# SEIU-West: Submission of SEIU-West to the Saskatchewan Ground Emergency Medical Services (EMS) Stakeholder Consultation

**Submitted July 31, 2017**

## List of Recommendations:

1. Maximize transparency in EMS reform and delivery.
2. Give the Saskatchewan Health Authority (SHA) clear statutory responsibility to ensure the provision of adequate EMS service throughout Saskatchewan.
3. De-casualize and adequately resource the EMS workforce.
4. The SHA should own and directly operate all ground EMS services throughout the province.
5. Reduce or eliminate ambulance fees.
6. Repeal the contracting provisions in ss. 10(1.1)-(8) of *The Ambulance Act*.

## Background

On June 8, 2017 Barbara Cape, President of SEIU-West, received an email from Evan Ulmer, Director of Cancer Services and EMS, Acute and Emergency Services Branch, Ministry of Health, inviting SEIU-West "as a stakeholder within EMS in Saskatchewan" to "participate in the consultation process regarding Ground Emergency Medical Services". The Ministry was seeking to "modernize and redesign" ground EMS to "provide a more consistent and efficient patient-centred" system. The email further stated that a Ministry representative would call in the following week to arrange a meeting with SEIU-West to discuss EMS issues and the Ministry's plans in more detail. That meeting took place on July 17 in Regina. Present for SEIU-West were Ms. Cape, Bob Laurie, Director of Contract Bargaining and Enforcement, and Shawna Colpitts, Director of Political Action and Education. Present for the Ministry were Mr. Ulmer and Deb Jordan, Executive Director of the Acute and Emergency Services Branch.

SEIU-West represents more than 13,000 workers in the province of Saskatchewan, in health care (including acute, long-term and home care), education, community-based organizations, private sector, allied and municipalities.

We represent approximately 120 EMS staff:

- In the public sector (owned and operated by a regional health authority), we represent Emergency Medical Responders (EMRs) in Heartland Health Region (16 locations) and Cypress Health Region (7 locations);
- In the private, for-profit sector we represent the Emergency Medical Technicians (paramedics) of Moose Jaw and District EMS, listed as a prescribed "health care organization" in the *Regional Health Services Administration Regulations*[1].

As part of preparing this submission we reached out to our members and received detailed feedback from members working in both sectors, in both the EMR and EMT-P classifications. We also conducted a non-systematic review of the relevant academic and grey literature.

Our recommendations for the strategic direction of ground EMS in Saskatchewan follow below. Many of our recommendations and supporting arguments draw on the Saskatchewan Emergency Medical Services (EMS) Review of 2009,[2] to which SEIU made a

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[1] *Regional Health Services Administration Regulations*, RRS c R-8.2 Reg 1, http://canlii.ca/t/l3rj

[2] Cummings D. Saskatchewan emergency medical services (EMS) review: final report. EMS Review Committee. October 2009.

written submission. Sadly, few of that review's recommendations were acted on, and as the Consultation Discussion Guide[3] for the present review suggests, the issues that those recommendations were designed to address continue, and in some cases, have become even more pressing.

Beyond our mandate and legal duty to advocate on behalf of our members and improve their wages, benefits and working conditions, SEIU-West strives to lead the way to a more just and humane society. We stand for economic and social justice, for dignity and respect, for having a voice on the job and in society, and for a secure job with the opportunity to advance. This mission heavily informs the recommendations below.

## Recommendations

### 1. Maximize transparency in EMS reform and delivery.

SEIU-West welcomes the invitation to participate in this consultation process, but we approach it with a significant amount of well-founded skepticism. We have striven to offer recommendations grounded in solid evidence, including the experiences of our members. However, our efforts to do this are hampered by the government and Ministry's ongoing lack of transparency.

