STANDING COMMITTEE ON PUBLIC ACCOUNTS

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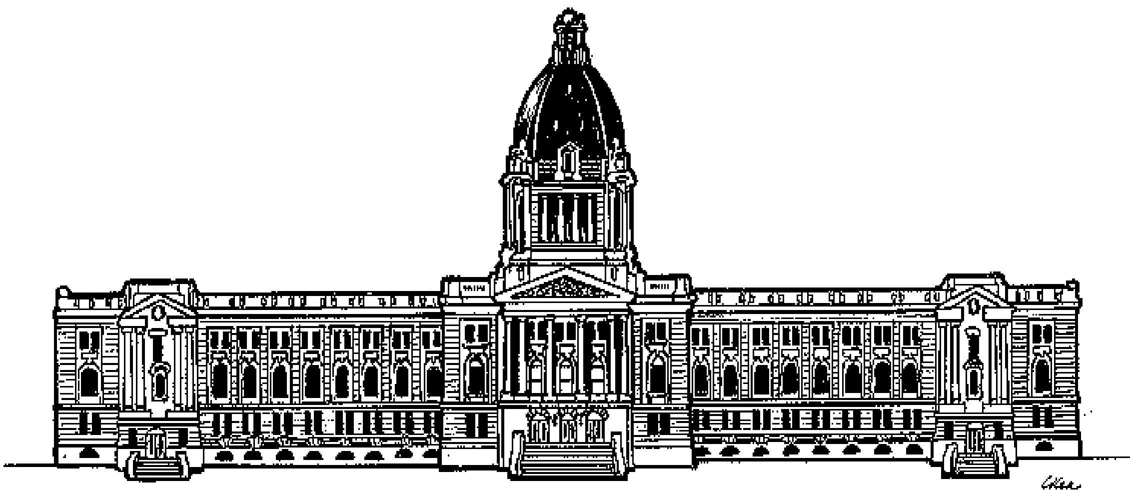

Legislative Assembly of Saskatchewan

Twenty-fifth Legislature

STANDING COMMITTEE ON PUBLIC ACCOUNTS
2006

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[The committee met at 10:30.]

Public Hearing: Health

The Chair: — Good morning, ladies and gentlemen. We'll call this Public Accounts Committee meeting to order. I'd like to welcome each one of you here.

Today we have only one item on the agenda, and that's to conclude chapter 2 of the 2005 report volume 3 on Health. As you might recall before the session resumed, we dealt with chapter 2, parts A and B. At least I think we completed B. I guess if there was any questions on B that weren't answered, we could address those, but we will focus on chapter C, and that is primarily dealing with the regional health authorities pages, 67 to 81.

Again I'd like to welcome the Provincial Auditor and several members of his staff to our meeting. The Provincial Comptroller's office has representatives here, and we have the deputy minister of Health and several colleagues from his department here as well. I will ask the auditor to review the findings in chapter 2, part C. Doing that this morning is Mike Heffernan, deputy provincial auditor. And then we will call on John Wright, deputy minister of Health to introduce his colleagues and respond. And then we'll open up the floor to questions. So Mr. Heffernan.

Mr. Heffernan: — Thank you, Mr. Chair, members. Part C describes the results of the audits of 12 regional health authorities for the year ended March 31, 2005. All RHAs [regional health authority] need to continue to improve their reports to boards of directors by setting the performance targets needed to monitor progress in achieving the RHAs' objectives.

Prince Albert Parkland needs to follow its processes to ensure its employees are paid only for work done. Kelsey Trail and Mamawetan need to improve their controls over payments to suppliers. Regina Qu'Appelle has not formally assessed the need for an internal auditor. This region also needs to prepare adequate written policies and procedures to safeguard public resources. Regina Qu'Appelle, Keewatin Yatthé, and Sun Country need better processes to safeguard their capital equipment. Regina Qu'Appelle and Sun Country's agreements with their affiliates are not adequate to ensure the affiliates achieve the RHAs' financial operation and compliance with the law objectives.

Seven regions need information technology disaster recovery plans to ensure they can continue to deliver the programs and services if their critical information systems are not available. Six regions need to establish information technology policies and procedures to ensure the confidentiality, integrity and availability of information systems and data.

All regions need to improve their annual reports to help the Legislative Assembly and the public to assess their performance. The annual reports do not describe the regions' key risks in achieving their objectives or their performance targets to monitor progress in achieving their objectives.

Three regions incorrectly recorded revenue for future construction costs — Five Hills, Sunrise, and Sun Country. That concludes my remarks.

The Chair: — Thank you very much, Mr. Heffernan. Just prior to calling on the deputy minister, I neglected to mention that we did receive communication from the Department of Health regarding our March 9 meeting, and that has been tabled. This letter from the assistant deputy minister, Mr. Fisher, has been tabled with the committee, and I believe copies have been distributed to all of the members.

Thank you again, Mr. Heffernan. Mr. Wright, would you introduce your colleagues and respond if you like please.

Mr. Wright: — Thank you very much, Mr. Chair. To my right is Mr. Duncan Fisher, the assistant deputy minister within the department. And behind me from my right or your left, Mr. Chair, is Bert Linklater. Bert is the executive director of the regional accountability branch. Beside Bert is Rod Wiley. Rod is the executive director of the regional policy branch. Beside Rod is Ted Warawa. Ted is our chief financial officer. And sitting beside Ted is Bonnie Blakley. Bonnie is our executive director of the workforce planning branch. Behind is Gina Clark. All members have been introduced to Gina before. She is a Masters of Public Administration student and an intern within the deputy minister's office. And the tall, good-looking guy beside Gina is Garth Herbert, and Garth is our internal auditor within the department.

So, Mr. Chair, we're pleased to be here again to wrap up the report for the Department of Health. In general terms, Mr. Chair, the Department of Health is in agreement with the recommendations of the Provincial Auditor, and we look forward to answering any questions that you or your colleagues may have.

The Chair: — Thank you very much, Mr. Wright. Mr. McMorris.

Mr. McMorris: — Thank you, Mr. Chair. Well there's certainly a number of questions that we have stemming from the report, Health department being the biggest budget item in the province at $3 billion and 2 billion going to regional health authorities. I don't think it really matters which department it is; you want to make sure every dollar is spent properly and accounted for, and in health authorities it's no different.

And so when we see some of the concerns raised by the auditor, we'll be interested in hearing what has been done into the future, what will be done into the future to address some of the issues because certainly some of these issues are not new from previous auditor's reports. They have been put forward in the previous reports regarding some of the same issues. And so I'm sure those same questions were asked two and three years ago, what will be done going forward to address some of the issues? Obviously some of those haven't been addressed, and so we'll be interested to hear what will be done in the future to address some of the issues.

Some of the issues starting out regarding setting direction and monitoring performance, I can just say from over the last couple of weeks of questioning the minister in the House, and setting

targets regarding nursing retention and those type of issues, it's tough to get the minister to set any targets whatsoever. And I wonder if that is not maybe the culture into the health authorities as far as performance guidelines and what is expected of the regions.

