Title: **Monday, March 9, 1998** **Des.subcom: Health**
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8:03 a.m.
[Mrs. Forsyth in the chair]

Designated Supply Subcommittee – Health

Forsyth, Heather, Chairman	Doerksen, Victor	Pham, Hung
Barrett, Pam	Fritz, Yvonne	Sapers, Howard
Broda, Dave	Herard, Denis	Sloan, Linda
Dickson, Gary	Jacques, Wayne	Tarchuk, Janis

THE CHAIRMAN: Good morning. I'd like to welcome everybody. I'd like to read into the record a motion, and hopefully we'll receive unanimous consent. It reads as follows:

> Following previous discussion with my opposition counterparts, I would like to request unanimous consent of the committee to have the hon. minister speak for 20 minutes, the Liberals to have one hour and 48 minutes thereafter, and the New Democrats to follow with their 12 minutes, completing the opposition allotment of two hours as per the DSS agreement, and the committee then to adjourn.

All those in favour of the motion, say aye.

HON. MEMBERS: Aye.

THE CHAIRMAN: Opposed, say nay. Let the record show the motion carried unanimously.

We are going to be starting at 8:04 with the minister for 20 minutes.

MR. JONSON: Thank you, Madam Chairman, for the opportunity to speak to the Department of Health estimates for 1998-99. Prior to considering the questions that members will raise, I'd like to just comment overall on the directions that Health is taking. First of all, certainly Alberta Health has been part of the overall government plan, on a fiscally responsible basis, to balance our budget and work towards paying down our debt, but I would like to talk about the overall situation as far as health is concerned. All across this country and certainly in Alberta I think we're not being too presumptuous to say that we have, as we have dealt with our overall fiscal direction, looked at the health care system in terms of the changes that needed to be made to it, and those changes I think are mirrored in many of the efforts of other provinces in Canada.

First of all in terms of the money being spent on health, there was the need to make the whole system more accountable and to understand what we were spending our Health money on and what results we were getting for that particular effort.

Secondly, the health system of the future, the health system that we're working on, is one that is designed to become more community based and less focused on acute care.

Thirdly, we've taken major measures to reduce administrative costs and, as a corollary to that, make sure that the greatest percentage possible of health care dollars is directed directly to patient care.

Fourth, we've been looking at and making progress in the delivery of a broad spectrum of health services and trying to, and I think making significant progress, better co-ordinate those overall services.

A fifth area that has needed attention for some time in our health care system is a direction, a plan to make the whole area of occupations and professions working within the health care system work together from more of a team approach. This is part of our effort within Alberta Health and of course is also very much related to the very extensive work that is going on with an overall umbrella health professions act.

Sixth, the system has to be one that's open to change and innovation – the health care system cannot be immune from looking at new ways of doing things – by trying pilot projects, by improving and capitalizing on best practices.

Last, Madam Chairman, our health system needed to place much more emphasis on health promotion and on preventing illness and injury.

So those, Madam Chairman, are a number of the directions we are pursuing in the business plan which we're reviewing today and are reflected also in the expenditures under the budget.

Now, Madam Chairman, I'd just like to focus on some of the key aspects of the restructuring that's been completed and show that the basic process of health reform continues to be pursued. I'd also like to indicate that the health care system has certainly been through a period of dramatic change. Change is going on this year, and it's going to be a fact of life for the health care system in my view. We are not any longer in a position in our rapidly changing society where any government delivery system, be it health or education or for that matter something such as transportation, is not going to be challenged to review and to change and adjustment.

Now, in the budget we have before us, there are a number of key initiatives. I would like to indicate that they're highlighted in the Health business plan, but because we're talking about expenditure today, I would like to just mention some of them generally and then get into the actual financial picture.

First, Madam Chairman, Alberta Health in co-operation with the regional health authorities will be developing specific health strategies to address priority health issues in the province, including such issues as the prevention and early detection of cervical and breast cancer, the prevention of accidents and injuries, and reducing the number of low birth weight babies in Alberta. At the same time, Alberta Health will be taking a leadership role with other government ministries and health sector organizations to improve the health of all Albertans but with a particular focus on our children, our seniors, and others with high health needs.

On the accountability side of the ledger, Alberta Health will be completing an accountability framework for the health system that will clearly identify who is responsible and accountable for each component of Alberta's health system and will outline the mechanisms for reporting results by the health system. Flowing out of that accountability framework will be a process for developing health and health system expectations and measures, including both standards and targets. This will allow for improved performance measurement and reporting to support continuous improvement in the management of the health system and the delivery of health initiatives. These initiatives along with the many, many others outlined in the Health business plan will help to ensure that Alberta's public health system provides the services that Albertans need when they need them both now and into the future.

Madam Chairman, earlier this year our Premier presented Albertans with a new three-year plan for reinvestment and debt

repayment. That Agenda for Opportunity, which set the tone and the structure for Health's 1998-99 budget, is based on some very clear principles that Albertans have conveyed to government. Albertans have told our government to be unwavering in our commitment to pay off our accumulated provincial debt and to be fiscally responsible. They have also said to continue looking for new, better, and more efficient ways of doing things. Albertans have told government to be accountable for what they are doing and to continue to let Albertans know about what government is planning and implementing not only in health but in all sectors. Finally, Albertans have told government that when we have the money, some of it should be reinvested in priority areas such as health, and that is exactly what this government has done not only in these 1998-99 Health estimates but in the previous few years. In fact, we have been able to reinvest a significant amount of money in the Health budget, and I would like to refer to one of the challenges in doing that, and that is that this has been done despite the fact that we have had to also accommodate the reductions in cash transfers for health to the provinces from the federal government, which have been very, very significant.

Health spending is increasing by $498 million to $4.48 billion, an increase of 12.5 percent over the next three years. In 1998-99 total health spending will be $4.206 billion, an increase of $220 million from the comparable 1997-98 budget. We will be spending around $11 million a day in the coming year to ensure Albertans have access to quality health services. This overall is I think an acknowledgment that with our spending under control as a government there is a need to reinvest in health as we face the increased demand for services from a growing and aging population.

8:13

Madam Chairman, some of the highlights of this reinvestment as reflected in the Health estimates under discussion today include: total funding for health authorities will increase by $81.9 million from the 1997-98 comparable budget, an increase of 3.4 percent. The increases in 1998-99 budgets for health authorities are on top of a onetime allocation of $40 million provided this year to help authorities address the issue of equipment replacement. The funding increases are also on top of another onetime allocation this year, this one in the amount of $39 million to seven RHAs to eliminate deficits and debts inherited by these RHAs when they became established several years ago.

The increased funding in the budget, Madam Chairman, includes an additional $9 million to the Provincial Mental Health Advisory Board to address the priority issues in mental health and in particular to enhance community-based mental health services. They include an increase of $20 million for drug costs to reflect the higher costs for new drugs coming into the market and to accommodate the increased utilization of current drug programs. An additional $3 million annually for the rural physician action plan is included, bringing its yearly budget to $5.8 million. This additional funding will further our efforts to recruit and retain physicians in rural Alberta and help to ensure that all Albertans have reasonable access to physician services.

Madam Chairman, there is also included in the budget $3 million in funding for a new initiative to enable more palliative care patients to receive appropriate care and support in their homes and spend their remaining days in comfort and dignity to the greatest extent possible. The new funds will improve our capacity for palliative drug therapies at home.

There is an increase of $29 million, or 16.4 percent, over comparable 1997-98 budgets for the Calgary and Capital health authorities for the provision of highly specialized lifesaving procedures such as organ transplants, cardiovascular and neuro surgeries, and renal dialysis. These services are provided by the two health authorities for all Albertans.

There is an increase of $69 million for physician services, or 9.2 percent, over the comparable 1997-98 budget. It is important to note here that this budgeted amount reflects government's most recent offer to the Alberta Medical Association in negotiating a new financial agreement between government and Alberta's doctors. The $69 million one-year increase in spending on doctors reflects an offer for a three-year agreement which funds current utilization of physician services, adds in a 5.5 percent fee increase for doctors, addresses the issue of an increasing population in Alberta, and provides funding to support other areas such as rural physicians and doctors' medical insurance. Overall, Madam Chairman, it is an offer that would see government spending on doctors increase by $140 million over three years and see the annual average billings increase for doctors by about $20,000 each.

Our government has continually stated our commitment to ensure quality accessible health services for Albertans along with our commitment that when additional resources are clearly required, they will be provided. In that regard, Madam Chairman, I would comment for a moment on some of the pressures faced by our hospital emergency wards and intensive care units in the past few weeks. These pressures are reflective of a peak in volumes of activity and are an inherent part of health care, especially during the winter months when flu and pneumonia are at their seasonal highs. Our health care system in Alberta responded well, and patients received the care they needed despite the peak volumes. I am, however, closely monitoring our health system to ensure that we continue to maintain our capacity to respond to these emergencies and that our health system continues to be able to effectively meet the needs of a growing and aging population, and if additional resources are clearly required, then we will review those needs and give them consideration.

The increased funding contained in 1998-99 Health estimates demonstrates our overall commitment to health. I believe, Madam Chairman, we have in place the solid foundation for a stable, accessible, and quality health system that is able to meet and deal with the new day-to-day challenges in health on a day-to-day basis. The funding being provided and the initiatives being taken clearly indicate that our overall priority is a health system that Albertans can rely on to meet their changing health needs.

Thank you, Madam Chairman, for these minutes to make my opening remarks, and I'm open to questions that members have.