Like many EMS experts and stakeholders, SEIU-West believes that EMS must be viewed as an indispensable part of the health care system. Over the past decade, in Saskatchewan and beyond, EMS has become increasingly integrated into health care, as EMS practitioners have become more highly trained and increasingly involved in activities other than emergency response and patient transport. In recognition of this growing role in activities like community paramedicine, the 2009 Saskatchewan EMS review called for EMS to be rebranded as "Mobile Health Services".[4]

The current EMS review is not occurring in a vacuum, but in the context of the Saskatchewan government's "transformational change" (TC) agenda. In the 12-15 months since TC was publicly introduced, the government and health ministry have been less than transparent about their plans. As of this writing there are so many uncertainties about the direction of TC it is difficult to speak with confidence and precision about the desirable or likely future state of EMS.

For example, it has been nearly a year since we first learned during a meeting with the Advisory Panel on Health System Structure of the government's plans to create integrated service areas (ISAs), and despite repeated inquiries we still know next to nothing about their number, boundaries, roles and responsibilities. There are hints in the Advisory Panel's report that ISAs will impact how EMS is organized and delivered: a passage calling for "consolidation of clinical services within and across the service integration areas" goes to mention "optimizing the organization" of EMS "through the consolidation of all planning, dispatch, and delivery". Will response zones correspond to ISA boundaries? Will current

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https://semsa.org/images/stories/news/EMS_Review_Report-09.pdf

[3] Government of Saskatchewan. Ministry of Health, Acute and Emergency Service Branch. Ground EMS stakeholder consultation discussion guide. 2017.

[4] Cummings D. Saskatchewan emergency medical services (EMS) review: final report.

response zones/provider coverage areas impact the choice of boundaries? These are important questions to which we have no answers.

When we seek clear answers to questions like these from key policymakers, we are told that our questions are premature, that matters like these are yet to be decided, that everything is still on the table. We have received similar answers to similar inquiries we have made during various consultative opportunities in the government's various TC processes, and have found that when decisions are eventually announced the stakeholder feedback seems to have been crafted and cherry-picked to legitimize a predetermined agenda.

We are hearing from multiple sources that Regina-Qu'Appelle Regional Health Authority (RQHR) may be in the process of selling/contracting out its owned-and-operated EMS operations, possibly to Medavie Health Services, a New Brunswick corporation that also owns Saskatoon-based MD Ambulance. We hope that this is not the case, first, because as discussed in Recommendation 4 below, SEIU-West favours public delivery of EMS in Saskatchewan; second, because such a move by RQHR would represent a profound betrayal of the current EMS consultation process. Government or Ministry tolerance, let alone encouragement or facilitation, of such a move by RQHR at this point would lend support to the allegations that privatization and contracting out are central parts of the government's TC health reform agenda.

SEIU-West also favours EMS options that maximize transparency. This is one of the reasons why we oppose options that increase the role of the private sector in EMS delivery in Saskatchewan. The difficult and protracted litigation that was necessary to enable the public to access information about the provincial laundry services contract between 3s Health and K-Bro Linen[5] is a cautionary tale: the more that health care delivery in placed private hands, the more that information that is key to assessing whether providers, the SHA and the Ministry and government are delivering on their service obligations to the public are shielded by the "trade secrets" principle.[6]

The discussion questions in the Stakeholder Discussion Guide invite us to comment on "performance management and contract management". This is difficult for us to do, for unlike some other stakeholders in this process, such as the Saskatchewan Emergency Medical Services Association (SEMSA), we are not privy to the terms of the contracts between regional health authorities (RHAs) and third party EMS operators.

What combination of regulations and licensing standards (enforced by inspections, suspensions and fines) versus performance-based contracts (enforced by financial incentives and penalties) will more effectively ensure that patient and health system needs are met? The devil is in the details, including the steadfastness of the party or parties responsible for protecting the public interest: Ministry as regulator, licensor, or contract party, the SHA or 3S Health as contract party. A public party with an ideologically-driven privatization agenda may not be sufficiently rigorous in the first place in drafting regulations or negotiating contract terms or enforcing them down the road.

