Legislative Assembly of Alberta

Title: **Tuesday, May 12, 1992 8:00 p.m.**
Date: 92/05/12

head: **Committee of Supply**

[Mr. Schumacher in the Chair]

MR. CHAIRMAN: Order in the committee, please. It is now 8 o'clock. We are looking forward to the discussion and study of the estimates of the Department of Health, but before calling on the minister to introduce her estimates, would the committee agree to revert to the Introduction of Special Guests?

HON. MEMBERS: Agreed.

MR. CHAIRMAN: Opposed? Carried.
The hon. Member for Edmonton-Mill Woods.

head: **Introduction of Special Guests**

MR. GIBEAULT: Thank you very much, Mr. Chairman and members of the committee. I'd like to introduce to all members of the Assembly this evening a group of 21 Girl Guides and their leaders from the constituency of Edmonton-Mill Woods. The Guides are in the public gallery this evening with their group leaders Mrs. Eunice Watson, Mrs. Cynthia Galusha, and Miss Cindy Overland-Cooke along with the parent helpers Mrs. Cheryl Emmerling and Mr. John Watson. I'd ask them all now to stand and receive our very warm welcome.

head: **Main Estimates 1992-93**

Health

MR. CHAIRMAN: On behalf of the committee it's the Chair's pleasure to welcome the Minister of Health and invite her to introduce her estimates.

MS BETKOWSKI: Thank you, Mr. Chairman. I would like to give a few opening remarks and outline the really tremendous work that's going on in Alberta to make the health delivery system more effective in partnership with health providers. May I say at the outset that it's an honour for me once again to present the estimates of the Department of Health to this Assembly.

People in this House and people outside of this House ask me how I can stand being the Minister of Health, and they suggest to me that perhaps it would be nice to get another portfolio or to do something different in government than be Minister of Health. I just want everyone in this Assembly to know that there is no other portfolio I would rather have than the Health portfolio. I feel I've learned an awful lot in three and two-thirds years. I know a lot more tonight standing up to deal with these estimates than I knew when I first stood in April of '89 to do my first set of estimates, and I truly can say without equivocation that I love my job. So in case there's any doubt, let me put that on the record.

Part of the reason I feel so honoured to be Minister of Health is because of the competence that surrounds me. There are members of the Department of Health here tonight, although not all of the people in the gallery are from the Department of Health, I hasten to add. Let me first introduce, certainly, the deputy minister, Rheal LeBlanc, and also introduce some people, some of whom are here, some who are not, who are the backup to the deputy minister in the Department of Health and are the real backbone and competence in the department. I mention specifically Don Philippon, the associate deputy minister; Aslam Bhatti, the deputy minister of finance and administration; Cecilia Lord, who is our assistant deputy minister of research and planning; and Steve Petz, the newest on our management team who is the assistant deputy minister of public health. I mention these people not to single them out but simply to outline that they and all of the members of the Department of Health make my job a whole bunch more productive, a whole bunch more satisfying because of the work they do for this province. Also seated in the gallery tonight from the department are Peter Hegholz and Rhonda Stevenson and Darrell Osbaldeston from my own office, and I thank them for all the work they've done to prepare me for this evening.

As well in the gallery, Mr. Chairman, I want to note the presence of Dr. Fraser from the Alberta Medical Association and other members of the AMA; members from the Alberta Healthcare Association, Lucille Moyer, the chairman, and senior officials with the association; from the Health Unit Association I think I see Sharon Kalinka and other senior people from that association; Alberta Association of Registered Nurses, Ms Smith and Ms LeBlanc; and I welcome them here and thank them very much for coming.

Nineteen ninety-two budget estimates represent clearly the commitment of this government to the health of Albertans. The budget demonstrates our resolve to make '92-93 a year of opportunity for our health system, and I want to acknowledge many of my colleagues in other departments who have had to make major sacrifices for government in order to show such a commitment to health. To those colleagues and to those departments I say thank you. Despite major reductions in resource revenue, as a government we have provided a generous increase of 4.2 percent to health.

In the early 1980s the health sector consumed 20 percent of available program expenditures in Alberta. In this current fiscal year health expenditures account for 30 percent. This trend and this rate of growth in one short decade cannot continue. We must live within our means. To ensure that we manage our way through the present fiscal realities, the Treasurer has laid out a plan for us as a government to provide fiscal balance. It involves both legislative spending limits and balancing the budget over the next five years. To accomplish this is not going to be easy, and it will require fundamental reform in the health system. This government will not shy away from the tough choices that we know we're going to have to be making, and as Minister of Health I realize that there are no quick fixes in health and no easy solutions, nor will I shy away from the tough choices that must be made.

Often I'm asked why we are pushing so hard to control costs, pushing as a government, pushing as a Ministry of Health. Do we have a choice? Yes, we always have a choice. Choice is fundamental to humanity. However, our choice comes down to: do we want to struggle a bit now or struggle a whole bunch more later? Do we want to deny a problem exists? Do we want to avoid the tough decisions and leave some at this point faceless Albertan with the problem in the year 2000? Well, that faceless Albertan is our children and their children, and nothing will close off their opportunities and the choices that they want to make faster than our undisciplined spending and their debt burden will. So make no mistake, Mr. Chairman, we are making choices.

Maybe you'll lose the next election, some say. Maybe you're going to cut too deep. Maybe people won't like some of the choices you make. That's true, Mr. Chairman. Those may well be the outcomes, and those things may well happen, but when I look back on the spring of 1992, May 12, I will know that we didn't avoid the decisions, we didn't deny the choices. We did

the right thing, we did the responsible thing, and in the end we will know we did our very best to ensure that our health system carries on. We'll be able to look those children right in the eye when we are senior citizens with gray hair, and we'll be able to know that our tough decisions today were worth it. That is the commitment of this government, that is the commitment of this minister, and that is the legacy and the only legacy that I seek.

We are pulling together Albertans to help us make the decisions, and I believe that solutions must ensure local responsiveness to community needs but must be in the context of the most effective utilization of resources on a regional and provincial basis. We don't have a lot of time. We do have one full year, this year of opportunity, and our plan is in place. We've set up processes of reform in this province that will allow us in partnership with health providers and all Albertans to live within our means while maintaining the principles of health services which Albertans have come to cherish.

On Friday last I spoke at a meeting of provincial health associations, a meeting which, I might add, was convened by the associations themselves to discuss the role statement process and how they might collectively define the future for health services in this province. They are very aware of the fiscal realities facing the health system in Canada, and they have risen to the challenge of health system reform in partnership with each other and with government. I am so proud to be associated with leaders, some of whom are represented here tonight in this Assembly.

8:10

Yesterday I spoke at our provincial conference on health goals. It was an historic occasion because I don't believe such a broad range of groups has ever been assembled before to deal with one specific issue: groups as diverse as the CNIB, the Alberta union of public employees, the family and social services association, health groups from all over Alberta, groups which really haven't been able to come together and look at what it is we want to accomplish in our health system and then figure out how. As the Minister of Health for this province I'm delighted with such a diversity of individuals focusing their attention on an issue so important to me, so important to this government and this Legislature, and so important to Albertans. We are all looking for long-term solutions. We're setting priorities. We're charting a course for the future.

I believe the process that we have set for reform in Alberta will allow changes to be the right changes and to be long lasting. We must all be partners in reform. We must own responsibility for the future. I believe that health providers and individual Albertans care about the sustainability of the health system and are not prepared to be just bystanders as the health system is reformed.

We're not the only ones looking at health reform. All across this country provincial governments are having to examine their health systems to determine what needs to change in order to sustain them over the long term. Discussions amongst health ministers are all about the same issues. The issues are: what can we do in our province? What can we learn from you in your province in terms of how we can sustain our health system?

I believe that an accessible, affordable Canadian health system clearly expresses some fundamental Canadian values. I also believe that the relationship between health care providers and patients involves much more than just supply and demand. The Canadian health system and the principles upon which it operates have proven to be the most just and the most effective way of delivering services. We see basic health services for those who need them as a right of citizenship, not as a charity, not as a special privilege, and it is a crowning achievement of our nation. In Canada we spread the risk to ensure that every Canadian need not fear financial ruin when they are ill, and though some would argue, I would say it is a benefit, not a deterrent, to Canadian economic competitiveness.

So when we ponder other health systems around the world, it frustrates me, frankly, when individuals who like to think of themselves as economic experts contend that we cannot afford our health system. My response is, "We can't afford not to have our health system if we are going to compete in a global economy." We can afford it if we are truly concerned about the vitality and the future of our country. We can afford it if we are concerned about the ability of our health workers to compete in a global economy.

Let's look at some of those other systems. The American congressional general accounting office has estimated the administrative savings which would result from the Canadian model of health delivery in the U.S., some $67 billion annually. If that were to be spent on health, then every American would be insured and insured fully. The duplication of administrative services results in American administrative costs being about five times per capita more than in the Canadian system. What a waste. The Canadian model is not without its imperfections. However, by comparison I believe the principles are sound, not only from a care delivery perspective but from an economic viewpoint as well. All that is needed, Mr. Chairman, is the resolve to live within our means.

Health issues are given prominence and focus in each of the provincial Legislatures. I met with some Senators from the United States recently, and they couldn't believe our political system would set up individuals as critics of the government on a daily basis. Well, I told them that I couldn't believe that a modern western democracy would permit individual citizens to fall to financial ruin in order to ensure that private insurance companies continue to operate.

Do we spend an appropriate amount of our gross national product on health in Canada? Should we spend more? It's a valid question. However, eight royal commissions across Canada have said that the health system is not underfinanced, Mr. Chairman, it simply needs to be better managed: better management for better health. We're taking steps to better manage nationally, and let me tell you that Alberta is a major player in national reform.

In January I hosted a meeting of ministers of Health in Banff which resulted in a national action plan on physician resource management. As well, let me blow our horn a little bit. Alberta chairs the National Health Information Council, Alberta chairs the national Advisory Committee on Institutional and Medical Services, Alberta chairs the Canadian Blood Agency, and Alberta chairs the federal/provincial advisory committee on AIDS. You don't get that kind of national recognition and national leadership without the kind of competence I spoke about earlier that exists in our own public service.

Alberta funding reforms in long-term care and acute care are recognized as models nationally. We have to reform. The first ministers of all the provinces recognize this too. At a recent First Ministers' Conference on the Economy Health ministers were directed to speed up the reform process. That is the urgency that's pushing us. Following this directive, ministers of Health and Finance will be meeting in June to examine the major cost drivers in health and the ways to accelerate reform in order to deal with our health system. There are a number of major cost drivers in health that require attention and scrutiny. Pharmaceutical costs, capital costs, unnecessary diagnostic tests, unnecessary surgical procedures are some of the areas that must be examined and examined closely. Reform process across Canada is taking

different approaches. In Alberta we have chosen to take a course which emphasizes partnership with health providers in reforming the system. I believe that the role statement process is perhaps the most important undertaking in health right now. On Friday when I spoke at the health agencies forum, I described the various sectors as pieces of a jigsaw puzzle that we're trying to reshape and bring together, making adjustments, recognizing gaps in order to form one big picture.

This is a year of transition. This is a year of opportunity. In this year of transition we have accommodated a healthy increase through the 4 percent general grant increase to health organizations. Frankly, Mr. Chairman, and as I told the agencies on Friday, I don't anticipate another 4 percent increase in this decade.

