Title: Monday, March 22, 1999 Des.subcom: Health
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8:01 a.m.
[Mrs. Forsyth in the Chair]

Designated Supply Subcommittee - Health

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

THE CHAIRMAN: Good morning, everyone. We're going to start with the motion that is required prior to commencement of our meeting.

> Be it resolved that the designated supply subcommittee on Health allocate the four hours allotted to it pursuant to Standing Order 56(7)(b) as follows:
>
> (a) the minister responsible first addresses the subcommittee for a maximum of 20 minutes,
>
> (b) opposition subcommittee members then have one hour for questions and answers,
>
> (c) government subcommittee members then have one hour for questions and answers,
>
> (d) opposition subcommittee members then have one hour for questions and answers, with the third party New Democrats receiving a block of 12 minutes to be used in either opposition hour,
>
> (e) government subcommittee members have the remainder. In the event government subcommittee members do not exercise their right under this agreement to use this final hour, the chair shall recognize any members of the committee who have questions.

I would invite someone to move this motion.

MR. HERARD: So moved, Madam Chairman.

THE CHAIRMAN: Can I have a seconder? By Gary, as moved by Denis Herard.

I would like to remind you that in order to conclude prior to the four hours allocated under Standing Orders 56 and 57, unanimous consent will be required. Further, obtaining unanimous consent for adjournment prior to four hours would be inconsistent with the undertaking by the House leaders and the agreement dated March 8, 1999. Does anyone want to make a motion about unanimous consent prior to the four hours? No? Okay. Note the time of 8:06 a.m.

Mr. Jonson.

MR. JONSON: Thank you, Madam Chairman, and good morning, everyone. Before I commence, I'd like to introduce to you Alberta Health staff members whom I've asked to join us this morning. On my right is Deputy Minister Don Ford; on my left, chief financial officer Aslam Bhatti. Also with us this morning is my executive assistant, Doug Mills.

Madam Chairman, I'd like to thank you for the opportunity to speak to the Department of Health estimates for 1999-2000. Prior to considering the questions that the hon. members will raise, I'd like to comment on some of the spending highlights as well as some of the tools that we've used to determine many of the decisions and allocations.

In preparing this year's budget, our government has lived up to the promise made by the Premier in February. In his televised address the Premier promised to strike the right balance between fiscal responsibility and sustaining a good quality of life. Madam Chairman, Budget '99, I believe, strikes that balance. It sets the tone for the balanced, responsible, and responsive set of actions our government will take over the next year to make concrete improvements in the everyday lives of Albertans, particularly in the area of health care.

The balanced approach to reinvestment and sound fiscal management in Budget '99 was possible only because of the hard work of Albertans over the last six years to get and keep the province's fiscal house in order. As a result of that hard work, we were able to announce in Budget '99 that total Health spending for 1999-2000, for that fiscal year, will increase by $386 million, or 8.7 percent, over current year projected spending. That's a 15.1 percent increase over the comparable 1998-99 budget announced last February. As a result, Madam Chairman, the total Health spending in 1999-2000 will be $4.85 billion. That means Alberta will spend over $13 million each and every day on health. I think it's important to pause here and just note a very significant fact. This means that we'll now be spending over $1 million more each day than we did last year. In fact, health spending is now more than $600 million higher than in 1992-93, the year health spending reductions began.

The 1999-2000 budget also looks to the future, indicating that in our overall three-year plan health spending will continue to increase. In 2000-2001 it will increase by another $243 million, or 5 percent, and by an additional $306 million, or 6 percent, in 2001-2002. In total, spending will increase by $935 million over the next three years, bringing us to a total annual expenditure of over $5.4 billion in 2001-2002. Madam Chairman, that means that total health spending in Alberta will rise by 21 percent compared to 1998-99 forecast expenditures, or 28.2 percent as compared to the 1998-99 budget. This, I believe, is a very significant investment in Alberta's publicly funded health care system. The additional funding announced will be directed to addressing issues and areas of need within our health system. The extra resources will be focused on hiring additional frontline staff needed to provide frontline services, especially in long-term care, home care, emergency wards, and high-demand acute care areas.

Total funding for health authorities will increase by $261 million from the 1998-99 forecast expenditure, an increase of 9.2 percent. This will bring the total Health spending on regional health authorities this year to $3.1 billion out of the total of $4.85 billion. This additional funding will ensure that each regional health authority receives at least a 3 percent increase in addition to increases for projected population growth for the coming year. Funding for health authorities will now make up about 63 percent of total health spending in the coming fiscal year. With the addition of province-wide service funding, the Capital health authority alone at $977.8 million accounts for 20.1 percent of Alberta Health's spending, while the Calgary regional health authority at $899.9 million makes up 18.6 percent.

After health authorities, spending on all practitioners services at $1.04 billion, or 21.5 percent of the Health budget, is the next largest component.

Madam Chairman, several of the decisions leading to this year's

budget for the regional health authorities corresponds with the final report of the health system funding review, which was released last fall. As you will remember, I asked the hon. Member for Calgary-Bow as chair and the hon. member for Peace-Wapiti to lead a special committee to conduct a comprehensive review of funding for Alberta's health authorities. The health system funding review looked at key funding issues with a particular focus on base funding requirements of the health system over three to five years, including the impact of changing population demographics. The final report made a number of recommendations on how to improve the funding for health authorities with an emphasis on providing predictability, sustainability, and continued confidence in the system.

Last fall our government responded immediately to the report's recommendation to increase funding to the regions to compensate for population growth. In addition, we accelerated our investment in provincewide services. The remaining recommendations received a comprehensive review, giving our government some clear direction as we proceed with the Health budget and planning process for the next three years and resulted in part in the new funding announcement. In fact, Madam Chairman, all of the recommendations contained in the final report of the health funding review are being addressed over the next three years, as was recommended in the report. The increased funding will give health authorities the capacity to deal with reasonable inflation in their costs and meet the demand for more services from an increasing population.

However, this Health budget is not just about dollars. It's also and perhaps more importantly about results. The increased health spending will be directed to the addition of 1,000 permanent frontline health positions in the coming year. This will increase the capacity of our health system, especially in areas such as acute care, long-term care, and home care. The two largest regional health authorities, Capital and Calgary, will see close to 75 percent of the increased staffing levels for this year. We realize that frontline staff have experienced pressures as a result of the increased demand for services from an increasing population. This additional funding will go a significant way to addressing these difficulties and result in enhanced access to health services for Albertans.

Meanwhile, Madam Chairman - and I think this is important to note - expenditures on administration will continue to be monitored, with the expectation that they will decline or remain the same. Health authority funding also includes an increase of $30.1 million, or 13.3 percent, for provincewide services, those key lifesaving procedures performed primarily in Calgary and Edmonton. This will increase major surgeries such as angioplasties, coronary bypasses, craniotomies, cardiac valve procedures, bone marrow transplants, and kidney dialysis treatments. While this increased funding goes to Calgary and Edmonton, all Albertans benefit from the increased number of services. This increase is in addition to the $20 million, or 9.7 percent, that was provided last fall in response to the recommendations of the Laing report.

8:11

While these funding increases will enable the regional health authorities to enhance frontline services on a daily basis, we also need to ensure that the health system infrastructure is being maintained for the longer term. Over the past few years we haven't seen an adequate investment in capital equipment to maintain ongoing viability. As a result, this year's budget responds to a recommendation of the review report to allocate some additional funds to reinvest in capital equipment. Increased funding for health authorities, therefore, will also include an additional $15 million to help replace essential medical equipment. Members will note that in years 2 and 3 of our plan, that will increase to $25 million.

Other funding highlights of the Health budget include an increase of $18.5 million, or 12.5 percent, for mental health, including $5 million to better integrate community services and funding for mental health throughout the province; an increase of $5.6 million, or 7.5 percent, for the Alberta Cancer Board; $10 million for a health innovation fund, as recommended in the review committee report. This is designed to encourage innovation and improvement and particularly the management and delivery of our health care services. I think this particular availability of money presents a great opportunity for the system, which has within it many forward thinking people and planners that can come forward with initiatives to improve and modernize and reform the overall operation of our health care system.

The budget highlights also include onetime funding of up to $33 million to health authorities where it is demonstrated - and I emphasize demonstrated - that funds are required to ensure that medical and health equipment is year 2000 compliant. I emphasize "demonstrated" because the government has already committed $170 million to the Y2K problem or issue. I'd also like to note for members of the committee that this issue had to of course be dealt with, but it has certainly taken away from government's ability to spend on and address many of the renovation and capital construction needs within the health care system.

The budget includes an increase of $4 million to jointly fund the cost of providing faculty and support staff in the two academic health centres. This is in addition to the $4 million provided last fall in response to the review report. An increase of $49.9 million, or 5.8 percent, is there for physician services. This additional funding reflects the provisions of the government's contract with the Alberta Medical Association, including adjustments to reflect actual population growth and the increasing number of physicians in the province. This will enable a 2 percent fee adjustment to be implemented April 1. Spending specifically on physicians now makes up almost 19 percent of total health spending in Alberta.

There is an increase of $3.2 million, or 32 percent, to the rural physician initiative program to continue to enhance efforts to recruit and retain physicians for rural Alberta and to fund the rural on-call program. An increase of $24 million, or 10.8 percent, is being made to the $245.3 million for the Alberta Blue Cross benefit program to reflect the increasing costs of new drugs and increased use of drugs. This is certainly, Madam Chairman, a very rapidly increasing cost of health care throughout the country.

In addition to the health system funding review report, this year's budget responds to another important review of our health system, the long-term care review, which is currently underway under the direction of the Member for Redwater and which also has as a member the chair of the seniors secretariat, the Member for Calgary-West. It is developing long-term strategies for our aging population in Alberta. In response to questions posed by myself and advice received, this year's budget acknowledges in a preliminary way the work of the long-term care committee. We are launching a new $6 million program to help support the cost of drugs for short-term acute care patients in a home setting. It also includes an additional $9 million to address other recommendations that are anticipated from the committee's final report later this year.

In addition, the health summit, held at the end of February, was an important step in bringing together health authorities, health providers, and members of the public to look at ways to improve our current system and to build the framework for the future of health care in Alberta. Already we know there are some key themes that emerged in the discussion of the four key questions that were asked of participants, and these include the following: individuals want access to a publicly funded and administered health care system

when they need it. Secondly, changes to the delivery and management of the system should include emphasis on community and primary care. Thirdly, there should be recognition that we each have a responsibility for our own health, but we also share the responsibility for the health of our communities. Fourthly, while health summit participants agreed that there are no easy answers over the long term regarding how much funding is enough for the health system, the budget does address many of the priorities and ideas that came out of that particular very important gathering, the health summit.