It's pretty tough to, at the end of the year, say we've had a good year, you've done what you've set out, if you haven't set out any targets. So can you maybe inform the committee what is being done from, you know, what you're looking at the health authorities to do into the future, to set some targets and some performance guidelines.

Mr. Wright: — Certainly, Mr. Chair. In order to set performance targets, one of the fundamentals is to have a good foundation of knowledge, which is to say to have historical records for each of the proposed targets so that one can measure the progress over time.

As you're aware, Mr. Chair, the RHA still are a relatively new entity, which is to say by the close of '05-06, which was last week, we will have three years worth of historical data upon which we can build from.

We've been working closely with the RHAs in developing targets. One of the other key criteria is not only to have data available, but it's also to select the proper targets to make sure that you're not too expansive, to make sure that they're relevant targets, and to make sure that management is extremely focused in on those indicators in all of those targets.

So I'd like to think that we are moving forward on this. We have a new committee in place that's recently been established to take a look at performance measures and performance targets in conjunction with the RHAs. And we have invited the Health Quality Council to participate with us in establishing appropriate targets.

Mr. McMorris: — I realize that the health authorities have only been in the works for three years, but there was regional health — not authorities — districts prior to that for a number of years, and the new health authorities went pretty much directly on the lines that were drawn before. It was just putting three or four health regions into one authority.

So there should be some history, corporate history within that region, as to what has been done, what was looked at moving forward. So I don't know if I agree totally that just because it's three years old, there is no corporate history. There is because there was the health regions before, which are on the same lines — just three into one.

Mr. Wright: — Well, Mr. Chair, in part the hon. member is correct that there is data out there from the districts. You'll recall that there were 32 districts, and these were amalgamated into 12 regions. So it's not always just a simple aggregation of the data. It's making sure that in fact the correct data was collected and it was collected in a uniform fashion.

So often with 32 districts, they may have collected it in different ways, counted it somewhat differently. A good example of course is surgeries. Everybody up until several years ago, when the Department of Health established the Surgical Care Network, each health care facility certainly had the data, but they collected it in a very different way using different definitions.

One has to make sure that the aggregated data is aggregated on the same terms, on the same conditions, and that it's the correct data, and it's the most meaningful data. So in part, absolutely correct. But are we moving forward? Yes.

Mr. McMorris: — Could you give me some examples then of targets for a health authority that you'll be working towards in the future, that you'll be asking health authorities to work towards in the future. Because certainly again if we don't have a target set, we don't hit it. So what would some of those examples be of performance targets that you're going to be asking the regional health authorities to work towards?

Mr. Wright: — Sure. Very simply, Mr. Chair, they may come in several forms. I'd like to think of it as targets within specific areas. Let me give you an example, financial targets okay: to maintain a balanced budget; to maintain an adequate working capital ratio or a current ratio; to ensure that the accumulation of debt, should there be debt in certain regions, is moving in the correct fashion, which is to say going down instead of going up. So there's financial targets.

There's also what I'll call customer service targets which is ensuring that patients . . . and their responsiveness through annual surveys which we've undertaken, recording of that and making sure that they're satisfied with the delivery of service; and where they're not, that we're identifying that. So we may set performance targets within the patients' responsiveness to situations.

Equally so and perhaps very important is the employees. Targets may be set around workmen compensation, lost days. Targets may be set around sick days. Targets may be set of course around employee satisfaction. So those are some examples.

Others one could go into . . . targets around the number of CAT [computerized axial tomography] scans being performed, the number of MRIs [magnetic resonance imaging] that may be performed, the number of surgeries of different types and natures may be performed. And that latter part will be extremely important should the federal government go ahead with wait time guarantees. We need to know what we're doing and where we're going on those. So those are some examples, Mr. Chair.

Mr. McMorris: — I think you know hearing that list . . . just by listening to you talk about it, I mean I can see that setting those targets are extremely important because if you don't have, you know, anything set by the end of the year and you do an employee satisfaction survey and didn't really have any target to hit or outcome that you are looking for, what good is the survey?

What about the other issue and . . . Just when you were going through that . . . and I know that there's probably many other examples that you could give. And you didn't mention the retaining and recruiting of health care professionals, i.e., doctors and nurses. Would that be a target for health authorities

to shoot towards? And if that is the case, then perhaps we have to have a target to meet. In other words, we need X amount of health care professionals in this authority. Would those be some of the targets that you would expect a health authority to set?

Mr. Wright: — Well, Mr. Chair, we tend to be focusing in on others at this point in time. Certainly that's an option for us to take a look at, the number of physicians. But it's not simply the number of physicians. Every physician is indeed different. There's general practitioners that are out there. There are specialists. There are subspecialists within specialty lines. Same with simple nurses, it may not be adequate to tell you that there are X number working in a particular area. You'd want to break it down of course by registered nurse. You'd want to break it down by registered psychiatric nurse. You'd want to break it down by licensed practical nurse.

And in addition, the nature of the work is constantly changing. Scope of practice in one region may be changing and evolving over time. So it's an option for us indeed.

Mr. McMorris: — Another target area . . . and just talking to some of my colleagues from around the province . . . and I don't know whether this really falls under the health authority or the Department of Health . . . targets on when you're going to start capital projects like hospitals that have been announced six years, seven, or eight years in a row. You know I mean it's easy to make an announcement, but it sure would be nice if a target were set saying we're going to start on this facility so that the local community can plan their capital costs, as opposed to announce it but with no target date for breaking ground.

Mr. Wright: — Fair enough, Mr. Chair.

Mr. McMorris: — Is that then more the purview of the department or the health authority?

Mr. Wright: — Well one could argue that it was the purview of a former department of mine, which is called the Department of Finance. There are annual appropriations, there's an annual budget, capital projects are considered within the context of the fiscal framework for the province, and the priorities are established.

It is our clear hope as we move forward not to have communities waiting, okay — not to be able to say yes the planning dollars are in place, and indeed coming back and not making progress on that specific project for whatever good reason, okay. We want to do the right thing by the communities to make sure that as we move forward, that when we say go, you go. It's not go-stop, go-stop. So I would concur, I think, with the general direction of the good MLA [Member of the Legislative Assembly].

The Chair: — Could I just interject, Mr. McMorris, just for a second on that issue.

Would you, Mr. Wright, could you indicate that your department is to the point where, when you give the okay for a project and a number is determined as to what their contribution should be, that you would not ask them to increase that because of delays?

This is happening far too often and . . . A community has gone out and they have to raise the money locally through their local ratepayers and through other fundraising activities. And they may be asked to commit, let's say $2 million for a round number. And they're prepared, and they go out and do that. And then they're told no, the project's been delayed; now it's $3 million. This is unfair to those communities who have lived up to their end of the bargain. But because of delays on the provincial government's part, suddenly they, you know, the old agreement, the old rules are thrown out and new ones are presented.