As well, we have an historic agreement with the Alberta Medical Association, to the credit of practitioners across our province, which provides a predetermined limit on medical expenditures. A predictable budget gives us the discipline to examine the effectiveness of the delivery of services, and I thank our physicians in this province for the work they've done to get us to this point.

I believe in the positive effect of limits. It focuses our mind on what is important. Answers in the health system will be found in ensuring that appropriate and effective care is delivered and not just in cost sharing with the public or in seeking new sources of revenue. That doesn't provide the discipline. New revenue doesn't create discipline; managing expenditures creates the discipline. Funding reforms like the acute care funding plan and the long-term care case mix index allow us to target dollars to where they are needed most. We are reallocating in Alberta, not just adding resources, and this is a positive discipline.

Three areas will receive special attention this year in the Health budget. Home care continues to be a priority and must be a priority and will receive a 9.4 percent increase this year to $73 million to demonstrate our commitment to promoting independence. Children's health is a primary concern, and in addition to general increases for immunization, funding will be provided to allow all children over the age of two months to receive the hemophilus B vaccine. We anticipate that this very severe disease, a strain of meningitis in children under five years, will be almost completely eliminated in Alberta. Funding for the immunization program will increase by 4.3 percent or $1.6 million.

Alberta Health in co-operation with Family and Social Services, the Solicitor General, and the Women's Secretariat will be contributing $450,000 to the provincial initiative on family violence through services for victims and perpetrators of family violence. Obviously the issue's solution is not found in government programs alone, but hopefully the initiatives we're taking this year will increase the awareness and turn around some of the attitudes that are so fundamental to getting rid of the scourge of family violence.

8:20

Over $175 million will be spent for continuing the design and redevelopment of facilities including the Holy Cross and the Calgary General hospital in Calgary, the Royal Alexandra and the Cross Cancer Institute in Edmonton. We will also proceed with a limited number of previously deferred capital projects.

As our health care needs change, Mr. Chairman, capital needs also require re-examination. I'm pleased to say that in the past year several communities have agreed to changes in their capital projects which better reflect the contemporary health care requirements and our fiscal realities. In other words, those communities have changed what was already committed to them by this government, by their own voluntary efforts, in order to ensure that health dollars are being spent in the most appropriate way. Capital projects will only be approved if they are found to be necessary through that role statement process. That is a big change, and that is the commitment of our health sector.

Mr. Chairman, provinces across Canada face new fiscal realities. In Alberta this government's 1992-93 budget gives us a year to plan, a year to work in partnership with health service providers to plan out over a longer term in order that all Albertans can help reshape our health system for the future. This is a year of opportunity for the health system, and I welcome any comments and questions from hon. members.

MR. CHAIRMAN: The hon. Member for Edmonton-Highlands.

MS BARRETT: Thank you, Mr. Chairman. I know that the minister loves her job. I'm following her speech notes now. She says so out of the House. It's absolutely true. I also know that tough decisions have to be made. There's no question that anybody with their eye on the ball is going to say that one has to contain costs of the health system, successful and efficient though it is. Nonetheless, one has to say that it cannot expand at exponential rates.

However, Mr. Chairman, I do take issue with the statements that the minister made thereafter. She talked about her meeting with the provincial health associations on Friday and the importance of the role statements that are in process, and I agree that that's true. Quite frankly, when a minister announces that cuts are coming to the acute care system and long-term health care facilities well before the transition to preventive and community-based health care is in place, I must say that I worry. I have no objection to a transition. In fact, it is the New Democrat caucus, at least since I've been sitting in these benches for six years, that has called for an emphasis on a wellness system as opposed to a sickness system and a noninstitutional system as opposed to an institutional system. I understand that the minister is working in the right direction, but I'm not so sure that the timing is appropriate. Probably the move towards a wellness system and a noninstitutional system should have commenced long before announcements were made for cutting the institutional system.

The minister identified some areas that still need work, and I couldn't agree with her more: pharmaceutical costs, capital costs, diagnostic costs including technological costs, and unnecessary surgeries. I believe that the minister does have her eye on the ball. I'm not so sure about the appropriateness of the process that has gone forward to date.

Now that I've sort of responded to her outlines, I would like to just make some general comments and then move on to comments on a vote-by-vote analysis. I would just like to make a general comment first about the kind of priorities that I'm talking about.

If you look at the increase in funding for home care, which is laudable, it comes to $7 million more this year than last year, but if you look at the kind of increase that's going into acute care, it's $84 million more. Now, that I think demonstrates the kind of change in emphasis that I and the New Democrats would like to see. If you're going to advance your in-home care programs or your community care programs, the way to do that is to upload those in a year before you start to download from the other types of care, and I don't see that happening. I see that the $7 million more that's going into home care is only just going to be able to cover the costs of the system being allowed to treat people in their homes, those who are under the age of 65. Absolutely a good policy. Probably should have been implemented many years ago. But it's not going to allow for any other types of increases. It seems to me, for example, that in certain types of environments,

especially outside of the self-managed care component of home care, that the $3,000 a month ceiling, which may appear to be reasonable in most instances, has to be subject to an appeal in cases where spending a bit more than that to keep the person in home is going to save the institutional costs of the health care system a great deal more.

Maybe I'll just go into the general stuff and get specific in a few minutes. In general, Mr. Chairman, what you're looking at here are job losses in the department. If it's just removing unnecessary layers, no one has a concern about that, except for: are those jobs going to be reassigned into frontline environments where they can be of more direct use in our health care system? I must also point out that our premiums are increasing by 3.8 percent, and I would like to contrast that to the rumours that had circulated for the last few months in Saskatchewan, where talk had been that the government was contemplating the reintroduction of health care premiums. Health care premiums are a much more flat tax approach to raising funds for the health care system than are general progressive taxes. Now, I'm not happy that the government of Saskatchewan had to look at increases in taxes, but at least they are done on a progressive base; that is, the less you earn, the less you pay into the system.

Now, jumping around on the general stuff. I'm not going to talk too much about the capital costs that we're looking at this year, but I want to make note of a couple of things for the minister. One is that the Fort McMurray hospital is getting a new construction fund of $300,000, and I hope that the minister will say at the end of tonight or sometime soon that that money is going to be allocated to some form of long-term care, fast track or planning, and that it's not a parkade. That community has been desperate for years, and whatever step is going to be taken, I will join in the applause.

The other point that I'd like to make about the construction costs, and it's partly construction, partly capital costs – I deal with these all the time. I know the minister does as well. This one happens to be fresh. This is a woman I talked to last night. Two weeks ago a woman in Fort Saskatchewan took her child with severe abdominal pains to the hospital having seen the doctor a few times, and the doctor was recommending admission for the nine-year-old child. There was no bed in the pediatric wing, and there was no bed even in the surgery wing for the child. She had to come back the next day.

Now, this speaks to a general problem that happens in a lot of acute care facilities partly related to the fact that we don't have enough community care facilities to take care of the small problems that people might face, whether it's stubbing their toe, maybe cutting a finger. If they don't have a community-based facility to go to to have those problems addressed, they go to a hospital. The net result of course is that the queues in the emergency wards build up. The same, of course, is true with long-term care facilities. Because we have not yet emphasized sufficiently the efficiency of expanded home care policies, we have queues of people in extended health facilities, and some of them are currently occupying acute care health facilities which means that when you really do need acute care sometimes you can't get it.

The minister may respond by saying, "Well, that's a good point, except you can always go to another hospital in the region." That's true, and that's going to happen with regionalization, and I acknowledge that. In this case, though, the problem is that their beds are being filled with long-term care facility patients who really should be elsewhere in the health system, which causes financial efficiency for the system in the long run. So I'm not going to talk anymore about the capital costs, because I know the trap. Once you get into capital, you never get out. You lose your half hour; it's gone.

8:30

Now, the Aids to Daily Living grants are down by 1.9 percent, which is a decrease of $1 million. I know that last year the budget increased substantially to $59 million. That was despite the fact that the minister said that they were shifting funding to benefit those people who needed services. And this is just one example. One doesn't want to criticize absolutely everything, but I did write to the minister about this. The power wheelchair program, for example; nothing happened for a long time. No wheelchairs were handed out until February of this year. Therefore, what you've got is spending estimated at $350,000 less than what was budgeted for. It's that kind of small thing that makes a big difference, as I think the minister appreciates, in the health care system. I mean, if people are willing to live independently and all they need is the power wheelchair and you've got the funding allocated for it and the program there, why doesn't it happen? As I say, this is just an example. If the minister, in her direction of new and better management, is addressing it, then fine; that'll be good to hear, and I think the public will be happy to hear.

Mr. Chairman, last week I sponsored a motion calling for a 1 percent increase in the funding going to preventive health care. It's called the 1 percent solution. The minister concluded her remarks by suggesting that I was asking for additional money. I checked *Hansard* because I was pretty sure that I had spent a couple of paragraphs at least – and yes, I know, every sentence I speak is a paragraph – explaining that we were talking about a shift of extant funding, money that was already allocated to the department, into preventive health care. So I'd just like to go through a couple of the large goals that I think we should try to accomplish in the health care system and hear where the minister stands in more concrete terms either this evening or in writing later on, and that is the establishment of community health centres as a general replacement for a lot of facilities that are currently costing a lot in terms of capital requirements and, say, high-tech requirements, not to mention, you know, physician-to-nurse-to-LPN ratios, et cetera. I think we should implement the 1 percent solution, which I spoke about extensively last week.

Improved long-term care and expanded home-care services. Surely there isn't even short-term pain for this one. This is short-term gain and long-term gain.

The improvement to Mental Health Services is something that I will go into in a few minutes, when we get to that vote. I think it's pretty obvious, Mr. Chairman, that with what I understand is now one in seven people in Canada and Alberta through the course of their lifetime registering as having some mental health need that's not being met through their own lives, this is going to require more emphasis.

Accessing new technology and reducing unnecessary surgery and lab tests. One couldn't agree more. The private sector developing the high technology on the basis of public-sector investment through the advanced education system, capturing it, developing a few molds, and selling it back to the public health care system is surely no longer affordable in this day and age.

I'd like to re-emphasize our call for the creation of an ethics centre, one which has funding. It doesn't have to be a lot of funding, but as the minister well knows, in the years ahead ethical questions are going to be increasingly central to medical decision-making.

Finally, the New Democrats advocate the Ontario model for negotiations with the medical association as a way not only to cap billings, which do cost a significant amount of money to the

province, but also to start to prevent other health care professionals from demanding of the minister that they be entitled to fee-for-service billings as well. I know the minister is getting this as a request from all sorts of health care provider associations because I sure am. I resist that.

To go a little more specifically, I'm going to give examples of concerns that I have in each of the votes. With Health Care Insurance, I've already mentioned that the premiums that Albertans are going to be paying will increase. I am, in principle, opposed to that. However, I'm not sure I can change the system at this point.