THE CHAIRMAN: Are you going to start, Gary?

MR. DICKSON: Yes. You bet.

THE CHAIRMAN: Okay. We're starting at 8:20.

MR. DICKSON: Okay. Good morning, Mr. Minister. Welcome back, Mr. Bhatti, and, Mr. Ford, congratulations.

Mr. Minister, I take you directly to program 1, ministry support services, element 1.0.11, the appeal process. On May 5 of 1997 when we did this a year ago, you told us you were looking for a new system to deal with complaints. In fact, your response – and I can quote it from page DSS20, May 5, 1997. You wanted a "more effective and co-ordinated approach to appeals on issues and problems within the health care system in individual cases." Also, last year my colleague for Edmonton-Riverview had pointed out at least five different complaints offices all with decreased budgets. Now we see the Health Facilities

Review Committee up $484,000. My question is: what happened to the proposal to expand the jurisdiction of the Ombudsman? It seemed to me it was back in December of '96 when you had announced you were working on a new process to deal with complaints. We've got the Provincial Health Council recommendations of 1996. What happened to that recommendation, and why the increased funding for 1.0.11?

The next item, Mr. Minister, while we're on program 1, is public communications, 1.0.3. You've got an increase from $733,000 to $759,000. I find this particularly puzzling, because if you go back to May 5, 1997, and your quote at page 26 of the estimates debate last year, when you were asked about a decrease in your communication budget – it's basically the same item; there was an 11.6 percent decrease – you said that the government

> has tried to get away from the assumption that if you're doing something that requires adding some more money into the budget, there are ways of doing things more effectively and efficiently and still meeting your goals.

Your then deputy went on to expand and said, "We used to have a division . . . that did all [this] work, and now we have it distributed throughout the department." So why is it that you were able to do more with less a year ago in terms of communications and now we're looking at a significant increase in that area? Is there a particular project or projects that require and warrant that additional money? If so, perhaps you could share that with us.

Page 238 – this is in the budget book – is part of your business plan summary, and the first item under major strategies is to "finalize an accountability framework which clearly identifies responsibilities". Now, does that envisage further work on your report from August 13, 1997, entitled Towards a Core Health Services Framework for Alberta? Mr. Minister, are we now into phase 2? Because you remember when that initial report from phase 1 received some public attention, there was considerable concern, and you had a phase 2 that was laid out by your consultants.

The other thing around that towards core services report, if you look in the report, V and VI, there were seven decisions to be required in terms of the next steps. To save time, I'm not going to go through and read each of the specific items, but my question to you would be: have each of those things been done; in other words, a detailed specification of services, the separation of individual and population-based services, specificity of policies and standards? I think Albertans want to know or certainly are entitled to know where the government is going with that towards core services report.

8:23

Now, I want to turn to 2.1.2, alternate payments. I take it the alternate payments item is the tripartite process, Mr. Minister, essentially. On May 5, '97, when I had the chance to ask you some questions about this – just for your reference, it was page DSS26 from a year ago – you said then:

> We are moving to implement . . . six pilot projects with new models of paying physicians, different clinic and delivery arrangements.

This initiative I think is now at least three years old in terms of developing pilot projects to explore alternate physician compensation models. My general question is: for the $440,318 in tax money that's been spent, where are the results?

If we go through the programs, firstly new directions in family practice in Calgary, I'd like to know how many doctors are involved in that program, how much has been spent on that particular pilot, what the results are to date.

Secondly, the Bassano community health centre in the Palliser region. Agreements had been done up by Alberta Health in June of 1997. How many doctors are currently involved in the Bassano centre? How much has been spent on that project? What experience, what lessons and conclusions have been teased out of that experience to date?

Number three, the Capital health CHOICE program. My recollection is that there was some $250,000 per year that was going to be committed by the Capital RHA. How many physicians are involved in that project? How much has been spent on that project to date? What lessons have the department and your ministry taken from that program?

Similarly, the northeast Edmonton community health centre. There was $230,000 that was going to be spent on that. Has all of that sum been spent? How many doctors have been involved in that alternate model, and what success has been determined from that model?

Five, the CRHA chronic nonmalignant pain program. I think $185,000 has been spent to date. How many doctors involved in that program? What success, Mr. Minister?

Finally, the Colonel Belcher program. How many doctors involved in that program, how much has been spent to date, what success, and what lessons do you take from that?

Then while we're talking tripartite, have you maintained the distinction between the fee-for-compensation care model and tripartite projects? Certainly the chairperson will be alive to this because she sits on that committee. There's been some issue in terms of where tripartite ends and where the other fee-for-compensation model fits in. You might also share with us, Mr. Minister: what's the status of the Fort McMurray project, and why is that independent of the tripartite working committee?

My other question, Mr. Minister, with respect to those same six care programs: does the ministry plan to abort or discontinue any of the six projects before the scheduled termination? I know at one time the tripartite committee had considered a forum on alternative physician payment models. Is that still happening? If so, when? If not, why not?

There were supposed to be some health transition dollars in the budget and some money for demonstration projects. I'll ask you at your convenience to just point out where that is in the budget.

The other item I wanted to touch on, Mr. Minister, is funding to regional health authorities. You'll remember that when I asked you questions about this last May 5, '97 – this is page DSS18 – you were commenting then on a 4 percent increase to regional health authorities and you said:

> . . . now gives [RHAs] a solid, predictable, and stable funding base. It enables the authorities to deal with local pressure points and local priorities ensuring access to quality health care for all Albertans.

Now that was quite reassuring, I'm sure, to Albertans when you told me that May 5. Less than 12 months later we have 15 regional health authorities anticipating deficit budgets. The CHRA – and you might confirm this – has advised me they are at least $25 million short. If they've told you something different, please advise. The Chinook health region vice-president says and I quote: health employees are cracking under pressure of trying to do more with less, closed quote. There's a problem of sick leave, low morale, and the $1.9 million they're getting falls short of the $3.5 million they're obligated to pay in salary increases. I think my colleague for Edmonton-Glenora may have some specific questions about the Capital region, which I'll leave for him to touch on. Mistahia, I understand, Mr. Minister, is expecting a $2 million deficit; region 15, Keeweetinok Lakes, $1.5 million deficit anticipated; East Central, $5.6 million deficit anticipated; David Thompson, $6.2 million deficit anticipated. That's the information I've got. If I'm wrong, please advise.

What's the plan? Is there going to be permission for regional

health authorities to run deficits? If so, for what period of time? Is there a ceiling on the amount of a deficit that can be run? What services will your ministry allow regional health authorities to delay, defer, or cancel because of their funding problems?

Then, Mr. Minister, a bit of a more general question: what do these problems in 15 of your 17 RHAs tell us about the population-based funding formula? When I did a bit of a tour around the province last fall talking to regional health authorities, physicians, health administrators, there were plenty of problems that were relayed to me relative to the population-based funding formula. So I'm interested in you sharing with Albertans: is the formula going to be scrapped? Is it going to be radically overhauled?

Then I guess the issue that flows from that. If I look at elements 2.3.18 all the way through to 2.3.23 inclusive, those six elements all operate outside the population-based funding formula. It appears, Mr. Minister, you keep on grafting. Certainly from an RHA perspective it's welcome relief to have additional dollars come in, but at some point when you graft so many layers of independent direct provincial funding, one has to ask: what's the point in the population-based formula? Where is it deficient that it doesn't address so many of the other issues that have to be addressed in the alternate fashion?

Now, Mr. Minister, 2.1.5, rural physician action plan. I see $5.8 million. I was looking the other day at a study, and I don't know whether I have it at my fingertips. You may recall it. It was Pockets of Good News: Physician Recruitment in Rural Alberta. That was from January of 1994. At that point more than 60 percent of rural communities with hospitals anticipated no difficulty recruiting and retaining family physicians. What's the percentage now? That was 1994. In many of those rural communities there's no longer a hospital, and I'd like to know what impact that's had on your recruitment strategy. At that point 20 to 25 percent of the rural communities, in January '94, reported difficulty recruiting and retaining family physicians. Would you tell us what the number is now, sir? The problem at that point was communities less than 4,000. Perhaps the minister could identify: is that still the major market that causes the biggest difficulty in terms of physician recruitment?

8:33

The other thing – and I should know this, Mr. Minister – is that you had an incentive payment program, and at one point the maximum incentive payment was $40,000 per year. Can you clarify whether that cap still exists?

Now, Mr. Minister, just in terms of the business plan, one of the difficulties I have – and I'll start right off. If you go to page 238, it talks about core businesses and related goals. Item 1: Set Direction, Policies and Provincial Standards. I and many health care professionals are having difficulty finding out: where are the standards created by your department? We've seen business plan after business plan after business plan, and there's a lot of talk about standards. But when I did my little health tour and when I talked to health administrators, when I talked to the physicians with administrative responsibilities, people still lament what they describe as an absence of provincial standards.

Again, we look through the major strategies, the third bullet: "Develop health and health system expectations and measures, including standards and targets." If there are standards, a lot of people who are professionally involved in delivering health care don't know where they are, and I think it's not unfair to say to you, after the number of years we've talked about provincial standards and you describe that in your business plan, that it's time to look at the substance of it. Where are those provincial standards? I don't expect you to have that at your fingertips this morning, but I'm going to ask you to undertake through the agency of your office, your department, to provide me as specifically as possible with the enumeration of the provincial standards that currently exist. Those would be the standards that you talk about in core business goal 1, in major strategies bullet 3, and any other places where you talk about standards.