Madam Chairman, most participants said that much more work needs to be done to develop answers on the issue of funding, and as that work progresses, they also said that Albertans need more information about the costs and impacts of these decisions. Overall, the health summit ended with the challenge to all parts of the health system to work together to bring forward workable solutions that will ensure the viability of our future health system. The recommendations from the health system funding review, the long-term care review, and the health summit provide a solid foundation for not only the new budget but also for future health policies and services delivered to Albertans.

These health funding increases included in the budget meet a number of this government's commitments. Madam Chairman, the Premier was very clear in his commitment to match funds made available by the federal government. Following through on that commitment, our government has matched the additional federal funding of $192 million to be provided in '99-2000. As I noted earlier, in the following two years health spending in Alberta will increase by $243 million and a further $306 million in 2001-2002, for a total of $549 million. I think that it is important to note that almost all of these increases will be funded by provincial revenues; that is, in the second two years. The federal government contribution covers only $53 million of the further $549 million increase in the two years.

With the '99-2000 budget, our government is also following through on our commitment to address health system pressures by increasing resources where they are clearly needed. We have done so for the past four years, and we will continue to do so to ensure Alberta's health system is there when Albertans need it.

In addition, our government's commitment to an accessible, publicly funded health system remains strong. The Health business plan for 1999-2002 specifically states:

- Alberta will continue to be part of a publicly administered health system that guarantees universal access to medically necessary hospital and medical services without user fees or extra billing.
- [Our] health system will continue to provide benefits in excess of Canada Health Act requirements.

Madam Chairman, I think it's important to emphasize that last week's budget announcement does not represent a new or different direction for health spending. For four years now we have increased health spending and focused that spending on patient care, and we have continually stated that when there is a demonstrated need for additional resources in health, those resources will be provided. The new funding in last week's budget together with those made over the past four years are clear evidence to our government's commitment to a quality, publicly funded health system in Alberta. While significant new funding is being provided this coming year and over the following two years, it is absolutely essential to clearly understand that there are limits to the dollars that can be provided.

Madam Chairman, this year's health budget reflects the largest increase in government spending over the next three years. By the year 2002 health spending will be one-third of government program spending, compared to about one-quarter in 1992. The cost of health care in Alberta currently exceeds the total amount of revenue received from personal income taxes. Health costs are also growing at about twice the rate of the average long-term growth in government revenue. If health costs continue to increase at current rates, health spending will crowd out spending on other priority areas such as education.

So in concluding, Madam Chairman, I want it to be very clear that the health funding increases provided in the budget we are discussing today as well as in the two years following are very, very significant in the context of the overall revenue and spending picture of our province. I also want it to be very clear that while as a government we're committed to addressing priority areas such as health and education, we also remain strongly committed to the principle of fiscal responsibility. In other words, as the Premier said in his televised address in February, Albertans want to see their government strike the right balance between fiscal responsibility and sustaining a good quality of life and a good health care system. The new budget I think overall achieves that goal, and in health care we are certainly making a major effort to maintain and improve our health care system.

Thank you for the opportunity to share some opening remarks. We now are available, of course, for questions.

8:21

THE CHAIRMAN: Thank you, Mr. Minister.

Who would like to start?

MS LEIBOVICI: I would.

THE CHAIRMAN: Okay. Ms Leibovici to start. The time is 8:21.

MS LEIBOVICI: Thank you, and thank you for the opening remarks, Mr. Minister. I followed very closely your comments, and at the outset I would like to say that I will only make a couple of remarks in general and then go specifically into the budget. The reality is that I have a large number of questions that have been forwarded to me either through meetings or through letters from Albertans across the province as well as observations that myself and colleagues have made with regards to the different regional health authorities across the province. I would like to bring those questions forward so that there can be answers provided.

At the outset what I would like to say is that it took almost 18 minutes, Mr. Minister, for you to mention the words: publicly funded health care system. The concern that Albertans have with regards to our public health care system is a huge one, and perhaps if the minister at the outset indicated that the government's commitment to public health care was first and foremost, that concern might be alleviated.

My second comment is that there is, of course, a responsibility to be fiscally accountable, but the reality is that the health care system is not only what we can afford but also what our values are with regards to health care and with regards to the vision that we have for a healthy Alberta and healthy Albertans. Not everything in this world can be measured by a monetary value.

My third comment is with regards to the outcomes or the results. The outcomes of Health should be an improvement of health, not just a provision of services. Again, in your remarks you seemed to focus on the provision of services as opposed to the outcomes or the improvement of health of Albertans.

The fourth comment that I would like to make is with regards to a comment you made on the budget and the health summit. Somehow you tied those two together. It was my understanding from the health summit that individuals there could not answer the

question with regards to: how much could we afford? They felt that there was not enough information there and that that was an inappropriate question to be asked. In fact, they felt that there was the responsibility and onus on the government to provide that. So the tie-in that I heard - and I'd have to read the *Hansard* to look at it more closely - was tenuous at best.

A fifth comment is that you indicated that in 1992 the expenditures were one-quarter of the health care budget, that in 1999 we're now at one-third. Perhaps if the province is looking for a reason, if the government is looking for a reason as to why the increase in costs is there, they have to look at themselves and their method of management. In fact, it takes a whole lot more to rebuild something that has demolished than to renovate, as was the original metaphor that was used by this government in the so-called health care reforms.

I'd like to move into program area 2.3, which is the regional and provincial health authorities, and I have some general questions and some specific questions as well. I will just run through the questions. I don't expect an answer from the minister today. I do, however, expect something in writing to come from the department in as quick a manner as possible.

My first question is with regards to the job descriptions of the CEOs across the province. What we would like to see is what they are, whether they're standard across the province, and any recent postings that have been put forward with regards to the job descriptions of the CEOs. We would also like a breakdown of the costs of board members and chairs of boards, and this is for all the regional health authorities as well as for the community health councils. There is no line item in the budget that indicates what the cost of the community health councils is.

We would also like to know what happened to the surplus dollars that individual hospital boards had prior to the reorganization in 1993. Where did those dollars go? How were they accounted for? In particular as well, what happened to the equipment that was in each of those particular hospitals that were closed down? Are they being mothballed somewhere? Were they auctioned off? Are they being utilized, and if so, where are they being utilized? As part of that review of the dollars and the equipment, what was the breakdown of those dollars and equipment that was put forward by volunteers and donations to the individual hospital boards, and where have those dollars gone? In particular, if we look at the Myrnam hospital, as one example, my understanding is they had a surplus of $256,000. They now have no hospital, no equipment, and no services.

With regards to the boundaries of the regional health authorities, what is the plan of the government to review those boundaries, especially in light of an upcoming election in the next two years? Is the government in fact planning to hold to their commitment this time of electing the regional health authority board members? Also, what is the plan for an ombudsman? It has been recommended on a number of occasions by either summits and different other groups, and what is the government's plan with regards to an ombudsman?

Specific to 2.3.6 - and I will jump around a little bit - the David Thompson region, I looked in Public Works, Supply and Services and did not see any allocation for that region for capital improvements or renovations of the Red Deer regional hospital. I would like to know. Perhaps the minister can point me in the right direction as to where those dollars are, or if the dollars are not forthcoming, perhaps he can explain why they're not forthcoming with regards to the hospital. I know there are very explicit concerns with regards to 37 W and north. I've taken a tour of the hospital, and it is not, I believe, to a standard that we want to be proud of in this particular province.

Item 2.3.7, East Central. Mannville has requested reinstating health care services to pre January 1, 1998, levels, and I would like to know what the minister's response is and whether the minister can explain why those residents feel they are not being represented by either the community health council or the regional health authority. They have been told explicitly on certain occasions that if they have any concerns to talk to a liaison between the board and themselves. I do not think that is appropriate.

If the minister can also explain: where do the residents of Mannville go when they need to obtain services? It seems that they are shuttled between Vegreville and Vermilion on a daily basis.

8:31

WestView, 2.3.8. We know that WestView has been chronically underfunded because of the formula, that the minister is not prepared to fund so they can come out of that deficit position. Does the minister have any plans to ensure that WestView can provide the services that are required?

This is a general question that can apply to WestView or East Central or David Thompson or any of the primarily rural RHAs. What is the acceptable distance for placement of loved ones? It's my understanding that 100 kilometres is what is being deemed as acceptable. I'd like to know if that's the minister's standard as well. Perhaps we can address that a little bit further when we're dealing with long-term care, because that's an area that I would like to address as well.

Lakeland, 2.3.12. We note that there are significant problems, environmental problems in the northern part of the Lakeland region around the Cold Lake area. What is being done to ensure that there is water there that the residents can drink? This is not a problem for study. This is a problem for action. What immediate action is the minister taking in conjunction, perhaps, with other ministries such as Environmental Protection, Public Works, Supply and Services to ensure that there is at least drinking water? The other issue, of course, I'm sure the minister is aware of is with regards to the needs for livestock and crops.

Again under Lakeland there is a question as to - there was a board from the Lakeland regional health authority. There were recommendations. There were recommendations from the Cuff report. I have not seen what the final recommendations are. The administrator that has been placed in charge by the minister is implementing recommendations that are in neither of those two reports, so where are those recommendations coming from? What is the current position of the acting CEO? That is a concern that is being raised as well. Has that position been posted, and if so, what is the appointment process for that particular position?

Huge concerns around St. Joe's in Vegreville and the fact that the third floor - the proposal is that it is basically deleted. There are, I believe, 15 patients - if that's not the right number, I'm sure that the minister will inform me of that - who are there, although that is an intermediate level of care, I understand, because there is no place for them to go with regards to long-term care. If that third floor is not operational, then the reality is that the acute care beds get backed up and you have a situation that occurs in that area where you may not have access for acute care services.

A question around - and this may be a general question as well - specifically Lakeland as to the funding of the hospitals within the Lakeland region. Is there a standard funding formula that all hospitals within a regional health authority receive, dollars that they can count on, or are hospitals treated differentially within regional health authorities? As I said, Lakeland in specific but I would also like to have that question answered in general.

There seems to be a singling out of the faith-based hospitals in

Lakeland. Is that a conscious effort, or is that just happenstance? In the new organization plan that is being put forward by the administrator in Lakeland, it appears that - and I may not have the right names for the positions - the unit supervisors who are hands-on nursing staff are being eliminated. In fact, what is happening is that there will now be a nursing care supervisor who will not perform hands-on work. So in fact though there are supposedly 30 positions that have been eliminated out of Lakeland that are administrative, at least 10 of those are hands-on frontline staff. I would like for the minister to explain that and to explain whether that is a control issue to ensure that again the faith-based hospitals are not directly accountable or under the control of the central regional health authority.

Specifically with regards to Myrnam, they were promised that they would have a nurse and a lab tech at least twice a week. There was an agreement made between the regional health authority and the residents of that particular area. The question is: how binding are those agreements that are made between regional health authorities and residents, and are there any opting out clauses? What is the ability of the regional health authority to break a promise of providing service? As you all know Myrnam was one of the first hospitals in Alberta, formed in 1938.