I have a question that is going to surprise the minister. It's one of those ones that I told her yesterday I would like to get a chance to get on the computer and write to her about, but the day and night go so fast that I don't get a chance to turn on the computer anymore. Anyway, it relates to the interocular lens implanting that follows the cataract surgery that is done in private centres. I understand two of the private centres bill the Alberta health care system directly, while the others ask the postcataract recipients to fill out a form and ask Alberta health care to reimburse them individually. I bring it up because it's a fairness issue. I'd hope the minister would look into this. You see, the thing is, if you've got to have your cataract replaced really quickly, you know the fee is $900, and you just don't have the $900, for example, or the $1,200, whichever it is, and if you knew the $225 would come off the top of that, that you wouldn't have to pay directly, we might be able to facilitate people having their cataracts removed in a more timely fashion. There are a whole bunch of health care insurance plan issues that really come down to fairness to the patient. I do assure the minister that I will get some of them put in print soon.

I'm really glad that the minister raised the general subject of pharmaceutical costs. I'm sure she receives a copy of *The Straight Facts on Pharmaceutical Prices, Manufacturing and Research*, which is published by the generic drug industry. Month after month they make the case for increasing our focus on the use of generic drugs at all levels within the control of the public health care system, and I would hope that the minister is speaking out against proposed changes to the drug patents Act – I'm not sure if that's the exact title – which will further protect the patents of manufacturers at the exclusion of generic production. Mr. Chairman, I put to you that in all the years that we did not have this move to protect the patents, we enjoyed both the research and production from the brand name companies. They kept on doing their research, and we enjoyed the generic drug manufacturing on a reasonable basis.

On the subject of – oh, I put this one in the wrong location. Sorry; I'm going to jump back . . . Well, no, it's okay; it's not bad. The comprehensive health organization program that's now being conducted in Ontario. The minister – today or yesterday; whichever day it was – was talking about the regionalization that she's acknowledging is inevitable. This is the Ontario approach, in a way, to regionalization. What they're doing is giving power to the local communities to decide in what fashion they shall priorize their needs. So if they only need a community health centre when the population is X, if they need a small hospital when the population is Y, a regional hospital when the population is A – what have you – that's what's going on in Ontario. It seems to me that it's being done in a very co-operative fashion, and I wonder if the minister would care to report on progress in this regard, if we're going to see it done in a co-operative fashion and by what year she expects the regionalization to be in place. That, by the way, is going to save an awful lot of money and grief. If you get to know your concentric circles of health from home to the largest location, you utilize on that basis and not more than that. It's going to be a very cost efficient system.

Under Financial Assistance for Acute Care there are a couple of questions that I have to ask particularly on behalf of smaller hospitals. We know that management of biomedical waste is an important issue, and the minister has addressed it. However, smaller hospitals, in the process of accumulating their biomedical waste to the point where it can be cost efficiently removed for – what's the word I'm looking for? – a destination at waste facilities, are being asked to buy these special coolers which cost $24,000 each. They're saying: "Jeepers, you know, why can't I go and buy a used walk-in freezer? Wouldn't that do the trick?" I wonder if the minister can tell us, you know, why it is that this special designation cooler is being required and if the fund for each hospital is going to be increased by the $24,000, if that's the way they have to go.

8:40

The other concern that's been brought to my attention is the lack of an appeal mechanism when it comes to the case mix indexing at long-term care facilities. Everybody knows that the moves that were made in case mix indexing and hospital performance indexing were really long overdue, and while every institution had to go through – what do you call it? – growing pains while they got used to the new system, some other problems are now surfacing. For example, one is the lack of an appeal mechanism to accommodate changes in the mix that happened in the middle of the year that might not be financed. So, if the minister is looking at that, I'd like to hear her answer.

The other thing is that certain rural hospitals, members of the EEMA, the Electric Energy Marketing Agency, may be facing increases in their utility costs if an EEMA review proceeds, and they are curious to know if they're going to be compensated for that.

Now, when it comes to acute care, there's acute care and long-term care. I'm just going to say that one needs to look overall at the mix of health care professionals to make sure that you don't have nurses doing jobs that could be done by LPNs, LPNs doing jobs that could be done by RNAs, nursing attendants, personal care aides, and so forth, that the mix of employees is appropriate to the kind of work they're doing.

In terms of Community Health Services – I realize I'm going to get out of time real soon. I think I made my comments that we need a much stronger focus in this direction. I wonder if the minister will soon be prepared to announce whether or not she will be supporting the request by the Alberta catalyst group on healthy communities to help co-ordinate within the communities for, I guess, the establishment of the community network that we think is going to be necessary to get full community-based health care.

I think I'm going to conclude on mental health, Mr. Chairman. The community mental health programs were only increased by 2.5 percent this year. We know of the growing need for front-line workers in this really important area, an area that didn't even used to be talked about. Fortunately, it's now talked about, but it is not getting the type of increase compared to acute care and long-term care facilities. Again, I'm talking about facilities.

I understand that increases to the NGOs will be 2.5 percent. In some cases that may not be appropriate. For example, an organization serves people in the core inner city of Edmonton in my riding, often dealing with deinstitutionalized patients who for one reason and another find themselves dumped in the core of the inner city. I mean, one facility like the PIN house for example, cannot function on a 2.5 percent increase. Real needs have to be

addressed here. I put it to the minister that it is cheaper to fund community care for these people than it is to put them back into institutions which don't believe they should keep them there.

Mental Health Clinics last year experienced a 5.5 percent reduction. This year their budget is going to increase by 5.3 percent, so they're not even going to make up for last year's cut. I realize that the general message from the minister is not to spend more but to spend more wisely. It is a message that New Democrats have been bringing to this debate for six years now. What I'm saying is, spend more and more wisely in the community and front-line care environment, and then look at reductions in institutional care, and I think she'll have a good system on her hands.

As I mentioned to the minister and to the third-party critic before we started, I unfortunately need to leave now, but I certainly look forward to seeing the minister's comments in tomorrow's *Hansard* and to any follow-up we may have in writing and thank her for her attention.

MR. CHAIRMAN: The hon. Member for Edmonton-Gold Bar.

MRS. HEWES: Thank you, Mr. Chairman. I'm pleased to have an opportunity to speak on the estimates on health care, and thank you to the minister for once again leading us through another year with a steady hand. Although I have some disappointments in this budget, I recognize the work and energy the minister puts into it, and I want to comment and commend her on that.

Mr. Chairman, just at the outset I was a little concerned with what seemed to me to be the minister's preoccupation with the legacy of living within our means. I'm sure that while I couldn't agree more – and we in the Liberal caucus like to believe we're the architects of all the new interest in fiscal responsibility – we must, however, not just think about leaving a debt-free legacy to our children but a legacy of healthy children in healthy communities. That should be our first responsibility. If we do not have healthy communities and healthy citizens in them who are educated, we will not have any economy whatsoever to pay for anything. So I just hope that the minister, in thinking about her comments, would perhaps like to turn them around a little bit. I expect that's really what she had in mind.

Mr. Chairman, just in general I was somewhat disappointed in the budget this year because although it attempts to hold the line on expenditures, it does not indicate to me in any conclusive way that we are moving to a more rationalized system. Now, the minister has spoken to that, and I acknowledge that, but I would like to have seen more reflection of it in the presentation of the budget. We have talked at length in our caucus about the need to move to a system of health care promotion and prevention and to develop the healthy environment, and I believe the minister herself agrees with that. As we have seen technological change and attitudinal change and change in life-style and certainly change in demographics, it has become more and more apparent that we must move to a system that is more rational than the one we have enjoyed over many years, which has been mainly a medical institutional model. We have been pushing for a long time in our caucus for a community-centred model, one of promotion and prevention. We have acknowledged to the government that over time the community-based, preventive model will probably save not just lives but money, but in the interim we recognize that both the medical institutional model and the community-based model have to be running unilaterally. They both must be funded and supported and operate side by side until the effects of the community-based model kick in.

I would have liked the minister to give us more evidence in this budget of her plans to rationalize and regionalize the system. Now, I know the minister has spoken to us about reform, and my observations would say that, yes, reform is happening. It seems to me that we are seeing a tremendous amount of collaboration and co-operation between institutions in all parts of the province, and I'm very grateful for that. But that reform, I submit to the minister, is happening because resources have not been as available as they have in former years, and so our institutions, our public health boards, our school boards, and so on, are having to collaborate in order to make do. Now, that's not a bad thing at all. In fact, that's of tremendous benefit, and I have watched it with gratitude. But, Mr. Chairman, in a sense we're backing into that. It's not a managed reform system; it's a reform that's being forced on our institutions by the absence of sufficient resources.

While I appreciate that the results may be of benefit, I think while we move from one system to another, people can get hurt, whether they are care givers, people who need care, or people who are running and operating the institutions. This can be a damaging process unless it is managed as opposed to being forced because of absence of resources. So I'd ask the minister just to comment on that. I think it's working. I watch with interest the kind of thing that happened in the Three Hills area, where hospitals and institutions got together and said: "Look, we can collaborate and do this better. We can save money and save people." Unfortunately, they perceived themselves to be penalized in doing that.

8:50

I watched the Royal Alex with interest, and I'm grateful that the extension and expansion of the Alex is going ahead and is now joining forces with the Camsell. I think that will make for a more efficient system and probably one that will serve people better than the two hospitals operating separately. Of course, we all know what's happening in Calgary and with the Misericordia and the Grey Nuns in Edmonton. I have also supported publicly the notion of the Northern Alberta Children's hospital as opposed to a new free-standing operation with satellites, but I do have some questions for the minister about that.

In other words, Mr. Chairman, I would like the minister to explain as we go through this session, perhaps not just all in one, what her real plans are for reform, how she sees us moving from this year down the road two or three years and five or six or eight years to a system based more in the community, more on promotion and prevention, more on the healthy environment that I think we all see as being the objective that we're looking forward to.

Just a couple of other general comments. The minister mentioned children's health. While I appreciate what's happening there, I would perhaps like some comments about food, about nutrition for children, children in poverty, and the mental health of children. These don't seem to me to be addressed.

Home care: yes, I appreciate the 9.4 percent increase, but it doesn't even begin to keep up with what I think we need to have if we're going to move into a more independent life-style for people needing minimum supports.

I have supported, Mr. Chairman, acute care funding and the HPI but believe that there have been some difficulties that have ensued as a result of the way the new funding was put in place. I hope those are being dealt with and are no longer causing the problems that I hear about from day to day.

Mr. Chairman, I'd like to go to the votes, if I may, because I have a great number of quite specific questions. I'd congratulate the minister on the Minister's Office, holding the line in terms of spending. That's good to see, Madam Minister, and I hope it can continue throughout other departments of the government.

Vote 1.2, the Health Services Innovation Fund. This one is somewhat troubling because last year we had a million dollars in it and only spent some $350,000 to $375,000. I don't know what happened to the rest of the money, where it went. This year $960,000: I'd like to know what the plans are for that and where the unexpended funds went last year.

Mental Health Patient Advocate. Do I assume from this reduction in the increase that the demands on this office have reduced? I have asked that the patient advocate's mandate be reviewed to see whether or not this office could in fact be given the mandate to investigate complaints from other than involuntary patients. I think that would be an excellent move as we go to more community living.

Mr. Chairman, the Rural Physician Action Plan. I understand it's under way. I'd be grateful for information about how well it's working as well as the study that was done on immigrant doctors and whether or not that has been successful in placing them.

Vote 2, Health Care Insurance. Mr. Chairman, it was my understanding that there was going to be some review of the maximum income level for subsidy to health care insurance. As far as I know, that is still at what I consider an insensitive level of $3,500 for singles and $6,000 for families. What's going there?

