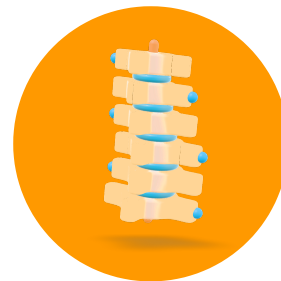
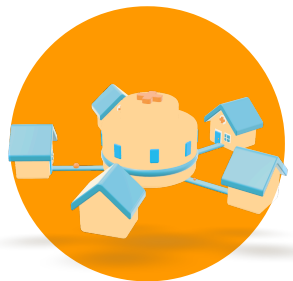


The Saskatchewan NDP **Four Pillar** **Primary Care Plan.**

Your Healthcare Home. Your Healthcare Hub. Your Bridge.
Your digital Backbone.



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Plan Summary.

THE YCYS PLAN TO BUILD A PRIMARY CARE SYSTEM AS THE FOUNDATION OF SASKATCHEWAN HEALTHCARE



Saskatchewan's first great health-care transformation made sure everyone could afford medical care. **The next step is to make sure everyone can actually access comprehensive, coordinated, and continuous primary care.**

It is not a consultant's idea. And it wasn't modeled in an SHA executive suite in Regina. It is rooted in Saskatchewan's own history: from the building blocks of Medicare – the first public health plan established in Swift Current in 1947 and Saskatchewan's pioneering community clinics, to the innovative team-based models clinicians are building today. **The task is to connect those pieces and make comprehensive primary care universal.**

Our Promise: Every Saskatchewan person will have a Healthcare HOME – a team that knows you and remains responsible for your care, guaranteed based on your postal code and as automatic as a child's place in their neighbourhood public school (care by community, not by chance), a HUB behind that team, shared connected capacity when you need more and one place to start, a BRIDGE so care can reach you wherever you live, and the missing BACKBONE of the system, one connected record that follows you throughout your care.



YOUR HOME – A guaranteed, enduring primary care team. Every person has access to an enduring local primary-care team with a no-abandonment guarantee. If an individual provider leaves, the patient remains the responsibility of the team. Never again hear “wait list closed” or “not accepting new patients.”



YOUR HUB – Shared connected capacity. No local clinic, physician's office, or team can stand alone or provide everything. Healthcare Hubs give Homes a broader reach – home care, mental health and addictions, allied health, diagnostics, social work, pharmacy, system navigation, specialist connections, and more. They will also connect you to any needed community and social supports that address the conditions affecting your health – issues around housing and food insecurity to income, transportation, isolation and other social determinants of health. Hubs will include community navigators that actively match unattached patients with primary care and ensure they have ongoing access in the meantime.



THE BRIDGE – Care that can reach you. Build the missing front door through a modernized 811 navigation system. Expand Community Paramedicine, mobile nursing, home-based services and *relational* virtual care options that connect patients to care, bringing this expanded capacity within your reach.



THE BACKBONE – One patient. One record. One connected system. Deliver the interoperability that the Sask Party has been promising for over 15 years so you, the patient, can access your data, and so that relevant information follows you across primary care, hospitals, EMS, specialists, virtual care and community services.

Your Healthcare Home.

**Healthcare Homes: Ending the Health Care Lottery —
a guaranteed primary care team for every
Saskatchewan person, not just the lucky ones**



Situation

More than sixty years ago, Saskatchewan changed health care in Canada. We led the country first on hospital insurance then Medicare, establishing a simple principle: access to medical care should never depend on how much money you have. But Douglas did not believe paying the doctor's bill was the end of health reform. Universal insurance was the first step. The next was a health system built around people and communities: prevention before crisis; doctors, nurses and other health professionals working together as teams, continuity throughout people's lives; and care delivered as close to home as possible.

That next step was never completed province-wide.

Today, whether a Saskatchewan resident has access to a family doctor, nurse practitioner, or primary care team, depends on one thing: luck. Luck of which clinic hasn't closed. Luck of whether your doctor retires this year or stays another ten. There is no plan, no promise, and no guarantee you'll have a primary healthcare home – just a draw, and hundreds of thousands of people losing the lottery with no access at all.

And even those formally "attached" to a provider aren't necessarily experiencing the benefits of accessible care. A 2026 national Angus Reid Institute survey found Saskatchewan had **the worst primary care access in Canada:** six in ten Saskatchewan people either had no family doctor or struggled to see the one they had.

The Sask Party's own March 2026 budget shows exactly how thin the winning ticket is. After years of promising Patient Medical Homes, they are available in only a handful of locations.

And we know what happens to the people left outside those winning tickets. In December 2025, the Gardens Community Health Centre in Regina closed just five years after opening, despite receiving over \$8.5M from the Sask Party government. Heralded as the "future" of primary care, 5,000 patients were left scrambling to find a new provider overnight. The NDP asked the Sask Party to intervene. It refused. *[CBC News]*

The cost of that lottery extends far beyond inconvenience. When people cannot get reliable, ongoing care, preventable problems become crises and patients end up in emergency rooms and hospital beds.

The Sask Party's answer is another attachment target: that "every resident" will be attached to a single primary care provider by the end of 2028. But we've heard this before and the Sask Party isn't making this promise for the first time. **In 2012, during their second Patient First Review, they promised**

same-day access to a care team, coordinated teams and “[a]ll people are connected to a care team that includes a family physician.” **Fourteen years later, the government is again promising patient attachment** – but this time not even within the current election cycle.

Saskatchewan doesn’t need another broken promise or another attachment target that can disappear with the next doctor retirement or clinic closure. It needs to finish the transformation governments have been promising for nearly two decades: a permanent Healthcare Home, a team responsible for your care, and a system designed around continuity rather than individual appointments.

Precedent

- **Every other public service already works this way.** We would never accept a school system where parents phone classroom after classroom hoping someone has room for their child. We would never accept a police system where you call detachment after detachment hoping one has capacity to respond. Your address determines which part of the public system is responsible for serving you. **Primary care should work the same way: care by address, not care by chance.**
- **Saskatchewan ended this lottery before and we can do it again.** The solution to Saskatchewan’s primary care crisis isn’t something we need to import from elsewhere. It is an idea Saskatchewan helped pioneer.
 - In 1946, sixteen years before province-wide Medicare, **the Swift Current Health Region became the first place in North America to guarantee comprehensive, tax-supported medical care to every resident of a region, regardless of ability to pay or which doctor they happened to see.** Dr. O.K. Hjertaas, who helped build it, went on to help design province-wide Medicare itself. *[Johnson, A.W]*
 - **Saskatchewan’s proud legacy of community clinics carried this idea forward.** Medicare meant Saskatchewan people would never again face a doctor’s bill because they became sick. But early health reformers understood that removing the financial barrier did not by itself create prevention, continuity, teamwork or community-based care. **Beginning in 1962, the community-clinic movement pointed toward the next stage: multidisciplinary teams, community governance, prevention and ongoing relationships between caregivers and the populations they served.** That vision was ahead of its time. Saskatchewan helped imagine the future of primary care decades ago. We simply never made the future available to everyone.
 - **Saskatchewan is still breaking the mould.** Whether it’s Regina’s SHA-run Community Health Centres, the first of which was opened in the 1990s, or Swift Current’s Associate Family Physicians Clinic, or continued advances made by legacy community clinics mentioned above, there are other working examples of team-based primary care – this isn’t a theoretical fix, it’s already running successfully inside Saskatchewan’s own borders. The problem is that this model isn’t available to everyone in the province and we haven’t seen the political will needed to replicate this in a systematic and ongoing way. Only a few lucky individuals in a few communities benefit because the Sask Party always chooses to do just enough for the headline but nothing more.