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[5] Canadian Centre for Policy Alternatives Saskatchewan Office. The wrong track: a decade of privatization in Saskatchewan 2004 – 2015. October 2015. www.seiuwest.ca/files/2015/10/On-the-Wrong-Track-A-Decade-of-Privatization-in-Saskatchewan.pdf

[6] See e.g. ss. 18(1)(a) & 19(1)(a) of the *Freedom of Information and Protection of Privacy Act*, SS 1990-91, c F-22.01, <http://canlii.ca/t/52lh0>

Another issue that goes to transparency: does the government plan to prescribe some or all EMS employers or employees as essential services in accordance with Part VII (Essential Services) of the *Saskatchewan Employment Act*[7] *(SEA)*? This has the potential to significantly impact the rights and obligations of EMS operators and employees. The term "essential service" is not defined in the *SEA*. Yet, the Government has extremely broad powers[8] under 7-1(f)(ii) to deem by regulation that Part VII applies to "any employer, person, agency or body, or class of employers, persons, agencies or bodies."

## 2. Give the Saskatchewan Health Authority (SHA) clear statutory responsibility to ensure the provision of adequate EMS service throughout Saskatchewan.

Under s. 10(1)(a) of the *Ambulance Act*, each RHA has the responsibility to ensure "adequate ambulance service" in its region. It may discharge this responsibility either by "direct operation" of EMS services, or by contracting with a third party operator. Although they had been performing this role for years prior, RHAs did not formally acquire responsibility for it until *Ambulance Act* amendments were made in 2009.[9]

Will this responsibility transfer automatically to the SHA upon proclamation of the *Provincial Health Authority Act*[10] *(PHAA)*? The answer is not clear. The *PHAA* makes consequential amendments to 50 Acts, including the *Paramedics Act* and the *Emergency 911 System Act*. The companion *Provincial Health Authority Consequential Amendment Act, 2017*[11] amends a further three Acts. With few exceptions these consequential amendments change references from "RHA" to "PHA". However, the *Ambulance Act* is not among those Acts changed.

The *PHAA* does not mention EMS services, though it contains a number of vague and general powers that might be used to define and assign EMS responsibilities. For example, Cabinet is given the power under s. 9-5(1)(e) to make regulations "prescribing services as health services". The Minister has responsibility under s. 2-1 for "strategic direction of the health care system", under s. 2(8)(a) to "provide health services or arrange for the provision of health services", and under s. 2-4(d) to "determine the health services to be provided by the provincial health authority". Under s. 4-1(1) the SHA is given responsibility for the "planning, organization, delivery and evaluation of the services it provides".

These provisions are insufficient. The Advisory Panel recommended that "governance, management and delivery of EMS services be assumed by the Provincial Health Authority". Improving EMS was clearly a high priority for the Panel. To properly reflect this priority, to signal and facilitate the emerging integration of EMS into the health care system, there should be a clear statement in the *PHAA* reflecting the Panel's recommendation. The statement is of sufficient enduring importance that it should be in the Act itself, not in a regulation.

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[7] *Saskatchewan Employment Act*, SS 2013, c S-15.1, <http://canlii.ca/t/52twb>

[8] Subject to *Charter* rights as spelled out by the Supreme Court of Canada in *Saskatchewan Federation of Labour v. Saskatchewan*, [2015] 1 SCR 245, 2015 SCC 4 (CanLII), http://canlii.ca/t/gg40r

[9] *Ambulance Act Amendment Act, 2008*. http://docs.legassembly.sk.ca/legdocs/Bills/2_26/Bill-49.pdf

[10] http://docs.legassembly.sk.ca/legdocs/Bills/28L1S/Bill28-53.pdf

[11] http://docs.legassembly.sk.ca/legdocs/Bills/28L1S/Bill28-54.pdf

Properly drafted, the statement of SHA responsibility for EMS would be wholly compatible with the ministerial powers and responsibilities described above; for example, the statement could specify that the SHA's responsibility focuses on day-to-day delivery in accordance with more specific service standards spelled out in accompanying regulations.