Mr. Chairman, in extended health care benefits for seniors in the same vote 2, is the minister looking at income testing here? Seniors have expressed a great deal of fear about this, and I think they deserve an answer.

Vote 2.1.4, Information Technology. I'm getting a number of questions, and I expect other members are, Madam Minister, about the electronic data processing. I understand this is being done for some efficiency reasons. Would the minister explain why it isn't being done directly? That is, why don't we have an electronic system that goes directly from the practitioner to the health insurance plan? Why does it have to go through some commercial outfit in the middle? There may be a good reason for it. I haven't been able to discover it as yet.

2.2.4, out-of-province costs, the prior approval committee. I've asked some questions in the House, Mr. Chairman, about the process that's used. I am concerned about the results of the committee's decision going back to the referring doctor. Patients have expressed that they simply don't get the information that they would like as to why they've been turned down. In fact – I'll speak to the minister privately – we had a rather sad one expressed to us today from that committee. Then again, the minister has in some ways cut off the avenue of treatment for people suffering from substance abuse. What I want to know is: what are we doing to make sure that residential services are available in the province?

Financial Assistance for Acute Care, vote 3. There are no surprises here. We knew this vote was coming. The minister had announced it before. I want to thank the minister and suggest that the notion of two-year grant programs is a good one. I don't know exactly what feedback you've had from the institutions, but it's one I heartily agree with. In fact, I'd like to see us go to a three- or four-year program so that there would be more stability in the budgeting process. Again, I've already mentioned the acute care funding formula. I would like to ask the minister about the acute care funding plan that was being discussed by a rural subcommittee and where that is, if it has been completed.

If I can go on to vote 3.1.7, Medical Education Allowances. Some concern about this one this year on whether it goes in adult education or advanced education. I'm not sure that's a bad thing, but I think people need to have some idea whether they're going to be grandfathered and exactly where that's going to end up.

Ambulance Services. Mr. Chairman, the minister knows my concerns here. I've expressed them over and over again in the House: the mysterious final draft of the regulations and the great concern and anxiety it has created not only for ambulance operators and owners but for municipalities. I would hope the minister is going to allow for input prior to the regulations being written in stone. I think removing the position of medical director or allowing that not to be a physician is something that has created great concern in the community. These are the people who are perhaps most at risk, and I'd ask the minister to answer that one.

If I can go on to vote 3.2, urban medical and referral centres. Again, thanks for the expansion on the Alex. Everybody in Edmonton thanks the department for that. We're all grateful. I don't think, however, Mr. Chairman, that Albertans want to face any further reduction in terms of hospital services, any more bed closures. In fact, people are still begging most of us in our constituencies to do something about opening them up and shortening those waiting lists. They're still causing a great deal of difficulty. Today we had expressed some concerns about the cancer clinics and the sort of anxiety that creates. It's simply not cost-effective in my mind, either in human or in dollar terms.

9:00

Mr. Chairman, I want some assurance that the people of Alberta need from the minister that patient care is not going to be jeopardized. I want to know, too, if the department is playing a part in the mergers of some of these major acute care institutions, such as the Alex and the Camsell, as to how they will apportion their activities and their services.

The northern Alberta children's hospital. We've had some expressions of concern regarding the satellite centres, Mr. Chairman. I think this is the most creative idea, having a hospital that is not confined to one locality, and I have in principle supported that idea. I think it's a workable one, but the notion that a satellite centre could only keep a child if it were going to be there for three days or less I think is troubling a great many physicians and families. I'd like to know if in your mind that is a flexible time, if that's got stretch in it, or if this is an absolute. Perhaps that would relieve some of the question marks related to the whole development of the northern Alberta children's hospital.

What about hospital facilities in the north? Any plans to make one of the regional hospitals in northern Alberta, such as the Grande Prairie hospital, a satellite of the children's health care centre? If not, why not? Also, any plans to extend the northern Alberta children's hospital to children's mental health?

Mr. Chairman, again to the minister. The critical shortage in pediatric neurology: what if anything are we doing to convince the doctors to stay in Alberta?

Going on to vote 4. General Administration: a question that has been reoccurring is the rumour that senior's lodges are going to be moved under health care and come out of Municipal Affairs. Can the minister comment on that and what the rationale would be for such a process, which at this point I certainly don't agree with? I think needs for seniors' living need to be looked at in the long term and go far beyond a medical model. I think they need to be within proximity to health care facilities, but they also need to be in an environment that improves their quality of life and is close to shopping and so on. There are one or two concerns about hospitals that are going to develop long-term facilities but they are not within the context of a town.

Mr. Chairman, going to vote 4.4, Private Nursing Homes. The increase in home care: does the minister have any information on how much pressure this will relieve on nursing homes and

auxiliary hospital waiting lists? Have we any research done on the impact so far of the increases last year in home care?

Palliative care in Alberta. The draft for discussion report that was circulated last December: what's happening with that document?

Vote 5. Mr. Chairman, the great increase in the public health advisory board: I need an explanation as to what has occurred there. Also, in sexually transmitted diseases, the increase is still fairly major there. Does that reflect some new strains that are appearing in the province, Madam Minister? What direction is the department taking? Again, in AIDS prevention, 5.2.5, why was it reduced? Does this mean that we're well in hand? Has the department felt that they can reduce after a major increase last year, and if so, perhaps some statistics on it? Concern is still being expressed to me about the provincial labs being under siege. I'd like to know what the minister's position is with respect to this component of our health care system and what the future is for provincial labs.

In 5.3, Madam Minister, Alberta Aids to Daily Living, I'm glad that the minister reconsidered some of the supplies that were removed last year in the budget that the seniors were very upset about, but very little was put back. Has the department been considering the consequences of those cutbacks? Have we any information on what difficulties seniors have endured as a result of them? Another concern that has been raised is the discrepancy in terms of the maximum price the government pays under Aids to Daily Living compared to the retail price. Consumers tell us that the shelf price is much lower than the charges made under the ADL program.

Mr. Chairman, 5.4.3, Community Agencies. I'd like to have some breakdown of this, if I can, about the amount that is going towards home care and perhaps some details about the numbers of Albertans that are receiving home care and the type of service and how this has changed. I appreciate that we put considerably more resources at their disposal last year.

Families with special-needs children: I've asked the minister about the home care benefits that they need. We've highlighted the circumstances of an Edmonton family who haven't been able to bring their baby home because they can't have consistent home care service, yet it would be considerably easier for them to manage. It would certainly be cheaper from a taxpayer's standpoint to have the little one at home, but it exceeds the $3,000 a month limit. I'd like to know if the department is thinking about another formula that would kick in when you get to the $3,000 and that is not enough yet it is more economical and certainly better for the family. It seems to me that we should be able to work on that one.

Program Management, 5.5.1. The vote got a 16.2 percent increase, and perhaps the minister would tell us what types of programs are in fact being developed and where that money is going.

Health Unit Grants, 3.6 percent. Not enough. Last year it was 11.3. I say so much for prevention.

If I can go to vote 6, Mental Health Services. I really find this one quite shocking, Mr. Chairman: up 3.8 percent. I've seen the document Future Directions, and I'm glad that we finally did it, but for people like me who have been in the mental health field for a long time, that's déjà vu, or as Sheldon would say, `vu jà dé.' That's nothing new in that document. I'm grateful that it's there, and I would like to know when it is that the minister and the department intend putting some of those recommendations into place. Are there new programs coming on stream? If so, when, and what are they? We are all deeply concerned about what's happening in our communities with mental health patients who are coming out of hospitals and are not able to manage on their own in communities and for whom the support systems are not there. They are mainly visible in urban centres, but I'm sure they are in all centres across the province. It is not any kindness to people to discharge them from institutions in our province when there are insufficient community facilities to give them some kind of support to lead some kind of quality of life.

Mr. Chairman, vote 6.2.3, Mental Health Clinics: this year it's up 5 percent; last year it was cut 5 percent. I don't understand this sort of off-again, on-again system, and perhaps the minister can explain. Also, what kind of consideration is given to regions that have had an increase in the number of their clients served? When will we see some action from the department with respect to the Premier's Council on the Status of Persons with Disabilities? Where is the department in terms of providing quick responses, life skills training, individualized support, regional autonomy, and case managers to help lessen the confusion for the mentally ill in accessing services? What happened to the $1 million for the children's mental health initiative? What happened to the crisis unit, and why is there no commitment to new community care initiatives?

9:10

Vote 6.3, Extended Community Care Programs. The Inette John tragedy: I'm pleased that the minister took quick action on this one. I would like to know, however, if there was any thought given to the cause of such incidents in addition to the effect that developed.

Mr. Chairman, if I could go on. The continued move to deinstitutionalize mental health patients into our communities is one that's causing a great deal of difficulty. We all know there are insufficient community supports. It often leads to these individuals running into trouble with the law and the judicial systems. It is no credit to our system that this occurs. The John Howard Society has pleaded with governments to do something about this. Two hundred and fifty thousand mentally ill in Canada: a third of them are detained in prison for criminal activity. Certainly that should be avoided. Where's the money saved in cutting back our mental health institution? Where is it going? What assurances do we have that it's going to be poured into community support services rather than go back into general revenue?

The Mental Health Association estimates only 5 percent of the province's health budget is allocated for mental health; 86 percent of that goes for institutional care. People end up in courts and jails, in trouble on the streets, waiting as long as five months for appropriate housing. CMHA estimates the number of prisoners with some form of mental illness at 25 percent. I'd like to know what the minister's plans are for phasing out psychiatric hospital beds in Ponoka and Claresholm as well as cutting back psychiatric staff. I just think it's time, Mr. Chairman, Madam Minister, that we really put our minds to the circumstances of mental health: mentally healthy workplaces; mentally healthy communities; children, particularly in our northern and isolated areas, that are in desperate need.

Mr. Chairman, the family violence initiative: the minister mentioned $250,000 targeted for the treatment of child victims of family violence. What types of initiatives? Are we talking about counseling? It's $250,000 for children. Is that over and above the $450,000, when is it coming on stream, and where is it in the budget?

My final comments, Mr. Chairman. There have been rumours flying around in the past week about cuts. We need some assurance from the minister that before any cuts or any changes

are made, the minister will indeed consult in every sense of that word with stakeholders and consumers.

I also want to commend the minister for her strong and continuing stance in support of our health care system and the Canada Health Act. That takes courage, and I really appreciate that. We appreciate the position she's taken, particularly with respect to user fees and her refusal to submit to the notion of establishing a two-tier system. We are all pleased that the minister has been strong and firm on this critical issue with respect to our health care system.

Thank you very much, Mr. Chairman.

MS BETKOWSKI: Mr. Chairman, I thought it probably useful if I talk about the advocates, as opposed to the critics, in the other two parties' general comments before we go on.

First of all, let me say to both the members for Edmonton-Highlands and Edmonton-Gold Bar that some people think that the health system is dominated by Edmontonians. May I say that I'm pleased with the way we've approached Health in this Legislature. It has been a very constructive environment, I would suggest, and I think that is what the issue of public policy, as important as it is, deserves. Certainly I listen carefully to the questions and to the comments by both hon. members, because I think health is not an issue of partisan politics; it is an issue of public management and public responsibility. As I've said before, when I sit around the ministers' tables with all the health ministers across Canada – we used to have four parties represented; now we have three – the issues are not about partisan politics at all. They are about: what are we doing in our province, what can we learn from you, not pointing fingers and laying blame but accepting our responsibility to ensure this health system is around in the future.