- **Ontario provides a contemporary example of making universal attachment an explicit government responsibility.** In December 2024, Ontario appointed Dr. Jane Philpott – a practising family physician and former federal health minister – to chair its new Primary Care Action Team, with a five-year mandate to connect every Ontarian to a publicly funded care team. Her own words for the goal: “the guarantee of access to a primary care team is as automatic as the assurance that every child will be assigned to a public school in their neighbourhood.” And Ontario is putting that guarantee into practice: within its first year, the province reported connecting roughly 275,000 more people to primary care teams and clearing 75 per cent of its family-doctor matching waitlist.. *[Ontario’s Primary Care Action Plan]*
- **Active matching not just a passive list.** Ontario’s Health Care Connect and B.C.’s Health Connect Registry don’t just publish who’s accepting new patients – they assign a care connector or attachment coordinator to actively search for and contact a match on the patient’s behalf, prioritizing patient need first. Saskatchewan has no equivalent.
- **Alternative payment already has a foothold here.** Saskatchewan pays roughly 52% of family physician compensation through alternative payment models – third-highest in the country, behind only Nova Scotia (61%) and Ontario (53%) – per CIHI data cited in the C.D. Howe Institute Doctor Dilemma report. The funding architecture for team-based, non-fee-for-service care is already substantially in place; it just isn’t organized around teams yet.
- **The “no abandonment” promise is already written into a gold standard this province could adopt.** The OurCare Standard states plainly that “everyone receives ongoing care from their primary care team,” not from one individual who can retire, relocate, or close a clinic without notice. Continuity isn’t a nice-to-have layered on top of attachment. It’s one of the six things Canadians already told researchers they expect from primary care. *[MAP Centre for Urban Health Solutions, Primary Care Needs OurCare Final Report, 2024]*

Assessment

Finishing what Tommy Douglas’ generation started does not mean recreating the health system of the 1960s. It means applying its principle of universality to a modern health system. Every Saskatchewan person should know who is responsible for their ongoing primary care – as a guarantee, not a lottery.

How that responsibility is organized should reflect the community. Healthcare Homes should be designed around population needs, available providers and community circumstances, with Indigenous communities directly involved in designing the models that serve them. A Healthcare Home in a Regina neighbourhood will not look exactly like one in rural Saskatchewan, and neither should be imposed unchanged on a northern community.

The organizational principle, however, should not change from one postal code to another: **Care should be organized around the patient and community, rather than forcing patients to organize themselves around the system.**

That distinction matters because Saskatchewan’s problem is bigger than attachment. Attachment campaigns are built to answer the question “do you have a provider.” They are not, by themselves, built to answer the harder question: what happens to you the day your provider leaves? As the Gardens closure demonstrates, having a provider today is no guarantee for tomorrow if a retirement, relocation or clinic closure sends every affected patient back into the lottery system.

The answer is attachment to an enduring team at a Healthcare Home, not dependence on one individual provider. When a physician or nurse practitioner retires, relocates or leaves a team, **the patient remains with the team.** The system reorganizes care around them rather than making the patient start over. When an entire clinic closes, **the health system assumes responsibility for transitioning every affected patient to another health-care home within a defined period.** Finding replacement care is a system responsibility, not an individual scavenger hunt.

This is the **no-abandonment guarantee**, which effectively changes the fundamental relationship between Saskatchewan people and primary care. Today, patients carry the risk that their provider will leave. Under a health-care-home model, **the system carries that risk.** That is what makes this more than another attachment target.

In 2026 in the birthplace of Medicare, universality should mean more than having coverage when you get sick. It should mean knowing that someone remains responsible for your care.

The Counter-Case.

We don't have enough doctors/NPs to guarantee everyone one.

Our answer: that's exactly why we need a guarantee to an enduring team rather than an individual physician. Workforce scarcity is another reason to organize scarce capacity better, not a reason to leave responsibility with the patient. The initiative can start where primary care gaps are greatest and expand from there as capacity grows.

Key Recommendations

- **End the lottery in law, not just in language or practice.** Pass a **Primary Care Act** that guarantees every Saskatchewan resident connection to a full primary care team — not just an individual provider — as the legislated standard.
- **As part of that Act, legislate a no-abandonment guarantee** — Healthcare Homes will ensure that when individual providers retire, relocate, or leave, patients remain attached to their Healthcare Home. When an entire clinic closes, the health system becomes responsible for assisting unattached patients and navigating them to a home with a publicly reported time frame.
- **Establish Care based on where you live** — Imagine if public education worked like primary care: families phoning school after school, hoping someone will take their child. We would never accept that. In 2026, in the birthplace of medicare, we shouldn't accept it in healthcare either. **Every Saskatchewan person should have a Healthcare Home responsible for them based on where they live — care by address, not care by chance.**
- **Replace passive search with active matching** — create a province-wide attachment system that actively matches unattached patients to available teams, prioritizes people according to need, and gives patients a navigator responsible for helping them find a permanent home rather than leaving them to phone clinics themselves. The Sask NDP introduced legislation that would require a registry of NPs and family doctors accepting new patients on the heels of a petition launched by the College of Family Physicians calling for one. In its absence, a Regina resident built his own website attempting to track local doctors accepting patients. But the goal should go further: **patients shouldn't have to search for care; the system should be responsible for finding them a Home.**

- **Build different Homes for different communities** – set a common provincial standard for the functions every health-care home must provide, while allowing urban, rural, northern and Indigenous communities to design different team configurations around local population needs and available workforce. **Universality does not mean “all the same”.**
- **Publish a needs-based rollout and measure continuity, not just attachment.** Prioritize communities with the poorest access and weakest team-based coverage, publish dates for bringing every part of Saskatchewan under the guarantee, and publicly report both **attachment and continuity**. Government should have to show not merely how many people got a provider, but whether they remained connected to ongoing care.

Your Healthcare Hub.

Healthcare Hubs: continuous, coordinated,
connected care behind every Home



Situation

A Healthcare Home solves the first problem: it ensures someone is responsible for your ongoing care. But attachment is only the beginning.

Even if we believed that the Sask Party was finally serious about their primary care promises, **the Sask Party's guarantee centres entirely on attachment to an individual physician or nurse practitioner – not a guarantee of continuous, integrated team-based care that survives when a provider retires, relocates or a clinic closes.** What's more, a Saskatchewan resident can have a family doctor or nurse practitioner and still have nowhere to turn when they need home care, mental-health support, help with managing a chronic condition or just basic assistance navigating the health system. A fifteen minute appointment cannot provide everything a patient needs, and no Healthcare Home – particularly in rural and northern Saskatchewan – can reasonably employ every health professional or provide every service on its own.