Could you indicate that you're taking steps that when you announce a hospital or some other health care project, capital project in a community and you say that they have to raise a specific number, that you'll stick to those numbers and if the costs go up, then you'll bear the costs rather than the community?

Mr. Wright: — Well for example, Mr. Chair, if one had've announced a project — project X in community Y — last year and all the work hadn't been completed in terms of the architectural drawings, program space, space requirements, programming, a variety of other things, it'll be very difficult. Again X and Y, one may have established last year that the cost of the facility would have been $10 million. This year, when you start to actually do the project — with cost inflation out there, be it on inputs or be it on labour — it could be anywhere from a project from 10 million escalating to 11 to $12 million.

We've seen very significant increases all across the province in terms of the cost of these capital projects, not only in the Department of Health but everywhere. To lock in a number would suggest that the residual would always be picked up by the Department of Health.

I'm also reminded from time to time one could argue there is only one taxpayer. But I appreciate the viewpoint and I certainly understand the difficulties that Humboldt, for example, has been facing with a large increase in the overall costs of the project. But having the involvement of communities in financing the project is really important. It's a good check and balance on the department, on the RHA. And it makes sure that we don't have a project that runs away with itself in terms of the overall cost. Having a, what we call, skin in the game is really important to make sure that the facility at the end of the day is the correct facility for the community and not overbuilt.

I'd like to be able to say definitively, we'll do that, Mr. Chair. The problem is, though, that there are a lot of issues affecting the overall cost of a project, including delays and including inflation. So it would be just a little difficult.

The Chair: — My observation is the delays are caused by the department, not by the local health authority. And therefore don't you think that your department would be more diligent in meeting its targets and meeting its budget and meeting its timelines if the additional costs were carried on your shoulders rather than on the local community?

Mr. Wright: — Well, Mr. Chair, if we did proceed in that fashion I would certainly be very, very, very cautious about any announcements. In fact I would want to ensure that the

Department of Finance provided me with the money, the OKs, the signatures upfront. I would want DNA [deoxyribonucleic acid] samples from the deputy minister of Health.

Because for example, Mr. Chair, as you know, the volatility of this province in terms of GDP [gross domestic product] over the years has significantly shrunk. One can go back to the 1930s and see extreme volatility from year to year. Over the last several years, because of the diversity of the economy, indeed that has shrunk over time. That being said, the price of oil could change — the price of natural gas, potash, uranium, coal. And that can charge and cause sharp fluctuations in the overall revenue balances of the province.

So one would want to make sure that one locks in the dollars to the best of one's ability before one ever made that promise. Because if one made a commitment that a project shall be done, but for whatever reason the finances of the province went south or deteriorated, I'd want the money upfront.

That being said, I think the Provincial Auditor would probably want to say something about the Department of Health wanting the money upfront from an overall accounting framework. All I'm getting at here is it's very difficult at times.

The Chair: — Thank you. And it's not unusual, certainly for projects in the private sector, that contracts are signed and commitments are made and guarantees are put in that contract that certain numbers won't be exceeded. That's quite a common practice. You would think that in the public sector the same procedures could be followed. I'll let Mr. McMorris continue with his question. I apologize for interjecting but I wanted to pursue that somewhat. Mr. McMorris.

Mr. McMorris: — Yes. Just I guess, and the deputy minister mentioned Humboldt, and that's the one that comes to mind. And I certainly would, you know, understand the fluctuation and budget, you know — some years better situation, financial situation, than others. But when a project has been announced six years running that gets past, I think, the issue around finances and gets more into the issue of politics which I won't have you answer.

Mr. Wright: — Thank you.

Mr. McMorris: — But it seems to play more into the issue of politics than it ever does proper financial planning.

I did want to pursue one other question regarding health care professionals and I would say mentioning targets around health care professionals, be it nurses or physicians. And I understand that again there's a changing environment, but we're looking at one-year targets; we're not looking at 10-year targets. We're looking at one-year, so yes there could be some changes within one year.

But with physicians that are leaving, I mean if we don't have a target on how many we should have in that region or whatever, and we lose a couple, I guess — so what, because we're below or above our target which we never had. But my question is, is there any work done when people, when health care professionals leave, and especially in particularly doctors, any sort of an exit strategy to see why they're leaving? I mean this gets away from the target, but I mean if you've set a target and you have people leaving, I want to know why those people are leaving.

Is there any sort of exit survey done with physicians that leave regions or the province and finding out what those reasons, why they're leaving? Because we hear from them. We certainly hear from the odd one that has left the province and the reasons why they've left. And, you know, I mean it's valuable information to me. I couldn't help but think this would be extremely valuable information to the department.

Ms. Blakley: — I'll answer your question. First of all right now regions tend to do exit interviews as individuals leave but it's not a consistent or constant exit interview. And the regions have recognized that they need to do that and therefore there's actually a tool being developed that will have all our HAs [health authority] using the same questions when all health professionals leave the workplace. It's been under development for a year and it's a two-year project. It'll include an entrance survey, an exit survey, a satisfaction survey, and two other sort of review surveys. So they are working towards this.

But right now they do do it. It's informal. It's usually done as a conversation as opposed to a survey actually landing on their desk that they fill in. But that will be coming to ensure that we are also asking the same standard questions so we can compare across regions as well. And that should be in place within the next 12 months.

Mr. McMorris: — I think, you know, a standard survey will be very valuable going forward. I think it will also have to be somewhat individualized. You know for an example, an oncologist that has left to go to BC [British Columbia] and was vocal in the media. And when we've talked to that oncologist, they said nobody talked to us from the department. I mean we didn't, you know, hear our concerns as to why we are leaving. And some of those concerns are specific to the area that this doctor was working in.

So I think, you know, a general survey is important but also getting some of the specifics depending . . .

Ms. Blakley: — Absolutely.

Mr. McMorris: — So just to get the timeline down, you were saying that this should be complete . . . We're halfway through developing the program now and it will be complete. For anybody leaving after next year we'll be able to . . . And I don't know who that information will be available to. I guess that's the next question because I sure would be interested in knowing some of that information. So it will be ready in two years, is that correct? And who will be privy to that information?

Ms. Blakley: — The tool's been under development for a year already. The first part — it was a five-part tool and the first one was the employee opinion survey of which you'll know was released, the results were released in May. And the regions are using that to build some quality workplace initiatives. The exit survey and the entrance survey are the next ones under development and the entire survey tool will be complete within 12 months. So it was a two-year project. We're in a year. It'll be done by the end of this year, this fiscal year.

Mr. McMorris: — Okay. Then the second part of the question is, who has access to that information?

Ms. Blakley: — As it's currently being developed it's a project amongst the RHAs and the Saskatchewan Cancer Agency and they individually would get their own data to their region. And then we would work with them to share that information at a provincial level to ensure that we have some standardization and that we're comparing across for best practices.

Mr. McMorris: — Okay.

The Chair: — I recognize Mr. Chisholm.