With respect to your key performance measures, there are some that I would describe as being very serious and appropriate, but if we look at a number of them, they're not really very helpful, Mr. Minister. If we talk about percent of low birth weight newborn babies, which is certainly an important measurement of population health, what's the specific strategy that you and Alberta Health have to address? We have an unacceptably high rate of low birth weight babies in the richest province in Canada. It's a problem that's even more serious in Calgary, the wealthiest and fastest growing city in Canada. So what's the specific strategy to not just track the percent of low birth weight babies but in fact to make a significant difference and reduce that unacceptable statistic?

As you go through your key performance measures – to save time, I'll come back to that a little later when I can refer you to the specific provision.

This may be a good time for me to stop and let one of my colleagues put some questions to you, Mr. Minister. I'll get back later. Thank you.

THE CHAIRMAN: Mrs. Sloan.

MRS. SLOAN: Thank you very much. Good morning, Mr. Minister. I have not publicly been a proponent of this government's reforms to the health care system, so my comments and analysis of the budget are offered in a critical way but also with the intent to provide once again or one more time perhaps a broader view or definition of health.

I would like to begin with the minister's opening remarks and specifically talk about some of the terminology that you used to define your ministry's priorities, that being the broad spectrum of health services, teamwork, and health promotion. As I look at the performance measures, as I look at the allocations in the budget, I'm wondering if you can concretely define for me where the terminology is factually based in funding and in programs. As I look at this government's reforms and the budget and the priorities, I see a great deal of emphasis still on illness-orientated care, on medical-focused care. I see incentives for physicians. I do not, however, see any incentives for midwives, for physiotherapists, for massage therapists or alternate therapies, of which utilization is on the increase. I do not see any consideration or incorporation perhaps of the utilization of nurse practitioners, an initiative that many provinces are taking as a healthy reform to operate the system effectively with reduced budgets.

I also would raise a question with respect to teamwork in conjunction with this government's pursuit of the introduction of the health professions act. This legislation in my opinion is dangerous legislation. It will establish a policing body appointed by government to control health disciplines. It will effectively obscure the boundaries of the professions, and all of the public I've spoken to about that have absolutely no idea what this government's intent is with that legislation, yet the government is pitching that as being a bill they are introducing first and foremost for the public's benefit. I would question and ask the minister how he believes, how his department believes teamwork will be facilitated through the introduction of that legislation. I'm aware that at least 13 disciplines are mounting opposition, strong

opposition, to that legislation. In my view, in the reality of what's arising, it would appear that the initiative is having the opposite effect.

I would like to turn now to the performance measures which are on pages 240 and 241 of the business plan. I always read these with great interest and to some degree a bit of amusement, and I would offer as a question but also as a stimulator why this government chooses to measure roughly the odd six, I guess, that are incorporated on these two pages and not others such as teenage pregnancy, waiting lists for GP referral to treatment by specialist, waits for heart surgery, waits for general surgery, why this ministry does not measure poverty in this province, why they do not measure family violence, why there are no measures incorporated for income, why there are no measures for rates of accidental deaths. There are also no measures about employee satisfaction, turnover, or stress leaves, all areas that have been prevalent and increasing over the course of the last three years.

There are also no measures on the very basic necessities of life, like shelter and nutrition. We've had external agencies offer analysis indicating that there are a growing number of children in this province that are not on a daily basis receiving nutritional requirements according to the Canada food guide. I ask this government why that is not deemed as being a realistic measure of performance for this ministry.

Further, there's no measurement of the incidence of professional responsibility, complaint increases. There is no measurement of the grievances, arbitrations, or labour disputes within this ministry, and I would ask why, if your overall objective, as you stated this morning, Mr. Minister, is teamwork, there is no commitment to measure the effectiveness of your policies and to further teamwork.

8:43

Just in a specific sense with respect to the measures that you've provided, I would be very, very interested to know how the percentages are arrived at, what process is utilized for the attainment of these percentages, specifically with respect to Albertans' ratings on the quality of care they've received, their ratings on access to health services, and their rating of their own health. Who performs these measures? Who does the interviews or surveys? Are they done once a year or multiple times a year? I would suggest that the percentage of your findings may fluctuate based on the answers to those questions.

Just again general questions with respect to spending. The minister in his opening remarks talked about the increases, I believe $498 million this year. The way in which things are presented is always relative. When I look at our spending as a percentage of GDP, we are still the lowest in the country. Even if I recall from memory what the Health budget was in 1992-93, when I assumed the presidency of Staff Nurses Associations of Alberta, I believe we were operating at around $4.1 billion, $4.2 billion at that time. So the increases of today are in my opinion band-aids that to some degree are stemming the flow from the artery after the government cuts of the last four years.

Also if we look at the spending per person on health care, we are now, at least at '96 rates, down to $976 as taken from the report of the Critical Assessment Committee of Region 10 Medical Staff. I'm wondering if the minister can provide some explanation as to what that rate is today based on the budget for '98-99.

Also there is no incorporation into the performance measures or the budget of the beds per thousand. We have seen it, since '91-92, drop from 4.12; in '95-96 it was 2.5. That may be incorporated. Perhaps I have missed it. I'm wondering what the bed ratio is in the '98-99 budget.

Also with respect to continuing care beds, again if it is measured per thousand, we've seen that rate drop from 55.7 in '91-92 down to 50, which was the target for '95-96. I'm wondering what that measure was for '96-97 and what it is targeted to be for '97-98.

I would like to move now specifically to program 1 and just raise some general questions with respect to the allocations. With respect to 1.0.2, the deputy minister's office, there's been, I believe, an increase there. Or actually you're maintaining it on par with what it was gross comparable for '97-98. I'm wondering if you can provide some explanations with respect to that.

As well, in 1.0.5, health information and accountability, a decrease there, which I find extremely puzzling, particularly given this government's plan to pursue the introduction of the health professions legislation which will bring about significant changes, obscurity, more complexities in my opinion, yet the overall commitment to providing information and achieving accountability within this budget is decreasing.

Gary mentioned the Health Facilities Review Committee increasing slightly. I would link that to health information and accountability. We do not in a public sense see much in the way of measurement, reporting, follow-up from that committee by this government. I would like to see in the future a summary of that committee's work incorporated into the business plan, a summary of the reviews they've undertaken in the last year, what recommendations they have made, and subsequently what this ministry intends to do to address those issues.

As well, I find it extremely puzzling in program 1 that the Provincial Health Council's budget is being maintained status quo, and I would ask the minister what the rationale is for that.

In general terms I'm seeking some response in terms of all the issues raised, whether in generalities or specifics, as to whether or not this ministry is prepared to consider the broader definitions or incorporation of additional measures into their business plan.

The other matter that is extremely puzzling in program 1 is 1.0.15, standing policy committee on health planning. An increased budget there, and I contrast that to no increase for the Provincial Health Council. Granted, neither are elected, neither incorporate all parties, neither could be said to broadly represent the interests of perhaps employees, stakeholders in the health care system. Why the increase, Mr. Minister, for the standing policy committee and no increase for the Provincial Health Council? Again I find that extremely puzzling. I also find a lack of accountability when this committee meets on a regular basis and again there is no reporting of, in general, what topics are discussed, what business or actions or recommendations are undertaken and provided to cabinet. This is not specific to the Ministry of Health; I would make that statement in a generalized way for all the standing policy committees. I don't believe that if the general taxpayer were to analyze that, they would view it as being a good expenditure of their tax dollars, because there is very little publicly in the way of measurement of their work for the public to see any benefit from.

The capital investment, 1.0.5, for health information and accountability. I'm assuming that that is computer software and hardware. I'm wondering where all that hardware/software is going to go, given the dramatic reductions within the ministry itself, which we will speak to somewhat later.

With the reforms that were undertaken in '96 to the department itself – the reduction in staffing, the whole health information management being privatized or contracted out – why this government would then still see it as their responsibility to pay for the hardware/software is, I guess, a question of prudence and good management. But that was my understanding of what your

reforms were intended to do in '96, and I am wondering whether or not that hardware/software is then going to be utilized by the private firms that are doing that work. Or will it be maintained by the ministry, who will be in fact utilizing that equipment?

That concludes my first set of questions, Madam Chairman.

THE CHAIRMAN: Mr. Sapers.

MR. SAPERS: Thank you. Good morning. Mr. Minister, we're going to go back to the beginning here I'm afraid. I'll just pick up a couple of things that my colleagues have left for me, to do with the goals and strategies. I'm referring to the white book, not the budget book: the business plans of government book. I'm referring to page numbers; that might help you. I'm looking at the Ministry of Health's mission and core businesses as set out on page 262 under goals, 1.1, what Albertans can expect, the first bullet: "Access to quality health services." This has been a topic of discussion now for quite some time, and I note that the registered nurses released some information about their rate of complaints and concerns raised both from a professional responsibility standpoint but also complaints to the AARN about standards of care by patients.

I'm wondering whether or not you're going to factor these kinds of reports and third-party complaint adjudication mechanisms into your goals, strategies, and performance measures. If not, why not? It seems to me that we can take a little bit of comfort from some of these third-party measures. Of course, there's always the suspicion that when the government sets its own goals, its own process for measurement and then determines its own reporting structures, the information might just be massaged a little bit. So it might be nice to see the government's measures contrasted and compared to the measures that are put forward by other groups such as the AARN.