This is Saskatchewan's comprehensive care gap: having a doctor or NP does not necessarily mean having access to comprehensive primary care. The problem is not Saskatchewan's health-care providers. It is that primary care, home care and community services are still too often funded, planned and delivered as separate systems serving the same patient. **So while a government can increase attachment numbers on paper, patients will continue falling through the gaps between services that were never organized to work as one.**

The consequences are visible downstream – in hospitals, longterm care facilities, and emergency departments. Saskatchewan has built a reactive health system that is exceptionally good at spending money after people become sick or are in crisis. But we have failed to build a system to keep them well, catch issues early, manage chronic illness, support people at home, and coordinate services. Saskatchewan's primary care gap is actively filling hospital beds with people who don't need to be there. **Done properly, Saskatchewan's primary care system has the potential to change what happens before the crisis and relieve enormous pressures (and cost) associated with care accessed in hospitals, emergency departments, and long-term care facilities.**

High rates of hospitalization for ambulatory care sensitive conditions, alternate-level-of-care patients occupying acute-care beds, delayed discharges and unnecessary transitions into institutional care are not separate problems. **They are different symptoms of the same failure to build enough capacity outside the hospital.** And they cost the system a lot: both in terms of lower quality of life for patients and system expense.

While this is an issue across Canada, Saskatchewan is doing this particularly poorly. Saskatchewan has posted among the country's highest hospitalization rates for ambulatory care sensitive conditions — illnesses such as diabetes, asthma, heart failure and COPD that strong primary and community care can often manage before hospitalization. One national study found Saskatchewan's rate was the second-highest among provinces (**72% above the national average**, with particularly serious disparities in rural areas).

The **lesson is that having a provider ("attachment") is not the same as having the care you need.** Saskatchewan needs local primary-care teams that know their patients, but it cannot realistically put every service and every health professional in every community. So getting attached to a provider is not the finish line, it's a starting point. The challenge is therefore to make comprehensive care universally available **without requiring every local team to provide everything itself.**

Workforce challenges after two decades of the **Sask Party's failed record of recruitment and retention in healthcare is another reason to organize scarce capacity better**, not a reason to leave patients to fend for themselves.

Precedent

● The Roadmap already exists here in Saskatchewan and Canada

- **Saskatchewan already pioneered the idea behind Health-Care Hubs.** The province's community-clinic movement demonstrated more than sixty years ago that primary care could mean more than an individual doctor working alone. Saskatchewan's community health co-operatives have delivered multidisciplinary community care for decades. The Saskatoon Community Clinic opened in 1962 as a patient-governed co-operative and today brings family physicians and nurse practitioners together with mental-health counsellors, community nursing, physical and occupational therapy, dietetics, pharmacy, laboratory and diagnostic services. Regina Community Clinic and Prince Albert's Co-operative Health Centre grew from the same tradition. **Saskatchewan didn't just pioneer universal medical insurance. It helped pioneer comprehensive, multidisciplinary community care. The unfinished job is making those principles available beyond the communities lucky enough to have them.**
- **Indigenous-led integration is already working in Saskatchewan too.** All Nations' Healing Hospital in Fort Qu'Appelle, governed by the File Hills Qu'Appelle Tribal Council since it opened in 2004, integrates acute care, the Eagle's Nest Primary Health Care Clinic, diagnostics, rehabilitation therapies, and traditional healing — Four Knowledge Keepers work alongside physicians as part of the care team itself, under a single Indigenous governance structure. It is a working template for closing care deserts in First Nations and northern communities specifically, not a pilot that needs reinventing.
- The Canadian Home Care Association has built a practical framework for connecting primary care with home and community services rather than expecting patients to bridge those systems themselves.

- **Other Saskatchewan models continue to demonstrate pieces of the same approach, such as** Swift Current's Associate Family Physicians Clinic or Regina's SHA Community Health Centres (Four Directions etc). There are other working examples of team-based integrated primary care – proof this isn't a theoretical fix, it's already running successfully inside Saskatchewan's own borders. These matter not because every community should copy one clinic's organizational chart, but because they demonstrate that **shared multidisciplinary capacity is already being delivered inside Saskatchewan. The task is to move from isolated examples to a province-wide system.**
- **Other jurisdictions show how the same principle can be organized at population scale.**
 - **Co-Location & Unified Governance (Quebec and the Netherlands):** Quebec's Centres locaux de services communautaires (CLSCs) have combined front-line medical care, home and community care, social services, and public health under a single roof and unified local governance for decades.
 - **Examples from around the World (England, Ontario, Alaska, Barcelona):**
 - England NHS's current neighbourhood health strategy (2025 Ten Year Health Plan) similarly proposes a neighbourhood centres bringing general practice together with community nursing, mental health services, diagnostics and voluntary sector partners under shared local governance.
 - Ontario's Primary Care Action Plan is funding similar local integration – as of the 2026 provincial budget, a \$3.4-billion, four-year commitment has attached roughly 330,000 people to primary care teams and funded over 130 new and expanded teams, including examples like the Hamilton Family Health Team's "Health Care at Eva Rothwell Centre" and the Lakehead Nurse Practitioner-Led Clinic's direct partnership with local EMS in Thunder Bay (Government of Ontario, Primary Care Action Plan budget update, 2026). The Guelph Wellington Ontario Health Team's integrated primary care model, which links primary clinics with community nursing and local social agencies, points the same direction.
 - **Indigenous-Led Care (Alaska's Nuka System):** Alaska's Nuka System of Care, owned and governed by Alaska Indigenous people, embeds behavioural health consultants directly on every primary care team and treats patients as "customer-owners." Between 2000 and 2017, the system achieved a 40% reduction in emergency room visits and a 36% reduction in hospital admissions.
 - A smaller but instructive example comes from Barcelona's Raval neighbourhood, where primary care teams trained community health navigators from local immigrant communities to close language and trust barriers keeping people out of care, showing even a lightly resourced, culturally grounded outreach role attached to a primary care team can improve access.

Assessment

The first great Saskatchewan health-care transformation ensured that getting sick wouldn't bankrupt your family. **The next must ensure that you can get ongoing care that keeps you well and integrated, continuous care if you become sick.**

This is the job of the Healthcare Hub. Healthcare Homes will not stand alone. They will be supported by Hubs with shared regional capacity giving local teams access to the broader multidisciplinary services they cannot reasonably staff themselves: mental health and addictions support, home-care coordination, rehabilitation, pharmacy, social work, diagnostics, navigation, specialist connections

and other community services that no local team can reasonably sustain alone. **It allows the relationship to remain local while capacity is shared across a larger population.**

Unlike the Sask Party's current approach – new attachment targets and standalone team announcements that do nothing to solve the abandonment dilemma and a fragmented system – the Sask NDP will guarantee continuous, connected, and comprehensive care: **The Home answers: “Who is responsible for me?” The Hub answers: “What can my team do when I need more?”**

An urban neighbourhood may be able to sustain a larger multidisciplinary team locally. A rural community may require a smaller local team drawing on regional allied-health capacity, Community Paramedicine, mobile providers and virtual specialist support can fill geographic and mobility gaps. A northern community may need a different configuration again, designed with the people who live there.