First of all, with respect to the meeting last Friday, I think there's a perception out there that this is in some way a reduction in support for Health. It is not. It is simply looking at Health over the longer term, giving the five-year plan, if you like, that both members have advocated, and saying, "If we are going to take the resources we have for Health, if we are going to share in the fiscal responsibility that we need to have in Health, then let's draw a scenario of flat expenditure." That's not a reduction, Mr. Chairman. It's flat.

What that does is immediately strike a discipline in terms of how the system looks out over the future. We know there are pressures on the system. Let's just look at cancer incidence and treatment numbers growing. Well, if it's flat in terms of expenditure, that means that in order to accommodate that increase, we're going to have to effect reductions in other areas. Perhaps that's not a bad thing, but we can't have it both ways, Mr. Chairman. We can't argue for rationalization of the system but not here and not here and not here. We have to be looking at how we can get the best value out of the system, and it is, in fact, a managed reform.

I would take issue with the Member for Edmonton-Gold Bar. Some of the examples of the managed reform are the health performance index, the Utilization Monitoring Committee, the role statement process. It seems to me that both members have forgotten fundamentally when they keep asking me, "What do you think the system's going to look like in five years' time?" I don't know, and I don't think it's for an individual to define. That's why we're compelling this system to look at that. Because quite frankly, from a purely selfish point of view, perhaps, and as I said to the Alberta Healthcare Association, as soon as I tell you what I think it's going to look like, you're going to take the shots at me for saying: "No, no; not like that. It's got to look like this." So all of the responsibility for this reform is about all of us accepting our role in the change and accepting our sequences that we have to follow, and then the consequences will be a reformed and sustainable health system. I don't have an idea in my head what that looks like, but let's look at some of the components of it, if we may.

On the role statement process – and the Member for Edmonton-Highlands advocates more community centres. I don't have any problem with more community centres, but you tell me how you're going to get the resources away from the big acute side and move it into the community. That's what we're trying to do through the role statement process. Up to this point the role statement process has been vertical. The acute sector is looking at what's their role in health: the long term, the mental health, public health. What's happening now is it's going to be horizontal as well. So you're actually creating a grid. I like to think of it as a globe, because it is three-dimensional. So the continuum of health is not a straight line; it's part of a global access to health, which I think is where we want to go.

We can't have it both ways when we say, "We want to rationalize, but don't close down hospital beds." We have one of the highest numbers of acute beds per capita in the country as a province. Maybe there are some things we're doing on an inpatient basis, which is also high relative to other provinces, versus what is done on outpatient. Maybe one of the impacts of that is to have fewer acute beds and maybe reallocate them into long-term beds, maybe look at the idea of a community health centre where we have currently an acute care hospital, maybe where we can't get doctors into communities look at the whole issue of nurse/practitioners coming into those communities, but you don't create another profession unless you have a network. You can't leave either a physician or a nurse or anyone out there alone as an isolated piece. What we're trying to do is create the network and do it with all of the people involved.

9:20

No one's mentioned midwifery, but let's look at midwifery. If midwifery is going to take some pressure off the system, it is only going to take pressure off the system if those who currently deliver the babies, the physicians, work with the midwives to look at what are the appropriate births that can be carried out by midwives and which ones can't. I think in fact there is a demarcation, but you're not going to get to that point by continuing with the solitudes between the professions. You've got to get them together. That's what we're attempting to do with the advisory committee on midwifery, and that kind of theme is something that pervades all of health care.

Basically, we are serving notice this year that this is a year of 4 percent. We're probably not going to have another 4 percent year in the '90s. So what are the things we need to do and accelerate our reform in making some of those changes in role in this year that are going to allow the continuum maybe in a different shape or form to continue on? That's the whole goal.

Let me turn, then, to a few of the specifics that the members have mentioned. The Member for Edmonton-Highlands: the whole issue of home care and the $3,000 a month ceiling. We could basically discharge everybody out of institutions in this province if we had the resources in the community to support them. I don't think anyone in this Legislature is suggesting that, so that is why we came up with the idea of having a limit. I don't think we can run any program in health without a limit. I think that has to be the discipline. The question then becomes, and the very valid question of the Member for Edmonton-Gold Bar is: is the $3,000 an appropriate limit?

MRS. HEWES: It's an appropriate limit, but something else should kick in.

MS BETKOWSKI: Okay. Well, the member says it's an appropriate limit that should be appealable. Well, it reminds me of another famous Liberal in Canada who said, and I'm paraphrasing: a limit if necessary but not necessarily a limit.

MRS. HEWES: Mackenzie King.

MS BETKOWSKI: It was indeed. I think if we're going to accept the concept that there is a limit, then we have to work with that concept. Should there be a different limit for children versus adults? Perhaps there should. I think there is in fact a greater value in keeping children who are particularly medically fragile at home than perhaps an adult. I think that's one of the questions we have to answer, but I don't agree that we should have the limit unless something happens. I think we have to discipline ourselves with the limit, and the hon. member and I may have discussion further on that one.

The Member for Edmonton-Highlands asked about the Fort McMurray long-term care. Yes, the project in the book is long-term care. We're not going to pave paradise and put up a parking lot. We are going to upgrade the existing acute care, which has some two floors of space that hasn't been developed for acute care, and we're starting the planning on adjusting that to long-term care. It was seen as the highest need for the reason that there is no long-term care within 400 kilometres of Fort McMurray. That had to be the high priority, and it was one that came in this year.

The issue of AADL grants being down: there is no program change in AADL this year. I appreciate the Member for Edmonton-Gold Bar's suggestion that there may be better ways to manage the dollars we currently have in AADL with retail costs versus coverage costs in AADL. The new deputy minister of public health has the same concern and has some familiarity with other programs in Canada from his former postings. That will be one of the issues which we will be getting into this year.

Preventative health care and the whole issue of promotion of good health. I think the key to the promotion of good health is that it's not a program in health. Promotion of good health is something that everyone has to accept responsibility for. If an individual happens to access the health system by going to see their family doctor for something that's bothering them, health promotion can be practised right at that point. It doesn't have to only be accessed through programs. So what we're trying to do as part of our role statement process is move into the whole area of promotion of good health.

Let's look at the issue of cancer. Cancer incidence and treatment numbers are up about 13 percent last year over this. That number continues to grow. We know that with an aging population your incidence increases. We also know that within age categories the number of people getting cancer is increasing. Our approach in Alberta has been to not only deal on the relatively short term with the issues of ensuring that appropriate facilities exist, that appropriate waiting lists are managed properly, but to look into a longer term including health research that we fund under the Heritage Savings Trust fund and including the whole issue of prevention. Let's lower the incidence. We know how we can do it with respect to skin cancer,and we know how we can do it with respect to lung cancer. There are choices that individuals can make in order to lower their incidence of cancer. It doesn't mean that we're going to wipe it out completely. I don't for one moment think that, but there are some things we can to do to better manage our health, and cancer is a primary example of how to do that.

The Member for Edmonton-Highlands mentioned the Ontario model. They're working with the medical association. The Alberta Medical Association may well have some comments on the Ontario agreement that was reached. We didn't believe that moving to individual level-of-income caps was the Alberta way, because it may well be that someone that's billing the system at $900,000 is providing more value in fact than someone who might be billing it at $100,000 if utilization is being driven for other than appropriate reasons. Working with our association we now have an advisory committee in place and have far more integrated the profession into virtually all of the decisions being made in health, rather than what I believe is a model in Ontario which is their own way of getting to the issue. I don't criticize it for that, but I think the co-operation that we're working with our profession on is something that we all want to continue to work towards and improve.

Lack of appeal on the case mix and HP index, the whole issue of the double-count, a desire to have an appeal: remember that the decisions on case mix and HPI are both driven by steering committees made up of members of the association. So while some may want to double-count if their numbers are going to improve, I'm not sure they would feel the same way if their numbers were going to go down. It's exactly the same issue the Minister of Education is working on with double-counting the school system, but certainly both of those index steering committees are continuing to learn, working with those and trying to manage them better, and I think the model is an appropriate one.

Mental health theory, and then I'll sit down. I will respond to all of the individual questions. The Member for Edmonton-Gold Bar always gives me a good long list, and I will respond to her in writing, but just on the mental health side, I agree with both members when they say that mental health is so fundamental to our health generally. I believe that with all my heart. Our Future Directions in mental health care is a directional statement. It's not going to be happening overnight. Some steps have already been taken with respect to designating regional centres around the province. I think we have to continue to work to get the issue of mental health out in the open, continue to push for board governance for institutions – I believe it's a very progressive step – and certainly not phase out psychiatric beds – we need them – but rather spread them out around the province so that families have access to acute psychiatric beds if their friends or family are in there.

We have to continue to work at mental health, and frankly, Mr. Chairman, I'm not proud that mental health continues to have relatively the same proportion of resources in the whole scheme of health that it's had over the last decade. I'm not convinced necessarily that it has to have a whole bunch proportionately more, but maybe it does. Maybe there's a better mix of services between acute and long term and mental health. Maybe some of the things we do in mental health are far more endemic to the system, can be far more supportive of the whole system. Those are the questions we want to hopefully move towards resolution on as we move to this grid which doesn't just look at the stovepipes of health but the horizontal access regionally.

I wanted to just mentioned STDs, sexually transmitted diseases. The member asked if there were new strains coming. One of them which is very scary is resistant gonorrhoea, which is not responding to traditional antibiotic care. We have some real leadership being provided in this province by Dr. Romanowski and others who are working very hard with all the communities to ensure

that people understand the important steps they can take to protect their own sexual health. Certainly this new strain is a scary one and one where I believe we are providing the leadership needed to ensure that we stop it as soon as we can.

Thank you, Mr. Chairman. I look forward to other members' questions.

9:30

MR. CHAIRMAN: Thank you, hon. minister.

Would there be consent in the committee for the hon. Member for Drayton Valley to share his time with the hon. Member for Red Deer-North?

HON. MEMBERS: Agreed.

MR. CHAIRMAN: Opposed? Carried.

The hon. Member for Drayton Valley.

MR. THURBER: Thank you, Mr. Chairman. Sometimes when I ramble on, I run out of time or run out of words before I do get to the time limit.

Mr. Chairman, first of all, I would have to compliment the minister and her staff for working through the very complex and complicated challenge of maintaining the excellent health care system that we have in this province, which is probably the envy of most places in the free world. They have a terrific challenge and a terrific job ahead of them. Sometimes hard decisions have to be made, and certainly these are the people that are going to help us all through it to maintain this system.

Mr. Chairman, I was a little surprised at the hon. Member for Edmonton-Gold Bar being rather nice when it's definitely been stated publicly that their policy is opposed to having hospitals in little rinky-dink towns across Alberta. I would like to comment a little more on some of our hospitals in little rinky-dink towns, but I'll do that at a later time, if I may.

Mr. Chairman, the minister and her crew of public servants have been working very hard in the last few years on the process of the role statements, and I believe it's one of the best processes that the whole health care system has entered into in a good number of years. When you ask people like the hospital boards, the health units, the FCSS, home care, home help – and it goes on and on and on, with mental health and all the rest of the care givers – when they have to actually sit down and decide and disseminate what they are doing in comparison to what the others are doing, hopefully in the long term we'll get away from some of the overlap and the overuse of the system. Certainly the stakeholders have met on several occasions in the last couple of years here to try and determine how they can maintain this health care system with the dollars that we have. I personally believe that there's enough money out there. I don't think we need to keep increasing the budget. More money doesn't necessarily mean a better service. I think there's some cost-effective measures that can be put in place to save the taxpayers of this province a lot of money and still provide the service.