### 3. De-casualize and adequately resource the EMS workforce.

SEIU-West endorses the view that Saskatchewan's health system must be centred on the needs of patients and families. However, system planners must not lose sight of the needs of the workers who serve the needs of patients and families. They make the system run. Without workers who are valued, supported, and safe, there is no health care system, let alone the "singular system, focused on meeting patient needs through seamless, integrated and team-based care" envisioned by the Advisory Panel on Health System Structure.[12] In the EMS sector in particular, the biggest obstacles to achieving "a more consistent and efficient patient-centred ground EMS delivery system"[13] are, at their core, human resource issues: how best to recruit, train, retain and deploy enough qualified staff, especially in rural and remote areas, to deliver timely and appropriate care. Addressing these issues will require significant investment and/or reallocation of funds.

EMS in Saskatchewan is heavily dependent on casual, on-call workers, especially in rural areas. For at least a decade, EMS stakeholders have been remarking on this situation and how it is increasingly unsustainable. In a Letter of Understanding dating back a decade, and incorporated into their collective agreements ever since, the three health provider unions (SEIU-West, CUPE, and SGEU) and the health employer group the Saskatchewan Association of Health Organizations (SAHO) have acknowledged the importance of maximizing the number of full-time and part-time permanent EMS positions and of ensuring that all EMS workers have access to sick leave, benefit plans, and seniority.[14]

The 2009 Saskatchewan EMS review called for EMS to be "adequately and predictably resourced", especially with respect to "human resource needs". It called for a comprehensive HR strategy that addresses urban staff shortages and increases the number of full time rural positions, including for example return-of-service bursaries for EMS students.[15]

Our consultations with our members confirmed the problems posed by the province's heavy reliance on casual EMS workers. A paramedic who works in both urban and rural settings told us simply, "Casual and on-call doesn't work." An EMR based in a small town

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[12] Optimizing and integrating patient-centred care: Saskatchewan Advisory Panel on Health System Structure Report. December 2016. https://www.saskatchewan.ca/~/media/news%20release%20backgrounders/2017/jan/saskatchewan%20advisory%20panel%20on%20health%20system%20structure%20report.pdf

[13] Government of Saskatchewan. Ministry of Health, Acute and Emergency Service Branch. Ground EMS stakeholder consultation discussion guide. (2017)

[14] See the following (all of which cover the period April 1, 2012-March 31, 2017): Letter of Understanding (LOU) #26 in the SAHO-SEIU-West Collective Agreement www.seiuwest.ca/files/2014/10/CBA-SAHO-April-1-2012-to-March-31-2017.pdf; LOU #9 in the SAHO-SGEU Collective Agreement www.saho.ca/_literature_214395/SAHO_SGEU_-_April_1,_2012_to_March_31,_2017; and LOU#1 in the SAHO-CUPE Collective Agreement www.saho.ca/_literature_211454/CUPE_Collective_Bargaining_Agreement_2012-2017

[15] Cummings D. Saskatchewan Emergency Medical Services (EMS) Review. October 2009. https://semsa.org/images/stories/news/EMS_Review_Report-09.pdf

Saskatchewan implored, “Let the medics make a living wage”. He went on to describe the state of EMS in his community in some detail:

> *Our rural response times are outrageous. This is due to not having full staff at facility at all times. We are allotted 9 minutes to make it to the station to then "roll out”. We should be staffed at all times with a crew at base ready to roll.*
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> *We have people come to work with us but they cannot live off the wages offered. An EMR will only receive 5 dollars an hour to be on call. This does not allow for the average person to hold a regular paying job elsewhere. If a call comes in at 6am and they are now doing a transfer that is 10 hours, it means the person is now missing their regular paying job.*
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> *EMRs have been known to be on call for 100 hours in a row. We are short staffed as no one wants to make 5 dollars an hour. Short staffing causes major fatigue--when the staff are overworked at times they burn out. This then causes one service to have to call in another service to come to the area for standby, thus the costs are greater and it means that there are parts of the province now not within a timely response.*

In short, and to reiterate language in SEIU-West’s submission to the 2009 EMS review, we need to work together to make working in rural ambulance service an attractive career opportunity. We can no longer rely on the patchwork efforts of those who are gainfully employed in other sectors to bridge the gaps in EMS.