Fortunately, Saskatchewan has a roadmap: community clinics, All Nations' Healing Hospital, and SHA primary care health centres should not remain exceptions in an otherwise fragmented system. **Their underlying principles should inform how comprehensive care is organized province-wide.**

The first great Saskatchewan health-care transformation removed the financial barrier between patients and medical care. The next must tackle a different barrier: **the organizational walls between the services caring for the same person.**

A Healthcare Home gives you a team that knows you. **A Health-care Hub makes sure that team never has to tell you, “That’s not something we can help you with,” sending you off to navigate another part of the system alone.**

The Counter-Case.

But don't the workforce challenges under the Sask Party make this unrealistic?

Our answer? This will increase the capacity of our existing workforce and make the job more sustainable and attractive by addressing the underlying causes of burnout and drivers of mass exodus from healthcare. It will also improve patient quality and experience.

Isn't this one more bureaucracy?

No, the opposite. This is about connecting the services we already have so healthcare can be accessed in a low barrier, integrated way. This is about shared frontline capacity and bringing more services within reach of patients and providers, not another layer of bureaucracy above them.

Key Recommendations

- **Build a Healthcare Hub behind every network of Homes** – establish regional Hub capacity so every local primary-care team has access to services it cannot reasonably provide on its own, including mental health and addiction care, rehabilitation, pharmacy, home-care coordination, dietician, social work, diagnostics, specialist support, patient navigation, and other community programs that impact people's health.

- **Integrate primary care, home care, and community services around the patient.** Adopt an integrated people-centred care framework, drawing on the Canadian Home Care Association's March 2025 Enhanced Framework for Integrated People-Centred Care Model as the statutory guide for this primary care transformation agenda, so these services share responsibility for populations rather than operate as separate silos that patients must navigate themselves.
- **Measure all existing and new primary care investments** against an integration standard from the beginning.
- **Scale Saskatchewan models that already demonstrate comprehensive care.** Use the principles demonstrated by a handful of existing approaches – from community clinics, to SHA-run primary care centres, to Swift Current's Associate Family Physicians Clinic (AFPC) model – to transform primary care and to expand into today's care deserts rather than leaving integration as exceptions.
- **Consider using the All Nations' Healing Hospital's Indigenous-governance model** as the template for First Nations and northern communities specifically, with flexibility for unique local needs.
- **Set a public, phased target for closing Saskatchewan's primary care investment gap.** Move towards – and then beyond – the 8.1% OECD average share of overall health spending on primary care. **Direct new primary care dollars first toward team-based attachment** with a public target and a public dashboard tracking people newly attached to a family doctor or nurse practitioner.
- **Establish a public roadmap and clear accountability.** Publish a needs-based rollout prioritizing communities with the weakest team-based care, with clear timelines for province-wide coverage. **Measure Hubs by what changes for patients** – avoidable hospital use, delayed discharges and care coordination – **and publicly report where gaps remain and what is working.** Scrutinize closing care deserts as closely as attachment. At the same time, **cost every health platform commitment against this return-on-investment logic.**

Your Bridge.

Your Bridge: care within reach wherever you live



Situation

Saskatchewan has geographic challenges that exacerbate the lack of **coordination between services** and the significant workforce gaps that have developed after nearly two decades under the Sask Party. **People do not always live where the care they need is located.** For rural, northern, remote, homebound and mobility-limited patients, accessing care can mean travelling significant distances – sometimes for an appointment, assessment or follow-up that could have been provided closer to home.

Saskatchewan has been promised tools that would overcome that distance but only some of the pieces are in place. **HealthLine 811 has connected patients to nurses for more than two decades. Telehealth has connected communities to remote providers since 1999. A patchwork of community paramedicine programs has brought hands-on care directly into people's homes.** More recently, virtual programs have expanded as workforce shortages and service disruptions have grown.

But these have developed separately and often problematically, rather than as one connected and coherent primary care system. 811 can tell someone where to go without helping them get there. Virtual care can end at the screen. Community Paramedicine, mobile nursing, and home care exist only in some communities and operate alongside primary care rather than consistently as an extension of it. Saskatchewan's ViPER program demonstrates the risk of expanding virtual care for political expedience without safeguards for quality, safety, transparency, and accountability.

Meanwhile, the system forces the patient to do the connecting. Patients can still be left moving between phone lines, virtual appointments, clinics, emergency departments and community services themselves. The result is a basic mismatch: **Saskatchewan has built some ways to deliver care across distance, but has not woven them into a coherent and high quality way for care to reach people.**

That gap matters most where distance and workforce shortages are greatest. A virtual appointment is of limited use when a patient needs someone to listen to their lungs, check a wound or assess a fall. A community paramedic can provide hands-on care, but cannot replace the broader clinical expertise a patient may need. And 811 can tell someone where to go without necessarily helping them get there or guaranteeing the service is accessible.

Saskatchewan has only built some of the ways that care should travel across distance. But even if all the pieces existed today, connection between them does not. Your Healthcare Home ensures someone is responsible for your care. Your Healthcare Hub gives your team a broader bench of services and expertise. **Your Bridge guarantees you have care within reach wherever you live.**

Precedent

- Community Paramedicine and Mobile Nursing is one of the clearest ways to make a province-wide health-care-home guarantee real in rural, remote, northern and high-needs urban communities. Pockets of these services exist today but they are not universally available or integrated into the system.
- **Saskatchewan has already built two of the three pieces itself.** Community Paramedicine has been running in this province since 2011, and HealthLine 811 has been answering calls for two decades. Both were built here, both work, and neither was ever connected to the other as a single point of entry. This isn't an idea Saskatchewan needs to import — it's a Saskatchewan idea that's still sitting in pieces. [*Saskatchewan Health Authority, "Community paramedicine SHA's 'best-kept secret'"*]
- **Nova Scotia built three separate programs, not one.** The original Long and Brier Islands model (2005) addressed island access. Care by Design — in development since 2005, launched in 2009 — embeds family doctors, nurse practitioners, and paramedics as standing teams inside long-term care homes, and is credited with reducing the need for physician call-outs by as much as 75 percent in some facilities (Nova Scotia Health). And a newer paramedic home-visit program, announced in 2018 at roughly \$900,000 a year, manages chronic conditions and post-discharge follow-up as a service distinct from emergency response (CBC News). Three distinct, purpose-built, separately funded streams — not one program stretched to cover everything.
- **Renfrew County, Ontario proves the connected version works.** Its Virtual Triage and Assessment Centre gives residents without a family doctor one number to call; a paramedic or nurse is then dispatched to the patient's home carrying diagnostic equipment, while a physician assesses them remotely in real time. Built in 12 days at the start of the pandemic, it is now permanently funded, has handled roughly 80,000 visits, and has attached more than 6,000 residents to a family doctor they didn't have before. [*Renfrew County Virtual Triage & Assessment Centre* "] *This is the strongest example of what we would probably want.*
- **The Netherlands has run a version of this nationally for over two decades.** Out-of-hours primary care runs through GP cooperatives serving 100,000 to 500,000 people each — staffed by physicians from the patient's own region on rotation, not a nationwide contractor pool — using a standardized four-tier urgency protocol where home visits are a built-in feature, not an exception. Patient satisfaction sits around 80 per cent for in-person and home-visit encounters. [*World Health Organization, "Primary Health Care in the Netherlands?"*]
- **Ontario made it permanent, not a pilot.** Ontario's Community Paramedicine for Long-Term Care program now runs through 56 municipal, District Social Services Administration Board, and Indigenous-governed paramedic services, including expansion into First Nations communities. Since it launched in 2020, it has served more than 81,000 people and delivered over 310,000 hours of direct care. After six years of project-to-project funding totalling \$426 million, Ontario converted it to a permanent, ongoing commitment — \$89 million a year — in 2025 (CBC News).
- **British Columbia scaled it province-wide on a fixed timeline, with a built-in advanced tier.** BC didn't wait for individual communities to apply for funding one at a time. It rolled the program out deliberately: nine prototype communities in April 2015, seventy-six more in April 2016, and ninety-nine communities total by January 2018 — with a dedicated advanced role, the Rural Advanced Care Community Paramedic, who can treat higher-acuity patients,