Mr. Chisholm: — Thank you. You mentioned that one of the main measures of financial performance is the budget process itself within all the regional health authorities. I guess my question is, what happens when a regional health authority is either in a surplus or a deficit position on an annual basis and on a longer period of time and that? What actually happens when they come in? Obviously they're not going to come in on the dollar, they're going to be either over or they're going to be under. What is the procedure when the RHAs come in over or under?

Mr. Wright: — Over the course of the year, Mr. Chair, I have a bit of a forum. It's called leadership forum where the CEOs [chief executive officer] meet with myself generally once every two months. During that we'll discuss issues of common interest, and that would include of course financial performance. We have ongoing weekly contact with the RHAs to make sure that their budgets are on line, moving forward.

But at the end of the year, and I'll give you an example, that an RHA planned on a balanced budget — and you're right; it's never within the penny — and they came in with a surplus, fabulous, okay. That's terrific. That improves, as part 2B of the Provincial Auditor's report noted, the working capital scenario and situation of the RHAs. We need to be improving that so we view that as a very, very positive element. The surpluses could be used, in discussion with the Department of Health, to purchase additional equipment, could be set aside in reserves, could be used for working capital for a variety of other items.

When an RHA runs a deficit, we as a department will go over it with a fine-tooth comb with the RHA to determine the causes of this. From time to time we'll bring in external reviewers to take a look at the financial situation, to provide us with some suggestions for adjustments that could be made, to improve things overall, and we will attempt to set a course with the RHA to get them back into that balanced situation.

In order to finance it, I should mention, many of them have lines of credit and that they'll draw on those lines of credit from the banks.

Mr. Chisholm: — Thank you. So I assume then that an annual surplus or deficit would in one way or another carry into that RHA's operations for the next year. Is that right? Or if there was a surplus it just goes back to the General Revenue Fund or the Health department, or does it stay within their purview?

Mr. Wright: — It will stay within their purview. If you look at it from the overall accounting framework of the government, summary financial statements, surpluses and deficits are rolled up into those summary financial statements in one form, fashion, or another. That being said, at the local level a surplus stays with the RHA and a deficit stays with the RHA. That being said, we'll work with them in both cases to ensure that they're properly accounting for on the financial statements and they're properly ensuring that the public are aware of the surplus or deficit position, and we go from there.

Mr. Chisholm: — Thank you. I have another question regarding . . . I noticed that one of the health regions doesn't have a appointed auditor. The Provincial Auditor does the audit for Regina Qu'Appelle Health Region. I was just wondering, how did this come about that all of the other regions have their own auditors?

The Chair: — Who wants to answer? The Provincial Auditor, Mr. Wendel, you wanted to answer?

Mr. Wendel: — We actually audit all of the regional health authorities even though there is an appointed auditor. And in the case of Regina Qu'Appelle, we audited all the individual hospitals before it became a regional health authority, like South Saskatchewan Hospital Centre and the Regina — what do you call it? — Pasqua Hospital. So we audited them at one time and just carried on auditing them.

Mr. Chisholm: — Okay. Thank you.

The Chair: — Perhaps I can just intervene, Mr. Auditor. Is this a financial benefit then to the Regina Health Authority that they don't bring in an outside auditor? How does the accounting work when you audit a health authority versus an outside auditor doing it?

Mr. Wendel: — If there's an appointed auditor, the regional health authority pays those costs and when we are the direct auditor I bring my budget forward to the Public Accounts Committee and they give me my money to audit the government agencies.

The Chair: — So what you're saying then is Regina Health Authority has one less expense because they use you as an auditor. You do not bill them for that service the way the other health authorities would have to bill the outside auditors.

Mr. Wendel: — We don't bill them for the service we provide them either. Like we also are out there with the appointed auditor. So I don't bill them for my services when I'm out there but they do have an additional cost the Regina Health Authority doesn't have.

The Chair: — Mr. Deputy Minister, can you explain why the . . . You talked about collecting data and doing things differently in the different authorities. Here we have another. How are you going to get accurate, even accounting when it's done differently from district to district?

Mr. Wright: — Well inevitably we do have the Provincial Auditor with oversight of all the RHAs' accounting framework and that is typified by this very section that we're dealing with here. So we have not only the check which is the local auditor,

but we have the balance, which I like to think is the Provincial Auditor, in this to make sure that things are recorded appropriately and so on.

A couple of comments on this though. Certainly Regina has and avails itself of the Provincial Auditor to what one may perceive a financial saving to the region relative to other regions. Certainly as we deal with appropriations for Regina Qu'Appelle we take that into consideration.

The other side of the equation that I think is important is that I'm led to believe that the local RHAs use local individuals out there. For example in Rosetown, Heartland may be using a local auditor's office out there. I think it's very important that from an overall economic development, economic strength, that we are supportive of auditors be it from P.A. [Prince Albert] through to Rosetown through to other parts of the province. And that provides important employment, important stability to many of these local offices and so on.

The Chair: — Just one follow-up question. And we may not have time to deal with it today, but there were problems with some of the procedures in some of the health authorities. I mean there wasn't proper control over the bank account and those sort of things. Are these independent auditors not picking this up? Or is the Provincial Auditor expecting, you know, expecting procedures and the . . . Does he have different expectations than the independent auditors when it comes to looking at some of these health issues? Why, you know, do we keep seeing some of these problems reoccur where there isn't proper control over a bank account or isn't proper signing authorities — you know, basic stuff? And it seems like it's been happening for quite a while.

Mr. Wright: — I wouldn't want to speak for the individual auditors that are out there. Generally it would be my experience that the Provincial Auditor operates in a broader framework than perhaps some of the individual auditors do. In addition it may be the case that the Provincial Auditor picks this up from the audit report that's being done by the local auditor. So it can be a combination of factors in moving forward on this, Mr. Chair.

The Chair: — What kind of demands do you make of the regional health authorities that they get these deficiencies rectified very quickly? I mean sometimes, you know, we keep hearing, you know, progress is being made. But yet the auditor looks at some of the problems for your department, and it's not fixed, you know. How do you measure progress when it's not being corrected?

Mr. Wright: — Mr. Chair, I agree with you very much on that point — that we need to make better progress. We are making progress on many of these. And we need to, in certain circumstances, make better progress. To that extent I have had at least two conversations with all the CEOs reinforcing this whole section of the Provincial Auditor's report as it pertains to their activities, reinforcing the need to get on with these items, reinforcing that the Department of Health is available and ready and willing to assist them in getting the job done. So the message has been delivered, I'd like to think, Mr. Chair, in no uncertain terms.

The Chair: — Mr. Chisholm, were you wanting more questions? No you're . . . Mr. McMorris.

Mr. McMorris: — I guess my questions are further to what the Chair had asked but maybe one step further. You've had a couple of meetings with the different authorities saying, this is what we want to see done. What disciplinary action or what do you have to, you know, if for example . . . And you know the example of Prince Albert Parkland. It needs more control over its bank accounts. That's troubling, number one. But, you know, I mean if that's not corrected next year and we see it next year that two or three years . . . What avenues do you have? I mean these health authorities are supposed arm's length but what . . . So I guess what means of discipline do you have to ensure that this will be done, taken care of?