SEIU-West has historically supported and helped to facilitate the creation of “blended” positions where the employee works in the health care system in another role (e.g. maintenance, care assistant, food services worker) while on call as an EMR. One of our members strongly endorsed the idea: “If fully staffed and there is no call for EMS, have the staff help with care, thus relieving the stress and workload of acute or long-term care staff.” However, it has been difficult to find people willing to take these positions.[16] This may be because, in the words of one of our members, “people who want to do EMS, want to do EMS”. In addition, pulling a blended EMR away to answer an EMS call can worsen the workload in the many health care facilities that are already short-staffed. The only long-term solution is to hire more full-time and permanent part-time EMS workers. However, this raises the question of how those workers will keep up their skills if they are based in a low-volume rural community. One of our members suggested possible solution that is also endorsed in a recent review of Alberta EMS[17]: under a borderless, provincial model, rural EMTs could occasionally be rotated into an urban area to keep up their skills, while urban staff could do occasional rural rotations to provide relief coverage. Compensation models would have to be adjusted to incentivize and compensate for these rotations. However, this

[16] Heartland Health Region Annual Report. 2015-2016. http://hrha.sk.ca/wp-content/uploads/2015/04/2015-16-Annual-Report-final-July-29-16.pdf

[17] Health Quality Council of Alberta. Review of operations of ground emergency medical services in Alberta. 2013. www.health.alberta.ca/documents/EMS-Review-HQCA-2013.pdf

would require a level of HR coordination (e.g. more centralized EMS scheduling) that might be difficult to achieve under the current model of fragmented ownership. (See Recommendation 4, below.)

We do not envision that the de-casualized EMS workforce we are recommending will be made up exclusively of EMT-Ps or higher. For rural and remote locations, such a proposal is neither realistic nor necessary. We believe that EMRs, with full-time and permanent part-time status and appropriate compensation, can and should be a key part of meeting patient and community EMS needs. This will be particularly true if the current attendant qualification mix standard in ss. 53(8) of the *Ambulance Regulations*[18] is maintained. This standard allows rural EMS to respond to calls by deploying 2 EMRs. In submissions to the 2009 EMS review the Saskatchewan College of Paramedics and some EMS services called for a province-wide application of the urban standard in s. 53(7) of at least 1 EMT per call[19]. Such a move could significantly increase EMS system costs, for no proven benefit. One of our members noted that as a matter of policy or practice, his RHA was regularly staffing its owned and operated ambulances with two EMT-Ps.[20] He called this “a huge waste of taxpayer money”.

We recognize that it is neither possible nor desirable to completely eliminate on-call staffing. One EMR whose community is near a popular resort community said that the health region’s EMR funding and staffing models did not take account of the fact that the area’s population and traffic significantly increased during summer. There needs to be an element of flexibility so as to customize the use of resources based upon the unique circumstances presented in each community. We point to communities where paramedical staff have become a necessary player in the advance of a Collaborative Emergency Centre. Such strategies provide a more stable human resource in the community and will, inevitably result in more reliable service delivery options. As a strong public service, EMS can be dispatched in each of our unique rural, remote and urban communities based upon the model that best meets the needs with such creative approaches being available to help de-casualize the work force.

## 4. The SHA should own and directly operate all ground EMS services throughout the province.

The 2009 Saskatchewan EMS review stated, “Separate players acting from distinct perspectives create a disjointed development of the system. It is unlikely that Saskatchewan can achieve a common vision focused on change that best serves patients, if these individual perspectives are allowed to continue driving the operation of the EMS system.”[21] We agree. The 2009 review was confident that the degree of coordination needed to reach and implement a “common vision” is possible in an EMS system with “diverse provider agencies”.[22] We do not share this confidence.

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[18] *The Ambulance Regulations*, RRS c A-18.1 Reg 1, http://canlii.ca/t/k5dn

[19] Cummings D. Saskatchewan emergency medical services (EMS) review: final report

[20] Cummings D. Saskatchewan emergency medical services (EMS) review: final report.

