if I can just add to that, we also have to work with the local foundations because they play a huge role in this to be able to help recruit and what they can bring to the table to be able to complement what we can as government to make sure, as Max was identifying, that it's a good fit for the community and it's a good fit for the doctor.

And we're not just going to be doing it at our white coat ceremonies. My expectation is that we will be going to other provinces to make sure that we are recruiting. Because we know that some other provinces are recruiting our people, so we want to be actively recruiting in their provinces as well, and it won't be just at the job fairs. We'll make sure that we're engaged at many different levels to be able to bring people from across Canada, because it's always — and I've mentioned this before — it's easier to recruit people within our own country because they're familiar with the system, they understand what the expectations are. And there's very little training time to get them up to speed versus bringing somebody from around the world or outside of Canada, that there will be a little time for them to be able to get up to speed on what's happening within our province.

So we will be actively recruiting across the country as well, but I can't emphasize enough the foundations play a big role in this. And they're very excited about this, from what we've been talking to them about.

Hon. Mr. Hindley: — Just further to that, just the local involvement of the local communities, that's going to be so crucial to this, I think, going forward.

Just the other day actually I had a chance to meet with one of the communities that was here for the SUMA convention. And they reported to me — small community in Saskatchewan, couple thousand people — and they reported that they actually, they're in a good spot right now for docs. They got the full complement of doctors, but they actually have a couple of local students, I guess, if you will, that are currently in med school and getting close to completing their training. And they're anxious to come back.

So they are actually asking the community, saying to the community, hey if any of these current positions, physician positions happen to open up, let us know, because we'd love to snap up those positions.

So that's a great news story to have, and that's, you know, intel that came to me from the local mayor and council. And so we reported that. We had an official there at the meeting from the ministry, but those are more of the types of stories that we want to have. And that's why the local community engagement piece is going to be so important and critical, I think, as we go forward to try and address some of these challenges that we have long term.

Ms. Mowat: — Thank you. We've been chatting about doctors mostly in our examples here, but I understand that a lot of services that are disrupted right now are because of a lack of registered nurses. So I want to ask about that specifically.

But more broadly, the . . . I haven't been the critic for jobs for a few years now, but I know that there used to be a labour market analysis that happened in the province to forecast what the jobs will look like in the future. I haven't seen one of those recently. I don't know if there's something comparable in health care, but sort of tracking the trends in health care and forecasting exactly what we're going to need in the province. It seems like some of the big-picture items that would be a very appropriate fit in this type of agency.

I just wonder what the scope of this is going to be. Like how big is this agency going to be? Are they going to be able to do that sort of big-picture work so that we don't get in a situation where we're having the shortage of RNs [registered nurse]? We can

forecast down the road and see that that's going to happen and then make sure that we have the seats so we're proactive instead of reactive.

Hon. Mr. Merriman: — As far as the labour market, I'm not sure exactly where that is with the ministry. I'd have to check with Minister Harrison to see if there's something on that.

But at a very high level, the ministry and the SHA will be identifying positions within our Health Authority that needs to be looked at and needs to be addressed immediately and also long term. And some of that work has already started with the announcement of the 150 new nursing seats that we've added in. That's part of it. But once we get all of this information, we will start to formulate the plan and start to look at trends. The problem in the last couple of years with the trends is that everything was kind of all over the place with the pandemic, and it was . . . The recruitment nationally was off.

So this labour market analysis that we're going to be able to do in the next little while, sitting down with the ministry and the SHA to be able to do this. The scope of it, back to your question of scope, this is going to be all areas within health care — everything.

I see it right down from like a very specific anesthesiologist recruitment down to more labour-intensive positions of, you know, whether it's cooks or whether it's people all throughout. If they're in our health care system and we identify that there's going to be a gap and a need for that position, then it's our job to make sure that we're going out and recruiting or we're working with the Minister of Immigration or we're working with the Minister of Education, Advanced Education to be able to get people prepped for those positions because we see that there is going to be in a couple of years out, there's going to be a gap in that specific area. We're seeing a lot of retirement in a specific position. We'll make sure that we identify that. That's exactly what this entity is going to be doing.

Ms. Mowat: **—** Thank you. And I'm glad to hear that there is going to be a focus specifically on health and all the positions, because I don't think it can be . . . Obviously partnering with Immigration and Career Training makes sense, but it is such a big responsibility. And I don't have to tell you that, obviously.

In terms of the nursing positions, I have so many questions, so I'm trying to figure out how to best direct them here. In terms of those nursing positions, you've mentioned a couple of times today that there will be more training seats. Could you explain where those seats will be and who's offering them, etc.?

Hon. Mr. Merriman: — I think the information I have — and Advanced Education Minister Makowsky might be able to get into more specific detail of the training seats and the locations and that — but we'll provide is, what I have here is the University of Regina-Sask Polytech collaborative program. The University of Saskatchewan will each add 62 RNs and five nurse practitioner seats, Saskatchewan Polytech will add 16 RPN [registered psychiatric nurse] seats as part of the expansion, and a planned expansion of eight RPN seats by the North West College.

So that kind of gives us some rough numbers. But Advanced Education would have that exact where the seats are and the very specific details on it. But at a high level, that's where it would be.

Ms. Mowat: — Thank you for that. I think that the Advanced Education estimates already happened.

Hon. Mr. Merriman: — Oh, did they?

Ms. Mowat: — I guess we will not be able to ask a follow-up question there. But yeah, I wonder about how this matches up with need. So it certainly sounds good to say 150 seats, but for example, you know, I remember seeing that the registered psychiatric nurses put out a press release in, I want to say, December where they forecasted need. And the number, you know, was much higher than 16. I can dig it up quickly.

But they're saying, you know, we need this many psychiatric nurses to move forward, and it's much smaller than that amount. So what is the ministry's sense of when we're going to be able to have the full complement of staff that we need to be able to get these services up and running?

[19:45]

I found the press release here. So the key findings that they indicated . . . This is from their press release from RPNAS [Registered Psychiatric Nurses Association of Saskatchewan] on December 8th. Some of their key findings are that they estimate there are currently 165 vacant positions for RPNs in the province; that 120 education seats are required immediately to sustain the profession in Saskatchewan, specifically pointing to the fact that Sask Hospital North Battleford has units that can't open; other mental health units in the province have had to temporarily close beds due to lack of staff; and that the retirements right now are exceeding those who are graduating and entering the profession.

Hon. Mr. Merriman: — Minister Hindley will touch on the psychiatric nurses, but I just want to make sure it's clear that we're not just doing 150 nursing seats. This is an increase of 150 nursing seats on top of what we're already doing. Okay. Just wanted to make sure that that was clear. Minister Hindley can touch on the psychiatric nurse because it's more on his side of the file.

Hon. Mr. Hindley: — Yeah, thanks. Just on the registered psychiatric nursing situation, yeah, so this fall — and I'm not sure if maybe Minister Merriman may have mentioned it — but this fall, adding 24 more registered psychiatric nursing training seats of all designations, which brings us up a total of 80.

They're not funded by this ministry. They're funded by Advanced Education, so those discussions obviously have to happen with Advanced Education. And that, you know, leads into just some further . . . You know, where are we going to go in the future when we have this health human resources agency established? And identify, you know, based on the conversations and the projections that we're having, in terms of what the needs are. We take this all into consideration, have these discussions with Advanced Education.

But I wouldn't be surprised if there's, you know, as a result of that that we look at, you know, adding into that the number of training seats . . . But again through Advanced Education's dollars, and you know, trying to bill to that.

I met with the Registered Psychiatric Nurses as well earlier this year, I think it was back in the fall, and where they informed me of some of their pending, you know, retirement pressures and that sort of thing that they're seeing in their profession. And there was a period of time where there weren't any being trained, so you know, trying to catch up on those numbers. But also building towards the future demands and not just to address the . . .