8:53

The next one that I wanted to question you about is under core business 2, the allocation of resources, again in the highlight box, what Albertans can expect: "Consistent and predictable funding for health services." I want to particularly ask you about the strategies listed under 2.1.2 about further developing "province-wide services funding system for highly specialized and complex services." Could you please tell us how you are further developing this funding system? The Percy/Guenter report has been on the shelf now for a while. There was a pretty thorough review, I think, of provincewide services. Some of the high-tech services were left off and were still left to regional funding; others weren't. There are ongoing questions about what was taken out of the regional envelope and put into the provincewide envelope. Could you let us know what the specific decision points are, what the criteria that you're using are for what's in the regional envelope and what's in the provincewide envelope? And if this is an ongoing process – and I expect to some extent it is – could you define for us the frequency of review? Is it upon application, or is it when a group of professionals get a nifty idea and the only place they can get funding is by calling it a provincewide service? Are you dealing with that as well? By the way, I should hasten to add that I'm not saying that's necessarily a bad way to do it. I just want to know if that's the way it's happening.

Under 2.2, "health system makes optimal use of the workforce," there have been some queries already regarding the health professions legislation that's coming and the tension. I can tell you – and I'm sure you know this yourself – that there continues to be a high degree of tension and anxiety in most health care institutions. People are very uncertain about their jobs, very uncertain about not just whether they'll have a job but what the nature of their work will be when they show up for their shift the next day. The goal of an "appropriate supply and distribution of a well-trained workforce" is a laudable one, but I can't reconcile in my mind the messages I'm getting from health professionals across the province and Alberta Health's statement, "Well, we just want an appropriate supply and distribution of well-trained workers." It seems to me the administrators I talk to tell me that they still can't shift properly, that they still don't have enough people, that their overtime budgets are still being blown, that they're having a heck of a time managing sick leave and stress leave and long-term care budgets as well as just filling in the shifts.

It wasn't that long ago, in a monthly shift map I saw at a major hospital in Calgary, that fewer than 12 percent, I think it was, of the shifts were actually filled by the people whose job it was to be in that shift. In other words, over 80 percent, 85 percent of the shifts were being filled by people who were temps or on call or overtime or something extraordinary, and I don't think that's the way you'd want to see our health care system run.

Also, there continue to be the ripple effects of the financial cuts, and one specific example that I would appreciate you looking into is the use of respiratory therapists at the Good Samaritan site in south Edmonton. I'm told that because the budget for respiratory care has been cut by the Capital health authority – and this is still an aftermath or a shock wave of the whole thing that happened with the community rehabilitation program – RTs will no longer be on shift 24 hours a day at that site. That worries me because, as you know, that site has two major units, 15 beds for people who have pulmonary illnesses, respiratory problems. Most of them are ventilated. The other wing is mostly for people suffering from MS. Even in that 15-bed unit there are patients or residents who are on ventilators.

There have been some tragedies at that site. Just in the terms of the acuity of the residents there, Mr. Minister, you may be interested to know that in the three years since the program was transferred from the Aberhart to the Good Sam site, 12 of the original 15 patients have subsequently died. Now, I'm not saying that as a critical assessment of what goes on at the Good Samaritan site. I think it's a fine facility, but what I'm saying is that that should give you some measure of the acuity of the illness the patients are dealing with and that the staff there are coping with.

When you talk about an "appropriate supply and distribution of a well-trained workforce," I can't imagine a situation where it would be more obvious that they would need well-trained RTs on site 24 hours a day. The tension there between RTs and LPNs, for example, when the RTs take two years of postsecondary training specifically to learn their specialities – they're now being told, I understand, that LPNs can be trained to deal with trachs and ventilators and those kinds of things in a two-day orientation session. I'm casting no aspersions on licensed practical nurses, but I don't think even the PCLPN would suggest that two days' training is equal to two years' training.

Under core business 3, ensure delivery of quality health services, the highlight box, what Albertans can expect, the last bullet in the box: "Clear and simple processes for expressing concerns and appealing decisions." The first report of the Provincial Health Council drew this spider's web of the complaint and appeal processes that Albertans face. I will acknowledge that there has been some work to try to deal with that. The largest volume of complaints that I continue to receive in my constituency office regarding health care is that people have clearly identified what the problem is; they just can't clearly identify who cares about their problem. If this is in fact a goal, that there is a clear

and simple process for expressing concerns and appealing decisions, I think that Alberta Health has fallen very short of that goal becoming operational. I didn't see anything in the strategy statements that gives me hope that in this next year that's going to be manifestly different. Now, this is tremendously complicated because of the structure we have, so when I make the critical statement that Alberta Health has fallen short of that goal, I'm fully cognizant of how difficult it will be to accomplish.

Mr. Minister, government policy has created these 17 health authorities and the Cancer Board and the Provincial Mental Health Board and the others. It used to be that people, if they had a serious concern, knew that there was ultimately ministerial responsibility. What Albertans have experienced over this last number of years is a lot of finger pointing. I know *Hansard* can't record when I go like this, but if *Hansard* wants to try, I'm crossing my arms in opposite directions in front of my chest and pointing out into the ether. That's what Albertans see: that it's not my fault; it's somebody else's fault. So I would encourage you to be much more specific in how you're going to change that and tell us what your very specific plans are. It might even be worth while to see the government publish a document that reacts maybe line by line to the Provincial Health Council report.

9:03

Under 3.3, "Community members have opportunities to participate in improving the health [care] system." Under "What Albertans can Expect," the last bullet is "Active community health councils providing input to regional health authority boards." Mr. Minister, I'd like your opinion on this. I understand from my review of the community health councils in the Capital region that they were not informed about the bed shortage, the emergency room backlog, about the press conference that was held on short notice at the University hospital talking about the canceled surgeries. We could go back and we could quote it, but you know the language as well as I do. The way the community health councils were set up, they were supposed to be if nothing else a two-way mechanism for dialogue regarding health concerns on a region-by-region basis, and they were supposed to help localize those concerns. I don't think that it's acceptable at all that community health councils would not be involved in the discussion if not the decision about how that particular crisis we've endured in this last little while has been handled and communicated.

Again, ultimately the legislation under which those community health councils were established is your responsibility, and I'd like to know what remedial action if any your department is planning to take when it comes to how community health councils do their work and how regional health authorities either do or do not utilize community health councils to do the work they were set up to do.

Under Measuring Performance – I'm now looking at page 265 – the first performance measure, "Albertans' ratings of the quality of care they received," I note that the target for '98 is that 90 percent rate it as excellent or good. Currently it's measured at 86 percent. Can you tell us: in your survey do you do a breakdown of chronic users of the system versus occasional users of the system? I was struck the last time I looked, which I believe was '95-96 data, that the typical experience of an Albertan vis-à-vis the health care system was to utilize that system to the tune of about $300 on an annual basis, which isn't really a lot of involvement with the health care system. So for somebody who goes to the doctor once or twice in a year or takes their child to a pediatric clinic once or twice a year, it seems to me that their view of the health care system is going to be dramatically different from somebody suffering from a chronic illness or somebody who's been in a traumatic accident. I'm wondering whether or not your measure makes that distinction.

Under number 3, breast cancer screening rates, I was very surprised to see two things under that measure. Number one is that you're using '94-95 data as the point of comparison, and number two is that in '95 less than two-thirds of women over 50 were receiving their screening mammographies every two years. That worries me. Now, at the same time I say that worries me, I'm encouraged by the fact that you've listed that as a target and that you want to see that increase, but maybe you could tell me what's happened in each of the years between '95 and the target year of '99. How are we building? How close are we to that 75 percent figure?

Number 5, trends in fee-for-service expenditures for doctors as a percentage of total spending. I was amused to see the 1 percent as the current, and I know there have been some other queries by my colleagues about that. Have you specifically looked at the experience in Ontario and in British Columbia and the job action by doctors in those areas and some of the solutions in those areas to determine their applicability if any to Alberta? Can you tell us whether or not the move towards hourly compensation for doctors, particularly in on-call situations to work emergency rooms in smaller hospitals, is something that is being considered outside of the tripartite process? In other words, is Alberta Health working on that as a policy and cutting dollars loose and giving them to the RHAs and saying to the RHAs: "Fine; you've now got a part of that physician pool. Now you go out and hire your doctors to operate." I've heard that that's being considered. I'd just like to know.

MR. JONSON: Can I just ask, Madam Chairman, just so I understand this. I understand the last part of your question about a status report on alternative methods of payment and so forth. I didn't understand your first reference. That is, you said: what are the solutions in B.C. in light of the job action? It would seem that it's apparent that maybe there aren't solutions.

MR. SAPERS: As a result of what's happened in both British Columbia and Ontario, I understand that those medical associations and those provincial governments have come up with some rather innovative solutions that they are at least discussing. I'd like to know which of those you're looking at, and do you feel that they are applicable to Alberta?

How am I doing for time?

THE CHAIRMAN: You started at 8:53; it's 9:11.

MR. SAPERS: All right.

Under "Health Access – Are Services Available When People Need Them?" point 6: "Albertans' ratings of access to health services." I'm particularly interested in the strategies of building to the next 6 percent and why the target is a modest 80 percent. I mean, that's like saying it's okay to have a 20 percent failure rate. Why would we be happy that Albertans' own perception of access is only 80 percent satisfactory? I mean, I don't think we should be in sort of the B minus territory here when it comes to access. The "percentage of Albertans reporting failure to receive needed care" is currently at 7 percent. The target is 3 percent. That's great, but I guess I have a similar question there. I'll be subject to correction by anybody with a calculator, but if we've got 3 million people in the province, it seems to me we're looking at – what? – 210,000 Albertans who could expect not to receive care when they need it. Is that what you're saying, that 7 percent or even the 3 percent is okay?