[21] Cummings D. Saskatchewan emergency medical services (EMS) review: final report.

[22] Cummings D. Saskatchewan emergency medical services (EMS) review: final report.

As suggested by the recommendations of the Advisory Panel and hinted at in the EMS Consultation Guide, the Ministry and government are looking for a much higher degree of integration, coordination and standardization of EMS and of health care in general than was contemplated in 2009. SEIU-West is adamant that this level of seamlessness is simply not possible in the current diverse ownership landscape.

In the words of one of our members, it is difficult to make the patient transfer system seamless when there are multiple private providers. He described instances of ambulances driving empty from rural Saskatchewan into Regina to pick up a patient from hospital. In many cases, he said, those cars could easily have stopped in a community on the way to Regina to pick up another patient needing non-urgent transfer into the city, but could not do so because that patient "belongs" to a different, rival EMS provider. Such instances are not cost-effective or patient-centred.

The need for significant consolidation of providers is clear. Multiple sources, including reports from our members, indicate that many smaller providers are struggling to make ends meet and achieve modern service expectations. The 2009 Saskatchewan EMS review suggested that there needed to be a consolidation of providers, and that those whose survival hinged on the provisions of s. 10(1.1) of the *Ambulance Act* (e.g. automatic contract renewal) should be offered "exit strategies" including some form of fair transition assistance.[23] We support this recommendation. The move to one health authority in Alberta led to more than 40 operators "divesting" their EMS assets, in most cases to the provincial health authority.[24]

Some EMS consolidation will occur automatically when the *PHAA* is proclaimed: the Saskatchewan Health Authority will immediately become the owner-operator of all of the former RHA owned and operated EMS services. These services have bases in about 50 communities with populations ranging from a couple hundred in Richmound to a couple hundred thousand in Regina.

The EMS Stakeholder Consultation Discussion Guide asks, "What is your view on the Saskatchewan Health Authority introducing competition or other methods of obtaining EMS delivery?" This question is both leading and misleading, especially in its use of "competition". There is not now, and is unlikely to be in future, the opportunity for patients to choose among multiple competing ambulance companies. The future state contemplated by this question would seem to be the SHA tendering out EMS provision on a province-wide (or integrated service area?) basis. There would technically be competition during the tendering process, but once a provider was chosen, patients and families would be locked into a private monopoly for long periods (for example, the ten year deal between Medavie and the government of New Brunswick[25]).

As discussed above, SEIU-West is skeptical of any reforms to EMS or to health care delivery in general that increase the role of private, for-profit entities. Province wide EMS delivery

[23] Cummings D. Saskatchewan emergency medical services (EMS) review: final report.

[24] Health Quality Council of Alberta. Review of operations of ground emergency medical services in Alberta. 2013.

[25] Usher S, Buffet W, Marois R. High quality ambulance service for all. Health Innovation Forum. 2008 https://www.healthinnovationforum.org/article/high-quality-ambulance-service-for-all/

by a private provider will not meet the standards of transparency and public accountability that, as discussed above, SEIU-West fervently supports.

Nor are we confident that a private provider will provide EMS workers with the kind of wages, benefits, and security needed to address the HR crisis in EMS discussed in the previous section. In our experience, the privatization of hospital linen services to K-Bro Linen provides a cautionary tale: the result has been poorer wages and working conditions for employees, and a decline in access to quality linens.

A move to the SHA as the single, public provider of ground EMS would also enable Saskatchewan's health system to more fully embrace and get maximum benefit from innovative and cost-effective practices like community paramedicine and "treat and refer". There is a growing body of evidence that community paramedical initiatives are "successful at reducing transports to hospital, making safe decisions about the need for transport and delivering acceptable, cost-effective care out of hospital."[26] Our members have had first-hand experience of apparently successful community paramedicine pilots in Wynyard[27] and Eastend.[28] Unless paramedics working within the SHA all have the same employer, the SHA, it will be impossible to expand, staff, and properly coordinate community paramedicine initiatives. Having the SHA as the sole employer will also help to ensure that the initiatives respect the work of established bargaining units and professional scopes of practice. No one health profession or class of workers, including paramedics themselves, should have sole authority or veto power over where and how paramedics are deployed. Community paramedicine initiatives must therefore include prior and ongoing consultation with all stakeholders, and must be accompanied by clear lines of authority and an emphasis of the team concept—all of which will be extremely difficult to do if the paramedics involve have different employers, some of them private, for-profit.