I guess when you talk about regionalization and rationalization, Mr. Chairman, I think back to one point in time when I served on a hospital board, and by moving one of our services to a regional hospital, we were able to save, on our global budget, better than a hundred thousand dollars. Now, you know, I'm saying that that is a good way to go, but I think we have to be very careful when we do these things to make sure that they are cost-effective and that they don't deteriorate from the service that has to be offered there.

The trend also, Mr. Chairman, has been to home care, and while I think that's a good move, I have to flag one thing that's going to become apparent in the next few years: we are going to create a backlog of people that have to go, at some point in time, into a long-term care facility. We're not going to be able to maintain them forever at home because the cost at some point in time will become too large to be able to do that. I think at this time, along with the other things that we're doing to try and save some money, we have to do some forward planning and look at some of the minor construction things that can happen in this province to allow the service to be offered in these smaller hospitals. With that, I'm saying that there are hospitals in rural Alberta that maintain a fairly large clientele of long-term care patients whether they want them or not. I don't believe that it's fair to these patients to be in an acute care setting being treated as long-term care patients; they don't have the treatment there that they should have for that care. I'm sure that we, any one of us in this House, could indicate small revisions that could be made in these smaller hospitals to allow them to switch the care to more of a long-term care thing, because we are going to need them. The home care program is a beautiful program, and home help, but there comes a point in time when they can no longer be looked after at home.

The other one that comes into the role statements and has a bearing on it is the ambulance districts. We're looking at the whole thing – I shouldn't say we are; I guess the stakeholders are, Mr. Chairman – at all of the districts, the boundaries, the responsibilities, and the areas that do overlap or where there appears to be no cost-effectiveness in it. I'm particularly interested in the ambulance one because it impacts particularly in rural Alberta, where you may find an ambulance contracted to one hospital and you go down the road and have another ambulance contracted to another hospital. With that in mind, one ambulance takes a patient to the other hospital but can't bring one back because it's a different contract. Certainly this impacts on the cost of these services. I'm a firm believer that in our negotiations in the next year or two, somewhere along the line we're going to have to go to central dispatch in order to make an effective ambulance operation within this province. Certainly the ambulance boards in the ambulance areas right now are looking very carefully at things like this to do it.

[Mr. Moore in the Chair]

When we talk about the boundaries, not only of areas but of responsibilities, we have to review the autonomy of these boards. I'm not saying it's a government policy, but I think we have to look at it very carefully. Maybe there should be some coterminous boundaries situated, say, within a hospital district, a health unit district, an ambulance district, or within an FCSS district. If these boundaries were coterminous, certainly it would get rid of the need for five separate boards to deal with this. Now, perhaps each of these services could be represented on one central board that dealt with not only the hospital but the ambulance, the FCSS, home care, et cetera. I do know that in some areas the health units are co-ordinating and co-operating with the hospitals in the area so that the service flows both ways. It's much easier to handle and at some savings, I might add.

I know that the minister had a meeting with some of the major stakeholders in the health care field just last week. She gave a very straightforward message, that there's not going to be any more money, that we've got to back off, that we've got to streamline, rationalize, and regionalize, if necessary, and if it's a viable alternative financially. I think it was well received. We've talked to some of them since then, and I think the key in this

whole area is that we have to not try and go too fast. We don't want to expand into several different areas all at once to confuse the issue. Let's keep on track and let's keep going, as long as all the stakeholders are involved.

It is so complicated, Mr. Chairman, that when the Rainbow Report was published a few years back and we looked at it, if I remember correctly there were about 12 different departments that had to be involved in the health care field to try and come up with the area that they dealt with. Certainly that has to be rationalized as well. The health department, when it deals with basically 30 percent of the total budget – and then you have 11 other departments that are involved in it as well in some manner and through different programs. We have to do a little streamlining on this end of it as well.

9:40

One of the other things, Mr. Chairman, that I think has to happen in the near future is to make Albertans aware of what the health care system costs. It's fine for us to sit here and say that it's 30 percent of the budget, but how many people have gone to a doctor or come out of a hospital and actually known what the taxpayers paid on their behalf? I believe one of the things that has to be done in the very near future is to make the people aware of what the taxpayers are paying on their behalf. I think we have about two hospitals in the province that do indicate, when the patient leaves, what the cost to the taxpayer was. I think that should be mandatory. I think any person billing the health care system on behalf of a client or a patient should provide that client or patient with a copy of that bill when they walk out the door or immediately thereafter. I don't think it would be a costly process, but I also believe that it would save us a lot of money, because I think people would look at it and say: "I was in there to see that doctor. It cost me $38. I feel fine. He tells me to come back next week. Why would I go back?" Or he may turn to the doctor and say: "I was only in there for half a minute. How can you charge $38?" Maybe the doctors would become more aware of what's being paid on the patients' behalf, as well, and think about it a little more carefully. I think that one can be solved.

Mr. Chairman, the hon. Member for Edmonton-Gold Bar and the Liberal caucus seem to indicate that they would rather have all the hospitals in the urban areas and that we don't need them out in our little rinky-dink towns. I have comments come to me from time to time from hospital boards and people in the health care system in rural Alberta. They say: "As a government, why are you squeezing us so hard? We're small hospitals. We provide a service out here, and we only amount to 15 to 20 percent of the budget." Now, we know that there's probably more flexibility in being able to do things in rural Alberta, and this is very true, but a lot of these people operate very efficiently now. I think if you're going to talk just about the hospitals, then we have to talk about the big urban ones as well. There needs to be a lot of work done on that. The HP index I believe is a start on that, Madam Minister, and with some refinement and more co-operation with the stakeholders in it, I believe that will eventually indicate how the hospitals are operating and where the funding should be.

Mr. Chairman, I've heard some comments here touching on the scope of practice. It's my belief that we have now opened the door on scope of practice because we've recognized midwives as possibly a cost-effective measure within the health care system. I think that has to be reviewed and looked at for some time to indicate whether in fact it will be a cost-effective measure. I think we have to look at the scope of practice of all of the stakeholders, all of the practitioners within the health care field. We have places, particularly in northern Alberta and in the isolated areas such as Kinuso, where if we had a nursing station and if nurses were allowed to do some practising – and certainly it's happened over the years, but it's backed off – we could have nurse practioners there. They could stabilize and ship. We could do the same thing in some of the not so isolated rural areas where there are small hospitals and they're unable to get a doctor stationed. The rural doctor program doesn't always work in some of these smaller places. You just can't get doctors there. I don't happen to think that you need a brain surgeon to put a band-aid on your finger or to prescribe some aspirin for a child or help a child with a cold. I think within the scope of the health units and within the scope of the hospital boards and the hospitals in the area, we have to look at this. It would not only be practical, but it would be a cost-effective measure.

There was a nurse who was actually practising in the Fort McMurray area for a good many years. She was told to quit practising. She was practising in conjunction with some doctors, but because it was beyond her scope of practice, she's had to quit doing that. I don't think that's fair. I think there are a lot of things that we can allow to happen in that area. We can look at the scope of practice of the LPNs as well as the nurses, and as I said before, I think we've opened the door with the midwives. I think we should continue to keep the door open and continue to look at it.

Mr. Chairman, in the budget, if I remember correctly, Madam Minister, we said that we were upping the health care premiums to achieve a goal of paying 50 percent of the health care costs. One question that I would ask you is: are we reaching that plateau? Are we there, or is there an indication that we can never get there? That would be one question, Madam Minister.

Health promotion has been talked about, healthy lives. I think we do it all the time through advertising on cigarettes and through education on safe sex and a multitude of other ways. The hon. Minister of Education, of course, does a lot of this through his education as well.

AN HON. MEMBER: Safe sex?

MR. THURBER: This is health promotion. I was going to say something else, but I'll leave it alone, Jim.

MR. DINNING: It's in *Hansard*; remember that.

MR. THURBER: We are doing this all the time. I don't think we need to allocate 1 percent of the budget. I think it's an attitude that has to be formulated and pushed out by politicians and by ordinary people. They have a responsibility in their own right to look after their body and their health and not become a burden on the health care system.

Mr. Chairman, I think with those general comments I'll leave it, and I'll defer some time to my hon. colleague from Red Deer-North.

MR. ACTING DEPUTY CHAIRMAN: Red Deer-North.

MR. DAY: Thank you, Mr. Chairman and hon. colleague. There's no question the costs are upon us and the challenge of meeting the cost is upon us, and not just on this government. Of course, in every province and virtually every country in the western world we're facing incredible rising costs. I think in the somewhat conciliatory tone of the two opposition critics tonight, it's evident that this isn't just an issue of political stripe but an issue that transcends that. It's something that we all need to work together on.

We need to somehow pull together all the sectors and individuals of our province in terms of looking at the problem of costs. We have operations now that we can do through the marvels and the wonders of medical science where the costs run into the hundreds of thousands of dollars. It's wonderful that those types of things can be done, but again the dollars come up. We have drugs now that can do amazing things both in recovery and in pain management and a lot of different areas, but, again, very expensive. We can do tests now that we were never able to do before; these are also very expensive. The equipment that's being used today runs into the hundreds and thousands and millions of dollars. Technology has allowed us to do marvelous, marvelous things, but all of these things cost money. It seems as if there's almost nothing we can't do. It's a matter of what we can do with the dollars available to us. What kinds of costs are people willing to bear? Getting the politics out of the challenge and out of the focus and getting the problem and the solution into it I think is definitely the positive way to go. A united effort is what we need.

I'd like to look at a couple of specific areas and then summarize with a general comment. As related directly to the Red Deer regional hospital, as the minister knows, the record shows clearly that Red Deer regional's record of efficiency combined with innovative approach to services is something that it is known for. We are impacted in Red Deer by some of the gaps in what is fairly good basic policy, but there are some gaps that come up. One of those, if I could make a reference to the case mix index – I'll just call that CMI for the rest of the discussion tonight just to shorten the time, so we know what we're talking about. When we look at our long-term care, the formula and the funding that's established is really done on sort of a Polaroid view of a particular care unit at a particular moment in time. The problem with that, though the basic formula definitely has substance and definitely can be worked, is that at the moment in time when a snapshot is taken in a particular facility, it doesn't take into account that on either side of that snapshot over the period of a year you can have 40, 50, 90 different admissions which can really have a significant change on that mix and can really affect the formula. I'd like to ask the minister to respond either tonight or in the near future if anything is being done to mitigate the effect of the Polaroid view, which doesn't have – what should I say? – the wide-angle lens that can spread over the entire year and look at the substantially different mix of admissions that can come in and alter that snapshot view.

9:50

Also, there's a rate differential in establishing funding for nursing hours. There's an average there that's used to determine the funding. I realize it's at somewhere along the fifth level, I believe it is, in terms of nurses' salaries. With a community like Red Deer, which is a fairly stable community with professionals that have been there a considerable length of time, you have most of your professional nursing care at the upper end of the salary scale. Therefore, the averaged funding formula again impacts a community like Red Deer, hospitals and care centres in Red Deer, because the nursing experience there is higher than the average and therefore there's a possibility of coming out short on the funding. So is something being looked at to also factor into the equation there?