I'm curious as to why this is a goal: "percent of general practitioner services obtained within Albertans' home region." Maybe you could just explain why this target is a useful one for managing Alberta Health allocation of resources and efficiency and effectiveness.

Under the other health outcomes, point 10 is "Life expectancy at birth." The target is 77 years for males, 83 years for females. Currently it's below that by a couple of years in both measures. I'm just wondering where we've been on the trend line on that over the last half dozen years. Are things already trending upward? In other words, is the target going to be a result of a general trend in North America? I mean, I understand that people generally are living longer, and it's got to do with population health initiatives, the food we eat, and other lifestyle kinds of choices. So I'm wondering whether there's anything specific to Alberta in that kind of measure or whether we're just sort of riding a wave of people in North America living longer.

9:13

There's already been some excellent questions about low birth weight babies. I'll leave that alone.

The injury rate and the suicide rate in Alberta are very troubling to me. Again, I didn't see any really specific statements in your business plan about how you're going to deal with that other than provide support to the institute and perhaps a couple of statements that come at it sideways when you're dealing with provincial mental health. I didn't see anything really targeted to deal with injury accidents and with suicide.

My colleague from Edmonton-Riverview asked you about key indicators, and I would like to underline the request that you broaden your horizon a little bit when you're looking at indicators, including waiting times and waiting lists. I know that you've got perhaps a bit of a difficulty there because of the way the Premier's once-upon-a-time health charter was dispatched, but it seems to me that we could benefit from at least the measures being collected and then reported on. As well, maybe some indicators about some other lifestyle issues could be used in terms of substance abuse, gaming and gambling addiction. It seems that with all of the controversy around things like VLTs, Alberta Health would at least be interested to know how gambling and how substance abuse have impacted population health.

A general question about funding, then I'm going to ask some questions about the Capital health authority, and then hopefully we'll have a chance to come back. The general question to you about funding is this. According to Alberta Treasury, about $940 million is projected to flow to Alberta from the federal government through the Canada health and social transfer. That's the global figure, about $940 million. In 1997 the actual amount received and brought under income by the Department of Health was $528.6 million, but that's a $75 million difference between what was originally budgeted. The original budget figure for '97-98 was $443.7 million, so you're about $75 million off.

Now, my inquiries to the federal government have indicated – and please correct me if I'm wrong – that that allocation is really an internal decision of the government of Alberta. In other words, if you budget for $443 million but end up taking in $528 million, that's because internally the government of Alberta has made a decision to allocate more money. If that's true, then I would like to know why the 1998-99 estimates only call for an allocation of $451.3 million from the Canada health and social transfer when last year you brought into revenue $528.6 million. It seems to me that we've heard a lot of rhetoric that the woes in Alberta are all because of the big, bad federal government and that they cut so much of the Canada health and social transfer. Well, the fact is that Alberta is still getting the better part of a billion dollars through the Canada health and social transfer, and the allocation decision of how that money is spent is largely an internal one. So tell me why you're only bringing into revenue $451 million this year as opposed to the $528 million that you spent last year.

While we're on the topic of revenue, you get $500 million from the Canada health and social transfer and another $640 million – $641 million is it? – from the health care premiums this year, so you've got $1.1 billion, $1.2 billion of money that you could consider dedicated program revenue or a special kind of a tax transfer. That seems to me to be considerably more than many other provinces have at their disposal, considering that Alberta is one of only two jurisdictions that still has a health care tax, called a premium. I'm again wondering about why all the complaints aimed at the federal government. Could you be a little more clear on how you make those internal allocation decisions yourself?

Also on the funding, I'm not sure whether this is best questioned under program 1 or program 2, and perhaps that confusion is part of my question. Where do you allocate all of the money for all of the boards and committees and task forces? What's the plural? Task forci? All of those advisory bodies that have sprouted up – we've got the 17 regional health authorities, we've got the Provincial Mental Health Board, we've got the Cancer Board, we've got the Provincial Health Council. Once upon a time the former Minister of Health gave us a very, very good list – it went on for a few pages – of all of the committees and task forces and working groups as well as a budget number attached to each one of them. I would really appreciate an update on that.

I'd also like to see the administrative breakdown again. I remember a couple of years ago the department issued a press release that trumpeted a real savings in administrative costs. If there's more good news in that regard, I'd ask you to share it. [interjection] I'm reminded: by region. I'm also looking for the latest policy directive in terms of accounting for those administrative costs, because part of it was the accounting issue before. What some regions counted as administration others didn't. As well, how are they breaking out the Alberta Wellnet expenditures on a regional basis? Are those being counted on a project basis, or are they going to be absorbed across the region as an administrative cost?

A question about line item 1.0.12 in program 1, the Mental Health Patient Advocate's office. For several years there has been a suggestion by many people, including the Mental Health Patient Advocate, that they deal with voluntary patients. Can you tell me what's happening in that regard?

When it came to the part of your opening comments to do with doctors, you mentioned a 9.2 percent funding increase to doctors in the hopes of achieving a three-year agreement, and you say that that is volume and price sensitive. In other words, it would give doctors a 5.5 percent increase on their fee guide based on current utilization. So if I understood you correctly, you're saying that Alberta Health's position is that the docs are going to get a 5.5 percent increase. You even mentioned an annualized billing figure, that it would add about $20,000 a year to the annual billing of a physician in Alberta.

Well, that is in stark contrast to what the AMA are saying. Now, part of that I can understand; we're in the process of negotiation. But there is such little agreement between that view and what I read from the president's letter from the AMA: that in fact what Alberta Health is offering is not volume sensitive, does not take into account the complexity of care, the increasing acuity at the community level, the rise in utilization that's driven both because of population increases and because population is getting

older, some of the other social issues that we're facing because of high degrees of stress, some of the addiction issues that I've already mentioned. The AMA is saying that doctors over the three-year proposed agreement in fact would be taking a further reduction in their income earning, and you're saying that it would amount to a 5.5 percent increase or an annualized increase of $20,000 in an average case. I imagine that the truth is somewhere in the middle. It would be really helpful to me if I knew what that middle was.

MR. JONSON: It would be to me too.

MR. SAPERS: Have you looked at the AMA's analysis of your offer? Are you telling me that that's strictly optics because it's negotiation, or have they raised some valid points, and how are you reacting to those valid points?

I asked about the Canada health and social transfer. Oh, I'm sorry. Aslam, you'll have to go back to the top of the second page, I think, because I forgot one of my questions on the general revenue side. Sorry to be jumping all around.

9:23

According to the Alberta Treasury figures the population of Alberta was about 2.65 million back in '93, and at that point the average health care per capita funding was $1,561. If the population is projected to be 2.99 million in '98, the average per capita funding decreases, even with the increase in funding, to $1,497. We've actually gone down about 70 bucks a person in funding, even though the volume of dollars has increased. I'm told that in some regions, because these regions are somewhat encapsulated – you know, they stand alone to some degree – that per capita figure is as low as $900 per person.

Now, if that's the case, then with that funding, if you take a national average, I think Alberta is ninth of 10 now. I think we've gone up from being the 10th of 10 to maybe ninth of 10 in terms of per capita funding. But it means that some of the regions are considerably less than that. I'm wondering how you can reconcile this formula that seems to be emerging: the same money that we had when all the cutting started but more people and less service. You know, we've got some of the longest waiting times now that we've ever experienced. We've got this predictable cycle of bed crunches in emergency wards now. We've got access problems throughout the province for a number of kinds of surgeries. When I was last in Grande Prairie, I was told that they are making provisions to cancel everything but caesarean sections and emergency appendectomies because they won't be able to handle any other volume of surgery unless they get some budget relief. So with this per capita funding being so low, can you tell me how you're going to achieve those access goals and quality goals that we've already talked about?

Calgary-Buffalo has already mentioned that there are some 14 or 15 regions that are predicting a deficit. The government in this budget has just announced deficit forgiveness for all of those regions that had an inherited one. Is the plan to allow regions to deficit finance for a period of time and then bail them out at the end? Is this a way of ensuring some kind of management or accountability, that as long as you keep them really skinny and keep them really hungry, they'll continue to do the real austerity kind of management, and then at the end you'll bail them out? Or is this not a plan? Is this just something that's happening?

Mr. Minister, I'll take a break now.

MR. DICKSON: Madam Chairman, a couple of questions. Mr. Minister, what I want to do is take you to element 2.4.1., health care insurance premiums. I see that you're budgeting for a modest increase in insurance premium revenue, which would make sense given our population growth. What I find curious is that if you look at page 235, the statutory program, and you talk about your health care insurance premium revenue write-offs, it looks like you anticipate a very aggressive program. Your write-offs are down significantly from where they were in '97-98.

So what that suggests to me is that if you've got a growing population and you've got overall an increasing volume of health care insurance premiums being paid, one would expect that your write-offs would increase at least modestly. Yet as I read this, unless Mr. Bhatti tells me I'm reading it incorrectly, it looks like you in fact plan on aggressively reducing the number of write-offs. So if you'd tell me, Mr. Minister: what changes are contemplated in your collection practice for health care insurance premiums? To a significant number of low-income Albertans, this health tax, as my colleague from Edmonton-Glenora described it, is a major concern. If in fact this signals that you're going to become more aggressive in terms of trying to recover premiums, what's it going to look like? What sort of impact is that going to have? How are you going to do it? If you can just give some justification for what I think is a fairly dramatic reduction in premium write-offs. I find that particularly important.