And again these are conversations, so we can't commit past education dollars, but conversations we would have with them in terms of filling and being prepared for those retirements and the positions that might be open there but also new positions that might be required as we continue to make record investments into mental health. And also trying to make sure that when we're training these individuals, that when they're doing their training, that we also look at their actual clinical placement so that we're getting into rural areas of the province, for example, and other communities besides just Regina and Saskatoon because we know that there is a demand and a need for having some of these professionals in some of our smaller regional centres as well.

Ms. Mowat: — Thank you. And just to clarify, I think I heard 16 and 24 from the respective ministers. So how many is it?

Hon. Mr. Hindley: — Yeah, it's 24. So it's 16 in the one program at Sask Poly and then eight in North West College. The total is 24 though. Yeah, just so we're clear.

Ms. Mowat: — Thank you. In terms of recruiting nurses, so one of the concerns that I've heard with the plan to recruit nurses from the Philippines is that the last time we did this and folks came to Canada, they weren't well supported. And I think the Saskatchewan Union of Nurses has sort of said this publicly and said we, you know, absolutely need to increase our workforce and there are a whole variety of ways to do that. And this is one of those ways.

So I'm definitely not saying it shouldn't be part of the equation. But what is our plan to make sure that those supports are there? You know, are there going to be those mentorship relationships? If we're recruiting people in areas that have been hard to recruit, who's there to help guide them along when they arrive?

Hon. Mr. Merriman: — Yeah, and thanks for the question. Any time that we're bringing anybody into Saskatchewan communities, we want to make sure that we roll out the best possible welcome wagon, whether that's within the profession or within the community. And I know Saskatchewan has opened up their communities, and we have the Filipino communities of Filipinos that have moved to various small towns in Saskatchewan and have been welcomed with that. So I'm not sure about the comment that they felt isolated.

But the other side of it is, is we also have some dollar incentives in there. We've allocated $1.5 million for settlement, for moving, as we discussed before, a possible incentive for them being recruited and coming halfway around the world. I've talked to many, many Filipino nurses, care aides. They seem to have integrated into the system extremely well. They're a very hard-working and dedicated community. I see them putting on fundraisers for their community. I see them very much integrated.

And I'm sure there's always a challenge moving from one side of the world to the other. Never done it myself, but I'm sure there's some challenges and some cultural shocks. Especially around October and November would be that biggest shock that I'm thinking that they might experience when Saskatchewan winter shows all of its glory.

But I know the Filipino community. I've met with them many times. I know that they're very anxious . . . Minister Hindley and myself met with the consul general. We've also met with the head of the Filipino community. They are very excited about this. They're offering to do whatever they need to do to be able to help this integration, not just in the community, but now that we also have people within the Filipino community in our hospitals, it will be easier for that mentoring because there'll be some maybe people from their part of the Philippines that will be able to mentor them.

So the first group coming across probably did have some challenges, but now they've broke ground for the group that'll be coming right now. And they could be the ones that are mentoring with up to 10 years' experience in their key positions to be able to help out everything from how things operate in Canada and what they need to know and how they can best integrate into our system.

Ms. Mowat: — I'm not a nurse and am simply relaying the concerns that I've heard. But it's not so much about culture shock. It's about what does the working environment look like in health care right now. And when you are sent to a rural location and you're under tremendous amounts of pressures . . . Like I've had nurses just bawling to me, crying about how they've never been this stressed. They've never had to do so much outside of their own scope of practice. You know, they feel the weight of the world on their shoulders in terms of staffing.

You know, we want to set people up for success. When we talk about retention, that's what I'm thinking about and the support that is required for mentorship. My understanding is that it's sort of the bringing along, the on-the-job training of just what our systems look like and stuff like that. I can imagine that the layer of culture shock is a lot larger when you are moving to an entirely different country, but I think that the primary concern that's been expressed is around just the mentorship in terms of our systems and processes and just acquainting oneself with those, on top of all the other layers and how that mentorship doesn't exist across the board for nurses that are entering the profession as is.

Hon. Mr. Merriman: — Yeah. And from talking to my predecessor, there were some of these concerns last go-round, and they were alleviated once it was understood that these individuals were coming in to complement and take some pressure off of them. I understand there's always that mentoring process of a senior person in a position, whatever it is. Whether it's a continuing care aide or an RN or any other position that we're recruiting for, there's always that mentoring that needs to happen.

And it does pull a little bit of time away from that individual's normal duties. But that's a huge opportunity for them to be able to mentor somebody that was going to provide relief within our health care system, not just at this specific moment in time but into the future. And that's a very good opportunity to be able to

bring somebody in and train them on how things are running within our system and how they can benefit. And I'm sure it is going to draw on them a little bit, but I would think when nurses start showing up and start taking some of the shifts that we've been talking about that might be unfulfilled, I think we'll have a general sigh of relief across the system that this is going to help out, not just here but into the future.

Ms. Mowat: — I guess part of the bigger picture as well is evidenced by the member survey that we saw released — was it just yesterday morning at this point? The days have been long — from SUN [Saskatchewan Union of Nurses] that talked about significant burn-out rates, people considering leaving the profession. You know, it strikes me that we also have to figure out how to stop the bleeding in the short term. Sorry for the turn of phrase, maybe it's not appropriate. It's a cycle, right. So what sort of immediate measures are going to help with these pressures? So we're creating the agency. You know, we're looking at starting to train some other folks. But what sort of hope do these workers have, short term, that things are going to get better?

Mr. Will: — Andrew Will, interim CEO with the Saskatchewan Health Authority. You ask a really important question and I would just say, and I mentioned this earlier in my comments, it's been a challenging couple of years for our teams and they've been working hard.

So the Saskatchewan Health Authority has a number of strategic priorities, and top on the list is caring for the caregivers. And I would just say, you know, whether it be our employee and family assistance program, we've put in place peer-to-peer support networks. We've gone to the front lines with critical incident debriefing to provide supports. We've provided additional training for our leaders so that they can support caregivers and actually identify when, you know, they're feeling trauma from the work that they're doing.

[20:00]

So I would just say, you know, we have 40,000 employees and, you know, it's leaders supporting our front-line staff. It's other health care workers that have experience mentoring and supporting our teams.

And you know, and I think it's just making sure that we're, you know, listening to our staff, that we're finding ways to engage them and you know, to hear their thoughts and suggestions about how we can, you know, improve the quality of their work life.

Ms. Mowat: — It's nice to meet you, and thank you for that answer, but I think we're taking a break here.

The Chair: — I hate to interrupt a good conversation here, but we've got four hours this evening and I think we're about halfway through, so probably a good time for a recess. So the committee will be recessed for approximately five, seven minutes. So thank you.

[The committee recessed for a period of time.]

The Chair: — All right, colleagues and officials, I think we've concluded our recess, and we're ready to resume the debates regarding the estimates. Ms. Mowat, we'll turn the floor over to you.

Ms. Mowat: — Thank you, Mr. Chair. I do want to ask a few more questions about the health care workforce. I think we've talked a little bit broadly about this, but more specifically I want to get a bit of a sense of what our levels look like right now in terms of staffing and who we have and what our attrition rates are and that sort of thing.

So what are the total FTE counts for the SHA by specialty? So you know, if we're looking at RNs, RPNs nurse practitioners, CCAs for the past couple of years, it would be good to see what that looked like for 2020 onward.

Mr. Hendricks: — So maybe if we can start by providing '20-21 and we'll try and find the previous year, if that's possible.

Ms. Mowat: — Actually I was going to ask for the previous five years, if we can just sort of look at a trend. Whatever you have data for. Because I want to get a sense of what the attrition rates have looked like before the pandemic and during the pandemic.

Mr. Hendricks: — That question was actually asked while Mr. Love was here. And it was 3.5 per cent two years ago, and then it fell to 3.3 per cent, and then it's back up to 3.5 per cent. So it's gone 3.5, 3.3, 3.5 per cent.