Mr. Wright: — Well, Mr. Chair, in issues of this nature perhaps the most important form of correction is moral suasion, okay. And moral suasion is a very, very powerful tool in and by itself, which is sitting down with individuals and talking about the issues and reinforcing to them the absolute importance of getting on with these items. So rather than running around and trying to — and I'm sure the hon. member isn't suggesting this — firing people and other items, one wants to engage in a meaningful dialogue. One wants to use moral suasion.

Are there tools available to the department? Yes, we could theoretically withhold funding until certain objectives were done. That being said, that's a very blunt instrument because if you withheld dollars, well it's not necessarily the CEO or his or her chief financial officer that suffers at the end of the day. In fact it may be others.

The other element to it is of course dealing with the board Chairs in making sure that they are not only well versed in the issues but that they are taking the correct actions. And long and short is that I would be loath — although I'm prepared to do so — to take disciplinary action. The real action should be taking place at the regional health board of directors. That's where the responsibility should first and foremost lie.

Mr. McMorris: — So if the board of directors . . . For example let's use this example of Prince Albert Parkland needing more control over its bank accounts. What steps are being taken there, since the auditor's report has come out, to rectify that situation?

Mr. Wright: — Mr. Chair, just so I'm clear, we're dealing with . . . [inaudible] . . . "Control over bank account needed," which is to say, Prince Albert Parkland RHA follows its processes to ensure that employees are paid on work for only done. I'm sorry. I just need the reference on which one this is.

Mr. McMorris: — On page 72. Yes, the bottom two paragraphs on page 72 of the auditor's report.

Mr. Wright: — So, Mr. Chair, this really didn't quite totally pertain to — oh I suppose it does — the bank accounts. What the situation was there is that supervisors were noting — and employees — they just weren't recording it properly. And I've been advised that they are in the process of ensuring and reinforcing with their supervisors that their written approval is going to be documented.

The Chair: — That's already happened?

Mr. Wright: — That's my understanding, Mr. Chair.

Mr. McMorris: — Another example here is Kelsey Trail needing to improve controls over payments to suppliers. No purchase limits for employees to authorize for goods and services. Employees can change names of eligible suppliers and approve payment to suppliers and record payments to suppliers into accounting system. There's a couple of issues around there. Those have been looked after as well?

Mr. Wright: — Well I can't speak that they've been looked after. They are noted dutifully by the CEOs, and currently Kelsey Trail has an acting CEO in place. And I'm advised that they're moving on this; they're aware of the situation.

Again, Mr. Chair, we do welcome these comments. It just goes a long way to making sure that at the end of the day we're all doing our jobs properly and so on.

With respect to whether it's specifically been implemented, I'm sorry, Mr. Chair, I don't know at this point in time.

Mr. McMorris: — Another issue around — and I guess whether it's been done or not — but the Mamawetan Churchill River Health Authority, there's some real issues around that as far as purchase orders being used regularly and issues around how they're managing their money. So that has been looked at too. That has been raised with that board, and they'll be looking into it and reporting back to you? And is that the process then, is once these recommendations go forward and you've talked to the health authorities, do they report back saying to you this has been covered off?

Mr. Wright: — Well with respect to the recommendation, the Mamawetan Churchill follows processes for making payments to vendors, which is the recommendation from the Provincial Auditor. I'm advised that they have developed and implemented processes to satisfy this recommendation.

With respect to the process on these items, again it's an ongoing one where they have completed this. My staff will be made aware of this through the chief financial officers for each of the regions, and we will record it as completed.

Mr. McMorris: — I forgot the next question I was going to ask. Do you have any on this before . . .

The Chair: — Just following Mr. McMorris then, are you confident that using your powers of moral suasion and whatever other powers at your disposal, that the next time the Provincial Auditor reports on the health authorities that these problems in Prince Albert, Kelsey Trail, and Mamawetan will be solved? Are you confident?

Mr. Wright: — As I indicated, Mr. Chair, Mamawetan has been resolved to the department's satisfaction and I fully expect that when the Provincial Auditor next reviews this he will say, job well done.

With respect to the others, we continue to work with Prince Albert and with Kelsey Trail. Prince Albert, as you know, has a brand new CEO up there. And as well as I mentioned there is only an acting CEO; there is a recruitment process in Kelsey. It's our hope and expectation to move this along, and I will be disappointed if it's not achieved.

The Chair: — All right, but it's not difficult to achieve. These are fairly simple administrative requirements that are being called for. Can't you give us more assurance that, say in a year's time, that we won't be revisiting this issue?

Mr. Wright: — I will do more than my best, Mr. Chair, to ensure that they're implemented.

The Chair: — Thank you. Mr. Cheveldayoff.

Mr. Cheveldayoff: — Thank you, Mr. Chair. Just a couple of general questions, I guess. And we've spoken about this before but it's the idea of best practices. And, you know, correct me if I'm wrong, but I see the role of the Department of Health to identify which region does very well in a certain area. If Saskatoon or Regina has an information technology disaster recovery plan that's just A1, I see it as your role to provide that information to those that either don't have the resources or just haven't had the focus on that particular area, and to identify the weak links and to make sure that they have the resources or to communicate with the CEO to find out, you know, what the problem is.

Quite frankly I, you know, as post-secondary education critic, and worked closely with the universities and the regional colleges, and the level of standard that they have is just way above, you know. And, you know, U of S [University of Saskatchewan] and the Saskatoon Health Authority would have similar budgets. But what the university has in place just seems to be way above what we're seeing here, and what we're seeing year after year after year.

I know the university, for example, has one individual that their sole job is risk assessment. And that means identifying risks on the university campus throughout. And that also means talking to his colleagues across the country to assure that those checks and balances are in place.

You know, we are talking about 25 per cent of the provincial budget here — 25 per cent of everything that we are going to see laid out in front of us on Thursday. So it's very important. You know, about 25 per cent, correct. So I'm just interested in the deputy's comments on that.

Mr. Wright: — Well first comment, Mr. Chair, would be that the Saskatoon Regional Health Authority has a budget significantly in excess of the budget of the University of Saskatchewan. Their budget is in excess of $600 million which . . . I'll stand corrected, but I think that that's a lot more than the University of Saskatchewan. And indeed there are risk managers within the regions. Indeed there is a chief financial officer. Indeed there is an accounting framework and individuals that move these agenda items along.

The nature of the organization and the structure that's been established in this province, and paralleled in many other provinces, is to have a board of directors that the executive and all report through to. One of our — and very important — jobs

is to make sure that the board of directors is fully aware of and functionally able to execute its duties. To that extent, we do provide training in a number of regards and with respect to financial performance and a lot of the items that are being discussed in here, they've been reviewed most recently by a training session that we put on up in Saskatoon for all board members.