Just jumping over to element 1.0.15, I think my colleague from Edmonton-Riverview had noted that the standing policy committee is looking at an increase in its funding. One of the things I find curious is that I note you have two physicians who sit as ad hoc members of the standing policy committee, and my belief is that the two ex officio physicians then sit in on the private discussions of the committee after the public is excused and opposition MLAs are excused. How is it, Mr. Minister, that you and/or the chair of the committee have decided that it's useful to have two representatives from one health care provider group? It's clearly a most important one, but we have a lot of health care providers in this province, and without in any way diminishing the important role of physicians, it's curious to me that we have only the one group represented around the table, particularly when you have your secret discussions in the standing policy committee. So perhaps you'd be good enough to share the rationale behind that.

Mr. Minister, I'm concerned in terms of the note on page 240, the $3 million that's going to be available for palliative care patients. Now, anything we do to enhance our palliative care program is important and worthy of support, but from my discussions with people involved in long-term care, here's what I think is going to be the problem. You now have had in terms of home care a legislated limit of $3,000 a month for an individual patient. I'm thinking of some cases, a constituent of mine for example, with amyotrophic lateral sclerosis, ALS, who's been fighting to be able to stay in his own residence as long as possible, and the cost of care is often between $2,000 and $4,000 a month. Now, what I've been led to believe is that the $3 million is effectively going to simply ensure that medication, prescription drugs that now would only be available in a hospital, is going to be available in private residences and other forms of accommodation. Very positive, but that doesn't get us very far, so I'm told by long-term care experts, if there isn't provision for care providers.

Now, my understanding is that there's currently some sort of a provincial task force looking at long-term care and so on. But I'm interested in what direction your ministry is headed in terms of addressing not just drug costs but the other costs involved in providing extended home care, in some cases to people who present a fairly high degree of acuity.

9:33

While we're talking palliative care, it's a short hop to long-term care, a couple of concerns there. I was most distressed to discover recently that in the Calgary region with its 800,000-odd residents there are nine respite care beds – nine respite care beds – in the entire Calgary region. Edmonton has 30. At a time when we see a larger senior population, more people presenting with Alzheimer's, with various forms of dementia, the toll on family caregivers is enormous. I must tell you, I couldn't believe it when I was told nine respite beds, so I investigated it further. I'm just astonished that we're not doing better than that.

I'd like to ask you, Mr. Minister: what specific steps does your ministry have under way to ensure that people who are in effect saving the health system enormous dollars by caring for seniors in their own homes can get respite care so they'll continue doing that? We both know that once those family caregivers and informal caregivers reach the end of their resources, it's a much bigger cost to the system overall. So that would be I think really important to beef up those resources.

The other thing. I've had some occasion to be touring nursing homes and a variety of seniors' facilities. It seems to me, Mr. Minister, that we're going to have to do a whole lot better in terms of staff-to-patient ratio. It's unfair to talk about some specific facilities because I think they're probably doing the best they can. I'd like you to address the current ratio that your ministry finds acceptable in terms of staff-to-patient in nursing homes, in places – and I can give some examples – like Bethany in Calgary, some of those long-term care facilities. If you can update me in terms of what level of staffing is found to be appropriate.

The other development that came to my attention the other day. Apparently there's a nursing home which is on the Bow Valley site which is closing, and I encountered some people who were scrambling trying to find a long-term care bed in the city of Calgary because of that closure. Mr. Minister, we both know that there's already a very long wait for long-term care beds in Calgary. I assume that the provincial government in its plan to divest itself of those lands where the Bow Valley centre currently sits accounts for the fact that you've got a number people who have to leave this nursing home and find residence somewhere else. I am wondering what the plans are. We can't afford in Calgary or I think anywhere else in the province to be closing nursing homes. So what immediate arrangements, bridging arrangements have been developed by Alberta Health to assist those people who are now scrambling trying to find a bed somewhere else?

Mr. Minister, I have some issues about mental health, but I wanted to turn specifically to suicide prevention. There are some major problems that have been identified by experts. Some of them I've raised and put to you in the House in question period, but I wanted to share with you some concerns and ask for the specific response of your ministry. One comment is that the suicide prevention programs have found that the regions are too large for either individuals or programs to provide efficient and effective service. Do you agree with that assessment? What are you going to do about it? It's been shared with me that there's no clear commitment from the province or regional health authorities to continue suicide prevention services following divestment. We're only a matter of weeks away from your divestment target. What are you going to do to address that? If the people who provide suicide prevention services are reporting a lack of clear commitment to continue those services, then I think Albertans should have major concerns. We already have an unacceptably high suicide rate, and surely this would be one of the top priorities for your department.

There are gaps in services, such as lack of 24-hour crisis response teams. What are your specific plans in this budget year to address that? The lack of provincial co-ordination and direction has been raised with me. What are your plans to address that? There are limited mental health services for assessment and treatment in rural regions, particularly after 4 p.m. and on weekends. Mr. Minister, what are your specific plans in this budget year to address that for those people who don't live approximate to Ponoka? The lack of psychiatric beds in small urban centres has been identified as a problem. What are your plans to deal with that?

I've asked you about suicide rates among young people and young adults. What the experts tell me is a big need is that there are simply woefully few resources to deal with the 40 to 60 age group in terms of suicide prevention. If you could share your concerns there.

One of the proposals that has been made to you, sir, has been to appoint a task force to establish minimum standards for suicide prevention core services to be provided by each RHA post divestment. Will you tell me why you haven't accepted that, and if you have, will you give me the particulars in terms of what the budget is going to be and what the mandate is going to be for that particular service?

Hopping to page 239 in the budget book, you talk there, Mr. Minister, about refining the "system for funding academic medicine." Would you give us particulars of that? I mean, I have received some information from the two medical schools in the province, but it's not clear to me what you're speaking of in that bullet. It's the second bullet from the bottom in the top section on page 239. Is that something different than element 2.1.6? I assume it is, but I'd appreciate some particulars there in terms of what that's going to look like in this current budget year.

[Mr. Jacques in the chair]

Just getting back to mental health for a moment. Mr. Minister, you recall an exchange of correspondence we had about the woman who had been sexually assaulted at Alberta Hospital Ponoka. The response was that an outside physician, I think an outside psychiatrist, was brought in to do an assessment, and that sort of was the extent of the check and review of your internal processes. I think I've tried to make it clear in our correspondence that I regard that as wholly unsatisfactory. I'm looking for a commitment, sir, that when somebody, particularly somebody who is detained in a mental health facility not of their own volition but by reason of a statute or warrant – when there is an allegation of a criminal offence, in this case a sexual assault, in every case there will be contact with the appropriate police authorities and the Crown prosecutors' office. We both know that Crown prosecutors and charging authorities are always very sensitive to some of the issues in a health context, but surely those are the people that should be making that determination, not internal administrators or people closely aligned with them.

9:43

Mr. Minister, there's certainly been some notoriety with respect to a letter from Craig Simmons of Pincher Creek, who had formerly been involved with the Provincial Mental Health Board, and he has some particular concerns in terms of where we're going with mental health. I'd ask you whether you're now able to advise us which programs are going to be defined as provincial programs and which programs are going to be divested to regional

health authorities and if you'd address the whole purpose of direction in terms of mental health. Because despite the protestations of the Provincial Mental Health Advisory Board and your ministry, we have people, even people who have been as involved as Mr. Simmons and certainly psychiatrists and psychiatric nurses, who still talk about a lack of direction in terms of provincial mental health. So if you could update us in terms of current plans and issues there.

[Mrs. Forsyth in the chair]

Mr. Minister, we dealt in the House the other day with a bill in fact sponsored by our chairperson in terms of human tissue donation, and what I heard many members say was a lack of provincial co-ordination, a lack of provincial direction when it comes to tissue donation. The fact is we're not doing very well in this province in terms of – there is no provincial co-ordinated strategy. While I laud the Member for Calgary-Fish Creek's initiative, my question has to be: not waiting for a private member's bill, what are you and your ministry going to do to provide that kind of provincewide co-ordination? Because I think it's essential to ensure that tissue donation is managed on a provincial basis.

There is currently a sale of organs from the province of Alberta to other jurisdictions. You might confirm, Mr. Minister, that that's done solely on a cost recovery basis. We don't want to see this jurisdiction in the business of harvesting organs for profit, for anything beyond cost recovery. So you might address that.

The 539 FTEs being lost from Alberta Health: can you give some indication of what kinds of positions those people occupied? Where are we losing people from? A gap has been identified by my office recently in terms of trying to do some work and some comparative analysis of teen pregnancy rates. Regions apparently are responsible for collecting the data. Some do. Some regions, amazingly enough, simply don't track teen pregnancy rates. This I think points out the importance of having provincewide information. You may tell me that's going to come from the wellness project and so on, but in the meantime, Mr. Minister, I'd be interested in finding out what steps your ministry has taken or will take to ensure that those key kinds of health indicators are tracked provincially.