The final question on Lakeland: why are there no central diagnostic services in the Lakeland area? A suggestion: perhaps Myrnam could be a pilot project, with regards to their status.

Mistahia, 2.3.13. Could you just indicate what the status of the MRI there is?

Mental health is a huge concern in the Mistahia area with regard to the ability to provide services, with regard to the co-ordination of services, the ability to refer. If I can just use Valleyview as an example, they have for a long period of time asked for a social worker to be located in Valleyview on a full-time basis. Their early intervention individual is doing social work, which is not what she is supposed to be doing. There are extreme stresses in the area, and there is a need for a full-time social worker there.

Also with regards to the long-term care side of the Valleyview hospital, there is a need to open up the long-term care beds. The facility is there; it is available. It is a matter of funding, and now with the extra dollars there I would hope that the region would look at providing for the additional beds in the Valleyview hospital.

A general question around what happens to individuals who are in acute care beds but are waiting for a long-term care bed. My understanding is that when they have been accepted for long-term care, they pay as if they were in a long-term care bed, even though they are on the acute care side. My question is: do they get a discount? The reality is that they do not get the services they would get in long-term care. They get fed; that is true. They get a spot to be cared for, but they do not get the stimulation, they do not get the extra activities, and they do not get the rehab that they would get if they were in the long-term care bed side. So I would hope that the government is not assuming that that is the full level of care and that they are paying the full cost when they are not receiving that level of care.

Northern Lights, 2.3.16. A couple of comments around long-term care, which is becoming an issue in that region. As the population is becoming older, more individuals are moving into the area who are older and have long-term care needs as well. As in the Mistahia area mental health is a huge issue as well.

8:41

Program 2.3.4. I know that my colleague from Calgary-Buffalo will have more questions around the Calgary regional health authority, but with regards to the capital costs - and this is the with regards to the Edmonton regional health authority as well. The capital costs that are required to maintain, sustain, and improve the facilities as well as the equipment I don't believe are adequate in the budget. What would be helpful is to know what the plans are for all the regional health authorities with regards to the capital costs, what their submissions have been to the government as to their needs? That goes back also to the Bonnie Laing report, where it's indicated that there needs to be a plan in place and an overview and that those issues need to be addressed in a comprehensive manner.

An issue with regards to Calgary is: how many sites and contractors is Calgary currently leasing with to provide public health care in private facilities? Who owns the space, and what's the cost of those services? What is the Calgary regional health authority's strategic plan, and how is it communicated to the staff?

The organizational charts - and again this is a specific as well a general - for all of the regional health authorities would be helpful to be provided as well. Having not looked at the organizational for the Calgary regional health authority, I'm not sure that this is the case, but why is the Rocky View hospital excluded from the organization's charts, and is there a VP of finance or a financial administrator for the Calgary regional health authority?

Another specific as well as a general question. To be able to see the line-by-line budgets of the regional health authorities throughout the province, and what arrangements can be made by either staff or by the public to go to - it may not be realistic to have multiple copies made because we'd like to save some trees, environmental purposes. Where can these line-by-line budgets be accessed? This is the public's money that's being utilized, and it would be helpful to see how those dollars are being utilized.

The contracts between private clinics and regional health authorities, specifically in Calgary because that seems to be where the leading edge is with regards to this particular issue. What is the cost of those contracts? Is there a cost saving, and how is that actually measured with regards to there being a cost saving? There was the recent study by the Consumers' Association of Alberta with regards to eye clinics that seems to indicate that the private clinics in Calgary are not efficient and not effective. I would like to know what studies the department has done with regards to eye clinics and any other clinics that have been contracted with, specifically as well with regards to the laboratory clinics. What are the cost savings there, and are there any potential conflicts between those who administer, manage, and provide the services in the Calgary and Edmonton area?

Physiotherapy and the provision of physiotherapy services. It seems that it's different in each regional health authority. How is that determined, and how is it assured that individuals receive the same standard of care with regards to physiotherapy services? Also, how does the government ensure, whether it is physiotherapy services, eye clinics, or any other clinics that are privately run, that there is not in fact double billing, in a sense, occurring, where the public sector is being billed as well as the individual? What are the systems that are in place to ensure that the fraudulent billings that we've seen with HMOs in the States do not occur in this province? There are many examples of that.

How is the $3.4 million that was allocated to mental health services in Calgary being distributed?

There's a huge concern still around the General hospital, as you're well aware. There's a concern that there's been no audit of the dollars from the surplus of the General hospital. That pertains to one of the earlier questions I asked as well as to the hospitals and hospital boards and foundations that were originally across this province before the reorganization. Where have those dollars gone, and how are they being accounted for?

A question with regards to the General. Again I'm looking

forward to any information or illumination on these issues. The regional health authority, it's my understanding, received $4 million for the sale of the General hospital.
We know that that facility was worth a lot more than that.

MR. DICKSON: Holy Cross I think.

MS LEIBOVICI: Holy Cross. Sorry. Holy Cross.

That was not sold at market value. Was there an audit that was done with regards to that particular sale? Also, we know that the Calgary regional health authority is in fact renting back space from the Holy Cross. How much is that costing the regional health authority in renting back space?

Why was $9 million spent on the Calgary regional health lab facility in '98-99? In that that facility is now supposedly privately run, why are we spending public dollars on that particular facility?

In 2.3.10, Capital regional health authority, I'd mention the issue around the backlog of outdated equipment, the capital equipment and that there are problems with that. In the issue around information systems - and this is also a general issue for the regional health authorities - there is a requirement for ongoing replacement over a four to five year period. In the Capital region alone it will cost about $63 million. Where in the budget is that? I don't believe it's under information systems either. Is that being accounted for?

How is the proportion of nurses and health care professionals decided, nurses specifically? The Calgary regional has a larger proportion of nurses, I understand, than does the Edmonton regional health authority. How are those decisions made? Is there some standard of nursing care per patient population that is required across the province?

Back to some general questions. If you can provide us with the details of the regional health authority innovation fund, who will be reviewing the proposals, and will it be an independent board? Who will make the decision as to who is on that independent board?

In terms of the population-based funding proposal, is the department now using those population projections for the population-based funding proposal? Is there a demographic breakdown for this population projection? What happens if an RHA submits a deficit budget? We know that WestView will be in that position. Calgary potentially will be in that position. How many regional health authorities under this new budget do you expect to be providing a deficit budget, and what are your plans around that particular issue?

Also, just to hop back to the Calgary regional health authority, this is an information question. Are the funds administered in Calgary for the Provincial Mental Health Advisory Board and the Alberta Cancer Board flowed through the regional health authority, or are they given directly to external bodies as they are in Edmonton? What are the reporting requirements for the funds?

There are a whole lot of other questions that I have to ask, but I will let my colleague from Calgary-Buffalo continue on. Then I have many more questions to ask.

Thank you.

MR. DICKSON: Good morning, Mr. Minister. Let's start with the Calgary Laboratory Services. There were some questions asked earlier; I have a couple of related concerns. After touring the facility a matter of months ago, I was surprised to find that Calgary Laboratory Services off 10th Avenue is operating out of two trailers behind the building there. I understand there's an excellent chance they will not get the accreditation they need to be able to do the kind of laboratory testing that's expected for people in southern Alberta. They were asked some questions in terms of the unique private/public partnership there. I'm interested right now in terms of simply how we get accreditation, how we're able to adequately manage laboratory testing in the Calgary region. You have some laboratory work being done out of the Foothills hospital and then the rest out of a facility which seems to be clearly inadequate. So when is that going to be resolved and how?

8:51

Let me turn for a moment to the Alberta Children's Hospital. You remember, Mr. Minister, that a presentation was made in mid-December of 1998 to the standing policy committee indicating that for this facility, which is hugely important to children in southern Alberta and in fact eastern British Columbia, there is an identified need for $30 million to $35 million. The request to you had been whether you were prepared to make a commitment to half of that in your three-year business plan. This was the same group that pointed out to you that Calgary has the fewest number of child mental health beds of any major centre in Canada, approximately 20 including the three just opened crisis beds. Edmonton has 54. So when you tell me what your response has been to that request for improvements and changes to the Alberta Children's Hospital, you might indicate specifically what we're doing about the mental health beds.

You remember that I pointed out to you a year ago how unsatisfactory I thought it was that because we had inadequate beds, we had children requiring psychiatric attention who were not able to find a bed in the psychiatric unit at the Children's Hospital being kept on a general ward with a security guard, a hired security guard sitting beside the child. I need assurances, Mr. Minister, that that will never happen again, that we're going to have a sufficient number of pediatric mental health beds that these children are going to get the kind of attention and support they need.

Just while we're talking about mental health, Mr. Minister, the Provincial Health Council produced that report in December of 1998 that you'll be very familiar with. I'd just ask you simply: given the identified lack of leadership in mental health reform in this province identified by your own handpicked Provincial Health Council, how are you going to resolve that? Where's that leadership going to come from? When are we going to see it? How much longer are people in this province requiring mental health services going to have to wait, for what seems virtually without end, for a reform process? The $3 million that's been recently announced to go into Calgary regional as I understand it will do little more than fill two vacancies. We, I think, need six people in forensic mental health in the Calgary region. I understand that the dollars are going to go basically to filling those vacancies. I assume but perhaps you can confirm whether that's part of element 2.3.19. Is this part of the 12.4 percent increase announced in the budget?

I guess related to that, in the Provincial Mental Health Advisory Board's last newsletter they talked about the children's mental health initiative. They said that there was a draft plan that was going to be finalized and to you by the end of March of this year. Now, have you got it? What are the recommendations from that children's mental health initiative, and when are you going to act on them? When are we going to see an adequate number of beds?

While we're on that, Mr. Minister, I have to go back again and say: how much longer are we going to have people in Calgary - I'm talking about adults now - having to wait as long as nine months to see a psychiatrist? When is that going to change? What length of time is acceptable to somebody who is in crisis, maybe not openly speaking of suicide but with serious mental health issues? The companion problem is: why is it that the 8th and 8th clinic still does not have a psychiatrist on staff, often does not have a registered psychiatric nurse, may have a counselor that can do little else other than a quick assessment and a referral to the Rocky or the Peter Lougheed?

Mr. Minister, your department has that map of Calgary which shows that the highest concentration of people with acute mental health needs live virtually within walking distance of the downtown core. It was your government that dismantled the excellent mental health facilities at the Holy Cross and the Bow Valley sites. The reality is that those people are not taking the C-Train and the two buses to get to the Peter Lougheed hospital. They're currently wandering the streets of downtown Calgary. I don't raise this simply as a parochial issue as a downtown MLA. The same kinds of reports happen of people wandering the streets in northeast Calgary. Par of that is no doubt because of curtailed access to inadequate mental health facilities, so I've got to know what the plan is and when we're going to see that resolved. That may be part of the lack of leadership identified in the Provincial Health Council report.