SHA ownership and operation of all ground EMS would greatly facilitate health system budgeting, including the kind of needs-based cross-subsidization and funding reallocation among regions and services which is essential to an accessible and equitable public health care system as envisioned by the Canada Health Act. The idea that any and all surplus funds in EMS should be channeled back into EMS and EMS alone does not reflect the idea of reallocating money to services and programs of higher priority or that serve greater emerging needs. Furthermore, we strenuously reject the idea of EMS profits being returned to shareholders of an out-of-province corporation in the form of dividends, instead of being funneled back into health care.

## 5. Reduce or eliminate ambulance fees

As the Stakeholder Discussion Guide notes, Saskatchewan has some of the highest ambulance charges in Canada. The 2009 EMS review was especially concerned about

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[26] Turner J, Coster J, Chambers D, Cantrell A, Phung V-H, Knowles E, Bradbury D, Goyder E. What evidence is there on the effectiveness of different models of delivering urgent care? A rapid review. School for Health and Related Research (ScHARR), University of Sheffield UK. June 2015. http://eprints.lincoln.ac.uk/17833/1/Rapid%20Review%203.pdf. See also Bigham BL, Kennedy SM, Drennan I, Morrison LJ. Expanding paramedic scope of practice in the community: a systematic review of the literature. Prehospital emergency care 17:3. July/September 2013. 361-72. Iezzoni LI, Dorner SC, Ajayi T. Community paramedicine: addressing questions as programs expand. N Engl J Med 2016; 374. 1107-1109.

[27] Community approach to care working in Wynyard. The Region Reporter: News from Saskatoon Health Region. April 8, 2015. https://regionreporter.wordpress.com/2015/04/08/community-approach-to-care-working-in-wynyard/

[28] Cypress Health Region Mobile Health Services. Eastend pilot. November 2012.

transfer fees, especially for rural patients, and the inequities this creates. It called for the elimination of transfer fees.

We call for all ambulance fees and charges to be drastically reduced, with the goal of eventual elimination.

It is common to hear media and other reports about excessive costs to a family who has had a loved one access EMS services. Our members who work in EMS appreciate this sense of frustration as economics drives the general public away from accessing safe EMS services when most needed. In the words of a member who works in rural EMS:

> *As for our cost of an ambulance, we hear time and time again how people will risk driving their extremely sick family members to the emergency as they cannot afford the cost of an ambulance. This puts the patient at huge risk as well as the person driving them. Think if you were driving your family member and they expire while you are driving, would you be in the best condition to be behind the wheel? Luckily we in [my community] have a very strong, well-educated and practiced crew. But we can't help if we are not called due to fear of a "bill" in the mail.*

We realize that this recommendation could represent a significant increase in health system costs. One way to offset this: carefully track inter-facility transfers, and minimize inappropriate transfers. The Alberta experience suggests that the move to one health authority may result in an increase in the number of inter-facility transfers.[29] This would potentially increase costs, and increase the frequency of coverage gaps (a.k.a. out of service time)[30]. It is therefore important to collect good data about transfers, so that their clinical appropriateness may be monitored. There is a growing body of research on the clinical appropriateness and cost-effectiveness of accepted treatments and practices, and a growing consensus on the need to stop using treatments and practices that do not reduce morbidity or mortality.[31] Ontario is currently reviewing its rules and policies regarding non-urgent inter-facility transfers, and is considering allowing them to be made in vehicles other than fully-equipped ambulances.[32] EMS funding models and targets should be designed to minimize the number of inappropriate transfers: both the 2009 EMS review and our conversations with members suggest that the current EMS funding system provides strong financial incentives for transfers. The expertise of the Health Quality Council might be very helpful in efforts to monitor and reform Saskatchewan's patient transfer practices.