That also raises the question in terms of Wellnet. Mr. Minister, one of the things I find interesting is that you have apparently agreed that IBM will own the copyright of the programs they're designing and all Alberta taxpayers are going to get is a licence interest in the technology. Now, IBM, one of the largest corporations in the technology industry in North America, doesn't need help from the province of Alberta in terms of making money. But if in fact we're paying a very large amount – we're talking about several hundred million dollars will go to IBM or the other members of that consortium – perhaps you'd share with Alberta taxpayers why it is that you didn't insist as part of the agreement that rather than simply a licence agreement, we would retain ownership in any intellectual property interests that would be capable of copyright protection, because the consequences could be enormous. I guess the other question, Mr. Minister. You recall a year ago my concern with Wellnet and the dealings with IBM. We had no health privacy legislation in place. The architecture was being designed. Your response at the time was: well, we're not making key decisions; don't worry, Dickson, we'll have legislation in place defining the privacy interests of Albertans before we get too far down the road in terms of developing the architecture for a health information system. While I applaud you for taking the time to make sure we get our health information statute right, we recognize now what's happened is that there will be no legislation dealing with health privacy until the spring of 1999. So I have to come back and ask you: what decisions are you going to now freeze, defer, postpone as part of the design of the health information architecture so that we don't end up in a situation of the cart before the horse? I'm very interested in what adjustments you've made to your program there.

AADAC: I had some questions in terms of methadone treatment, but that probably should be more appropriately put to the Minister of Community Development.

A lot of concerns have been raised with me in terms of subspecialties, and I'm thinking of a concern that had been raised relative to subspecialties in the Capital region. These relate to access to services, access to institutional facilities. There's been a steady decline, particularly in the Edmonton area and northern Alberta, in terms of subspecialties: ear, nose, and throat specialists. I'm interested in terms of the specific kinds of steps your department is going to take to address that, to ensure that those subspecialists are getting the kind of support they require. There's been a concern expressed in terms of aging and outdated equipment, particularly at the Royal Alex. There's been a note made of a decline in clinical resources for residents in undergraduate teaching. It takes a long time to attract subspecialists to the Calgary and Capital regions. There's been a concern expressed by subspecialists, Mr. Minister, that we're not providing that kind of support, and there may be a long-term cost in terms of this being seen as a place where subspecialists aren't welcome and aren't adequately supported.

Mr. Minister, what's the budget for the Public Health Advisory and Appeal Board? When I look at the last report that landed on my desk recently and I look at the terms of reference, the mandate set out in section 3 of the Public Health Act, virtually all of those things are already being addressed by myriad other boards, committees, commissions, panels. It seems wholly redundant in 1998 save for hearing appeals pursuant to section 4 of the Public Health Act, so you might specifically address why we still have a Public Health Advisory and Appeal Board.

There were some other questions I had around mental health and other areas, but I'm anxious that my colleagues also have some chance, so I'll stop there.

Thank you.

MRS. SLOAN: Thank you, Madam Chairman. Just further general questions, then, with respect to program 1. I would like the minister to clarify. Given that we have lacked a medical examiner's report publicly since 1994, I'm wondering if the Department of Health would commit to fund the publication of that report given that the Department of Justice will not. I think those statistics are relevant to the population and health interests of Albertans, and it should continue to be reported. The response of Justice in print has been that it is not published anymore because of budgetary cutbacks.

Further, I would like to have the minister's clarification with respect to the ministry's role in environmental issues: the water and other environmental issues surrounding the Chinook region and the feedlot growth implications there, the Swan Hills recent disaster, the monitoring of those instances, as well as the increased incidence of asthma and airborne contaminants in the Fort McMurray area given the industrial growth in that sector. I'm wondering if the minister could provide clarification with respect to that.

9:53

As well, I see no allocation of dollars, no process outlined with

respect to the Protection for Persons in Care Act. We know, as this was instituted this year, that from the 5th of January to the 30th there were 40 complaints. If that incidence continues, it is going to be an expensive process, and I'm wondering where, if in fact anywhere, the guidelines, the policies, the measures, the dollars are to facilitate that.

Further, we see no mention of the FAS initiative. I'm assuming that Health is one of the partners. Dr. Oberg in Family and Social Services estimates indicated that the department was. What is the role of Health in this process? Will there be dollars allocated? There are none reflected in this budget.

I would like the minister to clarify the department's role with respect to child welfare privatization and regionalization. Again, that process is occurring with the devolution of responsibilities to 18 regions. What will be the relationship of those regions to the health regions in this province? Will there be any overlap? What type of role do you expect to play in that? Will it be a leadership role or a submissive role?

Further, the federal government's announcement today of an initiative with respect to a national home care program: I would like specific commitments and clarification from this government with respect to the role and their commitment to that process. It is unquestionably something the citizens of this province are desirous of, and I would like to have on the record a commitment from this government that they will support that endeavour.

Okay. The next set of questions will be specific to program 2, that portion of the budget. Medical services, 2.1.1, is up to $812.8 million from $746 million, an increase of about 8.9 percent. I'm wondering if the minister could reconcile this item with the highlights note on page 239, that "an additional $96.1 million has been budgeted over the 1997-98 amount." I am in no way, shape, or form attempting to question the value or the emphasis that must be placed on the medical practitioner's role in the system, but there appears to be some discrepancy there.

With respect to 2.1.3, allied health services, this is up marginally. I'm wondering if the minister would specify exactly what that budgetary item includes.

Further, 2.2.3, purchase of vaccines and sera, an increase of $1 million, to $8.6 million. I would ask if that increase includes man-hours and supplies. I recall raising in last year's estimates that the government did not incorporate those things in their increases. They were only paying for vaccines, and the regional authorities had to find the man-hours costs and the supply costs from other aspects of their budget. I don't believe that's prudent. I believe those things should be incorporated in the costs.

Program 2.2.4. Approximately a $400,000 increase in provincial laboratories of public health. I'm questioning if this will be sufficient to cover additional costs for making HIV a notifiable disease under the communicable diseases regulation.

Program 2.2.5. A significant increase in nongroup drug benefits reflecting higher costs for newer drugs. I'm wondering exactly what those new drugs are.

Ambulance services, 2.2.6. I do not recall that the provincial report on ambulance services was ever published. Perhaps I missed it. If it has not been published, I'm wondering where that is at. I'm also wondering whether or not provisions for air ambulances are included in this budget allocation.

Aids to daily living benefits, 2.2.8. No increase. I guess I'm making an assumption, but I would like it clarified. Does this mean there will be no relief for those people who are suffering from incontinence problems, those needing oxygen? It is an area where this government has imposed again a tax called a user fee. I think it is again unfortunate that that is being off-loaded onto individual citizens to address.

The allocations with respect to the regional and provincial health authorities. There is very little change in our assessment in the budget for 12 RHAs. Chinook, Palliser, Headwaters, RHA 5, East Central, Crossroads, Aspen, Lakeland, Mistihia, Peace, Keeweetinok Lakes, Northern Lights: all of those are less than 1.5 percent. That is less than inflation. I'm wondering if the minister could clarify the rationale of not funding those regions on the basis of inflation, which according to the Treasury would be 2.1 at minimum. I'm also wondering how the minister would expect these regions to incorporate collective agreement increases over the next year given the pittance level of increases provided in this budget.

As well, we're looking at increases in Northwestern, Calgary, WestView, Capital, and David Thompson, with the exception of Northwestern, all under 5 percent. Again are salary increases that have been negotiated and ratified incorporated? I would question that.

I would like to move then, as well, to issues surrounding cancer. The Alberta Cancer Board, 2.3.18, is up $3.7 million, or 5.2 percent. Given that the same minister capped administration of school boards, has he ever examined what percentage of the Cancer Board's resources is eaten up by administration? Does the minister believe this to be an acceptable level? How much of this increase will go to actual services and how much to administration?

Further, I would like to ask questions with respect to children's services. How much of the increase in the overall budget or with the RHAs is targeted for the provision and co-ordination of children's services? I'm meaning that in a broad sense. I think the allocation of money for vaccines and sera is a very narrow allocation. Regrettably we do not see this minister funding school lunch programs despite the blatant, blatant need out there for young children, preschool and elementary, not meeting their nutritional requirements on a daily basis. Even with the allocation for vaccines and sera, I would question whether this means health authorities will be able to pay. Or will it be an expectation, as it has been previously, that school boards will be forced to assume some of the costs? Also, I would question what money is designated for the treatment of special-needs school children requiring speech or hearing diagnosis and treatment. Will school boards again have to incorporate costs for these interventions in their budgets, or will parents continue to have to wait or dip into their own wallets for services that are used? Again, I challenge this ministry and the minister with respect to their definition of health and the subsequent allocations for those areas.

Preventing health problems and instilling good living habits will save the province billions of dollars in the long run. Where are the dollars and how much is designated for teaching children about or providing them with programs surrounding family violence, substance abuse, gambling education and prevention, sexually transmitted disease prevention, pregnancy prevention, physical exercise, and diet education? I still see a stark lack of emphasis on that in both the Health and Education ministries.

Further, what funds are provided for the proper diagnosis of attention deficit disorder children, for their treatment, including alternatives to drugs like Ritalin? Could the minister point out where they are? I would also question the minister with respect to his commitment to address the issues surrounding anorexia and the growing prevalence of that within our province.

Just a subsequent question with respect to attention deficit: what are the targets for the number of children drugged with Ritalin across this province? Does the government not believe all possible alternative treatments should be exhausted before we start drugging children? The factual report on that is that the incidence of Ritalin prescription has increased tremendously. I'm not sure if the ministry is tracking that. It would appear that because of

the reduced supports in the education system as well as in the health care system, this is seen as being perhaps the only alternative that people can resort to. I would question that in the interests of the health of our children suffering from this disorder.