[Mr. Schumacher in the Chair]

That same type of thing also happens in auxiliary care. When the CMI was first introduced, it was started with the nursing homes and then went to auxiliary care, which is a lot more intensive, so again you have some funding shortfalls. Here on the one hand I'm saying yes, we've got some challenges ahead as we look at health care funding in terms of the flat funding projection ahead; yes, I am committed to working with the minister to seeing that happen and maintaining that; and I'm also bringing out the fact that in spite of the formulas we do have which are basically sound, we have to look for ways to deal with the gaps that come out.

I'd like to get very specific just for a minute on a particular issue. It's interesting. You know, if you have a knee joint that is injured for whatever reason, be it the trauma of accident or by reason of corrective surgery or by tension of the muscles or deterioration or whatever, you can get a brace, you can get a splint, and that's covered under health care. If you injure your elbow joint even by the trauma of accident or corrective surgery or deterioration of some kind, you can get a brace, you can get a splint funded by health care to cover that. If you hurt your neck joint, injure it for whatever reason – the trauma of accident, corrective surgery, deterioration, whatever – you can get a splint or a brace to cover that. But when the temporal mandibular joint is injured for whatever reason – either trauma of accident, corrective surgery, or deterioration – and you need a splint or a brace, it's referred to as a dental problem not falling under health care, and therefore it's not attended to.

I do realize that we used to fund temporal mandibular joints and the care thereof. I also realize we are the only province that has ever done that, and that's laudable. I also realize the cost implications that are involved and that decisions were made to de-insure that. I realize the chances of an overall reversal of that decision, as much as some people might like to see it, are very minimal. What I'm asking here is to say that we must have a mechanism so that, at the very least, we can give consideration to what are the very obviously clear-cut cases where it's not some kind of a minor dental problem or an elective problem, not some simple area but a real health care problem.

I'll give you a real-life example of a woman who, suffering severe and extensive and continual problems with epilepsy, traveled to Toronto to the world-renowned surgeon there, who operated on the cranium in terms of actually cutting into the skull, lifting it, removing certain of the brain matter, and putting the cranium back together; really an amazing operation. This particular individual has largely been helped in the area of having these constant seizures, but in putting the whole biological reality back together, there's a problem with the temporal mandibular joint. The problem was so excruciating that even this top surgeon in Toronto couldn't deal with it. It was relayed to him that by the use and the application of certain splints, a very simple process, this problem was totally alleviated. There's a case where it's a genuine medical problem.

Or another situation, where a woman had had so many operations on the temporal mandibular joint and the pain was so extensive in terms of still trying to correct this that both her arms would literally be in braces because of just the weight of her shoulder pulling down on the neck and the whole jaw muscles and area. The mouth had to be wired shut at times; the woman couldn't eat. There are cases. Others, and I've met individuals like this, where a car accident can happen and the temporal mandibular joint is actually knocked right out of place. It is a genuine, bona fide medical procedure to have splints applied to it, and yet it can't be done because of the decision we've made across the board to remove this from the health care insured areas. Again what I'm saying is that as nice as it would be to see a wholesale restoration of the full coverage of TMJ problems, at least we need to look at it. Some way we need to find a mecha-

nism for looking at the genuine medical problems associated with this. We have one of these situations where a lady's being charged for the operation to fix the temporal mandibular joint, and I'm just saying: can the minister look at it? Can we work together to develop a process of looking at these very agonizing problems that are genuine medical emergencies?

As we look at what's happening in health care, we see that there are not only the direct costs of health care, as I mentioned at the start of my comments, in terms of operations, drugs, et cetera, but the indirect cost that comes with waiting lists, which involve lost work time, decreased productivity, the physical and psychological problems of pain and suffering. We really need to work together to look at the problems and look at the solutions. It's kind of fascinating to see that in 1967, in a survey that was done for the British Columbia health service, they looked at time waited for surgery, and you know, in terms of waiting lists, in terms of time waiting for surgery, it's about the same today as it was 24 years ago, which may surprise a lot of people. The waiting time for surgery is about the same as it was 24 years ago. The difference is the number of people waiting. In 1967, in the one analysis in British Columbia, 12,000 people there, or .6 percent of the population, was waiting for surgery, whereas in 1991 it was 40,000 people, or 1.24 percent. So we see that although the time waiting is about the same, the number of people has about doubled in terms of percentage of the population.

Right now in Canada we have about 1 percent of our population waiting for surgery. In 1985, 30 years after Britain had instituted its nationalized health care program, 1.3 percent of the population was waiting for surgery, after 35 years of health care. In 1991 in Canada, after 23 years of health care, we have 1 percent of the population waiting for surgery. And this goes beyond political lines. It doesn't matter if we're talking a Labour government, a Conservative government, an NDP government, or a Liberal government. Whatever the political stripe, these health care challenges are upon us. It's incumbent upon us to get this message out to our constituents, to the larger population, and say, "Folks, here's the problem; we've all got to work together on it." It's not a matter of pointing fingers; it's a matter of pointing to the solutions.

I believe if we really put our heads together on it, get beyond some of the short-term, band-aid approaches and some of the name calling that unfortunately goes on when this discussion gets politicized . . . I appreciate that we've had good comments from around the House tonight on a variety of measures, and if we can continue that way, I think we can resolve some of these very significant challenges that face us not just in Alberta, not just in B.C., but across Canada, the United States, and, as a matter of fact, in the western world.

Thank you.

MR. CHAIRMAN: The hon. Member for Calgary-Mountain View.

MR. HAWKESWORTH: Thank you very much, Mr. Chairman. I've got a number of remarks I'd like to make this evening. I appreciate the opportunity to put them on the record.

We had an overview of the department estimates earlier from the Official Opposition spokesperson, the Member for Edmonton-Highlands. What you're going to get from me tonight is an eclectic collection of issues. The only common thread is that they've all been matters that have either been drawn to my attention by constituents in my capacity as the MLA for Calgary-Mountain View or, I might just add, as the evening has progressed, some of my colleagues have drawn to my attention some of the issues they'd like to have me raise tonight in the event that they can't get in.

10:00

The first thing I'd like to say to the minister is that we shared an experience this last year as joint members of the Select Special Committee on Constitutional Reform. I'd just like to express my appreciation to her for her contributions, and I appreciated the opportunity of getting to know her better in that context.

I'd like to begin with a couple of compliments to her and her department. First of all is the note that's been drawn to my attention that there's a compass; a family support services program is moving into a school in Calgary-Mountain View. It's a one-year pilot project funded by Alberta Mental Health. It's come out of the mayor's task force on family violence, and it's aimed at addressing the mental health needs of elementary-age children. It's an initiative I appreciate, and I'm going to be watching it very carefully. I'm going to get to children's mental health as I get on further in my remarks this evening, but I'd like to indicate that I'm aware of this initiative and appreciative of it.

The second thing is that the minister will remember that I raised a concern surrounding the design of the reconstruction of the Calgary General hospital during our discussion of the interim estimates earlier, a couple of months ago, when we first arrived at the opening of this session. Since that time I note that the planning consultants have met with the community; there are open houses scheduled to get community input into that design to make it fit more into the overall community of Bridgeland. I don't know how much the minister was responsible for that, but if she was instrumental in helping that process along, then I would simply express to her my appreciation. I don't know what the final design results are going to be, but I appreciate that at least a dialogue with the community has begun, and I hope that also will come to a successful conclusion.

On a more general note, the minister talked about making responsible decisions. I certainly recognize the challenges that she and her government face at this particular time, Mr. Chairman, but I would also note that the abandonment of any coherent fiscal policy by this government in this year's budget has been breathtaking to say the least. Let's at least understand what the choices are and that have been made here. There's $115 million currently sitting in a facility in a field in southern Alberta. The former Magnesium Company of Canada plant is sitting rusting; meanwhile, we have cuts being made in our health care programs. These are choices that are made that have real impacts. We know, of course, that Mr. Pocklington has walked away from his relationship with this government, and I've raised questions about why they haven't pursued more vigorously some of the millions that have gone with him. When this government talks about living within our means, I wonder why some of these other examples don't always get included in that.

I know and I'm aware of a cut of 28 staff people at the Bethany care centre in Calgary-Mountain View, Mr. Chairman. This is a choice that's been made to cut the people that deliver direct services to our people in this province. That's a choice that gets made, and I don't like the consequences when I see the results of money in a field in southern Alberta and, on the other hand, cuts being made to direct services.

A case in point, Mr. Chairman. An elderly 84-year-old man, a father and a grandfather, has been brought to my attention, whose condition is a difficult one, who's currently a resident of Bethany care centre. His situation is not unique. His family has written to me. He's on a floor with 64 other, similar people in a difficult, chronic health situation. On that floor there are one

and a half medical nurses looking after 64 people on an afternoon shift. If one person needs one nurse, who looks after the other 63 people? This is the quality of care that's currently being delivered through our health care system. It's gotten to a point that I don't believe the system can tolerate any further cuts. In fact, I believe that we've gone too far.

Others write and tell me about the same stories – again, Bethany health care centre, but I'm sure it's going on all over the province – and they're heartbreaking. These are concerns and fears of families and people in our communities all across the province, about their loved ones and their family members. I understand their concerns, and I understand the funding restraints that are driving this government. But why is it that the direct services to people right where they most need them are being cut this severely? I don't understand why it's gotten as deep as it has. I want to know if there's going to be a system for us when we need it. You know, we talk about saddling our children in the future with a deficit. We certainly don't want to saddle them with a health system in collapse when it's needed to care for their parents and their grandparents.

These are challenging choices that have to be made, I recognize, but my bottom line is that we've got to ensure that the quality is maintained and that it's not allowed to deteriorate further. I'd like to know what it's going to take to get more money into those chronic care facilities for those people not just at Bethany care centre but throughout the province. What will it take to reverse those cuts?

I'm aware of other problems with long-term care facilities. A consistent underfunding of capital, for example, over the years has resulted in a severe deterioration of facilities and equipment, and the longer you defer these expenditures, Mr. Chairman, the harder it is and the more expensive it is to correct it when finally you can't tolerate it anymore. By postponing the decisions that need to be made, you're only, on an almost geometric curve, increasing the costs over the long term. It's not a good policy to defer maintenance, but that's the kind of budget cutting that I understand is being made by some of our health care facilities because of the severe cuts that they've experienced in the last couple of years.

I want to turn my attention now to the out-of-province funding program, Mr. Chairman. I've had a number of contacts in my constituency office with people who've come forward seeking help because a service is not available to them in the province of Alberta, and they've had to apply for funding to go outside the province. Now, I understand the constraints that this government is under. I understand that especially in the area of drug treatment there's been a lot of controversy in the province about how that system has evolved, and to some extent I understand and support the minister sort of redirecting those funds to ensure that they're spent on programs within the province. But I'm talking about some other programs that people have applied for. I appreciate the help that has been provided to my office when I've brought those individual cases to the attention of the committee and the individuals responsible, but I still have to say that I've had some frustrating experiences.