Ms. Mowat: — He asked about the total workforce, not just . . .

Mr. Hendricks: — He asked about a specific, but we were only able to provide total.

Ms. Mowat: — Okay.

Mr. Hendricks: — So that's the answer to your question about total workforce. But in terms of the numbers . . . And we can endeavour to get the five years. We probably won't have that here tonight. We're just seeing if we can give you two years. So if you want the '20-21, I can give that to you in great detail.

So addictions counsellors — I'll round them for you, okay? — 244; advanced care paramedics, 80 — and this is paid FTEs, sorry; audiologists, 9; combined lab/x-ray technicians, 187; continuing care assistants, 6,077; cooks, 571; diagnostic medical sonographers, 61; dietitians, 138; health information management occupations, 168; magnetic resonance imaging technologists, 40; medical laboratory assistants, 184; medical laboratory technologists, 563; medical radiation technologists, 289; mental health therapists, 77; nuclear medicine technologists, 38; nutritionists, 14; occupational therapists, 213; perfusionists, 9; pharmacists, 228; pharmacy technicians, 189; physical therapists, 269; primary care paramedics, 209; psychologists, 94; public health inspectors, 65; recreation therapists, 158; respiratory therapists, 184; social workers, 382; and speech-language pathologists, 101.

Ms. Mowat: — Thank you. Yes, and if you could endeavour to get the other years, that would be . . .

Mr. Hendricks: — We don't have the previous year with us, sorry.

Ms. Mowat: — Okay, much appreciated. And then I was also . . . Entirely lost my train of thought here. Okay, yeah, I was going to say I didn't track whether you got through every occupation, but I trust that there's. . .

Mr. Hendricks: — Well I can give you total numbers for five years, if that's helpful for you?

Ms. Mowat: — That is very helpful.

Mr. Hendricks: — Sorry, you asked by . . .

Ms. Mowat: — Yeah, no. I appreciate by speciality.

Mr. Hendricks: — So '20-21 is 32,014; 2019-20 is 31,237; 2018-2019 is 35,093; 2017-2018 is 30,371; and 2016-2017 is 30,223.

Ms. Mowat: — And do you know how many employees those represent as well? Because I know one FTE does not equal one employee in many cases.

Mr. Hendricks: — The total employee count, going backwards again from '20-21: 46,723; 45,189; 44,304; 43,682; and 43,726.

Ms. Mowat: — Thank you. I believe that we could talk about recruiting and retention for several more hours, but I do have a lot of questions to ask. In terms of surgeries — we've talked about this a little bit already — we know that wait-lists are growing. This is well established, and I've started to hear from more and more people who are travelling out of province or out of country to get the surgical care that they need. How much is budgeted to address surgical wait times this fiscal year?

Hon. Mr. Merriman: — Thanks. And I think I may have touched on this before on our surgical initiative that we announced. We do have an additional 7,000 surgeries that are going to be scheduled this year which brings us up to 97,000. On top of that, next year we're going to do an additional 6,000 and an additional 5,000 on top of that. So it's accumulative, so over the next three years we're going to do an additional . . . scheduled to do an additional 38,000. So that will bring us from 90,000 up over to 120,000 surgeries that we will be doing in the next little while.

So obviously we know we have to catch up from the last two years. Plus as I've identified I think, maybe not in the House but certainly in the media, that there are people that have not been in to their GP and been referred to their specialist. So there's some surgeries that will be kind of out there that need to be scheduled as well. So we're anticipating that.

And as we touched on before, we're going to do those through both the public system and publicly funded, privately run system through some of our private surgical care centres. We had $20 million allocated two years ago that we never got to because of COVID and rescheduling. We had an additional $21.6 million that we're going to allocate in this year's budget. Plus we have the federal money of $62 million that has also been allocated that we have to work into our budget here because, as I mentioned before, at the time of our budget, we did not know that that federal money was coming.

Ms. Mowat: — So I do have a question — I have many questions — but about the $20 million that wasn't used from a previous budget. I'm just trying to wrap my head around how this works because that $20 million didn't just sit there because there were supplementary estimates. We needed more money in health care. So when you say it was rolled over from a previous year, what does that mean exactly? And so if you're saying there's $20 million from previous years, then are you budgeting 40 million this year?

Hon. Mr. Merriman: — Yeah, Mark can finish it. It was the $20 million that was allocated that we did not use because we didn't have the surgical capacity. So that money stayed there and it's flowing forward every year. So we didn't allocate any extra additional dollars for . . . If you recall this time last year, we were saying that we were allocating $90 million for COVID-19 and if there was any dollars that we did not use for COVID-19, we would roll that into surgical funds.

So we had $20 million that was sitting there that stays on our budget every year. Now we've added $21.6 million onto that. So in the last three years, we've added, well I guess you could say, $41 million into the budget for surgical initiatives.

Ms. Mowat: — Okay. I still don't understand. So the money didn't stay there though.

Hon. Mr. Merriman: — It was still on our budget item as $20 million allocated for surgical initiatives, but we just never spent that $20. But it's still there, and it wasn't a one-time funding. It was funding that carries forward for year to year. So it's always in our budget going forward.

Ms. Mowat: — Okay. So it continues to be a budget line item of the same amount. But there's not . . . like, that money wasn't allocated toward, it wasn't spent on surgeries but it would have been spent on health utilization pressures in the system.

Hon. Mr. Merriman: — For sure. What it was, yeah, there wasn't $20 million left over at the end. It created our base that we had, plus that $20 million. So now we have a new base of the $20 million included in that. So that's our new base now.

Ms. Mowat: — It set a precedent for the fact that you're going to spend $20 million on surgeries for the foreseeable future?

Hon. Mr. Merriman: — Correct.

Ms. Mowat: — Okay.

Hon. Mr. Merriman: — Correct. Yeah, and then this year we put an additional $21.6 million on top of that as our new base. So we've increased it again, not the same . . .

Ms. Mowat: — So the total number is 42 million?

Hon. Mr. Merriman: — Correct. Increase since two-years-ago budget for surgical initiatives.

Ms. Mowat: — I'm still, I'm failing to understand how this math works out.

Mr. Hendricks: — In '21-22, $20 million was added to the

surgical base funding, right? You made the point that that funding, where we said earlier that wasn't necessarily spent on surgeries, but we actually did spend on stuff to support the reduction of our surgical wait-list. Mark can go through that detail in a second.

Subsequently we added $21.6 million this year to, as the minister said, do another 7,000 surgeries. Our total base surgical has increased by $42 million over the two years, 20 plus 21.6 — right? — over two years.

Ms. Mowat: — You said that Mark could provide some more information on what things were spent on. I'm still . . . yeah.

[20:30]

Mr. Wyatt: — So with the $19 million that we had allocated, because we were slowing down services obviously, we weren't able to use the $19 million to increase volume. Having said that, we did spend about $7.7 million of the 19 on . . . And I can just walk through the headings. There was about a million seven that was spent on surgical equipment, basically helping to either replace equipment that was end of life, or in some cases providing surgical equipment to some of the regional hospitals to allow them to ramp up once we were in a position to expand volumes. So it was sort of preparing some of the sites that we knew we were going to be looking at either expanding volume or potentially moving into different specialty procedures.

We did actually provide $1.8 million specifically to support additional procedures at the end of the year, primarily orthopedics and some ear, nose, throat procedures. There was money that went for, about half a million, for perioperative nurse training, 270,000 for the O.R. manager information system in Regina. We used the funding from the surgical allocation to increase medical imaging volumes, and that was the announcement that was made last fall, increasing volumes in Regina, Saskatoon, Moose Jaw, and some CT [computerized tomography] in Estevan as well.