support local physicians and nurse practitioners, and mentor community paramedics in surrounding towns (BC Emergency Health Services).

- **Alberta went narrow and deep instead of wide.** Alberta's Mobile Integrated Healthcare paramedics carry one of the broadest scopes of practice in the country — suturing, urinary catheter management, IV and blood-product administration, palliative symptom management, all delivered in someone's home. But the program only reaches within 50 kilometres of Edmonton and Calgary, and 80 kilometres of six other cities. Most of rural Alberta has no access to it at all (Alberta Health Services).
- **The gold standard demands a navigator, not a stopgap.** The OurCare Standard states that everyone's primary care team must be connected to community and social services that together support their physical, mental, and social well-being — not just to a physician. It names virtual care integrated with in-person care, and shared after-hours coverage across a region, as the specific actions needed to get there.
 - A HealthLine 811 that only triages symptoms and points people to a clinic or an ER isn't meeting the minimum standard. One that helps every caller find a specialist, a home care program, an addictions service, or a housing support is. [*Primary Care Needs OurCare Final Report, 2024*].
- **The case for Relational-versus-Anonymous Virtual Care is supported by one of the largest studies of its kind.** Researchers at ICES, Unity Health Toronto, and University Health Network tracked 5.2 million Ontario patients and found virtual visits with an unfamiliar physician raised the odds of an ED visit within a week by 66 per cent, and direct-to-consumer telemedicine — on-demand virtual care with no ongoing relationship — nearly tripled it. The lead author's own conclusion: virtual care works best inside an existing relationship. That is precisely the model this RFP is preparing to buy. [*Lapointe-Shaw, L., et al.,*]
 - **See Renfrew example above**
 - **Newfoundland and Labrador already tried exactly what the Sask Party is doing and its own nurses' union is warning about it.** The province signed a roughly \$22-million deal with a private virtual care company to provide phone and video medical services — the same basic model Saskatchewan's RFP is now shopping for. The president of the Registered Nurses' Union of Newfoundland and Labrador said the deal was not reassuring for a strong, publicly funded health-care system, and that it should be treated as a stop-gap at best. [*CBC News, "Some virtual care companies putting patient data at risk, new study finds," Feb 2024*]
 - **Our position is reinforced by the position of medical professional advocacy groups.** Canadian Doctors for Medicare has warned that private-pay virtual care, without safeguards, risks worsening access for people facing hardship, increasing fragmentation of care, and expanding for-profit, investor-owned health delivery. A physician-authored critique published through the College of Family Physicians of Canada goes further, warning that corporate-driven virtual care can produce "fragmentation, duplication, unnecessary prescribing, gaps in care, and worsening inequity" — precisely because corporations view care through a profit lens first. [*Canadian Doctors for Medicare, Position Statement on Virtual Care; College of Family Physicians of Canada, "Virtual care: the promise and the peril"*]

Assessment

In building out that connective layer that Saskatchewan people don't currently have, we would not be starting from scratch. Rather than creating more standalone programs, Saskatchewan should

connect the capacity it already has and deliberately expand the missing piece.

811 should become a universal health-care navigator and a front door to primary care that connects people to the right part of the system rather than simply directing them elsewhere. 811 should move beyond symptom assessment and triage to become a universal navigator that actively connects people to the right part of the system — their Healthcare Home, regional Hub, home care, mental-health and addictions services, community supports, virtual care, mobile services, and it should actively take on the task of navigating the system in service of the whole patient. The front door should open into care, not simply point patients toward another door because the measure of navigation should be whether it connects people to the available care they need, not simply telling them where they might find it.

Community Paramedicine and mobile nursing should become dedicated extensions of primary-care teams, bringing prevention, assessment, monitoring, treatment and follow-up into homes and communities. Community Paramedicine shows both the opportunity and the unfinished work: Saskatchewan has the experience, professional framework and national recognition, but not yet the dedicated funding, province-wide plan or clear targets to make it a core part of primary care. Saskatchewan has yet to unlock the untapped potential of the nursing profession in team-based primary care, let alone mobile nursing. But we can build on home care and Community Wellness Buses, which already show what is possible when nurses bring care to patients. The next step is to make **mobile nursing a core extension of primary care.**

Relational virtual care should extend the reach of Homes and Hubs across distance, while remaining connected to ongoing care and hands-on services when needed. The Saskatchewan NDP embraces virtual care – with safeguards – and has developed a standalone framework to guide how virtual care is built, monitored and evaluated as part of the primary-care system and beyond.

These pieces are most powerful when they work together. A patient should be able to contact the system through 811 or their Healthcare Home, connect virtually to the appropriate clinical expertise when distance is a barrier, and receive hands-on assessment through a local nurse, community paramedic, mobile service or other provider when a screen is not enough. The Renfrew County model demonstrates the potential of this kind of hybrid approach: remote clinical assessment paired with nurses or paramedics who can reach patients at home.

This is the role of the Bridge: to make the capacity of Healthcare Homes and Hubs reachable across distance. It should connect navigation, relational virtual care and hands-on community delivery rather than treating each as a separate workaround for shortages. It should be designed around a simple principle: **the capacity can be shared regionally, but care should remain reachable locally.** A patient should be able to move from navigation to virtual expertise to hands-on community care without having to start over or navigate a new system at every step.

The Bridge should extend local capacity and the workforce, not replace it. That does not mean replacing local services with virtual care or pulling already-scarce paramedics away from emergency response. Community Paramedicine and mobile nursing expansion therefore requires dedicated capacity rather than simply reassigning emergency-response resources, while virtual care should strengthen local relationships and provide access to expertise rather than become a rationale for withdrawing local providers or services.

This builds directly on the commitments set out in *Your Care, Your Say*: comprehensive and coordinated primary care; expanded home and mobile care; and safe hybrid virtual and in-person care.” The Bridge puts those commitments together – **connecting people to the right care, extending the reach of their Healthcare Home and Hub, and bringing care closer to home.**

The Counter-Case.