That concludes my questions on this set.

Thank you.

MR. SAPERS: Thanks. I understand that we don't have a lot of time left. Mr. Minister, I want to focus in on the Capital health authority first by asking you a question about the population-based funding model. I note the increase.

I know that in total the regional health authorities are going to be spending about $2.3 billion, and the largest health authority by way of expenditure is the Capital health authority. I'm told that in the Capital health authority there are things this year like 26,000 more visits to emergency rooms than there were projected last year, that there are presently 500 people waiting in acute care hospital beds for long-term care beds, that there's a gap between home care assessment and the provision of home care services that's never been longer. So, clearly, the increases that you're projecting will allow the Capital health authority perhaps to do more of the same old thing and in some cases even less of the same old thing but not add any new value, that there isn't really any money in the Capital health authority to take advantage of new technologies or to use different modes of providing services.

10:03

One of the key indicators that leads me to that conclusion is one of your own performance measures about the percent of expenditures on community and home-based services. In '94-95 it was under 5 percent. In '96-97 it was just over 6 percent. It's going in the right direction, but I notice your target overall is just simply for it to increase. You don't have an actual number. So I guess if it goes to 6.31 percent, you'll have achieved your target. I think you'll agree with me that that's not really an appropriate measure.

I would be interested to know what that is on a region-by-region basis. I have not been able to find out that information, and again I think it's a counting or an accounting issue, that not everybody is saying what community and home-based services are at the same time and using the same language. A couple of questions packed in there. One, if that's true, how do we have any confidence even in this 6.3 percent figure? Could you tell us what it is on a region-by-region basis, and are you establishing a set of guidelines or accounting principles for what is community and home-based and what isn't?

I would like a response to what's going on with the $1.5 million that was supposed to come from Alberta Public Works to pay for the operating costs of the disused portions of the Edmonton General hospital. My information from Caritas and Public Works is that that money hasn't come, but the money was cut out of the Capital health authority's budget. So somebody is still paying those costs, and as I understand it, it's Caritas that's paying for those costs out of their agreement with the Capital health authority even though that money isn't specifically contracted in that agreement to pay those operating costs.

There's some pending job action here in the Capital region, the support staff. The situation is barely stable right now in our hospitals. I'm wondering if you can tell us if you were going to give the health authorities, particularly the Capital health authority, any flexibility in their budgets to deal with labour rate settlements so that we can avoid making the situation any worse than it already is.

I'm also interested to know if Alberta Health has established a list of approved charges for services or items. It seems to vary by region. The Capital health authority seems to almost vary by service. Albertans and particularly people who are coming into the Capital health authority are now being faced with a variety of charges, an array of charges that they haven't really experienced before: bed monitors, catheters, other personal hygiene material, the up charges for casting, for imaging agents, for drugs that are nongeneric drugs. There's pressure being put on people in terms of bringing medications into hospital with them, and if they don't, then there's an expectation that they'll have to pay for those even though they previously have been provided through the health facility. So could you tell me if there is in fact a list of approved things that Alberta Health says it's okay to charge for? If there isn't a list, how are you monitoring this?

THE CHAIRMAN: Sorry.

MR. SAPERS: I have one more question.

THE CHAIRMAN: I've already given you an extra, so be brief.

MR. SAPERS: Oh, have you? So I can't . . .

THE CHAIRMAN: Quickly.

MR. SAPERS: Okay. My question is about fund-raising and a list of items that you believe – actually, I'm having trouble phrasing this in five seconds, Madam Chairman, but thanks. Every health authority, including the Capital health authority, has a very ambitious fund-raising scheme. I just received a solicitation letter that talks about absolute basic items that funds are being solicited for. Has Alberta Health set any limits or set any guidelines for what should be coming out of general revenue from the Alberta government versus what health authorities are allowed to go to the public for through some fund-raising scheme?

Thanks, Madam Chairman.

THE CHAIRMAN: Ms Barrett, you have 12 minutes.

MS BARRETT: Thank you.

Are you sticking around?

THE CHAIRMAN: We've got people taking notes.

MS BARRETT: Well, the one question that I have I'm not sure the minister will answer, but here goes. I'll set it off with a preamble. In 1992-93 the budget for health care was $4.133 billion. The current budget is $4.206 billion. That constitutes a 1.8 percent increase after severe funding cutbacks over the previous interceding years. During that time, acute care beds in operation fell in Calgary from 2,550 to 1,845, a drop of 27.6 percent. In the capital region the acute care beds in operation were at 2,935 in March of '93 and as of January of 1998 stood at 1,685, which constitutes a 42.6 percent decline. Acute care beds per thousand population in Calgary: March of '93, 3.2; January of '98, 2.1 per thousand population, a reduction of 34.4 percent. In the Capital region in March of '93 it was 3.34 beds per thousand population. In January of 1998 it's 1.87 per thousand population, a reduction of 44 percent. My question to the minister is one simple one. What more information would it take for him to go back to the cabinet table to bring the funding levels to our hospital system back to the 1992-93 equivalent, which would come to approximately $300 million more for the regional health authorities to operate their hospitals? What more information does the minister need before he will go back to cabinet and ask for that needed money?

THE CHAIRMAN: That's your question?

MS BARRETT: You bet. But I do want it answered.

THE CHAIRMAN: Okay. Do we want to wait for the minister, or is in writing fine?

MS BARRETT: I'd be prepared to wait. I'd like to see if he'll answer it.

THE CHAIRMAN: It's your time.

MS BARRETT: Yeah. Thanks. Is he coming back?

THE CHAIRMAN: I think he is.

MS BARRETT: Okay.

MR. HERARD: Do we get a chance to . . .

THE CHAIRMAN: No.

MR. HERARD: Thank you.

MRS. SLOAN: You know, Madam Chairman, in the public's interest I'd like to hear Mr. Herard's question.

10:13

THE CHAIRMAN: You have before you the original motion that was made at the beginning.

MRS. SLOAN: Right.

THE CHAIRMAN: So this is Ms Barrett's time. She has indicated that with her 12 minutes, she's prepared to wait.

MRS. SLOAN: She has one question. But if she's prepared to wait and there's allotted time, why not use it?

MS BARRETT: Sure. I'd happily share my time, at least until the minister gets back. Okay? Thank you.

THE CHAIRMAN: Go ahead, Mr. Herard.

MR. HERARD: Well, I'm not sure that it's a question, but you know I have a great deal of respect for the traditional role of opposition in democracy. I think that we've had some very good questions here this morning. When the cameras aren't rolling, we get some good questions. But there were a couple of things that really get to the core, that sort of raise my ire a bit, and that's when people talk about Albertans who give their time, effort, and their integrity with respect to some of these committees, in particular the Health Facilities Review Committee that I chaired for a few years.

We get questions and statements like: "What facilities have been reviewed by that committee? They're not accountable to the public." It seems to me that if you're going to make these kinds of statements, you ought to know that all of the reviews they do are available at the Alberta Health Library. Then when I hear an hon. member who says that some of these reports might be doctored up somewhat by these committees, I feel that that's really a disservice to the Albertans who in fact serve on those committees and who care very much about the quality of health care and who care about their own integrity. So I guess I had to make a comment because those people work very hard and do have a great deal of integrity in how they handle themselves in these.

Thank you for your time.

MS BARRETT: My pleasure.

Was the minister advised of the question that I put? I basically only have one question: what does it take to get the full funding restored to account for inflation, population increases, and increases in demand? It comes to about $300 million.

THE CHAIRMAN: She would like that answered with her time.

MR. JONSON: Well, first of all, I believe you were quoting 1992 figures.

MS BARRETT: That's correct; 1992-93 figures.

MR. JONSON: First of all, Madam Chairman, I would acknowledge the member's interest in more funding, and fair enough. However, on the particular statistics, as I understand it, that were quoted from the major figures that you alluded to, I would answer the question this way. When it comes to the overall thinking and consideration as far as the health care systems of the future are concerned, one of the issues that has been, I think, long accepted is that you don't relate the capacity or the ability of a health care system to the number of acute care beds that you have or, for that matter, to all of the other settings and approaches that you had which were always built around hospitals.

I haven't had a chance to check these statistics, but I'm not questioning that side of it. At the same time as there have been those reductions in acute care beds, there has been an increase, just using one illustration, of long-term care capacity, home care. I'm not saying that that shouldn't be added to and extended further. Certainly the number of acute care beds should be reviewed as well. But the whole point here is that the premise of your question, I think, is not in keeping with what we need to be doing with the health care system, and that is: if we have more money, we add acute care beds, that if we had your $300 million, we could add acute care beds. So it's hard. I don't think it's even dealing with the issues facing the health care system to say that we would add $300 million and put it into these things and solve it.

MS BARRETT: Okay. Thank you.

THE CHAIRMAN: Okay. That's it.

Can we have a motion to adjourn?

MR. JACQUES: Thank you, Madam Chairman. I would move that the designated supply subcommittee on Health now conclude its consideration and debate on the 1998-99 estimates of the Department of Health prior to the conclusion of four hours, as unanimously agreed to.

THE CHAIRMAN: Agreed?

HON. MEMBERS: Agreed.

THE CHAIRMAN: Opposed? Let the record show it's been carried unanimously.

I'd like to thank everybody for their participation and being here so bright and early. Thanks.

[The subcommittee adjourned at 10:19 a.m.]