We also increased the number of TAVI [transcatheter aortic valve implantation], which is a specific, non-invasive type of heart valve replacement. So we increased our funding for TAVIs to work down a backlog there, and then some additional funding that went to medication equipment, and some funding that went into maternal and children's programs. So we did use, as I said, about 7.7 million of the 19 in order to either address some wait times in areas like medical imaging and cardiosciences or, and some dollars that did go into surgery at the end of the year, as well as equipment and a number of services.

Ms. Mowat: — Thank you. I suppose what I'm looking for is to reframe the question. So without talking at all about how much this has increased over the years, how many dollars will be spent on surgeries this upcoming fiscal year? What is the total, what are the total dollars?

Hon. Mr. Merriman: — So the total would be, 625 is what we have budgeted and planned for our surgical initiative this year. Now all things being equal and we could have a full surgical year, that's what we plan on spending. And if we can exceed that in the number of surgeries, then we would have to go back to our treasury board process and see if we can get some more money at supplemental estimates to be able to increase the amount. But if we can increase the amount of surgeries, I'm hopeful that we can get some extra dollars to be able to do that because I know people are waiting for their surgeries.

Ms. Mowat: — And many of those people reach out to our office and come to the legislature, so we know that very well as well. 625 million. How many total dollars were spent on surgery last year?

Hon. Mr. Merriman: — Just for clarification, that 625 is for the go-forward number. So we'll look at getting that number.

Mr. Wyatt: — So the figure that we spent on surgery prior to the pandemic would be around 585 million. As I mentioned a moment ago, you know, using the funding that we had allocated from last year, there were just short of $2 million that were spent on surgical volumes, 1.67 spent on surgical equipment. So I mean you can probably find another $5 million in addition that would have been spent on surgery last year.

The only qualifier that we need to put around this is because a lot of the staff who would be either operating room or perioperative, members of the perioperative surgical team, would have been redeployed to other areas. You would be paying for their salaries within the surgical budget; however, we recognize that in many cases there were staff who were redeployed to other areas that weren't actually part of the surgery delivery team.

Ms. Mowat: — I appreciate that flag as well in terms of where the pay comes from. So I asked about last year though. So you said prior to the pandemic it would have been 585 million. So you're talking about 2019-2020 fiscal year then, for 585?

Mr. Wyatt: — The figure of 585 is for the period that would be for the 2019-2020 fiscal year. And in both the '20-21 and the '21-22 fiscal year, we would have experienced that situation where you had staff who are part of the, you know, part of the regular surgical team who have been redeployed elsewhere. So for those two years we can't really give you an exact number as to what the costs were for the actual delivery of surgery as opposed to who was filling positions that would . . . home positions that would normally be performing surgery or part of the perioperative process.

Ms. Mowat: — Okay, that's fair. I appreciate the fact that you don't want to give a number knowing that it doesn't accurately represent what we're specifically talking about here. I think that's fair if you can't really quantify it. We had to work in unexpected ways, and obviously we know that the number of surgeries was quite a bit lower. So maybe let's work in that space.

How many surgeries took place last year? We're talking about . . . There's a goal this year that the minister has talked about. So how many surgeries took place last year during the pandemic? We know there were a lot of cancellations because of our health care system being overwhelmed.

Mr. Wyatt: — We don't have complete year-end data just because there is a reporting lag that occurs from the time the procedures take place until when they're entered into the surgical registry. But with that qualifier, we are projecting approximately 80,000 total surgeries for 2021-22, and just making note of the

fact that that's going to be a reduction from previous years based on elective procedures. We have continued through the pandemic period to provide emergency surgeries as well as urgent cancer and non-cancer procedures.

Ms. Mowat: — Thank you. How many people are currently waiting for surgery in Saskatchewan today? I think the last numbers we had access to were as of December.

Mr. Wyatt: — So the last number that we have reported is for the end of the quarter, December 31 of 2021. And at that time there were 36,426 people waiting.

Ms. Mowat: — And the minister talked about those individuals who haven't made the waiting list yet because they haven't been able to get a referral for surgery from their family doctor. Is there an estimate of how many people we're talking about here? Or is this just sort of anecdotal at this point, that we just know that the system is fully backed up?

Hon. Mr. Merriman: — Well I would just maybe clarify. My comments on that is it's not that they haven't been in to see their general practitioner from . . . They just might not feel comfortable going in to see that or have been referred off to the specialist.

As you know, there's a process. It's just not, I need a surgery and you're on a list. There's a referral process to be able to get that surgery, so we don't know how many. We just assumed because of the pandemic that people were not getting out and seeing their physicians as much as they were, or they weren't getting physically into the office to be able to be assessed in a more in-depth way by the physician or the specialist.

There was a lot of specialists that were just doing referrals and consultations basically by phone, but they needed to physically see some. So we understand that there might be some out there but don't know what that number is. I wouldn't want to speculate on that, but I want to identify it as a potential influx of patients that might be coming into the system in the near future when they get the referral from their general practitioner in to their specialist and then get cued up for potential surgery.

Ms. Mowat: — Certainly we know that specialist wait times are also a significant challenge. Can we get an updated number on how many people are currently waiting to see a specialist as well as the current wait times by specialty? In the past we've had a chart of average wait times in days and then a list of the top specialties. I think there's about 20 different specialties on the previous chart that we've had access to. It looks like it comes from the physician claims database.

[20:45]

Mr. Hendricks: — When we look at the provincial, the average wait time in days from March 2019 provincially, it went . . . It was 97 days across all specialties. In September 2021, it was 107 days. So it had only grown slightly. And you know, I think through a lot of the pandemic there were, you know, at the beginning, very beginning in April of 2020, you know, when we had our first wave, that really kind of slowed things down. But afterwards the wait times started levelling back off. Probably one of the factors that will impact referrals to specialists will be the, you know, whether they were seeing family physicians in getting those referrals, if people were seeking that service. But it's only increased marginally throughout the pandemic, that part of it.

Ms. Mowat: — So how many people are currently waiting to see a specialist?

Mr. Hendricks: — We don't have the number of people. We have wait times.

Ms. Mowat: — Okay. Can you table the wait times? The current, like, average wait times by specialty.

Hon. Mr. Merriman: — We'll get a copy of that for you.

Ms. Mowat: — Thank you. I understand that diagnostics are also a big part of this picture. If folks are waiting to receive an MRI before they can get their surgery, that that can also delay things and lead to additional waits. The last time I asked about MRI waits, we were told that the most recent information was from 2019. So we have not seen an updated list of current numbers for how many people are waiting for an MRI in this province. Please update us.

Hon. Mr. Merriman: — I can give . . . You know, a couple of things I want to mention. One is what we included in this year's budget was another $12.9 million for MRIs and CTs just to be able to address some of the things. And as I have mentioned before, we can't just look at the surgical process. We've got to bookend that with the whole process from the GP to the specialist to the scan to the rehabilitation on that.

I'll go through the numbers over the last few years of the MRIs performed. From 2018-19 there was 34,717; '19-20 there was 36,786; 2020-2021 — obviously this is the start of the pandemic — came down to 33,417; and then last year there was 27,961 MRIs performed. Now on the waiting list right now is, in excess of 12 months, we have . . . Is this the number there? We have 10,500 patients that are currently waiting for an MRI.

Ms. Mowat: — And that's just those that are over 12 months. Can you list the rest? Can you provide the full list, please?

Hon. Mr. Merriman: — Yeah. Just a couple clarifying points — thanks, Mark, for that — is that last number that I gave you, that MRI performed, 27,961 — obviously that was up until the last quarter we had reported, which was December. So that wouldn't be including the last quarter. So the number will be larger on the annual.

As far as the number of patients waiting overall, that is the 10,560. And I can give you a breakdown of . . . Moose Jaw has 650, Regina has 4,980, and Saskatoon has 4,930, for a total of 10,560 individuals.

Ms. Mowat: — Thank you. And just for clarification, the number of MRIs performed, does that include those that went through the user-pay system?

Hon. Mr. Merriman: — That includes the ones that were paid for by the second scan, like to the public system. But it does not include the ones that were paid for privately.