Just while we're speaking of that, we've seen the budget halved for the Provincial Health Council, so, Mr. Minister, you might just help me understand what's happening here. We've seen the mandate of the former Public Health Advisory and Appeal Board now restricted so that it processes only appeals. Even though there was no advocacy and leadership being provided there, at least in the statutory sense there was a vehicle.

The Provincial Health Council appears to be in the stage of being wound up; we see the reduction in the budget. I don't expect the answer this morning, Mr. Minister, but specifically before we vote on your estimates for the Department of Health, you might tell us: what precisely is the plan for the Provincial Health Council, and who's going to pick up the slack?

You've been asked by Edmonton-Meadowlark in terms of the plan to expand the mandate of the Ombudsman. That's fine, but presumably we're not looking to the Ombudsman to provide leadership in terms of evaluating and identifying weaknesses and so on. The opposition is happy to do it, Mr. Minister, but you don't always take the good advice you get from the opposition. If there's somebody else you're prepared to trust and invest with some legitimacy, then perhaps you could share with us just who that might be.

Mr. Minister, moving on, December 15 was also the day that you had presentations from radiologists and chiropractors in this province. There were a number of requests made. There's an issue there. I've been waiting and perhaps I missed it, but I didn't hear how you and your department plan on resolving that issue between radiologists and chiropractors. I hold no brief for either group, but I do have a concern. If this plays out for impaired access to that important diagnostic tool in any centre in this province, that's unacceptable. So you might tell me perhaps what you've done to resolve that issue between radiologists and chiropractors and just how that's going to be manifest to the rest of us. Also, there was to be an accreditation in the Calgary region by the Provincial Mental Health Advisory Board. Has that been done? If not, why not? If so, what recommendations for change as a result of that accreditation?

The Calgary region deficit is estimated to be $23 million now, after your budget announcement. Perhaps you could tell me just what services will be cut in the Calgary region to enable them to balance their budget. I'm not at all clear what we're talking about in the Calgary region, Mr. Minister. The additional money that's going to the Calgary region: is this going to be funded like school funding, where it's in dedicated envelopes so that the local region loses the flexibility to be able to put the money where they think the region requires it?

9:01

MS LEIBOVICI: It's a question for all regions.

MR. DICKSON: Quite. My colleague fairly reminds me that this is not an issue for the Calgary region alone at all.

There is this issue in Calgary, though, where we've put off capital upgrades, equipment repair, equipment replacement. My colleague touched on this. The Calgary region anticipated $40 million as what has to be required on an annual basis to ensure that equipment isn't falling down and becoming obsolete and ineffectual. I don't know at all, Mr. Minister, from your budget announcement whether all of that $40 million estimate will now be met, whether moneys can be spent on $40 million worth of upgrades. If not, what kind of assessment have you done? What kind of criteria do you use? If you've got a region spending a billion dollars a year, plus or minus, it would seem to me that there would be a formula, that a reasonable portion of that must go every year to make sure your equipment is still operating. So I need information from you in terms of what kind of flexibility is going to be afforded the region to deal with those things.

Long-term care, continued distress in this province. We waited two years for the answers in terms of long-term care. I have to tell you, Mr. Minister, that it is very disappointing with the announcement that that report is going to be delayed until November 1999. I say that because you know darn well you had the input before November 1998 from every health region in this province. You had input from seniors advocacy groups. You had input from gerontologists, from the experts. You knew what had to be done, and what you've done is embarked on a so-called consultation.

I went to one of the consultations in Calgary, and the effect of that was having a group of seniors concerned about what's going to happen to them and their care in the next six months, 12 months, 18 months invited to look 10 years down the road. Why didn't you bring out an interim report at minimum? You're prepared to commit $15 million, including $6.2 million for expanded drug coverage and another $9 million, to make up the $15 million, for other anticipated recommendations. Well, if there are recommendations that you're prepared to commit $15 million based on, is it not appropriate you share that with Albertans so we can test whether that corresponds with the kinds of needs identified by seniors advocacy groups and people delivering services in the health care field?

Just getting back. The so-called consultation that's going on now, since it appears to be designing a system when guys like my age need it, that should be absolutely no reason why you can't produce an interim report now so that we're able to evaluate this money going in in terms of whether it's meeting the kinds of needs.

Mr. Minister, I've had the opportunity to look at at least some of the recommendations you've got. When are you going to announce an increase in the $3,000 monthly limit available for home care? I know what recommendation has been made to you, and I just want to know when you're going to tell us that that's going to be expanded. It still makes more sense to be able to discharge seniors from an acute care hospital to their own apartment or their own house rather than waiting for them to go into a long-term care bed. Why is it we don't have convalescent beds, not only in Calgary but throughout this province? Why is it we have this system it seems we've now moved to almost by default where you either occupy an acute care bed or you're in a long-term care placement? In Europe, in a host of places, they have a broad range of convalescent care beds that provide short-term stabilization care before people can be returned back to their own apartments. Surely that makes economic sense. It respects the dignity of these people, and it's a measured, targeted response which we don't seem to be seeing now. So, Mr. Minister, I need to understand why that isn't happening.

Y2K. You told us quite candidly a year ago that the amount of money going into Y2K compliance - you did not know at that time what the cost was going to be. This money was put forward to start addressing the problem. I know that in the Calgary region they've

gone through and determined that all of their - how can I describe them? The sort of life-essential or life-threatening issues with acute care equipment have been tested, but a lot more has not been.

Presumably now, Mr. Minister, you can tell us precisely what the total cost will be for year 2K compliance, because it seems to me we're being a bit unfair with the RHAs. You announce some money, but you say: we don't know what the extent of the problem is. Then when they start diverting funds intended for patient services into Y2K, I hear complaints from Alberta Health saying: that's not what that money was intended for. Well, the regions are put in impossible positions. If they're to be Y2K compliant, then they've got to do the work. So you might tell us what our status is right now. Have each one of the 17 regions been able to ensure that all the life-support systems and those machines and equipment - I'm not talking so much diagnostic tools but pacemakers and those kinds of things that are essential to ensure that nobody dies, infusion pumps, that kind of equipment. Has all of that now been certified Y2K compliant? If not, how much more remains to be done? I need that overall assessment. What's the total projected cost from now right until January 1, 2000? In terms of pacemakers, we need some specific figures, because that's a big impact in terms of hospital beds, acute care beds. Anyway I'm looking forward to that information.

Why no increase in Aids to Daily Living, 2.2.8? My office gets a disturbing number of calls from people who are having to fight for incontinence supplies and oxygen. We know the population is growing. Your people doing the consultation around long-term care with Community Development have put the charts up projecting all of this increasing aging population. I don't see how it does not follow that there would have to be significantly more money available for Aids to Daily Living.

Mr. Minister, when I look at your business plan, to be able to respect the dignity of people who need incontinence supplies, why is it that people have to phone their MLA to have to lobby to be able to get an adequate supply? We continue to have significant problems there, and this is an area where frankly I'm distressed. I see no increase. Now, if you've got some other plan for dealing with that, I sure want to hear it.

Incidentally, we talked about some of the presentations made last December to your standing policy committee. You know, I've had an issue in the past. My caucus had an issue with health dollars desperately needed on the front lines. It's $89,000 last year. You're proposing to reduce it to $85,000. It's good to see a decrease, but what accounts for that? Why do we continue to build in money for your standing policy committee to hear submissions when we've got so many frontline needs going unmet?

You know, the Premier made a big thing about reducing MLA salaries before starting to chop nursing positions in the province. What happened to that notion of elected people first when it comes to all the other health care needs?

The 8th and 8th clinic. The use of that clinic is way higher than initially projected. What are you going to do about that? More disturbing is the fact that the 8th and 8th clinic is not serving the people who live in downtown Calgary, that huge immigrant population, that huge senior population, that huge number of people living in low-income housing. The reality is the 8th and 8th clinic has become a convenience for people living in suburban parts of the city who come downtown and happen to work downtown, and it's a darned sight faster to get care at 8th and 8th than it may be to pay a visit to the emergency ward at one of the three adult acute care sites. So I want to know specifically what the plan is so that you're going to be able to serve that high-needs community downtown that currently, for whatever reason, is not using that facility. That was the initial intention: we're going to close both the acute care hospitals in downtown Calgary, but we're going to beef up CUPS and create this 8th and 8th clinic. Well, we seem to have missed something in the transition. Now that we've had some experience, I want to know what the plan is to come back and deal with that.

9:11

I think I've mentioned before: why is it that we don't do psychiatric treatment downtown? The 8th and 8th clinic expanded and modified ought to be able to do that. The simple assessment and referral isn't working, and I'd mentioned that before.

I know I've got colleagues with lots of other questions, so I just wanted to quickly ask about the business of patient privacy. We've been told that the daughter of Bill 30 is going to be reintroduced in the spring session of the Legislative Assembly. The simple question is this. The very high standards of patient privacy protection that were codified in the Canadian Medical Association policy in this respect at their meeting, I think in Ottawa, last summer is the standard that I think Albertans would want to see maintained and respected. My simple question to you, Mr. Minister: is that standard going to be reflected in the daughter of Bill 30? Since this is such a complex area and I'm not sure it's realistic to expect you're going to be able to bring in a bill, pass it, and enact it in the next number of months, I'd like to know, all of those patient privacy concerns that have been basically suspended because they've been excluded from FOIP by regulation, how much longer are the patient privacy concerns going to be left in sort of the nether land? At what point are we going to ensure that there's a high level of concern?

That sort of, while we're talking about privacy issues, leads right into Wellnet, Mr. Minister, and perhaps you can share with us how much has been paid to the IBM consortium at this stage with respect to Wellnet. There just continue to be concerns. We see the $400,000 increase going into Wellnet. [interjection] Well, it's a substantial increase going into Wellnet, and I don't have the appropriate page in front of me right now. All of this is happening, but we still don't have health information legislation.

You were very frank in telling me a number of years ago that the rules would be in place before the system was imposed; in other words, the major architectural decisions for the health information system weren't going to be taken until we had the rules in place. At that time you may have expected that Bill 30 would have been quickly passed, but here we are a couple of years later. The IBM consortium is continuing apace, presumably, designing this system.

Can you confirm that still no significant architectural decisions have been made with respect to the health information system? Because we still don't know what the rules are going to be, and it may be opposition paranoia, but there continues to be that concern that we don't have the rules in place. Is there going to be a rigorous analysis of Wellnet in terms of what's going to happen there? What's the profit margin of the IBM consortium that's providing Wellnet services? We have a number of questions related to that, and I think one of the biggest parts is just finding out where we're at with Wellnet now.

One of the questions that was put forward was the number of hours of direct care given to patients before cutbacks and now. If you're looking for benchmarks, what would be a better benchmark than doing a contrast between the number of hours of direct patient care before the cutbacks and the direct now. We might use the example, make it real easy, Mr. Minister, of ICU, and let's talk about what the difference is now, because I think Albertans want to know that. Tell us what the number of full-time equivalents of staff were before cutbacks and currently.