Indeed I would be very surprised if even the University of Saskatchewan . . . And I did sit as a former member of the board of governors. Indeed there are always challenges in any institution, and the role and objective of the executive is to move these things forward and to have them resolved. I've yet to come across an organization that can't improve on its financial reporting and can't improve on its IT [information technology] and systems and a variety of other things.

Mr. Cheveldayoff: — Well thank you, Mr. Deputy. And certainly you know when I use that example I'm talking about — and maybe I should have been more clear — that once you reach a threshold of a budget over, say, $200 million that you should be held to a certain level of account.

And in my work in reviewing the annual reports and the budgets of the post-secondary institutions, you know I never came across segregation of duties, purchase orders, approving work done by employees. It seemed to be on that level. And maybe it goes back to the annual reports. And the auditor touches on that as well, that the need for improvements in annual reports are there. And maybe that's a way to catch what needs to be done at an earlier stage and on an annual basis.

But I thank you for those comments, and you know I certainly look forward to much improvement in this area.

Mr. Wright: — Mr. Chair, if I may, just very quickly. The member suggested that, at over a certain limit, one should be held to account. One should be held to account for every penny regardless of the size of the organization, okay. Regardless if it's a 1-million, a 10-million, or a $200-million organization, you should be held to account.

And again we are being held to account by the Provincial Auditor, and we're being held to account by the public accounts. And it is my job and my duty to get these items cleaned up and cleared up and to move forward.

Mr. Cheveldayoff: — I would agree with those comments, and certainly my analogies that I'm drawing are just to make that point very clear. I would agree with your final statement, and again I would reiterate we look forward to much improvement in this area.

The Chair: — Mr. McMorris.

Mr. McMorris: — I just have a couple of questions from . . . and it's going back. But I remember the last time when I was here, I missed the last Public Accounts meeting, but two meetings ago we were dealing with the issue around sustainability. And I was asking you questions, and at one point you said you really didn't have that information. You weren't prepared to answer some of the questions as far as looking long term on where we're going to be in health care.

We're just coming out of the '05-06 year at $3.1 billion. We've got a budget coming forward in two days, and I know that it's going to be increased to whatever number. And I don't really care where that number is, but I'm wondering where the number will be. I mean the department has to do projections going forward. Where were we going to be in five years? Where are we going to be in ten years in a province of right now shrinking population? Where is that Health budget going to be in short term of five years in your estimation?

Mr. Wright: — Well the simplest answer to that would be in a steady-state world, to which it never is, multiply it by 5.5 per cent per year. And that 5.5 per cent per year would reflect . . . remembering that approximately 72 per cent of our overall budget is wage driven and so one could make an underlying assumption of, say, 3 per cent, including benefits per year. Say 3 per cent.

On top of that, there are other issues, and those other issues deal with utilization of the system. Those other issues deal with external factors. Those other issues deal with the infrastructure needs. Those other issues deal with a variety of other items. I think it would be fair to say in rough terms, utilize 2.5 per cent for annual growth on many of those items combined, about 5.5 per cent in a steady-state world would take you forward.

Mr. McMorris: — So in five years at 5.5 you'd be looking at four and one-half billion dollars for health care.

Mr. Wright: — Well 5.5 times 5 compounded would be roughly 30 per cent increase, of 30 per cent times 3 billion would be about a $3.9 billion budget, Mr. Chair.

Mr. McMorris: — $3.9 billion in five years. And that's at 5.5 per cent; I guess it can be argued with the advancements. Yes, I realize that the majority of the money in health care — you're saying 72 per cent; I had heard as high as 85 per cent — were wage driven. But 72 per cent. The advancements — and we're certainly seeing it right now with the drug Avastin and the other drugs that are coming online — will be coming online into the future.

I would probably think your 5.5 per cent increase per annual is perhaps low, with the advancements in technology and everything else. There is some grave concerns going forward about the sustainability of health care even at 5.5 putting it at $4 billion in five years. And that's, I would say, would be a low estimate. But regardless the sustainability of health care going forward with the advancements . . . Does the department do any projections on how we're going to fund it?

I guess you don't have to worry about the funding; you're not in Finance any more. But how we're going to deal with this five years down the road?

Mr. Wright: — Mr. Chair, excellent questions. One could argue that it could be 8 per cent. One could argue it could be 2 per cent. I chose a phrase somewhat carefully — steady state. Okay. Now one side of this, that we always forget in this discussion and that we mentioned last time we were here, are what are the benefits, okay? And stop and think about the benefits of the system. It's not just cost driven. It's cost to provide a benefit out there, and that benefit is . . . we all benefit

from it. As I mentioned last time, we benefit from living longer. We benefit from reduced infant mortality rates. We benefit from — particularly us guys — reduced risk of death as a result of a heart attack, tremendous benefits out there associated with the dollars that we put in.

Last time I was here I talked about the number of new surgeries that we're doing in a variety of categories — the number in increases in MRIs, better delivery of services, getting people back out into the workforce sooner than they would have 10, 15, or even 20 years ago, and living more productive lives. So let's not forget that side of the equation.

Certainly there are going to be changes. There are, for example on the oncology side of the equation, over 400 drugs, cancer-related drugs, that are under development out there. And let's make the assumption, just for fun, that 100 of those drugs actually come to fruition. And the average cost of those drugs per treatment for an individual is $40,000, and there are 100 people in this province who will benefit from that. Do the math. That's $400 million, and that could be within five years.

Now the other side of the equation is not just to look at, as I mentioned last time, the public sector. Look at the private sector as well, and you'll find the private sector costs are increasing more dramatically than public sector costs. Also don't forget to take a look at how we stack up with others in the Canadian context and in the international context. I think that that's extremely important.

There is no jurisdiction that I'm aware of out there that has that magic bullet. For the best, well-designed system, each one has its benefits. Each one has its problems. Overall in Saskatchewan, I'll say it's pretty darn good. Sure it's got its bumps. It's got its burps. It's got its gurgles. And certainly one should be concerned about the future from a cost side. One should also delight in the benefits that the future will bring as well.

Mr. McMorris: — So using the one example that you used, and it's very fitting and it's timely, is oncology drugs. And we've just gone through the . . . you know, we're going through the debate or the argument or the discussion regarding Avastin, and there's a hundred more coming on stream. If I was to go out and tell my constituents who are 50 or 55 years old that are worried about where they're going to be in five years and what's going to be covered, should they start now and be putting money away to cover this? Because . . . Are we going to be able to afford to cover the standard of care in other jurisdictions? Are we going to be able to follow that here in Saskatchewan, or should we start to make arrangements?

Mr. Wright: — I don't mean to put this in the wrong context, but I'm not a financial adviser to individuals that are out there. There are challenges. There's no question about that. Just if I can expand upon those 400 drugs that are currently in development: 65 of them are for lung cancer, the leading cause of death by cancer. Fifty are for breast cancer, 50 for prostate cancer, 35 for colorectal cancer, which is Avastin. There's going to be tremendous challenges, not only around drugs, but also new technologies. PET [positron emission tomography] scans . . . but we're talking about da Vinci robots. And I'm sorry, Mr. Chair, I don't even know what a da Vinci robot is, but I know it's expensive, okay. But with it will come benefits, as well.