Ms. Mowat: — Okay, thank you. The numbers are quite different for different centres. And we've encountered this before where sometimes people will try and put themselves on multiple lists. Why no move toward a centralized booking system? I talk to so many people that say, you know, I would drive out to Moose Jaw to get my MRI.

Mr. Wyatt: — So when it comes to the imbalance and the wait-lists among different locations, we've addressed that in a few different ways, both by increasing capacity, in particular in Saskatoon where we had seen wait-lists growing. And so the addition of the private contracts in Saskatoon as well as some of the additional volumes that were announced last year are among the ways that we are trying to balance out some of the wait-lists. The other comment with respect to a centralized wait-list, that is something that we are developing and we're anticipating that it should come into place in the coming year.

Ms. Mowat: — In the coming year?

Mr. Wyatt: — '22-23.

Ms. Mowat: — Okay. I'm having trouble reconciling the fact that there aren't current numbers of folks who are waiting for surgery. You know, if this is a strategic priority of the ministry and there's a substantial effort toward a surgical initiative, I can't understand how we don't have updated numbers that are more relevant than three months ago for how many folks are waiting for surgery.

Hon. Mr. Merriman: — Sorry. They're done on a quarterly basis. We do have a number. I don't know if that's an accurate portrayal. This is how we've always tracked it, that we have this 36,446 I think was the number that was used. That's the number that we have as of the third quarter in December. In the calendar year, then we would add in our surgical . . . what has been added to the list over the last three months.

It's not something, from my understanding, that we update on a monthly basis, but on a quarterly basis. And that's exactly why we have our surgical initiative that we've put out. The only thing that isn't identified is the ones that have not been in to see their doctors, as we've already chatted about. But this is the number that we would have when the first final quarter from January until March of this year. When we get that number, then we can update you.

But this is a major surgical initiative from the government. We've invested a lot of money in this, a lot of time, and we're going to make sure that we are load-levelling across the system as much as we possibly can.

Ms. Mowat: — That was going to be my next question because the next quarter is completed at this point. Like we're into April. So you don't have an estimate of what the last quarter meant for us?

[21:00]

Hon. Mr. Merriman: — As you can imagine, it's like reporting any number on a daily basis. It's going to fluctuate. It's going to go up and down depending on how many surgeries were done. And it's not always amount. The number of surgeries is very important, but it's what those surgeries are. And as I think was mentioned before, we've still been doing all of our emergency surgeries and our cancer that are coming into our hospitals. Our emergency surgeries are getting done.

But this is exactly why we're doing this is to, in our budget, is to be able to address the need of getting this list down. Our goal is to make sure it's down as low as possible can, and we . . . that we would have surgeries done in a very timely manner, because I think that's what people expect.

I think people also understand that our health care system has been challenged for the last little while. We always have reported . . . as far as I've been told, we report out on a quarterly basis and we'll continue to do that. Because it fluctuates so much, it doesn't portray accurately what's happening. We've typically reported out on a . . . four times a year on what our surgical backlog is, because it can fluctuate so much within a month.

Ms. Mowat: — Okay. We have to move on because there are a lot of different topics to get through. We've talked a lot about rural health care and health care in particular in smaller urban centres in this Assembly. And a lot of this relates to the recruiting and retention that we were chatting about already and service disruptions that have been ongoing for years now.

You know, I think about the combined X-ray lab technician positions and emergency department closures. Out of the original 12 emergency rooms that were closed in 2020 because of the pandemic, how many of those are still closed? Which communities are those?

So I see a lot of conversation happening. I'm honestly somewhat floored by the notion that the minister doesn't have this information readily on hand. I'm not trying to be rude in any way but, you know, 12 communities. Which ones are still closed? I think this would be top of mind.

Hon. Mr. Hindley: — Yeah, we're just clarifying here. If you look back over the past couple of years some of these ERs [emergency room] were closed because of COVID and then came back and then went down a second time, back in the fall.

Case in point: I think Herbert as an example was . . . The ER was disrupted initially at the start of COVID and then brought back fully, then went down again is my understanding, was partially disrupted, and then has since — as of just last week — has had a partial but not a full resumption of services. So we're just trying to clarify of these which are back up and which are down. It's just . . . That's what we're just trying to clarify. So yeah.

Ms. Mowat: — Thank you.

Hon. Mr. Hindley: — All right, yeah. And some of these facilities are off and on. That's part of the . . . That's just what we're double-checking here. There's a couple of them been back up and then down again and up again and down again. But as of the ones that are still temporarily disrupted, we have four of them: Radville, Wolseley, Lanigan, and Broadview.

Ms. Mowat: — We talk a lot about rural communities, but I wonder about the bedroom communities of Saskatoon. And Martensville and Warman are sort of uniquely situated in the

province. Like I don't think there's anything that's quite comparable to what they are in terms of communities of their size. They have fewer doctors per population than any community of comparable size in the province. And they are facing very significant challenges with recruiting and retention of their doctors.

I've heard from many doctors in the community that are completely exacerbated by the situation — burnt out, people leaving, more people on the way out — that are frustrated with their status as sort of being in between. They're losing people to Saskatoon, but then of course then that adds to Saskatoon's pressures. But at the same time, they're not classified as a rural community and eligible for the same return-for-service agreements that would make them more attractive as communities that doctors could go to.

We've raised this concern by letter, but these folks do not feel heard right now. What is the plan?

[21:15]

Hon. Mr. Hindley: — Yeah, in the case of Martensville and Warman, I've had a chance to meet and talk to elected officials there, both municipally and then the MLA [Member of the Legislative Assembly] of course as well. And they've raised questions and concerns on behalf of both of those cities. And you know, you're right. It is a unique situation in that they're not, you know, they're not rural in the traditional sense that I guess we would think of, you know, just in terms of their proximity to Saskatoon. You know, you could make a similar argument saying, you know, for White City here in Regina, right?

So we recognize it that it is a unique situation there that we do have in Warman and Martensville. Growing cities, of course. Growing communities. But also that proximity to Saskatoon and a little bit, you know, different outside of what we would consider a rural community.

We have had a recent contact with them and have actually, or are in the process I think right now, of setting up some meetings there with some senior officials from the ministry to head out to Warman and Martensville and have a discussion about, you know, what we could do in terms of a creative solution outside of what we kind of have right now for rural versus urban when we look at tackling some of these challenges. That meeting, I understand, will be happening in the very near future. And then hoping to come up with some collaboration with the communities and come up with a bit of a solution to the physician recruitment challenges that they have there.

Ms. Mowat: — They will appreciate that much more than a form letter that says they are not eligible for return-for-service agreements. So yeah, thank you.

I want to talk about acute care capacity and emergency department waits. We know capacity has been a concern as of late. Well at the time that the children's hospital was being built, there were concerns raised about the fact that there weren't more beds in pediatrics than there were in the previous Royal University Hospital pediatric ward. And now we are seeing frequent over capacity of both the general pediatric wards and the PICU [pediatric intensive care unit]. If these pressures continue, what is the plan to be able to expand in-patient pediatric care?

Hon. Mr. Merriman: — I think I'll just maybe start off with, you know, we're very proud of the children's hospital. This is a state-of-the-art facility that we have in Saskatoon that was announced and built by this government, and attracting doctors from all over the world to be able to work in this state-of-the-art facility. I was just over meeting with the College of Physicians and Surgeons and talking to them specifically about, and they are still getting accolades on this facility that we built.

But the original design, and then there was an add-in design which I remember — and it might be prior to your time of arrival in the Chamber here — but on it being modified and being changed and being added in capacity. And we did add in capacity to the children's hospital to be able to do that.

And our overall capacity in acute care, which has been very public, is at 93 per cent, and overall is at 74 per cent for our ICU [intensive care unit] capacity. So what we have within the children's hospital is certainly complementing what we've had. We've pulled all of those pediatric care outside of the general and a lot of it outside of . . . or sorry, the University Hospital, and also from St. Paul's to be able to consolidate that all. And this is a facility that we're extremely proud of as a government and I think as a province.