Continuity of care was an issue certainly in long-term care reports, so if that's the kind of advice you're getting, are we respecting that

kind of advice in terms of the operational decisions made? Certainly, we'd want to know the number of direct full-time equivalents in direct patient care now and before the cuts.

What are the statistics with respect to overtime, sick leave usage, and stress leave now, currently, and before the cuts? What sort of evaluation has been done in terms of the cost to the system with things like the impact stress has on caregivers? You might confirm rumours I've heard that the Calgary RHA has paid something like $25 million in sick leave. If that's the case, that's a staggering amount. If that's the wrong amount, you might tell us exactly what the amount is.

How much money is being raised by hospital foundations? Mr. Minister, you and I were at a thing put on by the Calgary health foundation a number of months ago, and this was when the woman from the U.S., the public speaker, said that those of us who oppose change were dinosaurs, a message that I'm sure you were anxious to embrace. But the context was disturbing, because we have all these well-intentioned, public-spirited Calgary corporations raising staggering amounts of money. How do you ensure, Mr. Minister, that that money only goes for extras? How do you ensure that that money is not being used on the kind of thing we regard as essential to our public health care system, equipment and things like that? It sure sounds to me that the need grows and people are coming forward anxious to help. How do you avoid the temptation, Mr. Minister? How do you discipline yourself to ensure that it's still seen as a public responsibility, not a charity initiative to provide those kinds of needs?

Are there any plans to disband the Crossroads region, region 9, given the ongoing, persistent conflict between Drayton Valley and Wetaskiwin concerning equity of funding?

There's no mention in the throne speech of publicly provided services. You talked about publicly funded and administered. Can we look forward to even more contracts between RHAs and private providers? Are those contracts going to be made public? Even if you should claim that there are third-party business interests involved and you wanted to protect the names or whatever, which is a questionable assumption, surely Alberta taxpayers are entitled to know how much and for what kinds of services.

Mr. Minister, how do the health councils operate? What dollars are allocated? What's the relationship, if any, to the respective boards? What are the outcomes? How measured?

9:21

In Calgary you'll remember that for a long time we kept on looking for those advisory councils like they have in Edmonton, which are done on a sort of geographic basis. Finally the Calgary region announced that the advisory panels they had were going to operate on a sectoral basis, but we haven't heard much from them, Mr. Minister, and how you're monitoring whether that's working.

There's lots of concern around aboriginal health. There was a provincial report completed over two years ago. When are we going to see specific initiatives? Has there been an evaluation done of specifically what's going wrong, what needs are not being met in the area of aboriginal health?

Now, in terms of acupuncture, I received some information I found pretty fascinating. I was astonished to discover, Mr. Minister, that the committee in Alberta Labour that's setting the competencies and practice standards doesn't have people who are accredited acupuncturists on it. The majority of people on the acupuncture committee do not have degrees in acupuncture or TCM. Some don't have any degree, not even a diploma. This has been raised by acupuncturists who have extensive training in the People's Republic of China and in other places where there's a long history of practising this. They're astonished that not only were they excluded from the health summit but the registration system seems to be seriously flawed. I know that these concerns have been brought to your attention. In fact, I've raised some of them with both you and your colleague from advanced education.

How are you going to ensure that acupuncturists currently practising who don't meet the requirements set out in the competencies and practice standards for acupuncturists will be allowed to continue to practise? Is it going to be a requirement that those who are already registered have to upgrade their skills and knowledge within a certain given time? Would it not be a good idea to ensure Alberta Labour selected people with the highest possible training in acupuncture since they're regulating the qualifications for exams and practice and education in acupuncture. It also raises the question of how you ensure that your colleague in his department of Alberta Labour is more open and accountable as the actions to the acupuncture committee ultimately affect the health of the public.

There's an issue around death certificates. As I take it, Mr. Minister, you've taken the position that you have no responsibility for death certificates, that someone else does. I understand you're suggesting, Mr. Minister, that you're the one that should be responsible for administering the health information legislation rather than, for example, the Minister of Labour, who currently does it wherever FOIP is going to end up. It would strike me that you'd be the more appropriate person to be dealing with death certificates, and if you're looking to expand your mandate or that of your department in dealing with an entire range of health information, why is it that you wouldn't be responsible for death certificates?

There were concerns that have been raised . . .

THE CHAIRMAN: I'm sorry. Your time's up.

MR. DICKSON: Thanks, Madam Chairman. Thanks, Mr. Minister.

THE CHAIRMAN: We now have a government member, and we have Mr. Pham to start off.

MR. PHAM: Thank you, Madam Chairman. I would like to begin by discussing the government commitment to the publicly funded health care system. As my colleague from the opposition mentioned earlier in her speech - she complained that it took the minister 18 minutes to mention the publicly funded health care system, and she also raised questions about the fear some Albertans have regarding that commitment. I share some of that sentiment as well. I have heard some comments from constituents regarding that, but after talking to them, most of those things are just rumours and, I guess, fear that people have for no well-founded reason.

When you look at the total budget of this government, more than 30 percent of the total spending is dedicated to health care, so that is a very strong commitment. I would ask the minister to do whatever he can and the members of the opposition party as well to make sure that the right message is being sent to Albertans, because it is not fair to spend 30 percent of the taxpayers' money on health care and at the same time there's misinformation out there.

I also want to talk about striking the right balance. That is the approach your ministry is trying to achieve. But look at the total spending in health care. It has gone from 25 percent of the total budget spending to 30 percent. I and many other people fear that that rate of growth is not sustainable and wonder if that is the right balance in the long run. Health care, even though it is one of the most important priorities of Albertans, is not the only priority. If it continues growing at the rate it is growing, how can we as a government find enough resources to address the other areas of public need?

It could beg the question that I think was raised at the health summit: how much money is enough? What will your ministry do to ensure that a sustainable solution is found to ensure that the money required for health care and other programs is there? Comparing what we are spending today to the year 1992-93, before the restructuring, we are spending $600 million more, and many constituents of mine would like to know what we have achieved with that additional money. How much more do we have to spend to satisfy the requests of the regional health authorities?

On the human resource side the additional funding we put into the system is aimed at hiring a thousand more nurses in Alberta, and people are also aware that in Ontario they are trying to acquire 12,000 more nurses to meet the increasing demands in their province. Do we have enough qualified nurses in Canada to fill all these positions? What action do we have to take if there are not enough candidates to fill the positions as required by the system?

Moving on to another area - that is, the regional health authorities in the province - is the ministry planning to conduct a management audit of all these regional health authorities to ensure that the money being spent is being used appropriately? In the long run, people today feel that we should have more control over how the money is being spent, because sometimes no matter how good the policy is, the people who implement it can certainly screw it up if you do not follow up properly.

My next question deals with the Y2K situation. Have we done a systemwide simulation pass across the province? If we have not, then when are we planning to do so?

9:31

The next issue I want to touch on is contract negotiations with the AMA. Every time during contract negotiations with the AMA we begin to hear horrible stories about the treatment of patients and about the health care problems we are facing. After that contract is settled, then everything subsides for a while, and it will resurface again during the AMA negotiations. I will probably make a friendly bet with the minister that the same process will happen at the next round of negotiations with the AMA.

One thing that really bugged many of my constituents is that even after we went through those contract negotiations, there are still members of the AMA who do not agree with the terms of the contract. If you recall, we had that problem with the baby doctors in Calgary. I just want to ask you, Mr. Minister: do we have any measures to ensure that every member of the AMA has to follow the terms of the contract that we have negotiated in good faith with them? If not, then what action should be taken against those people?

One of the last questions I want to touch on is the problem of rural doctors. I understand that we have a shortage in that area, and we are trying to spend money to recruit doctors to serve in rural Alberta. However, I have talked to at least two Canadian citizens who got their training in medicine from foreign countries before they emigrated to Canada. They brought a very serious situation to my attention. They passed the qualifying exam to become doctors again in Canada, but the policy we have now is that every one of them has to go through the two-year internship training in the hospitals. Many of these people have practised for as long as 20 years as medical doctors in other countries. They passed the exam. They don't mind taking the two-year internship training in a hospital environment. The problem is that there is no position for them to do that. That is a waste of money because some of these doctors end up working in other fields.

When I talked to the deans of medical science at both the University of Calgary and the U of A, they indicated to me that they have the ability to take in additional trainees if they have the proper funding. If you look at the amount of money we need to put a physician like that through a two-year internship, it's a lot cheaper than if we train a physician from the beginning. I would like the minister and his ministry to take a hard look at the situation and come up with the best way to utilize these people at the same time saving taxpayers tons of money.

Thank you.

THE CHAIRMAN: Mr. Minister, under Standing Orders you have the ability to answer questions if you choose to. Do you want me to go on?

MR. JONSON: I would like to first of all, Madam Chairman, just indicate that there have been many specific questions raised by members. We will undertake to reply in written form as we have in the past.

I would just like to touch upon about four or five issues that have been raised. The first one perhaps is just a kind of general one. The comment - I think it was the first questioner's remarks - with respect to a publicly funded health care system. Looking at my notes, I mentioned that very early in my remarks. As you know, when you make a speech, if that's what it was I was giving, you either put it at the beginning or at the end if you want to have emphasis and priority given to it, and I certainly emphasized it at the end of my remarks.

One point I'd just like to touch upon, Madam Chairman, is that in a number of the questioners' remarks, particularly the first, there were various specific questions raised about regional health authorities. In those questions there were two things I'd like to respond to. First of all, there were several references to the regional health authority funding formula and how that operates. I'd just like to emphasize that the funding formula is applied the same way to all regions in the province. It is not a secret formula. We do have a recently produced overall funding formula manual, and we're certainly prepared to share that information. If any members are interested, Alberta Health staff would be quite prepared to sit down and go through it.

The second thing in this area of the regional health authorities is that various references were made particularly to the Lakeland regional health authority. I think it's important here to note that the Lakeland regional health authority for a number of years now has benefited from being grandfathered with the budgets that they had when they entered into the region, which, when you added everything up, were several millions of dollars higher than they would have been entitled to under the strict application of the formula. Now, that decision was made by government, and I'm not expecting the people of Lakeland or their representatives to in any way feel guilty about having had that additional funding over the last three or four years. The reason I raise the issue is that they have been well funded even relative to our funding formula in this province. So the frequent references that seem to be made and the questions about there being a lack of funding really is not, I think, a correct conclusion to reach.

The other thing is with respect to, again, several references to Lakeland. We do have an official trustee that is acting as the board currently. In my view, the better controls on administrative expenses and some of the changes that are proposed are designed to improve the overall operation of that regional health authority.