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[29] Health Quality Council of Alberta. Review of operations of ground emergency medical services in Alberta.

[30] Heartland Health Region Annual Report. 2015-2016.

[31] See e.g. Choosing Wisely Canada. https://choosingwiselycanada.org/ ; Friebe I, Isaacs J, Mallu S, Kurdin A, Mounasamy V, Dhindsa H. Evaluation of appropriateness of patient transfers for hand and microsurgery to a level I trauma center. Hand (NY). 2013 Dec; 8(4): 417-21; Reimer AP, Schiltz N, Koroukian SM, Madigan EA. National incidence of medical transfer: patient characteristics and regional variation. J Health Hum Serv Adm. 2016 Spring; 38(4): 509-28.

[32] Enhancing Emergency Services in Ontario (EESO) & Ontario Ministry of Health and Long-Term Care. Emergency health services system modernization: briefing paper on legislative amendments to the *Ambulance Act*. July 2017. https://www.amo.on.ca/AMO-PDFs/Reports/2017/BriefingPaperonLegislativeAmendmentstotheAmbulance.aspx

### 6. Repeal the contracting provisions in ss. 10(1.1)-(8) of *The Ambulance Act*.

If, contrary to Recommendation 4 above, private contractors are to remain a part of EMS delivery in Saskatchewan, we recommend the repeal of ss. 10(1.1) through 10(8) of *The Ambulance Act*. As was recognized when they were first introduced in 1988, these provisions significantly altered normal contract law to the benefit of private sector EMS providers: unless it has just/reasonable cause, an RHA cannot terminate a contract with a private EMS provider, and must renew the contract when it expires. The private provider, on the other hand, can terminate the contract for any reason on 120 days' notice. The legislative record suggests that these provisions were the result of heavy lobbying by private ambulance providers, especially smaller "mom and pop" operations, who claimed they needed the provisions (enshrined in the body of the Act, not, as the government originally planned, in regulations) as "security" to protect their investment in equipment and to incentivize future investments.[33] Even if these were legitimate considerations at the time, the provisions are no longer needed today. The private EMS providers who are likely to survive the likely (and, from our perspective, desirable) consolidation of the industry in Saskatchewan are not "mom and pop" operations. They are relatively large, and have relatively easy access to competent legal and business advice. It is unclear that these provisions have made a positive contribution to service quality or have delivered value for money to the people of Saskatchewan.

## Conclusion

The current review of Saskatchewan's emergency medical services system is the second review in less than a decade. The recommendations of the 2009 review were largely ignored, and as a result, the challenges facing the system, especially in rural areas, are even more pressing.

With the creation of the Advisory Panel on Health System Structure the government signaled its desire for a "singular" health care system "focused on meeting patient needs through seamless, integrated and team-based care". The Advisory Panel rightly saw that EMS is an important part of the health care journey of countless patients and their families, and recommended that EMS be fully integrated into that system.

However, if that system is to be transformed, EMS must also be transformed. The current reality of diverse ownership, of "separate players acting from distinct perspectives", is no longer tenable. Consolidation is necessary. As discussed in our submission, only consolidation in public hands, under the ownership and management of the Saskatchewan Health Authority, can meet the above health system goals in a manner that respects the no less important goals of accountability, transparency, accessibility and equity. Only such an arrangement can address the significant human resource challenges the province's EMS is facing, especially in rural areas.

The changes we propose will require important new investments in de-casualizing the EMS work force and in divesting and transitioning current private providers. However, there are significant economies to be achieved, and that are only fully possible under a public model,

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[33] Legislative Assembly of Saskatchewan. Debates and Proceedings. 2nd session, 21st Legislature. NS volume XXI, no. 69C. June 28, 1988.

such as discouraging inappropriate transfers and making greater use of community paramedicine.

SEIU-West thanks the Ministry for engaging with us on EMS reform. We welcome all future opportunities for meaningful consultation with other stakeholders to ensure the delivery of essential emergency medical services within Saskatchewan.