So I'm not sure if that answers your question specifically about pediatric care at the children's hospital. But did that capture it?

Ms. Mowat: — It doesn't, because I agree with you — it's a beautiful facility, but if we don't have the space for the sick kids in our province, what is the plan? It's over capacity, so what is the plan to deal with our sick kids?

Hon. Mr. Merriman: — Sorry, when was it over capacity?

Ms. Mowat: — Right now, it's over capacity.

Hon. Mr. Merriman: — Maybe I'll touch on this, because this was brought up in the Chamber by the Leader of the Opposition in incorrectly calling this very much a "code black," which is, from what I understand, a bomb threat. That's how the Leader of the Opposition classified.

The JPCH [Jim Pattison Children's Hospital] right now is . . . the overall capacity is at 92 per cent. So I'm not sure where the information is that you got, but . . .

Ms. Mowat: — I'm talking about the pediatric ward.

Hon. Mr. Merriman: — Sorry. I'm sorry, I'm not sure what you mean by the pediatric because it's a pediatric hospital. There's not a ward in there. Like I'm not understanding.

Ms. Mowat: — We have been told that there is no capacity for any more children.

Hon. Mr. Merriman: — I'm sorry. There's no . . . I can just tell you that we're at 92 per cent. If there is ever a situation, and I know that there has been some seasonal spikes in respiratory issues that are non-COVID-related. If there is a need for children to flow out of that, we have the University Hospital right . . .

That's why it was built right beside it, so we could flow back and forth in that. And during COVID we did have patients that went into the pediatric hospital, to the children's hospital, the Jim Pattison Children's Hospital to be able to receive care there. That's why it's designed like that, so if there is capacity needed in other areas, we have the ability to do that.

Ms. Mowat: — Okay. I want to talk about emergency department wait times. I've had these conversations over the years with the previous minister of Health. As we have seen, the annual plans change over the years. I think they're called business plans now which makes me feel a little bit bizarre when we're talking about people's lives and health. But the plans change over the years and the goals have changed.

So the initial goal was to reduce emergency department waits to zero. Then it became to reduce emergency department waits by 60 per cent, then by 35 per cent. And then by the time we got to 2019-2020, the goal was to see some reduction. In this year's business plan I saw the same language used, I believe: some. We'd like to see some reduction in emergency department waits.

It feels like this is not a priority to this government, or that these goals have been walked back. And we've seen a steady stream of folks come forward to talk about their experiences in emergency departments. I was an unlucky patient a couple of weeks ago that had the exact same experience in a hallway in an emergency department. And I appreciate what the minister is saying about 93 per cent, 94 per cent. It sounds okay. It sounds like there's that little bit of room of flex. But there are established beds in hallways that don't have call bells. You know, this is not an acceptable situation. These waits are unacceptable.

We know that this isn't the fault of staff. Staff are doing their best. But we've talked about, and I think it's well documented that there are significant challenges with recruiting and retention.

So can we have an update on the most recent emergency department room wait data for each major centre for the following categories. So there's the four different categories for ED [emergency department] waits: time to see a physician initial assessment, wait time for an in-patient bed assessment, length of stay for admitted patients, length of stay for non-admitted patients. And we'd like that for Regina, Saskatoon, Prince Albert, Lloyd, and North Battleford. And then I'd also like the wait time data for Moose Jaw and Swift Current. And if that takes a moment to gather and table, I certainly understand that we won't be able to rattle that off, all of that off verbally.

Hon. Mr. Merriman: — Could you just repeat the categories that you wanted them in? You said there was four.

Ms. Mowat: — Yeah, they're the standard four categories. I can list them again, but I think the ministry will have them. It's typically what we have had tabled at previous years. So it's just how they're reported out. Physician initial assessment, time waiting for an in-patient bed, emergency department length of stay for admitted patients, emergency department length of stay for non-admitted patients. I think these are standardized categories across the field.

Hon. Mr. Merriman: — One of the things that I want to identify that was in this budget, that the member opposite is certainly aware of is our urgent care centres that have been announced in Regina. We had an opening just last week. Minister Hindley was able to attend that opening. We've also got the one in Saskatoon.

This is specifically designed to be able to take the pressure off the emergency care. So this is something that's going to add in to our large repertoire of getting people that need to go to the emergency centre to the emergency centre, but also taking that pressure off those ones may not need to be an emergent but somewhere between. As Premier Moe identified today at SUMA that soon enough, that they have to get . . . They can't wait for their doctor in a few days, but they need to get in. But it's not an emergency room situation.

So this is exactly what we're allocating $15 million for — for two urgent care centres in our two major centres — is to help take the pressure off of the emergency room. I don't know, Mark, if you have the numbers or are you still . . .

Mr. Wyatt: — Sure I do. I can walk you through the . . . We have both 90th percentile and median for each of those four categories and can provide you the '21-22 year to date as well as the '20-21.

So first of all emergency department length of stay for admitted patients, the wait time in 2021-22 year to date was 26.2 hours.

Ms. Mowat: — Sorry to interrupt. What facility are we talking about?

Mr. Wyatt: — This is provincial.

Ms. Mowat: — Okay. Can I get a breakdown by facility please?

Mr. Wyatt: — Okay. So for that data point the 90th percentile is 26.2 and the median is 7.7 hours. That's provincially. If you move to Regina, 90th percentile is 25 hours, median is 10.1. In Saskatoon, the 90th percentile is 38.1 hours; the median is 11.6. Prince Albert, 90th percentile is 11.3 hours; median is 5.4.

[21:30]

Moving to emergency department length of stay for non-admitted, the provincial total at the 90th percentile is 7.3 hours, and the median is 2.4 hours. In Regina the 90th percentile is 10.5 hours; the median is 4.8. In Saskatoon the 90th percentile is 7.8 hours; the median is 3.5 hours. And in Prince Albert the 90th percentile is 7.8 hours; the median is 3.5.

Moving to the next category of time waiting for an in-patient bed, so that's the time from the determination that a patient's going to be admitted until they are admitted into a medical unit or whatever the in-patient unit would be. So at a provincial level the 90th percentile is 18.6 hours; the median is 1.7 hours. In Regina the 90th percentile is 16.1 hours; the median is 2.7 hours. In Saskatoon the 90th percentile is 29 hours; the median is 4 hours. And in Prince Albert the 90th percentile is 3.3 hours; the median is 1.3 hours.

And then the last category is time to physician initial assessment. Provincially the number is 3.1 at the 90th percentile and 0.8 at the median. Moving to Regina, time waiting for initial physician assessment, 5.1 hours at the 90th percentile; 1.7 hours at the

median. Saskatoon, 2.6 hours at the 90th percentile; 0.6 hours at the median. And Prince Albert, 3.6 hours at the 90th percentile and 1.2 at the median. I'll just make the comment that those three regions don't fully comprise the provincial average because the provincial average would also include some other facilities.

The other comment to make is this is capturing CTAS [Canadian triage and acuity scale], I believe. And just making the point that CTAS 1's are seen immediately and CTAS 2's would be also seen, you know, faster than what we would show as the provincial average.

Hon. Mr. Merriman: — Sorry, I'm just maybe going to add in that if I just could. There's just some other information that is completely relevant to this. In the '22-23 we're also allocating an $11 million for 36 additional acute beds at RUH. We had 22 that have been added into Pasqua. We also, as I mentioned, the urgent care centres. We have almost $3 million for the high-acuity beds in Regina. So these are all of the measures that we're taking, is to be able to get people from the ER up into their room to continue their treatment.

So all of the capacity that we've added in that I just mentioned, along with the two urgent care centres, is going to take a tremendous amount of pressure off the emergency rooms in the major centres. As you identified, that's where we're seeing the pressures.