Will the Bridge become an excuse to replace local care with screens or pull scarce workers away from existing services?

No. **Virtual and mobile care must add capacity, not substitute for it** — with dedicated resources and clear pathways back to a patient's Healthcare Home and hands-on care when needed. Workforce shortages make that safeguard more important, not less. Expansion should be publicly measured so mobile and virtual care cannot quietly become substitutes for the services communities already have.

Key Recommendations

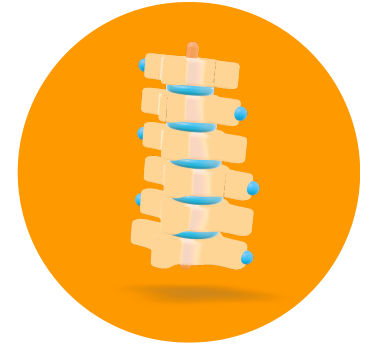
- **Create a community navigator role within Hubs for people who need more help navigating the system.** For people without access to primary care or a Healthcare Home, assign a community navigator to bridge their care and assist in active matching to a permanent team – a concrete mechanism for the no-abandonment principle this plan has already committed to under “Healthcare Home”. **No revolving door of providers, and no one left to navigate the system alone.**
- **Adopt a Relational Virtual Care Standard and make virtual care an extension of a patient's Healthcare Home and Hub.** Set a provincial standard requiring publicly funded virtual primary care to provide continuity with a responsible team, appropriate follow-up and a pathway to hands-on care when needed. **Virtual care should strengthen relationships, not replace them.**
- **Build a permanent mobile primary-care workforce.** Expand existing services that currently exist only in some communities, including Community Paramedicine, expanded home care, Community Wellness Buses, and mobile nursing and other appropriate services. Prioritize rural, northern, homebound, high-needs and post-discharge patients. **Bring prevention, monitoring, treatment and follow-up closer to home to save money and improve care.**
- **Reimagine HealthLine 811 as the missing front door and as a universal healthcare navigator:**
 - Move beyond symptom triage so 811 can connect every Saskatchewan person – attached or not – to the right care, including their Home, regional Hub, home care, mental-health and addictions services, community supports, virtual care and mobile care. **Patients should get connected to care, not another number to call.**
 - **Build navigation around the patient's Home and Hub.** When someone has a Healthcare Home, 811 should connect back to that team and its after-hours coverage wherever possible; when broader capacity is needed, it should connect into the Hub rather than yet another disconnected service for the patient to navigate on their own. *Your Care, Your Say* identified a “system without a front door,” where patients are too often left to navigate disconnected services themselves, and called for comprehensive, coordinated primary care that “connects the dots.” **Making 811 a universal navigator puts that principle into practice by giving every Saskatchewan person one place to start**
- **Connect navigation, virtual care and hands-on care into one pathway.** Enable 811, Healthcare Homes and Hubs to move patients seamlessly from navigation, to virtual assessment, to mobile or in-person care when required. Community paramedics, nurses and other mobile providers should be able to work with physicians, nurse practitioners and specialists remotely rather than leaving the patient to start again somewhere else.

- **Set the standard and prove the value.**

Establish common requirements for publicly funded Bridge services and publicly report access, continuity, geographic coverage, follow-up, ED diversion, patient safety and outcomes. Expansion should represent **additional capacity rather than a substitute for existing emergency or local services**, and any contracted virtual-care arrangements should be evaluated transparently before becoming permanent.

Your digital Backbone.

The Backbone: Building out the digital backbone once and for all



Situation

Healthcare in Saskatchewan currently suffers from disconnected, fragmented digital systems and the costs fall heavily on both patients and providers. Clinic staff still routinely rely on paper-based fax machines to share basic records between offices — a failure of digital integration in an era where other sectors digitized decades ago. Patients are expected to repeat their medical history again and again, expensive diagnostics are regularly duplicated, and clinicians lack reliable access to information from other parts of the system. **This isn't just an economic cost or an inconvenience, this is a patient safety issue.**

It's worth being precise about what Saskatchewan already has before arguing for what it still needs. In 2009, the Sask Party promised an interoperable health record in its **first Patient First Review** so information would follow patients wherever they received care. Since then, the government has invested heavily in digital health: a year later, it created eHealth Saskatchewan out of the Saskatchewan Health Information Network (SHIN) into a Treasury Board Crown to deliver on a promise of one interoperable record, with physician EMRs connected to the provincial system. A decade later, it launched **MySaskHealthRecord**, which allows users to view lab results, imaging reports, immunization records, prescription history, and set reminders.

But digitalization is not integration. Seventeen years later, and hundreds of millions on, different point of care systems still do not reliably communicate, fax remains part of everyday health-care administration, patients repeat their histories, and providers still lack a comprehensive record at the point of care.

The failure is especially stark because the commitment could not have been clearer. But as the years passed, the goalposts quietly shifted: the original promise was narrowed to a “core electronic health record”, which the Sask Party subsequently declared complete even though interoperability was never achieved. **The one record promise was abandoned and today, nearly two decades after its original Patient First Review promising “One Patient – One Record”, the Sask Party is still trying to solve the very problem that promise was supposed to fix.** Yet *another* provincial digital-health strategy has been commissioned identifying interoperability, connected care, and improved information flow as the goal (“Saskatchewan Provincial Strategy on Digital Health Care”: April 2024).

So here we are having spent hundreds of millions of dollars on electronic health record investment—and more than a billion dollars in total eHealth Saskatchewan expenditures since MySaskHealthRecord launched in 2019, and the Sask Party is still identifying interoperability, connected care and improved information flow as objectives.

Saskatchewan's electronic health record deficit is not a technology bottleneck; it is a failure of political will and vision. For 17 years, the Sask Party has undertaken individual projects that can be announced as progress – digitized records, clinical viewers, physician EMRs and, most visibly, MySaskHealthRecord – without completing the harder work of making those pieces function as the interoperable system promised in 2009. Meanwhile private vendors have made a killing.

Saskatchewan should stop treating digital health as a succession of projects and **make interoperability the Backbone of the health-care system**. That is why the **Your Care, Your Say Interim Report puts the original ambition back at the centre: “One patient. One record. One connected system.”** A modern primary-care system cannot function as one system if the information does not follow the patient. A health-care home, regional network, 811 navigation, virtual care, hospitals and community services all need to be able to securely share the information required to coordinate care.

It's time to finish the job Saskatchewan taxpayers have already spent years paying for. In 2026, this is not only possible, it's necessary. Other jurisdictions have surpassed us and it's unacceptable that the Sask Party has failed to deliver the interoperability promised in 2009.

Precedent

- **Denmark — the functional benchmark:** Denmark has achieved a nationally interoperable health information ecosystem in which separate clinical systems exchange standardized information and clinicians can access a broad longitudinal view of the patient at point of care. Launched in 2003, Denmark's unified public eHealth portal (*sundhed.dk*) does everything MySaskHealthRecord does, plus what it can't: every Danish citizen can book GP appointments, renew prescriptions, monitor medication compliance online, register as an organ donor, and check wait lists in real time. The Denmark example shows that there is a way – provided standards are put in place – which allow different system to exchange clinical information reliably, automatically and at point of care. They are much further ahead on information flow, providers to talk to one another.
- **Finland's national KANTA system is a clean “One Patient One Record” example.** Every healthcare organization participates. Clinicians have their own EMR but patient information is stored in a standardized Patient Data Repository. The information is available across organizational boundaries (4 Billion patients by 2024!). There is a citizen facing side available to patients.