And I think from a societal perspective, one has to weigh very carefully these benefits that are derived from these drugs or from the new technology or new procedures, against the costs associated with them. And at the end of the day, society has got to make some very difficult but very important decisions.

I can't advise your constituents. I don't even know what's around the corner in terms of new developments. I know they'll be tremendous. Many pharmaceutical companies are taking a look at drugs that target on a genetic basis, that are designed for a genetic defect, okay — Fabrazyme, other drugs that are out there that are tremendously expensive. They provide benefit to a certain degree, and there's a cost. And I think, I think society's just got to weigh those benefits and costs very carefully.

The Chair: — Just to follow up on Mr. McMorris's questions, perhaps it's not fair to ask you to be a financial adviser, but your minister in the House indicated that for the drug Avastin that it would not be, it would not be put on the formulary, at least not in the near future, but that that drug would be available to those who could afford to pay for it. In other words, they would be permitted to use it if they wanted to pay for it themselves.

This is somewhat of a different direction for health care in Saskatchewan than we've seen in the past where, you know you tended to have drugs that were recommended by the cancer agency approved by the Department of Health. This is, I think, the first time this hasn't happened.

Can you indicate whether there's . . . that you know, the people of Saskatchewan should expect this kind of policy to be more frequent in the future? In other words, as more and more drugs are coming on stream and you're limited by budget constraints of, say, five and a half per cent growth per year, that we would hear the minister — you know because of policy that has been put in place that you have to administer — telling the people of Saskatchewan that there will be more and more drugs that they, if they want the benefits of, they should plan to pay for them themselves?

Mr. Wright: — Mr. Chair, there are a tremendous number of drugs that are out there that are not covered under the formulary. So there are . . . Avastin actually isn't a formulary drug, oncology drug. But there's many, many, many other drugs that have been approved by Health Canada from the perspective . . . is it safe and sort of does it work, and the answer is yes.

However as you may know, we have a common drug review initiative in Ottawa, and that is not only to take a look at the safety and the effectiveness, but also the cost effectiveness of this. And Saskatchewan accepts the recommendation of the common drug review. We then have our formulary people review it yet again and make a determination and a recommendation to the minister.

There are a lot of drugs that aren't covered out there today. And a lot of those drugs, people can acquire those drugs from the pharmacy or in very legal ways and that physicians may choose to administer to or write the prescription for that. So Avastin is

one that's come into this bailiwick as well.

Into the future? No doubt there'll be many drugs that will be approved in this province, and there will be no doubt certain drugs that will not be approved for either the formulary or from an oncology viewpoint. Each drug has to be taken on its own case and on its own merit because each has unique properties. And so it's difficult to say holus-bolus will there be this or that. Certainly there will be drugs that won't be approved, and there will be many drugs that will be. And that's about the best that I can provide you with at this time.

The Chair: — Thank you, Mr. Deputy Minister. I'm not arguing with you on that point. But I'm asking you: should we expect to see this as a growing trend, where drugs that are considered to be fairly mainstream, you know, growing . . . and maybe you and I would debate whether Avastin was mainstream or not. But when it gets to the point where the cancer agency recommends use of the drug, I tend to think of that as being fairly mainstream. Can we expect, with budget constraints, that more and more . . . I'm not talking about whether it has happened in the past and will happen in the future. But will the trend be more and more that these types of drugs will not be covered by health care in Saskatchewan?

Mr. Wright: — Well just by way of answering if I may for two seconds, and it's typified through the cancer agency on how they will report and make a recommendation to the province. The first thing is that they will examine . . . is it safe, does it work, okay, is it effective in what it does? And they stop there. They don't ask, is it cost effective; what are the benefits weighed against the cost? Okay. So their analysis is only partial, whereas something like the common drug review is what I'll call a general analysis, a complete or a more complete analysis on it. The cancer agency did not conduct a cost-benefit study on Avastin for example.

Another item that you have to ask is, will that drug that come out . . . is it actually better than a current treatment? For example in colorectal cancer, chemotherapy for the average patient runs to 2,000 to $3,000, somewhere in that range. And that provides up to 16 additional months of life. Avastin, as you know, Mr. Chair, for — and I'll just round the figures — $40,000 provides perhaps five months of additional life. So other drugs that are actually better than current treatments, that's another consideration out there.

Again each one's going to be judged individually and considered in its own merit. So there's just a lot of factors. We could debate whether or not Avastin is mainstream or not, equally so. We'll see where we go.

The Chair: — So as your department then tries to evaluate the effectiveness of drugs, do you foresee the health care coverage in Saskatchewan evolving or devolving — I'm not sure which word you would prefer I use — to the point, say with a drug like Avastin compared to some other drugs, that perhaps the Department of Health would cover a percentage of that drug, saying that, you know, here's a drug that will prolong your life for two years. You know we think this is more valuable, so we'll cover 80 per cent of it or 100 per cent of it. Avastin we see as being less effective, but yet it's a recommended drug and it is helpful; we'll cover 40 per cent of Avastin. Do you see health care unfolding in that direction in Saskatchewan?

Mr. Wright: — Well where I'd like to see it unfold, if I may just for two seconds, is the national pharmaceutical strategy. Okay. That's clearly what I would like to see — and I think many if not all other provinces and territories join with me on that — a national pharmaceutical strategy that would provide catastrophic coverage, that would have a common drug formulary, that would have a common drug review not only for new drugs but for existing drugs with what they call new indications, and for oncology drugs is where we would like to go.

To that extent, we've been working with our colleagues and with the federal government on five steps or five issues that need to be identified, and we look forward to reporting to ministers as officials in June on steps that we've taken. I think that that's the most important thing — that we get commonality, we have experts reviewing this in a centralized way, cost-effective way, for all the provinces.

What the future will bring is not clear to me. I've had the pleasure of living in this province and watching it evolve and watching health care evolve in many, many different ways. And I know that the future will certainly bring better health care, better quality health care for all of us. And that's what I look forward to.

The Chair: — Do you think under a national pharmaceutical plan that Saskatchewan can afford that with a shrinking tax base versus provinces like BC and Alberta and perhaps even Ontario and Nova Scotia that seem to be strengthening their tax base?

Mr. Wright: — Sure. Last time I checked, Mr. Chair, I thought the tax base of the province was improving. That being said, I take your point. I think under a national pharmaceutical strategy, first off we have the federal government with certain financial muscle and leverage, and I think that that's very important.

As you may know, Mr. Chair, we have one of the best if not the best drug plan in the country currently. I believe for oncology drugs we were recently rated number four in the country, but for our drug plan — as we understand it — outside of oncology, again we have one of the best. And we have one of the best catastrophic coverages in the country.