Ms. Mowat: — Can we get those numbers tabled so that we don't have to transcribe this? And can you include, as well, the additional communities that I mentioned in the table? We don't have to read them out, but Lloydminster, North Battleford, Moose Jaw, and Swift Current.

Hon. Mr. Merriman: — Yeah. We'll try to . . . We'll get that to the committee, but it won't be right away. There's a little bit of information we have to get on that.

Hon. Mr. Hindley: — If I can just go back to one of the previous questions you had about the 12 rural ER ALC [alternative level of care] conversions, just got some clarity, just a correction. I listed Radville. Radville has since come back.

So just by way of background, in April 2020, the SHA had announced plans to temporarily convert 12 community hospitals to alternate level of care sites as part of the COVID-19 surge plan. So that's the 12 ERs that you were referring to. By July 1st of 2020, eight of those communities with emergency departments that had been temporarily shut down were restored.

So Kerrobert came back on June 12th. These are all 2020, not 2021. But Kerrobert came back on June the 12th; Arcola, June 16th; Preeceville, June 18th; Biggar and Oxbow, June 22nd; Davidson, June 24th; Herbert, June 25th; and Leader, July 1st; and I don't have the exact date, but Radville was also then resumed . . . resumed its services as well. So the three remaining community hospitals that the SHA is still working with are Broadview, Wolseley, and Lanigan, with the plan to resume to their previous level of service. So it's three of those initial 12 that still are temporarily disrupted.

Ms. Mowat: — There are still challenges with providing full services at some of the other facilities there? Yeah. Where were we here? So we're getting those numbers tabled.

I want to move to infrastructure. We know that there are a lot of projects that are mentioned in the budget. I'll highlight the fact that we've heard many of these announcements already, and that in many cases it seems like there's planning dollars provided but, sort of, we're in early stages in many of these projects to get them over the boards.

So I suppose my main question is, for each of the projects that are listed in the budget, in what year will we see these facilities open?

Hon. Mr. Merriman: — I'll just go through a list here, and as the member asked for, I'll give you . . . Now and I've got to couch this a little bit, because there's tentative, you know, these are all tentative dates based on construction and based on community consultation and various other things. So as we've seen, there's been a surge in the construction industry in the last little while, so . . . and if there's obviously specific areas that we have some challenges, these dates might be adjusted. But I'll go through.

Meadow Lake long-term care should be anticipated completion in 2022. The Meadow Lake dialysis, complete construction activities anticipated in 2022. Lloydminster dialysis, anticipated completed in 2023. Urgent care centre in Regina, which I referred to earlier, which began construction last . . . we started last week in Regina, completed in 2023. Grenfell long-term care construction phase, anticipated completion in 2023. La Ronge LTC, anticipated completion in 2025. Prince Albert Victoria Hospital and Weyburn General Hospital, the award construction services contract, both anticipated to be completed in 2027. The Regina General parkade, completed in . . . sorry, construction to commence in 2023, tentative completion 2024.

As the other ones that we have, other activities are the urgent care centre in Saskatoon, Royal University Hospital, some of the LTC projects in Regina, Estevan, and Watson. These are all in the planning activities. And this one has been indicated. This is our plan that is available online with all of these completion dates, that you can have a look at, that are available to the public.

Ms. Mowat: — Sorry, I might have missed this, but did you say the completion dates for the urgent care centres in Saskatoon and Regina?

Hon. Mr. Merriman: — Yeah, the urgent care centre in Regina should be completed next year, from what I'm seeing here, and the urgent care centre in Regina's anticipated the planning dollars. We're hoping for completion next year, but we're still working out some logistics on that one. And the one in Regina's progressing quicker than the one in Saskatoon. But both are scheduled planning dollars, and they are budgeted.

Ms. Mowat: — Okay. I think you said Regina at one point there, but I knew you were talking about Saskatoon with the planning dollars. Because there's no site for Saskatoon decided yet. But I understand that there's a site selected in Regina.

Hon. Mr. Merriman: — Yes, Minister Hindley was able to announce that last Thursday, I believe, and several of the Regina MLAs that are here attending were able to attend that event. And it was very excited. I know the mayor of Regina was there and

very excited about the location. And we will be moving forward on that one very quickly.

Ms. Mowat: — What is the . . . what time frame . . . So you said 2023? What month are we talking about here?

Hon. Mr. Merriman: — I don't have the month. I mean there's a whole bunch of things that have to happen between now and then. I guess my expectation is, is that it'll be done as soon as possible — the earlier the better. But again we don't want to rush the process. We want to make sure it's done in a proper way. So again working with SaskBuilds and their team on some of the logistics of this, we're anticipating that this will be up and running in 2023.

Ms. Mowat: — Okay. I would certainly like to see that. I hope that that happens because I know that there are a ton of pressures here.

Infrastructure. Are all of these projects traditional builds, and is that the standard practice now? Or are you looking at any public-private partnerships?

Hon. Mr. Merriman: — As far as I know, they're all traditional builds, and SaskBuilds actually does all of the procurement on that. So that might be a question better for Minister Reiter. But to my knowledge, none of them are public-private partnerships, the ones that I've gone through.

Now planning dollars, I don't know. We still have to look at that. But if there is an opportunity for public-private partnership, then I would assume that SaskBuilds would put that into some of their processes and be able to see if that's a fit. Usually on, like, the urgent care centres, because they're smaller dollar amounts, that's not something . . . We'll have to have a look at it; we're not ruling it out though. But none of the ones that I've identified here, that I know of . . . They're all traditional builds.

Ms. Mowat: — I've heard from some communities that they've had to fundraise in order to furnish facilities. Is this a standard practice now?

Hon. Mr. Merriman: — There used to . . . and I'm going to get the percentages. Hold on, maybe I'll just check.

Thanks. Yeah, what we call the FF & E is the furniture, fixtures, and equipment, is usually brought in by the community. That's something that the community pays for in the agreement on when they are getting a facility. Under previous government, under the previous government, it used to be a 65 per cent/35 per cent split, from 65 per cent being government, 35 per cent being the community. It is now at 80 per cent government and 20 per cent community. So that's been reduced by 15 per cent, which is a significant amount to what it was previous.

[21:45]

Ms. Mowat: — Looking for an update on Sask Hospital North Battleford. What is the status of the facility? Is the roof fixed now? Can you drink the water in the facility? We've raised concerns throughout the construction process. Can you provide an update on the construction of this facility. Are all the wards open?

Hon. Mr. Merriman: — Sorry, I didn't catch that last part.

Ms. Mowat: — Are all the units open as well?

Hon. Mr. Hindley: — So at Saskatchewan Hospital North Battleford, I guess I can speak to it not from the structural. That's, you know, more of a SaskBuilds question.

But in terms of the actual beds there that fall under this ministry, because there's a number of beds that are also under Corrections, there's 188 mental health beds there which are fully funded. Some of them aren't open right now just because of staffing issues, but the vast majority of the beds are open, the mental health beds I should clarify to be clear. The mental health beds are open and all are fully funded. But we do have just a . . . There's still some staff we're recruiting to open the remaining beds, the mental health beds.

Ms. Mowat: — What are the staff vacancies that exist right now that are preventing the full operation?

Hon. Mr. Hindley: — It's primarily nurses. Primarily nurses.

Ms. Mowat: — Can you give us numbers?

Hon. Mr. Hindley: — I don't have the number of nurses that we need there.

Ms. Mowat: — The overall vacancies? Because I think in the past we've been able to see sort of which specialties are required and who's still needed.

Hon. Mr. Hindley: — No, the officials don't have it with us tonight.

Ms. Mowat: — Okay. Is that something we could endeavour to table?

Hon. Mr. Hindley: — We can try to, yeah, try and track down that information.

Ms. Mowat: — Thank you. I'm just looking for current vacancies by position at Sask Hospital in North Battleford.