I'd like to highlight the problem of endometriosis. It's an extremely painful and debilitating problem for a significant number of women in this province. There's a network now that's been set up to inform women about an effective therapy and treatment program that's available through Dr. Redwine's clinic in Oregon, and as a result of this, I understand that the demand to get funding to go to Oregon far outstrips the amount of funding available. There are a lot of people who are being turned away, and I don't know what the decision-making process is in terms of triaging or a lottery system or first come, first served or what. I don't know how it is that some go and some stay, but given the kinds of demands and the recognition of the extent of the problem across the province, why can't we look at, say, the procedures that Dr. Redwine is offering through his Oregon clinic and, perhaps through our fee-for-service system here in Alberta or other ways, bring that procedure here to Alberta so that medical people can offer it here in Alberta? It would increase the accessibility for women in our province to that procedure, and in fact it may end up costing a lot less than flying people and putting them up in hotels and so on in Oregon. Perhaps there's now a volume that would justify looking at our procedures here in Alberta, bringing his protocols here, recognizing them in Alberta, and funding them here. I'd like to ask the minister what's happening on that front.

10:10

I've had some heartbreaking experiences with individuals coming to my office seeking specialized cancer treatments. There's been a number of cases where people have come to me, and because of the nature of their illness, there's no particular therapy available in the province of Alberta. They look elsewhere. Currently in the United States there are all kinds of programs on an experimental basis at a number of universities across the United States. People hear of these programs. They'd like support to go and get what is perhaps the only lifeline available to them, and in many cases they're getting turned down. Getting approvals for those kinds of therapies is next to impossible.

What is going on, Mr. Chairman, in terms of monitoring different cancer procedures, reviewing the whole approval process, recognizing new therapies? When is it acceptable in Alberta? When isn't it? How can we do more to help these individuals that come forward? You know, somebody comes into your office and six months later you're reading of them in the obituary column of the newspaper. It breaks your heart, and I'd just like to satisfy myself that everything is being done to ensure that people with particularly difficult forms of cancer are being recognized or somehow supported through our system of health care in the province.

I'd like to turn now to a recent example I've had about an individual presenting himself in my office with an environmental hypersensitivity – that's one terminology used – or multiple chemical sensitivity, another medical term that's growing in use and recognition. I've written to the minister for special help in this particular case. Assistance or further assistance to go to the United States was rejected. The individual is now chronically malnourished because of the nature of the disease or the illness that he has, multiple chemical sensitivity. Out of desperation this individual recently turned to the news media, and there was an extensive article that appeared in the *Calgary Herald*. I've in turn been amazed, Mr. Chairman, at the number of people since that article appeared that have stepped forward to tell me about their particular experiences. I think it's interesting to note that the doctor in Calgary, who has developed a specialized practice and knowledge in this area, is a medical doctor, but his specialty is psychiatry. The reason he's developed this specialized practice is because so many people ended up on his doorstep because they were diagnosed as having some form of mental illness, when in fact what they had was this physical malady which had these kinds of symptoms. So he's become aware and has developed a practice of helping people suffering from this kind of syndrome.

I'd like to table for the Assembly some copies of an article that has appeared in the *New England Journal of Medicine*, which estimates that the number of new cases in the United States ranges from 125,000 to 350,000 per year. In this article, which appeared on September 26, 1991: "On the basis of these estimates, we

calculate that the annual cost of occupational disease," the occupational manifestation of this disease, "in the United States exceeds $6 billion." This is a significant problem that is just recently receiving attention. I'd like to table that for the Assembly and for the minister.

I've also got a copy of an interim report on the operation of the Nova Scotia Environmental Medicine Clinic. I believe it's one of the very first in North America; it's certainly the very first in Canada. This article was written recently, January 1992. I'm not going to quote from it, but I'm going to table it for the minister. I hope it gets circulated through her department, because I think that given just the small experience I've had in my office, there's a much wider spread problem in this province. People are being treated in the system through the hospitals, through doctors, through psychiatrists. The money is going to go towards treating them, but it's all ineffective because the syndrome isn't properly recognized. So I'd like to suggest that the experience in Nova Scotia and elsewhere be studied with a view to perhaps co-ordinating the protocols or procedures and making a service similarly available in Alberta. I don't think it's going to cost any more. It would just mean that the money that's currently going towards the treatment of these people in our system would be more focused and more effective.

Moving along, Mr. Chairman. I've written to the minister, as she knows, about the CNIB service centre, which is in desperate need of renovation and upgrading. I'm sure she is supportive of that. However, we don't see any funding for it in the estimates. I know that a new program of support from the community has been recently launched, but I'm wondering whether the minister can give us any indication of whether this government is still reviewing that project and whether there's a possibility that that funding will be made available sometime soon in order to ensure that the CNIB gets the facility they need. My colleague for Vegreville gave me a letter he received from a constituent in Mundare who received services through the CNIB service centre in Calgary. I find that interesting. I'm well aware that people in Medicine Hat, Lethbridge, and other centres throughout southern Alberta get significant support through the CNIB service centre. While it's located in Calgary-Mountain View, it serves a very large population throughout Alberta, people who really need these services. I would hope that we can provide and help get some funding for them in order to ensure that that service centre gets upgraded.

I'd like now to turn to, as I mentioned earlier, children's mental health. The minister, I'm sure, is aware of a report from an Edmonton workshop called Accountability for Children's Mental Health: Let's Get on with It. The report brought together people in the community providing services. About 165 people, I gather, reviewed the delivery of children's mental health services and came up with a number of points. Their central message, Mr. Chairman, is that there's a critical need in our community and in our province to treat seriously ill children and a need to promote positive mental health for all our children. The minister in her opening remarks mentioned that we don't want to leave a legacy of unmanageable debt to our children, and I concur strongly with that sentiment, but there are things that we owe our children as well. We owe our children, above all, that we not deny them the critical things they need to cope and succeed in life. So when it comes to mental health needs for our children, it's something that I feel strongly about. I would hope that the problems identified in the report are going to be addressed.

10:20

Among those problems are limited resources to the system. The resources are inadequate to meet the current needs that are out there. In fact, the problems are underestimated, and the ability of the system to respond is limited. There is no continuum of care, and there are gaps and overlaps in the delivery of services to those children. Currently, four of this government's departments provide services to children, but there is no formal planning or co-ordination among them. As part of this problem, access to treatment is limited and inconsistent.

I would like to know what the minister's reaction might be to their recommendations. Among those recommendations for change and solutions are the following. They're proposing legislation to ensure that there's a mandate of someone to co-ordinate services. They proposed a family and children services Act as one possibility. They also called for the creation of a children's ombudsman; I gather because they don't see the current mandate for the Children's Advocate as being adequate. In terms of improving accessibility, the suggestion is to create a single-entry resource in each community for assessment and referral as well as a need to provide 24-hour emergency information and access to emergency treatment and beds. There's also a suggestion that services be provided on weekends and evenings so that working parents and school-age children can access services. I say amen to all of this as well as a call to expand counseling services and respite care. I'm convinced that with the proper co-ordination of services, the amount of new resources needed in the system is not going to be unreasonable, but if we use the funding that's there currently and spend it better, as well as inject some reasonable amounts of new resources, we can do the job.

I'd like to turn now to another issue, and that's treatment services and programs for batterers. I know that the Calgary General hospital in Calgary-Mountain View sponsored a program a couple of years ago. It was funded through their discretionary funds, but they couldn't provide it any longer even though they demonstrated its effectiveness and demonstrated the need. This ministry was not forthcoming with the resources to carry on that program, so it was dropped. But there is a need for it, and I'm suggesting to the minister that perhaps her department could look at using the innovations fund as a source of creating some pilot projects or supporting the pilot projects that have already been started in order to ensure their continuation. After all, Mr. Chairman, battered women and children end up in our health care system, and that costs. It's more than just a matter of dollars and cents, far more than that, but I think we have to recognize that the problem does create cost to the system, so if we can prevent the problem, then we can prevent the cost. It would seem to me fiscally prudent as well as socially just for us to put funds into programs of this nature and reduce the expenditures of the system in this kind of prevention.

I'd like to ask the minister about increasing the use of nontraditional professionals across the system in order to perhaps make them more cost-effective. What about the whole area of nursing clinical practice, where some of the services that are currently provided by general practitioners or family physicians might be replaced by nursing professionals? What about licensed practical nurses within our hospitals? I think we were all recently lobbied by their association. Is there any chance that their role can be expanded? What reviews are being undertaken to look at whether their roles should or could be expanded?

Then the whole question of midwifery and the licensing of midwives has been a source of discussion and some debate in question period. Midwives, I believe, could play a very important role in pre- and postnatal care and in counseling to mothers. I, for one, personally am a supporter of emphasizing making our hospital births more mother friendly and more child friendly, but as part of that I support a greater role for our midwives, and I

know that there's been an extensive report. I would just underscore and reiterate our caucus' support of that report and would once again use this opportunity to encourage the government to proceed apace with implementing those recommendations and not to unnecessarily delay their implementation.

I'd like to underscore the problems of trying to impose a provincewide ambulance service across Alberta without providing any serious resources to make it a reality. When we toured Alberta municipalities last fall, this was a constant issue that was raised with me in our meetings, that there are mandates and regulations that people are now being expected to meet or shortly being expected to meet without the resources in place to help make it happen. I'd like to know when we're going to get that system finally in place, up and running, without creating a severe – and I underline the word "severe" – financial difficulty for many of our smaller municipalities across the province.

I'd like to also indicate, Mr. Chairman, that on behalf of my colleague the hon. Member for Edmonton-Mill Woods I'd like to raise an issue that has been brought to his attention by one of his constituents, who took his daughter for treatment to the Grey Nuns hospital and as a result of this treatment was charged a $40 fee for a splint and child crutches. I've seen the invoice; it's $40, and it was for a splint and child crutches. He had no advance warning or clearance in advance about this bill. He was quite surprised to receive it and raised it with his member. It seems to him and it seems to me to be an example of how user fees are creeping into the health care system.

I know that the Minister of Health has consistently said that she's opposed to implementing user fees in our health care system and our hospital system. I support her in that. I think she's to be commended for taking that position. I'd like to use this opportunity to say so. But having made that statement and taken that position, I'm wondering if she would investigate at least the possibility that despite her knowledge or despite her best intentions, at least in this case a user fee is being implemented. Does this open the door to a wholesale development of user fees to support our health care system on a piecemeal basis? Is this creeping into our system and in fact creating a situation that she doesn't intend? I'd like her to perhaps address that particular question.

MS BETKOWSKI: Mr. Chairman, I would like to say thank you to the members for Drayton Valley, Red Deer-North, and Calgary-Mountain View, and certainly I will respond formally to them, to the questions they've raised.

Mr. Chairman, I move that the committee rise and report.

[Motion carried]

[Mr. Deputy Speaker in the Chair]

10:30

MR. MOORE: Mr. Speaker, the Committee of Supply has had under consideration certain resolutions of the Department of Health, reports progress thereon, and requests leave to sit again.

MR. DEPUTY SPEAKER: Having heard the report by the hon. Member for Lacombe, all those in favour, please say aye.

HON. MEMBERS: Aye.

MR. DEPUTY SPEAKER: Opposed, please say no. Carried.

MR. ANDERSON: Mr. Speaker, before moving that we adjourn this evening, I should indicate that tomorrow afternoon it's intended that we debate government Motion 17 and Bills 20 and 15 in Committee of the Whole and, time permitting, perhaps other Bills on the Order Paper.

[At 10:31 p.m. the Assembly adjourned to Wednesday at 2:30 p.m.]