People in many parts of the Atlantic provinces would be quite envious of what we have here in this province. And in fact many provinces, as we go through the development of a national pharmaceutical strategy, are utilizing our drug formulary and our approach to catastrophic coverage to model and to do some estimates on the cost of the national item. Should a national item come forward or a national program — certainly because again if we're not the leader, we're among the leaders of the pack — this would I would hope provide other financial relief to the province and that we could take and utilize those dollars for other areas that are needed, be it from the university sector or be it back into health care.

So I see great promise from not only the financial side, not only the commonality of approaches in Canada, but also assessing the effectiveness and the cost-effectiveness of these drugs.

The Chair: — Thank you. Ms. Crofford and Mr. Borgerson both wanting in, so I'll let you decide which one of you go first.

But I just want to put on the record, because I'm sure either Ms. Crofford or Mr. Borgerson will follow up on this tax base, what I was driving at. I know we have a strong economy right now because we're in an oil boom. But nevertheless, our tax base is eroding because we're losing taxpayers out of the province. And if the oil boom was gone, then we would see not only an erosion of the tax base but taxes received.

So is it Ms. Crofford or is it Mr. Borgerson? Ms. Crofford.

Ms. Crofford: — Yes. Actually I don't mind surprising the Chair by that's not what I want to discuss. What I do want to ask is whether anyone has done any serious research on the impact of the federal changes to the drug laws in governing drug companies and drug production in terms of the impact it's had on rising drug costs?

Mr. Wright: — Yes. And I'm going to talk in general terms. I believe the province of Quebec and the province of Ontario have done quite detailed analysis on the costs and the benefits associated with changes to the patent laws over the last several years — Quebec largely because a lot of the pharmaceutical companies are located there.

And certain, as I understand it, concessions were made to the pharmaceutical companies to encourage them to undertake additional R&D [research and development]. Quebec has made an assessment of how much additional R&D has been done in exchange for the extension of the patent laws. I'm sorry, I just don't know off the top of my head what the outcome of that . . .

Ms. Crofford: — And I don't need to know that answer today. I just wondered if anyone had followed up on that. If it is possible, even not within the context of the committee, I wouldn't mind just knowing where to access that information.

The Chair: — Can you provide that information to the committee?

Mr. Wright: — We'll see what can be done, Mr. Chair.

Ms. Crofford: — Yes. Thank you.

The Chair: — Mr. Borgerson.

Mr. Borgerson: — Well I as well won't respond to the Chair's . . . We've engaged in a free-ranging discussion that has, I think, gone far beyond the chapter.

But since we have gone into the area of pharmaceuticals, I just wanted to raise the same issue that Ms. Crofford has. The given . . . No, I'll back up a bit. The pharmaceutical business in North America is of course a trillion-dollar business, and CBC [Canadian Broadcasting Corporation] and a couple of news reports over the last couple of weeks have addressed this issue of the overpricing of pharmaceuticals.

So in the whole discussion that we've had this morning, it's sort of been a given that we're dealt the cards. You know, we're dealing with the cards that are dealt to us in terms of pricing as Ms. Crofford has raised. But when it comes to a . . . I suspect that the kinds of prices that people in Saskatchewan expected to pay for pharmaceuticals, that that is not addressed at the provincial level, that we take what we get. Is it your hope that a national pharmaceutical strategy would move beyond safety, beyond cost-effectiveness, duplication, that in fact it would look at the pricing and patenting that we're experiencing?

Mr. Wright: — Absolutely. That's one of the key elements to this. As you know, when you go shopping, sometimes if you buy in bulk you get a cheaper price. And as a province of Saskatchewan, we've done extremely well with our drug plan in terms of being able to negotiate effectively with suppliers. Imagine what we could do if ten provinces and three territories came together and we all commonly used our muscle through one entity — a national pharmaceutical strategy — to purchase these drugs. One would expect and hope that we would see significantly lower prices. And that's one of the key elements of a national pharmaceutical strategy.

Mr. Borgerson: — I see your official has moved forward. Did he want to add a comment? Okay. That's fine, Mr. Chair.

The Chair: — Are there any questions or comments for our witnesses here? Mr. Deputy, you wanted to . . .

Mr. Wright: — I beg your forgiveness here. I neglected to introduce Mr. Max Hendricks. Max is the newest addition to the ADM [assistant deputy minister] team in the Department of Health. Not only good looking, but very bright and very dedicated to health care in Saskatchewan.

The Chair: — I think at our last meeting I suggested you may have eyes in the back of your head. Now you may have to have them examined. Thank you, Mr. Deputy, and welcome to this meeting as well. Are there any other questions on chapter 2C? If not, we will go to the recommendations.

We are looking at four recommendations. They begin on page 73 of chapter 2 section C. I will read the recommendations starting with number 1. We recommend that the Prince Albert Parkland Regional Health Authority follow its processes to ensure that employees are paid only for work done.

Is there a motion? Ms. Crofford.

Ms. Crofford: — Yes, I'll recommend concurrence with the recommendation.

The Chair: — Okay. A motion to recommend concurrence. Is there any discussion on the motion? By moving concurrence that means that the . . .

Ms. Crofford: — That we agree with the auditor and work should continue.

The Chair: — Any discussion? I see none. Call the question. All in favour? You don't get a vote, Mr. McMorris, but nice to see your enthusiasm. You're too late. Not compliance and not progress, just concurring with the recommendation because they're . . . Right, right.

Ms. Crofford: — I'm moving concurrence. And I intend to do

that with the remaining recommendations as well if that assists the process.

The Chair: — All right, yes. I understand what you're doing. All right. And the second . . . That was carried unanimously by the way.

Second recommendation, no. 2, we recommend that the Kelsey Trail Regional Health Authority appropriately segregate the duties of employees making payments. Is there a motion? Ms. Crofford.

Ms. Crofford: — Again I'll recommend concurrence.

The Chair: — Okay, a motion to recommend concurrence. Any discussion on the motion? Seeing none, we'll call the question? All in favour? Again carried unanimously.

Recommendation no. 3, we recommend that Kelsey Trail Regional Health Authority set purchase dollar limits for employees authorized to order goods and services. Is there a motion? Ms. Crofford.

Ms. Crofford: — Mr. Chair, I'll move concurrence.

The Chair: — Again a motion to move concurrence. Any discussion on the motion? Seeing none, we'll call the question. All in favour? Again that's carried.

And recommendation 4 on the bottom of page 74 reads, we recommend that the Regina Qu'Appelle Regional Health Authority board assess whether it needs an internal auditor. Again is there a motion? Ms. Crofford.

Ms. Crofford: — And I'll move concurrence, Mr. Chair, as well.

The Chair: — Again a motion to move concurrence. Is there any discussion on this motion? Seeing none, we call the question. All in favour? Again that's carried. I believe that's the last recommendation.

I want to thank you, Mr. Wright, and your colleagues for appearing before us. I think we now have your section completed, and so you're off the hook until the auditor comes back with something else. We want to thank the comptrollers for being here. I want to thank my colleagues, as well as the Provincial Auditor. I declare the meeting adjourned.

[The committee adjourned at 11:43.]