A second area I'd just like to touch upon briefly is the references to Y2K. As I indicated in my opening remarks, we as government overall have taken the Y2K issue very seriously. Hundreds of millions of dollars have been devoted to that very important issue. There is a careful audit trail being prepared as we look to see that the money is being spent for the purpose for which it was intended and

that we are covering all possible bases with respect to this looming deadline that we have at the end of this year. In addition to getting the job done, which is important, we are also very careful in producing a record of where we spent it and how and so forth. The book I saw the other day is about so high. I can't say that I've read it, but it is there.

The third point I wanted to raise is that there have been references to the overall area of mental health, and I take some issue with the conclusions that are reached. We have a number of initiatives under way in mental health, one being the design of an improved overall plan for children's mental health. We have for isolated rural areas of the province a telepsychiatry project, plus we do know that in areas such as Mistahia and Northern Lights there is need for more community service there. We hope to be able to announce the transfer of our whole mental health clinic structure over to the regional health authorities in at least eight regions within a couple of months.

9:41

There were several questions raised with respect to the overall issue of capital equipment and capital expenditure. Quite frankly, with respect to this year's expenditure on capital projects such as Red Deer General, which was raised, Madam Chairman, I do not see us being able to make major progress this year with respect to capital construction. As I've said, we have a commitment to complete with respect to the more immediate Y2K issue, not that the capital projects aren't very important and in some cases highly needed, but we do have to address with the resources available the Y2K area.

One other comment I would just like to make before concluding these very brief remarks, Madam Chairman, and that is that there were references in the speaker's remarks to this whole area of surpluses that a foundation or a regional health authority might have had and there were references to deficits. Historically I think it's important to point out that regional health authorities retained and were able to use any surplus that existed within the hospital boards or jurisdictions that were put into that region. On the other hand, when our financial situation improved - I think it's a year and a half ago now - we paid off all the debts that were inherited as those regional health authorities were formed. So that, I think, is important to note.

I'll conclude my remarks at that point, Madam Chairman.

THE CHAIRMAN: Thank you, Mr. Minister.

Dave, please.

MR. BRODA: Thank you, Madam Chairman. The minister has answered some of the questions and made comments, as well as my colleague from Calgary-Montrose, but I do have a couple of comments and maybe questions here on frontline staffing of 1,000 for acute long-term care and home care. I presume it would be not only nursing but also any caregiver that would be required within the regional health authority's requirements. That would be the question I would have: what are they going to be; who are they going to be putting in? But that's I guess up to them.

Comments were also made earlier that the long-term care has been delayed until November 1999. It hasn't been delayed until 1999. The mandate is to be completed by 1999. As a result, some of the discussions we've had or discussion papers we had given to the minister have already resulted in palliative care drugs that were implemented on February 1 of this year for in-home use. So that is one very positive thing that I see in there.

We're also looking at additional funding of roughly $15 million into long-term care, which would be other recommendations and some drug utilization or strategies that we're going to have. So that to me is a very positive note.

I do have a question also on the rural physician action plan and was wondering how it's been working throughout the province, if the minister can make a comment on that. I think it's been well received in any rural areas which it's meant to be for. However, like I say, again there is a shortage of physicians in rural Alberta, as the Member for Calgary-Montrose indicated. How are we attracting physicians? The question I would have is: are they coming from urban centres to fulfill some of the needs in rural Alberta under the action plan?

All in all, I'm certainly pleased to see some of the results of the budget that has been put forward. I'll just close on that.

Thank you.

THE CHAIRMAN: Mr. Minister, do you want to respond to that?

MR. JONSON: Well, just very briefly. Certainly we very deliberately wanted to recognize that there were staffing needs, in our view, in a variety of areas, although we also note that the largest single component of need would certainly be registered nurses. There's a whole team out there, and there are shortages everywhere, from custodial positions in some cases to registered nurses. The important thing for the regional health authority is for the people managing the system to be able to put the staffing where it's most needed.

With respect to rural doctors, yes, it's been successful. We've recruited about 85 additional doctors. I would like to indicate that across the system we're also trying to recruit physicians, and it is a very competitive market right across Canada and across North America. We are short in some areas such as anesthetists and psychiatrists, and that is an ongoing challenge I think for every province in this country with the exception of British Columbia in terms of shortages.

THE CHAIRMAN: Thank you.

Mr. Jacques.

MR. JACQUES: Thank you, Madam Chairman. At the outset, Mr. Minister, I should mention that my constituency is Grande Prairie-Wapiti, not Peace-Wapiti.

MR. JONSON: I was trying to give you high profile there.

MR. JACQUES: At the outset I just want to express my appreciation and thanks to you and to your staff with regard to the overall issue of health and health care. If ever there was a demanding role in terms of our government, it's in the area of health care, and I want to thank you for the leadership you've brought to the portfolio and, I think more importantly than anything, the care you've brought to the portfolio. I say this sincerely in terms of what I've observed and particularly what my constituents have observed.

There are some specific issues that I would like to raise with you in terms of some comments and some questions, some of which are not necessarily for answers today but rather as we proceed through time, particularly through the balance of this year.

As you know, I had the honour of serving on the Bonnie Laing report back basically in the summer of 1998. As you may recall, Dr. Clarence Guenter, Doug Schindeler, and Mike Percy were also on that review committee. I'm pleased to see that many of the specific financial recommendations of the 27 total recommendations are included very specifically either in the announcement back in October or, more specifically, in the business plan you've tabled in the Legislature. I would suggest that it might be appropriate at about

a year's anniversary - and I'm using October as a round date, if you'd like - to issue a progress report or an update report with regard to the 27 recommendations. Bearing in mind that many of the recommendations are not financial recommendations but do tie into some very specific things, in particular, involving the regional health authorities, I think it would be helpful to all of us if at that point we had a kind of snapshot of where we are in relation to those recommendations.

The second issue is with regard to Wellnet. As you know, there were some comments of caution, if you like, that were contained in the Laing report, and you're also aware that there were some comments offered by the Auditor General with regard to Alberta Wellnet. Again, you have mentioned it in your opening remarks, and it is addressed in general terms in the business plan. I would suggest that perhaps some specific game plans as to how some of those specific issues particularly that the Auditor General raised - from an accountability process point of view, it would be appreciated if those could be reported more fully at a later date.

Also, with regard to the issue of regional health funding, which you've touched on and which you've also clarified in one of your subsequent remarks, that it is, if you like, an open process in the sense of how RHA funding is determined on the formula basis. Having said that, there have been some questions raised since the budget was released - depending on which particular region you happen to be in as to whether the comments came or not. Some fundamental questions have arisen out of the region that I'm in, which is Mistahia region 13, a very large region geographically - I'd use that as an example - where they received 5.7 percent. There were only three regional health authorities that were below that amount, therefore there were 13 that were above it.

9:51

The overall range on all the health authorities was from 5.4 to 11.8, depending on where you were on the scale, but quite a few in the 7 to 8 percent range. In this particular case again as an example, if I look at Mistahia at 5.7 percent and I look at - and let me pick one that is a major city like Capital, for example; just bear with me for a minute, I just want to refer to the percentage - Capital at 7.1 percent, it does beg the question: why is Capital significantly higher when it doesn't include tertiary care or provincewide services, which are separate, and so they should be, in terms of the funding? In other words, the funding we're seeing there is obviously related to primary care, secondary care, and those others such as long-term care, et cetera, provided in the region.

The only reason I draw that particular comparison for comment or explanation at some later date - again, I come from a very high growth area, probably a higher growth percentagewise when compared to Edmonton, for example, or the Capital region, and understanding the formula, particularly the many components of it, I know it can't be answered just off the top, but I think it would be helpful if on some of these, in fact I assume on most of these, you could quantify the dollar increase in particular areas. It may be, for example, the import/export, whatever the net impact of that is in each of those regions. So even a columnar approach breaking out the key components I think would be helpful to all members in terms of understanding the relationships between the regional health authorities in terms of the funding.

In terms of provincial health expenditures, one of the things that was identified in the Laing report was funding on a per capita basis and where we stood provincially as well as in terms of adjusting for, if you like, demographics across Canada and doing a comparison at that point as well as taking the Alberta demographics and comparing the four western provinces and the province of Ontario. The results of that were quite significant in the sense that it showed that if we were looking at strictly a Canadian relationship, in terms of the demographics again, adjusting for that, we'd place third across Canada. If we took a look at the four western provinces and Ontario and applied the Alberta demographics between each of those other four jurisdictions, we were first.

The question, I guess, that arises out of that is: in terms of adjusting for those things that really drive the cost factors in the health care system, age being of course one of them, and with a significant amount of funding that we're projecting and committed to in terms of the health care system and all its facets, why are we not seeming to be able to do more things with less dollars? I guess that's one of the fundamental questions that philosophically can come out of that. Is it a question of sparsity, for example? Does sparsity enter into this issue in terms of the demographics?

I'm not sure it necessarily does, because you could take the same demographics adjustment and it would not necessarily relate to or take into account a very sparse or distributed population. It's one of those questions that's out there because we've started down this path of kind of comparing, on the one hand, per capita, which we know is not very meaningful; on the other hand, we've adjusted those per capita for some of the things that make sense in terms of those things that relate to health care. But there are some other components out there that somehow also affect that comparison, that we really haven't perhaps got a handle on today.

With regard to long-term care, the report - and I'm referring to the Bonnie Laing report at this point, not the long-term care report - there were some projections in there that indicated that based on just an outlook on the aging population, which all provinces and indeed all of Canada and the United States are looking at more and more as we get closer to this wave of older people, including myself, that are going to be hitting the over-age-65 category and what the impact of that is going to be on our health care system, as we look at the long term, if I look at the simple data, which in the report suggests that over the next 16 years an additional I believe it's in the order of 9,000 beds would have to be generated, on a simple average that's over 550 beds per year starting this year. It's obviously not a simple calculation, even if that were true, in the sense of when that may happen. It's not a question of 550 a year. But what it does say, even if that number is lower at the beginning and higher later on, while it's not in our budget but extra years are in our business plan for the next three years - it begs the question: how do we go about planning in terms of not only Alberta but the adjacent provinces.

I believe strongly in the Canada Health Act, and I believe strongly in the ability of Canadians to move from one province to another, to take up their residency when and if they see fit. It could create a dilemma for those provinces, as the years unfold, that are very aggressive in this area. They become in turn a magnet, if you like, compared to those provinces that aren't at the same degree of advancement. How do we deal with that issue? Again, it suggests not a province, not something next year, but something that's almost national in scope in terms of the planning that's required by the 10 provinces on some unified basis to achieve some specific targets that are comparable and reasonable amongst all the provinces.

The last one is a similar issue in a philosophical sense. You talked about it briefly, and that is the physician shortage, particularly the distribution of physicians and their shortage throughout the province. Again, I come from a specific area, and I'm now referring to the secondary hospital QE II in the city of Grande Prairie and the adjacent area, which is finding it not impossible but next to impossible to get additional physicians.