Hon. Mr. Hindley: — Okay.

Ms. Mowat: — Okay, thanks. Getting back to infrastructure a little bit, a big part of this is building, but another big part of this is maintenance. The last time I saw a value for total deferred maintenance in all health facilities, it was $3.3 billion across the entire health system. What is the current value of deferred maintenance for all health facilities?

Mr. Hendricks: — You're referring to the VFA data that we have on our facilities or that we used to maintain. And so the last time we did this, there was a total deferred maintenance requirement of three and a half billion dollars, as you stated. And that was from July of 2019.

We're moving to a different process in collaboration with SaskBuilds. And so the Saskatchewan Health Authority will advance a new plan to commence building condition assessments of SHA facilities in July of 2022, and we'll complete all new

assessments for all 292 SHA facilities by March of 2024.

Part of the reason this is being introduced — and you can probably ask SaskBuilds more about this — is to provide kind of a common framework on which to gauge all capital projects across the entire public sector and not just within the health sector so we are able to compare the condition of a school to a hospital or long-term care home.

Ms. Mowat: — Okay, so the last number we have is from three years ago. And then we're not going to get an update until two years from now on what the total value of deferred maintenance is.

What is the average FCI, the facility condition index, for all of the health facilities in the province?

Mr. Hendricks: — So when we did the last assessment in 2019, the average provincial facility condition index was 46 per cent.

Ms. Mowat: — How many dollars are committed to this in this upcoming fiscal year to addressing deferred maintenance?

Mr. Hendricks: — The life safety and critical infrastructure is $57.3 million. As well, we're committing $6.3 million to long-term care ventilation projects specifically.

Ms. Mowat: — And what was last year's number? Actually I'd like from 2019 onward because that will help me to do some math here.

Mr. Hendricks: — So in 2018-19, it was, the life safety and equipment was 44.6 million. In '19-20, it was 18.7 million. In '20-21 and '21-22, there was stimulus funding and so those two years were a little bit higher at $80 million in '20-21, and then 73.2 million in '21-22. And in '22-23 as I mentioned, 63.66 million including the ventilation.

Ms. Mowat: — Thank you. I'm going to call this the rapid-fire round where we talk about many different topics in the last, in our remaining time. No segues.

Tobacco control. The Saskatchewan Coalition for Tobacco Reduction has written to the minister about the proceeds from litigation going towards tobacco control efforts in Saskatchewan. What is your response to this? And have we seen any changes to youth smoking rates in our province?

Hon. Mr. Merriman: — As far as the litigation, that's not completed yet, so we don't have a total on that. I can tell you . . . So would you like to know the Saskatchewan smoking rate versus the national? Or how would you like that broken down? In the last year, or the last couple of years?

Ms. Mowat: — In the last couple of years, yeah.

[22:00]

Hon. Mr. Merriman: — Okay. I'll maybe go back as far as 2018. The national smoking average . . . or I guess it's the national average of smoking rates of 12 and over was 15.8 per cent. Saskatchewan was 20.1 per cent. 2019, the national was down to 14.8 and Saskatchewan was down to 16.7, so almost a three and a half per cent drop. 2020, the national smoking rate had gone down to 12.9 per cent, and we were at 16 per cent even.

Ms. Mowat: — It's certainly encouraging to see. But also there's the consideration that youth are vaping now, and vaping nicotine products. So good to hear that things are going down. The main question that I have on this front though is, is there any commitment that, you know, if there are proceeds from that litigation, that they will go back into prevention to make sure that there's education across the province and we're protecting our kids from addiction?

Hon. Mr. Merriman: — Yeah, I understand exactly. And I've talked to the advocates about this specifically, about money flowing back in for advertising against prevention and usage and all of that, and I can't say where the money will go. That's not part of . . . What I would do is the money would come into the general revenue and then we would look at . . . But we do have a fairly aggressive advertising campaign about smoking and vaping. And I think these numbers include vaping as well. I'll just . . . Sorry, these are just the smoking ones, so the traditional cigarettes. These do not include the vaping. And from what I've been told, the newest and latest is the heat-not-burn, which is new to me but apparently it's a thing.

Ms. Mowat: — Tuberculosis, we have three major outbreaks in the province, and 50 per cent of those infected are children. Our rates in northern Saskatchewan are 20 times the national rates and they're severely linked to poverty, crowded and unsanitary housing, and the outbreak areas it's difficult to get a chest X-ray so sometimes people are being sent out of community. There's jurisdictional problems. What is the plan to get tuberculosis outbreaks under control in our province?

Hon. Mr. Merriman: — I've got a little bit of information here. Maybe I can start off but I don't know if my officials can jump in. But the Government of Saskatchewan, we're certainly aware of the tuberculosis. And I know the Leader of the Opposition's spouse does some work on this in northern Saskatchewan, and I follow that and thank her for that. That's amazing that she's going up to be able to work with some TB [tuberculosis] cases in the North.

As of March 16th we have three communities with a total of 54 cases of tuberculosis. The dollar amounts that I have is annual funding of almost $2.6 million — 1.91 of that is for tuberculosis prevention and control Saskatchewan; 180,000 of that is the former northern regional health authorities. It's allocated to that. And we have a half a million annually from the Ministry of Health since the announcement of the tuberculosis strategy in June of 2013.

We also — I'll continue on — formed in 2015 the tuberculosis partnership committee, functioning at a strategic level with expert guidance in policy, epidemiology, and evaluation to ensure that efforts are coordinated among TB control, the SHA, First Nations, the Inuit health branch, and the Northern Inter-Tribal Health Authority. So we've done some work on this. We know that there has been some outbreaks in three specific communities of about 54 cases total. And we'll continue to work with our partners to make sure that it is treated as soon as there is an outbreak.

Ms. Mowat: — In the past I've asked about mammogram screening and dense breast notifications to patients, since they interfere with mammogram results. I understand that only women with 75 per cent density are being informed by letter at this point. We were initially told to expect that by 2020-2021 we would see the rollout of a more fulsome notification system, but it's now 2022. So we've had significant delays here.

I understand that it's part of a system upgrade that needs to happen, but why can there not be an ability for Saskatchewan women to find out their density after a mammogram result by looking on MySaskHealth?

Mr. Wilson: — Hi. Kevin Wilson, vice-president with the Cancer Agency. So we do have plans for, I think first for the dense breast communication. I think part of it has been a delay due to some change in, or delay in a change in software upgrade that was partly I guess due to some issues relative to COVID, both for staffing with staff being redeployed and with some of the resourcing from the IM [information management] side of things. So that's on the works. So we do have some funding that we've received that will be going towards that.

So we're anticipating that our software should be completed, the upgrade, so that we should be within the next . . . We're hopeful to keep that on the track for the next year, to be able to do that. So we would be able to, with the upgrade in software, increase the reporting to both women and proprieties on the breast density information.

And as far as mammography, there is a plan within the next few months to have the results from mammography screening put on to MySaskHealthRecord.

Ms. Mowat: — I guess this will be my final question. There's a program, the Indigenous birth support program, supporting moms to be in Saskatoon hospitals. They've received calls from across Saskatchewan since they launched at the children's hospital in 2019. What funding is being provided to support this program, and is there any update on whether it is continuing to move forward?

Hon. Mr. Merriman: — Seeing that it's close to the end of the night, we'll have to bring that back. It would take us a little bit too long to dig that up. But we'll bring it back and have it ready for committee on . . . I think we're scheduled again on Monday. And I know you're not there, Ms. Mowat, but we'll give it to the committee and the Chair can distribute that.

Ms. Mowat: — Thank you.

The Chair: — We're good? Seeing no further questions we will adjourn our consideration of the estimates and supplementary estimates no. 2 for the Ministry of Health. I would ask a member to move a motion of adjournment. Mr. Domotor has moved. All agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. This committee stands adjourned until the call of the Chair.

[The committee adjourned at 22:09.]