● **Canadian examples include:**

- **Nova Scotia's SHARE / YourHealthNS — the model for the sharing piece specifically:** Nova Scotia's backend electronic health record, SHARE, already consolidates hospital admissions, lab results, and diagnostic imaging for authorized providers (*Government of Nova Scotia*). What makes it the sharper precedent than a view-only portal is the patient-facing layer built on top of it, YourHealthNS: since records became available in January 2024, Nova Scotians have logged in more than 1.2 million times, and in November 2025 the app added a feature none of the other examples here have — a *Patient Summary* that a patient generates themselves, containing allergies, conditions, imaging, immunizations, lab results, medications, and hospital stays (*Government of Nova Scotia, November 28, 2025*). That is a materially different capability than B.C.'s Health Gateway or MySaskHealthRecord offer today — both let you view your own record, neither lets you generate a time-limited, patient-controlled copy to hand to someone else. It also scaled cheaply: the provincial rollout was a \$3-million expansion of an existing pilot, not a new build from scratch (*Halifax Examiner, July 2024*).
- **New Brunswick — particularly relevant to our EMR argument.** Its provincial EHR gives authorized clinicians a single point of access to information including labs, diagnostic imaging, medications, immunizations and hospital visits. More interestingly, New Brunswick now **certifies community EMRs for interoperability with the provincial system**. Certified EMRs can pull provincial lab results directly into the clinician's EMR and access the provincial EHR in context; the program explicitly aims for bilateral data exchange between EMRs and the EHR.
- **Ontario — interoperability at enormous scale, although still fragmented.** ConnectingOntario, ClinicalConnect and the electronic Child Health Network have allowed clinicians to access patient information from different organizations and systems. Ontario Health is now consolidating those three systems into a **single provincial clinical viewer** because the existing regional viewers themselves created inconsistent access and experiences.
- **Alberta —** Alberta Netcare provides a province-wide electronic health record, while Alberta is now working toward stronger interoperability standards for the EMRs used in primary care and expanding its secure health-information exchange infrastructure. In other words, Alberta is further evidence that even a longstanding provincial EHR doesn't mean the interoperability problem is "finished."
- **Federal Connected Care Legislation (Bill S-5):** Reintroduced in the Senate on *February 4, 2026* (having first been tabled as Bill C-72 in 2024), the Connected Care for Canadians Act requires health IT vendors to make their products interoperable and prohibits data blocking, with a complaints and penalty regime for non-compliance. It has drawn public support from the Canadian Medical Association, the Canadian Federation of Nurses Unions, the College of Family Physicians of Canada, the Society of Rural Physicians of Canada, and the Canadian Cancer Society (*Health Canada, February 2026*). Critically, the Act only applies automatically in a province that lacks its own 'substantially similar' framework.

- **The Global OpenNotes Movement:** Sharing clinical visit notes with patients — not just the fact that a visit happened, which is all MySaskHealthRecord currently shows — is now standard practice for over 54 million people worldwide, across more than 250 health systems (*Healthy Debate, March 2026*). Canadian pilots led by patient partners at the Centre for Addiction and Mental Health (CAMH) found that 67% of patients said OpenNotes helped them better understand their mental health (*UHN PIPER Research Day, 2025*), and broader research has found up to 78% of patients report that reading their notes helped them take medications as prescribed, while roughly one in four patients who contact their doctor after reading a note identify a possible documentation error worth correcting (*OpenNotes / National Academies of Sciences, 2022*).

Assessment

Saskatchewan should stop treating digital health as a succession of projects and make interoperability the backbone of a connected healthcare system. After nearly two decades and billions spent on digital health – including costly IT failures like the \$200-million AIMS project – **Saskatchewan still hasn’t answered the question that matters most: when a patient moves through the health-care system, does the information needed to care for them move with them?**

Your Care, Your Say already provides the architecture: Healthcare Homes connected to regional Hubs, an accessible front door and Bridge through 811, virtual and mobile care, and integrated home and community services. **None of it can function as one system if the information does not.** A primary-care team cannot coordinate care if it can’t see the patient’s history, and patients should not be responsible for carrying their own medical history between disconnected parts of the system.

A Sask NDP government would finish the job, rather than launch another reset or chase another headline-driven digital project. Saskatchewan already has much of the infrastructure it needs. The task is to finish what was promised as far back as 2009: **set one province-wide interoperability standard for publicly funded healthcare**, connect the systems taxpayers have already paid for, expand MySaskHealthRecord into a genuinely patient-centered front door, and set clear milestones, public reporting requirements, and measure success by whether information actually follows the patient.

Any of this must be built with, not around, First Nations and Métis governance. CIHI’s own July 2026 report names Indigenous data sovereignty as a core principle of its national data stewardship work (*CIHI, July 2026*) — the right of Indigenous communities to govern how data about their own people is collected, stored, used, and shared.

This will be a no-regrets and historic project that the *Public Policy Forum estimates could save \$2.4 billion* from provincial and territorial healthcare budgets while drastically improving patient outcomes. **It won’t just give patients a clear right to access and control their own health information** so their medical history follows them rather than requiring them to carry it between providers. A connected system will improve the **safety and quality of care**, reduce duplicated tests, administrative work and time spent chasing records, and free clinicians to spend more time caring for patients – helping to make the profession more sustainable over the long term.

Key Recommendations

- **Pass the Saskatchewan Connected Care and Patient Data Rights Act.** Introduce a modern provincial legislative framework that mirrors federal *Bill S-5*, legally establishing a clear, enforceable right for Saskatchewan patients to timely, secure and no-cost electronic access to their complete health information.
- **Expand MySaskHealthRecord into a true one-stop shop**, with a long-term goal of navigation and triage capability that is integrated directly with a modernized HealthLine 811 so a resident can move from symptom to service in one place; two-way secure messaging within your own care team, not just static records; genuine appointment and lab booking, not just the reminders the tool already offers; and access to full clinical visit notes, not just the fact that a visit occurred.
- **Establish the eHealth Primary Care Integration Taskforce.** Launch a dedicated, clinician-led taskforce within eHealth Saskatchewan with a mandate to eliminate fax machines from all clinics within a set timeline. Provide support to equip primary care providers with modern, fully interoperable Electronic Medical Record (EMR) software that seamlessly connects to the provincial circle of care.
- **Legislate a public accountability gate — the direct lesson of the 2014 EHR finding.** Write into the Act itself that no major funding tranche for the MySaskHealthRecord expansion can be released without an independent, publicly published milestone review confirming measurable progress against a preset benchmark. This is the specific, named answer to the *2012–2014 eHealth Saskatchewan finding*, where more than \$500 million was spent with insufficient public accounting for progress along the way. Pairing this recommendation with the broader platform's own "Anti-AIMS" financial accountability clause turns Saskatchewan's two biggest Sask Party digital-government memories — one payroll, one health records — into the reason to trust this one.