There's been some success in terms of specialists, and I think to some extent the rural action program and some of the other incen-

tives have helped in that area. But the most difficult one that we're seeing today and have seen for many, many months and I suspect is going to be there for some time is the issue of general practitioners. Again, we've had high-growth areas. For example, the number of houses that were built in Grande Prairie in 1998 and 1997: we're third in the province. We exceeded Red Deer; we exceeded Medicine Hat and everything. Only Edmonton and Calgary built more homes. It's just one illustration in one area of the population growth.

10:01

What's happened is that because of the shortage of GPs and notwithstanding the fact that the Alberta Medical Association and the College of Physicians and Surgeons are providing that contact and trying to make lists available of which doctors are taking new patients, there simply is a continuing shortfall.

I'm not sure in my own mind that we're not faced with some greater issues in terms of this planning process. The more I see of numbers, the more I see of information suggests that physicians in general are becoming much more sensitive to, quote, lifestyle than to access in terms of major and urban areas. Certainly what we call the Edmonton/Calgary corridor, if you like, is a reality, and it's there today. It's becoming increasingly more of a magnet, and I don't think that's going to change in the future. In fact, if anything, I suspect it may become stronger. That begs the greater question: how do we attract physicians, particularly the specialists, if we are going to maintain adequate and above adequate secondary facilities other than in Edmonton and Calgary? We have five regional hospitals in the province today.

Again, I'm not suggesting that it's the magical answer today, but it may require something perhaps more innovative or different than what we have been doing and what we are planning to do in the near future. I know one of my personal issues - and I know I don't have a lot of support necessarily with the minister or particularly with physicians. I think this province has to come to grips with the issue of training physicians at a considerable cost to the taxpayers. How do we tie that into some return service commitment over the long run?

Thank you, Mr. Minister. That concludes my comments. As I've said, I'm not looking for any detailed answers to all of these today, but over time I would appreciate some comment on some of them.

Thank you.

MR. JONSON: First of all, I think there were some very well-considered comments and questions. I would like to comment on Wellnet. As we've been working on Wellnet, first of all there was a question raised from the Member for Calgary-Buffalo. In terms of any initiatives we take in Wellnet, we are being very careful that we check with the commissioner with respect to freedom of information and protection of privacy so that any specific action we're taking there has gone through his vetting or his assessment and is okayed before we move forward.

The second thing is that I think with the designing of Wellnet there were two schools of thought, and that is that you should get everything in place conceptually and that you should get the whole framework in place before you take on any specific deliverable projects, such as a pharmaceutical information system. However, you can only take the philosophical approach with the taxpayer and the public for so long. I recognized that a year or a year and a half ago. So I have asked as minister for certain specific deliverables in terms of programs or initiatives that we can actually get in place so that people can see what Wellnet can do for you, while we still have to keep looking at the overall planning of the whole package. That is what we're doing in this year's business plan, and we could provide information on just the specific things we want to get done so people can see it actually working in the coming year.

The other area that I'd just like to comment on. The whole area of the funding formula and long-term care is noted, but with respect to the shortage of physicians, there are two things. One is that with respect to lifestyle and the overall approach, we have through Tripartite and through the health transition fund initiative, which is in good part funded by the federal government, been looking at what are called primary care models. These are basically models of providing physician services and other professional services in a team setting, in a clinic setting. I think it takes off some of the pressure and helps with some of the lifestyle issues that doctors who feel isolated and without supports sometimes experience. I think it does have potential for leading to easier physician recruitment and retention in the whole area of general practice.

As far as specialists are concerned, we are always open to ideas as to how to get more physicians in the province who will commit to staying in the province. At the national level I will be raising the issue - I have already - of opening up that agreement that was made years ago in effect capping the number of physicians that are trained in Canada. The other thing is that I want to explore further whether there is some potential for the return service type of student financing that we've seen in education over the years and in some other areas. You always take a risk there, though, because I think you might put $50,000 into training a particular promising student and they might move to Saskatchewan after they graduate and pay you off. So that's the kind of thing you have to work on.

THE CHAIRMAN: Denis Herard, please.

MR. HERARD: Thank you, Madam Chairman. First, let me compliment the minister and his department. I don't think there's any question that running health care in terms of a portfolio is certainly extremely demanding. I think we've got the best man for the job, and it's certainly my hope that we'll continue to see that in the future.

One of the things I'm quite concerned about, though, is the rate of increase in health care costs. I wonder if it might be possible for the minister on a sort of macro basis, without getting too much into the details, to look at the health care system overall and provide a chart that would break down the main categories of health care expense and show their growth since 1994-95 to the present. I guess what I'm looking at is broad categories such as cost of physicians, cost of nurses and allied professions, diagnostic testing, the kinds of increases that we may have seen there in terms of MRIs and all sorts of other radiology things, the number of services and cost of services provided.

[Mrs. Fritz in the chair]

I can remember a few years ago seeing a chart that showed that in terms of increase in population in Alberta and the increase in number of doctors, they were pretty much aligned. You know, there was no major increase. Pretty much over the years they've gone up at approximately the same proportion. But the number of procedures that have been paid for by Alberta Health essentially just went straight up. I'd like to know where we're at today, whether or not that chart, if we were to look at it again, has seen any changes. Without having a lot of visibility into the system, it's very, very hard to understand why it doesn't seem to matter how much money one pops into the system, there will be any number of services or organizations within health care that will eat all of that up and more.

So the appetite seems to be increasing, and that concerns me.

One of the areas that you touched upon briefly was Wellnet. Of course I've had more than a passing interest in that: some three or four years ago now with respect to a report that was presented with regards to the Alberta health information network. Of course, I know there's been a lot of planning work done to date. I would just like to know whether or not the visibility side of the system - because I really firmly believe that things that are invisible you can't control, and the costs of health care are invisible to the users. The sooner we put visibility back into that system, you know, the better off I think all Albertans will be. I still believe that probably one of the only ways left to reduce health care costs without cutbacks is to have visibility into the system.

I'm reminded in a previous life of dealing with telephone services that were billed by the month, and of course they were totally invisible in terms of details of calls. You could find 30, 40 percent abuse and misuse in those kinds of services. Now, I'm certainly not suggesting that there's that kind of duplication or other problems within health care, but I'm just making the point that if something is invisible, you cannot account for it and you cannot essentially try and control those costs.

[Mrs. Forsyth in the chair]

I still think that in terms of our health care system we have something like 6,000 providers out there in terms of doctors and health facilities, and we've got hundreds of thousands of people lined up at the gatekeeper's door. Each one of these doctors and health facilities has a purchase order book, and they're issuing purchase orders every day in terms of millions of dollars a day, yet we don't have visibility into that system. I'm still convinced that the sooner we get visibility, the better off we're going to be with respect to health care costs.

10:11

The other side of that coin is also a system of best practices or excellence in clinical practice guidelines. You know, why does it cost more, for example, to do a gallbladder in one particular jurisdiction or one particular health authority than it does in another? Those kinds of questions I think are extremely useful in trying to manage and control health care costs in terms of best practices and excellence in clinical practice guidelines.

I've had many constituents tell me that they would like to know what they are costing the system, and until such time as we have a functioning Wellnet system, would the minister consider a return to providing Albertans with a statement of usage and costs as it used to be provided on a yearly basis? I'd like to know what that would cost and also some idea of what kinds of potential savings might be achieved simply by having those costs visible to all Albertans and simply from coming to the realization that all of us who use the health care system have certain responsibilities as well with respect to access.

So those are my questions, Mr. Minister. Thank you.

THE CHAIRMAN: Thank you.

MR. JONSON: Well, I noted the points that were made, the requests for information, and I think that to the degree we can, we'll have a look at that and see if we can respond positively.

Just the last statement I'd like to comment on, and that is that with Wellnet and with a better reporting network - and this is a personal view - if we've got an overall ability to state an individual's more or less total health care costs for the year and we've got the automated system to do it, I would like to go back and try once again issuing that annual statement of what it costs you for your use of the health care system. One of the problems we had before is that only part of the cost that you incurred showed. It was basically what the doctor charged and a bit of the hospital costs that were picked up, and that was it. So it was often an inaccurate picture, although it did show that it was quite a few dollars. I would like to try that again to see if it does have a moderating effect upon use of the system or at least a better informed public.

THE CHAIRMAN: Thank you, Mr. Minister.

Are there other questions from the opposition?

MRS. SLOAN: In the business plan and budget for that token reference there did not appear to be any programs of substance. In the 1980s another country, Britain in fact, provided government approval for research to explain the trends and inequities in health and relate these to the policies intended to promote as well as to restore health. The resulting Black report provided 37 recommendations, including information, research, and organization, to better create plans, particularly so that more emphasis might be given to prevention, primary care, community health, and, most importantly, to radically improve the material conditions of life of the poorer groups, especially children and people with disabilities. This research initiative was then followed by the Health Divide, which was authored by Margaret Whitehead and published in 1987. My questions this morning will be related to the application of such initiatives and research to Alberta.

Has the Alberta government, specifically Alberta Health, studied mortality by occupational class, age, and cause of death? Have they studied infant mortality by sex, age, occupational class, and cause of death? Have there been any initiatives that have examined mortality of men and women by housing tenure, education, and access to cars? Has there been any analysis of regional variations in mortality and illness? Have we examined long-standing illness ratios by sex and socioeconomic group in this province? Have we examined our alcohol consumption and tobacco use by sex and socioeconomic group? Has there been any examination of deprivation and ill health in our province? Have we identified the numbers and percentage of the total population and the disabled population living in poverty or on the margins of poverty in Alberta? Have we examined the rates of long-standing and acute illness in consultations by occupational class?

Further, has the department or any region examined the nutritional value of diet by region, income, and number of children? Have we done anything to examine the exercise undertaken in leisure time by socioeconomic group? Have we examined anything surrounding immigrant mortality? Has the department in its quest to reduce health expenditures asked: does a person's financial resources, social position, ethnic origin, or gender affect their chances of good health? Are certain areas of our province or communities disadvantaged in health terms? Are the unemployed disadvantaged compared to those who work when they access our system? Does the health care system treat some people more favourably than others? Are the resources available to the system fairly distributed?

I would submit that both inequities in health and deprivations in health must be examined if we're truly committed in this province to reducing, in a healthy sense, our expenditures, not rationalizing health services and health costs in the future. Further questions must be asked in relation to whether the department has considered, in its quest to regionalize and privatize, greater aspects of health services.

Has monitoring occurred to determine how funding and policy changes, privatization, and the delivery of services have affected

different sections of the population, particularly those that are most vulnerable? Has the department monitored the quality of premises, staff numbers, their training, and the distribution of services in different regions and, again, how those interrelate to vulnerable groups? How have referral and treatment patterns, disrupted through regionalization, affected each social group, particularly the most vulnerable? Has the department considered including equity considerations in the setting and monitoring of contracts?