Economic Argument.

Investing in Primary Health Care as an Economic Imperative.



Situation

Saskatchewan's 2026–27 health budget is the largest in the province's history: **more than \$8.5 billion**, up \$393.4 million, or 5%, in a single year — now roughly 38% of the province's entire \$22.2-billion expense budget, run against \$21.4 billion in revenue for an \$819-million deficit (*Government of Saskatchewan, March 18, 2026*). Health spending is growing faster than the money coming in to pay for it, and it is growing in the most expensive part of the system.

Saskatchewan is unusually hospital oriented — CIHI estimates that 38.5% of provincial health spending goes to hospitals compared to 36.1% nationally. Saskatchewan also spends among the highest in Canada for physician compensation at 23% of its health budget. This past budget, Saskatchewan added \$100 million just for emergency, acute and critical care, while asking zero questions about why that budget continues to balloon.

Because here is what that growth is buying: more of the same. Canada spends just **5.3%** of its total health budget on primary care, against an **8.1%** average across 21 OECD peer countries (*Kiran et al., CMAJ, Dec. 4, 2023*) — one of the lowest primary-care investment rates in the developed world, with the difference paid at the most expensive end of the system: emergency departments, hospital beds, and long term care facilities instead of the cheapest — primary care.

The Fraser Institute's 2026 wait-times study put the 2025 cost of waiting for care — lost wages and productivity alone — at **\$4.2 billion** nationally, an average of \$3,043 for each of roughly 1.4 million Canadians who waited (*Fraser Institute, 2026*). And the chronic conditions strong primary care is built to catch early carry their own price tag: chronic kidney disease alone costs the Canadian economy **\$11.7 billion a year** — \$7.6 billion in direct care, \$4.1 billion indirect, including \$2.6 billion in lost productivity from people too sick to work (*Deloitte / Kidney Foundation of Canada, Nov. 2025*).

The mechanics are not mysterious. A primary care visit costs 33% of what an emergency department visit costs; people connected to primary care have 36% fewer emergency visits (Quebec); people with poor primary care access are 29% more likely to be hospitalized (Alberta) (*Ontario MOH, Primary Care Action Plan, Jan. 2025*). Ontario's own Auditor General found one in five emergency department visits happen because someone couldn't get in to see a primary care provider in the first place (*Auditor General of Ontario, Dec. 6, 2023*) — the same pattern plays out in Saskatoon and Regina emergency rooms every day.

Another major theme of our consultation was the impact of a failing social safety net on the Saskatchewan healthcare system. The lack of housing strategy, and recent changes to social assistance have contributed to pressures on the most expensive end of the system. We heard

repeatedly that the pressures created by homelessness and housing insecurity has reached a breaking point – a reality plainly visible in major ERs across Saskatchewan. National and provincial data again and again outlines the enormous healthcare related cost of housing instability, yet our government refuses to accept that housing must be treated as healthcare and until we shift resources upstream to stable supportive housing, our provincial budgets will keep being eaten up by crisis management that puts us no further ahead.

Precedent

This is not a theory. It has been measured, repeatedly, in systems different enough from each other – an urban American Medicaid population, 2.6 million of our own neighbours in Alberta, a remote Indigenous-governed health system, a dense European home-care network, and our own neighbours in Ontario and British Columbia – that the consistency of the result is itself the evidence.

- **Oregon’s Patient-Centered Primary Care Home program – the most rigorously measured return:** four years of Medicaid claims data across 1.1 million people found every added \$1 in primary care spending returned **\$13** in system-wide savings – emergency, specialty, and inpatient care – climbing from \$12.50 in a clinic’s first year to \$14 by its third (*Oregon Health Authority, 2016*).
- **Alberta’s Primary Care Networks – the largest Canadian evidence base, right next door:** a study of 2.6 million Albertans – 1.5 million attached to a team-based Primary Care Network, 1.1 million not – found attachment cut all-cause emergency department visits by 169 per 1,000 patient-years, cut hospital days by 86 per 1,000 patient-years, and lowered the average inpatient cost per patient from **\$1,254 to \$1,102** (*McAlister et al., CMAJ, 2018*).
- **British Columbia’s NP-led primary care clinics – the team model costs less to run, not just to use:** 2022 operational data from BC’s four pilot NP-led clinics found they delivered equivalent care for about 87% of the cost of a comparable family-physician benchmark – roughly **\$742,000** in savings on a \$5.64-million budget (*Contandriopoulos et al., Healthcare Management Forum, 2024*).
- Even local organizations such as the Phoenix Residential Society have measured how building out housing and other social supports as healthcare have the opportunity for incredible healthcare savings.

Assessment

Put simply: Saskatchewan is spending more every year to run a system that treats the expensive end of illness while under-funding the cost-effective end that would prevent so much of it from arriving at hospital doors at all. Using CIHI’s **\$304** average full-hospital cost of an emergency department visit alongside Ontario’s own figure that a primary care visit runs about a third of that (*CIHI, Hospital Spending: A Focus on the ED, 2020*), every visit diverted from an ER to a family doctor or nurse practitioner saves the system in the neighbourhood of \$200. Multiply that across the 500-plus diversions Saskatoon and Moose Jaw’s paramedicine programs are already documenting, on pilot funding, at a fraction of scale – and the money already being left on the table by not scaling these programs provincewide is real and countable.

The Oregon 1:13 ratio should anchor how this platform talks about health spending generally. It reframes the conversation from “how much will this cost” to “what is the best return available anywhere in the budget” — and right now, primary care is that answer.

The Counter-Case.

We can't afford to invest more in primary care when we're already running an \$819-million deficit.

Answer: This gets the causality backwards. The deficit is being driven, in real part, by acute-care costs that primary care investment is proven to reduce. Delaying the investment doesn't avoid the cost — it locks in the more expensive trajectory for longer.

This is really a moral argument dressed up as an economic one. **Answer:** It's both, and that's the point. The fiscal case does not require choosing between compassion and numbers — the same investment that keeps a neighbour out of a hospital bed is the one that keeps the province's books in better shape. We don't need to hide the moral case to make the economic one; they were never in tension.

Key Recommendations

- 1. Set a public, phased target for closing Saskatchewan's primary care investment gap.** Move toward the 8.1% OECD average share of health spending over the mandate, with the first-year commitment costed and named. (*let's DOUBLE our expenditure on primary care in the first four years of forming government — that's BOLD — Finland is 12%; Netherlands ~10%; Norway 10%; Denmark 9%*).
- 2. Direct new primary care dollars first toward team-based attachment.** Follow the Hamilton FHT and Lakehead NP-Led Clinic model — the same approach Alberta's own Primary Care Networks have already validated at a scale of 2.6 million patients — with a public target and a public dashboard tracking people newly attached to a family doctor or nurse practitioner.
- 4. Cost every health platform commitment against this return-on-investment logic.** So the platform's affordability story survives scrutiny from the press and the opposition alike.
- 5. Publish a plain-language explainer of this note's numbers alongside the platform costing.** The thirteen-to-one figure belongs in a stump speech.

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