Further, I would ask this morning if the ministry is requiring that regional health authorities monitor unemployment and poverty and its health effects in the regions? Are RHAs identifying unemployment, poverty, and occupational class considerations in the design and provision of services in their region? Is there a recognition that recruitment in relation to physicians, perhaps nursing practitioners, and other health professionals must be specifically targeted to address inner-city needs in Edmonton and Calgary specifically?

10:21

With respect to the disabled and elderly, has the department examined access and quality of services for these vulnerable groups? What percentage of these groups would be able to be cared for in their homes if such home-based options were available? Are the resource allocation policies of this government and the regions in fact strangling the provision of low-cost home-based programs? What percentage of the long-term care bed shortage could be addressed through the enhancement of services offered in the home? What percentage of the homeless in Alberta is elderly or disabled? Does the department know? Have they examined this? Are there any statistics available? If they are available, I would submit they are not encompassed in the business plan of this government.

With respect to the shortage of low-cost subsidized housing in Alberta, has the department considered conducting research on the health problems associated with temporary homelessness to form planning and subsequently identify increased efficiencies within our health care system? What percentage of the homeless in this province are mentally ill, elderly, or disabled? Has the department considered co-operating with local authorities and voluntary agencies for the collection of more accurate information on homelessness in the province? I did not see an identified strategy that would specifically provide tangible initiatives in this respect. Has the department considered using their annual report to highlight the effects of housing on the health of Albertans? Further, has the department considered pressing for more training for physicians on housing policies and, similarly, more training for social services and housing staff on health?

Those questions are perhaps rhetorical. There has not been a lot of emphasis, as I could establish, within the business plan, the strategies, the objectives, or the priorities of the government with respect to those issues, but I would hope that in some subsequent reports those types of things might be undertaken.

I would like to base my next set of questions referencing the Health Trends document published by the health surveillance branch of Alberta Health in 1997 and specifically target some of the areas where Alberta is trailing the rest of the country with respect to health status. I'd ask the minister, if he would, to try and provide more specific responses in relation to what his department is doing in this respect. Under Child and Infant Health, Alberta has now for several years subsequently had a higher rate of infant mortality than the rest of the country. In fact, we are almost 3 percentage points higher than the best province in the country, which is oddly enough Prince Edward Island, a province that certainly does not have the resources to compare to Alberta. Their percentage was 4.6 deaths per 1,000 live births. Alberta's is seven. In the provincial initiatives the government identifies that it is providing input to the office of the commissioner and it's leading a children's health study which would examine factors in infant mortality, but there's no report provided for that study in the business plan or in the report from the health surveillance branch. I would ask that that report be provided publicly to the opposition and the citizens of this province.

With respect to low birth weight we are also consecutively higher than other provinces in the country, again about two percentage points higher than the best province, Yukon, when it comes to low birth weight infants. The province has identified that it is exploring the development of a strategy to address low birth weights in the province. Again, while this is referenced, the report is not provided. I would respectfully request that it be provided publicly.

Further, there is a related extremely poor performance in Alberta with respect to teenage pregnancies. Again we lead the country. We're significantly higher than the best province, Quebec, with an incidence of 17 births per 1,000 to women aged 15 to 19. Our incidence is 32.4, a shameful, shameful statistic in my opinion. Oddly enough, in this particular aspect of the report the geographical breakdown is provided, but there are no provincial initiatives identified. I would ask the question why that is. The department says that the primary prevention of adolescent pregnancy should focus on the development of responsible sexual behaviours. It implies that that responsibility is based in the family and in the community, or I would suppose perhaps even the school system is to provide that. No leadership or initiative taken on behalf of the government at large, and that, Mr. Minister, in my opinion is as shameful as the high incidence of teenage pregnancy this province has consecutively had while doing very little to address it.

Just with respect to an initiative under alcohol use, the department is indicating that it will be collaborating with AADAC and other agencies to develop initiatives related to the fetal alcohol syndrome. This is also an initiative that's mentioned in the joint children's initiative. I would state for the record that while that initiative is being funded entirely by lottery dollars, it would seem to me it is an exploitation of one addiction to take money from that particular area and allocate it for treatment of fetal alcohol syndrome. There are not a lot of detailed - in fact there are no details as to what the Department of Health's role will be in that regard. I would respectfully request those specifics.

Another particular area of concern is the high incidence of breast cancer and cervical cancer in the province. We have again the highest incidence, in 1997 about 7 percentage points higher than the best province in the country, which was B.C., and that is not being tracked. Prostate cancer is a related point.

While we have in the business plan a reference to that and a reference to increased screening, what, Mr. Minister, is being done to establish or to take part in initiatives that are undertaken in other parts of Canada as to the causes of breast cancer? What is the relationship of our higher incidence of cancers to, particularly, the environmental hazards we have in this province, the high use of fungicides and herbicides, which I will also reference later in this report? Is there any relationship? Is research being funded by this department in that regard? It is not enough to just co-ordinate screening when we have thousands of women in our province and in the country that are dying from breast cancer every year.

Related to that is our high incidence of cervical cancer. Again the only initiative I see this department taking is to co-ordinate screening. Not enough. In the breakdown provided by the health surveillance branch, we have no geographical incidence provided for cervical cancer in Alberta. That may have been an oversight. Geographical breakdown was provided for all the other sections. I would respectfully request that breakdown. Our incidence again

with cervical cancer is higher than the Canadian average rate of 2.85 and also higher than that of the best province, New Brunswick, at .98. Our rate is 4.89 per 100,000 deaths.

10:31

In relation to the environment, I was astounded when I looked at the incidence of herbicide, insecticide, and fungicide use, the feedlot water contamination breakdown, intensive livestock use, and this again was not something in the business plan that I saw. There were some rhetorical references made to improving physical environments. When we look at the incidence of these types of environmental hazards, the southern part of the province particularly seems to be a real focal point. We have a high use of herbicides and fungicides there, we have intensive livestock operations, and we have intensive gas flaring occurring there. Why is that not something that is given substantive reference in the business plan of this government? It's not acceptable.

I would like now to just turn briefly to the advisory committees to this ministry. Again, we did not see in presence or within the report itself references made to reports or activities of the Health Facilities Review Committee, the Public Health Advisory and Appeal Board, the Premier's Council on the Status of Persons with Disabilities. Recognizing that this is a business plan, it does seem odd to me that those committees, particularly given some of the issues they have dealt with over the past year, are not referenced in more detail and their relationship to the goals and strategies of the department are not highlighted in more detail.

Specifically with respect to the Public Health Advisory and Appeal Board annual report set for 1997-98, I noted that out of I think roughly 12 or so appeals in the last year, 10 of those related to the review of houses or living areas being declared unfit for human habitation. That was of particular interest in reference to the statements that I made earlier. Are there any initiatives that are being undertaken with respect to Municipal Affairs, consumer affairs in relation to housing in this province? We've seen the Minister of Municipal Affairs identify that on a number of occasions and the initiative she's trying to take with respect to derelict housing, but these were incidences where housing was unfit for human habitation.

Now, granted the appeal board served its function. It reviewed them and issued a decision, but what is the department doing in that regard? Is there any further monitoring? Is the incidence of this type of occurrence higher or lower than it has been in previous budget years? If that is the case, we don't see within the business plan that it's being tracked or that there are any mechanisms to address it. If we're committed to public health in this province, then we need to define public health in a broad respect and determine our budgets and policies accordingly.

I would like to just turn briefly now to the children's initiative. We recognize that the ministry is part of that initiative, has been a signatory to it, although we put on the record also that it's an initiative that doesn't have any budget. It has a CEO, but how in fact it's going to accomplish anything without any fiscal resources is still a matter of question.

Again the references in that initiative are supportable if they are attached to tangible initiatives. So we have the initiative stating expected outcomes:

a. Children are born healthy
b. Children are safe and free from abuse or neglect
c. Children and families have adequate resources to meet their needs.

Well, given the fact that I am intimately familiar with the Department of Family and Social Services and the reality that many children and families in this province do not have adequate resources to meet their needs, what in fact is the Ministry of Health doing with respect to the provision of adequate resources to be able to provide for basic food and basic housing in this province? We know that in Edmonton alone there are 25 schools that have been assessed as needing hot lunch programs. Only 10 are currently receiving that program, and for those 10 the majority of the funds provided are provided through charitable and private donors.

Now if, Mr. Minister, you are in fact alive in your endorsement of this initiative and committed to achieving a reality where children are born healthy in this province, it would seem to me you would be putting your mind to the provision of food as a basic necessity in this province. When hot lunch programs are raised, most often they're raised in the context of Family and Social Services.

The reality is that if a child does not receive the nutritional entitlements they require in their first years of life, they are not going to be healthy adults, and we will be sitting here 25, 30, 40 years from now waxing on continually about how expensive health care is when the reality is that if we'd had the guts to put some money where our mouth is now, we would, in fact, be contributing to creating a healthier population in the future. That lightbulb does not appear to have come on yet, and I'm hoping I will provide a little bit of the additional energy required for some initiatives to be taken with respect to children's health by this ministry.

I would like to turn now to a different area, the health workforce. It's referenced in the business plan that a variety of methods for paying health providers will be in place in this budget year, but no specifics are provided. I'm wondering exactly what the minister intends with respect to this variety of methods. We know that we have a high percentage of our health workforce that is unionized. Is he planning that that is going to change? What exactly does this reference mean, and what are the intentions of the ministry behind that?

Further, I would ask what the ministry's intending to do with respect to not only the physician shortage in this province but the critical nursing shortage that exists. I had for approximately a four-year period the privilege of sitting on the Nursing Workforce Planning Council, which was established after the '88 strike to deal with the cyclical nature of nursing utilization in this province. The reality was that despite the excellent contributions of stakeholders from within the system and within the nursing profession, that initiative did not receive the large-scale endorsement by the department, and it was usurped, I would say, by this government's fixation on cutting costs to the tune of almost a billion dollars through that same period of time and doing so without any consideration of what the impact would be to the workforce specifically in nursing or the workforce at large.

10:41

So now we find ourselves, yes, in a very competitive situation where all of the regions are short, and we also have many provinces in the country that are also seeking qualified nursing personnel. The reality is that we have a majority of our past years' graduating classes within the health professions and specifically in nursing that have left the province because they were able to find more secure employment in another setting. In so doing, I would submit, they are receiving provisions for advancing their education, employers covering their additional courses towards a degree or a masters, and those kinds of initiatives, at least to my knowledge, are not in place to attempt to recruit people back to Alberta.

In light of some of the controversial initiatives of this department in the last year with respect to Bill 37, the references in relation to the privatization of health care within this report are very vague. I think the majority of Albertans are now recognizing that we don't have a health summit report. Most suspect that it will be constructed

to provide the foundation this government is seeking for setting a percentage target in terms of health expenditures and also to set up a foundation for the initiation of establishing core and noncore or insured and noninsured services. It is somewhat suspicious that while we release the business plan and release the budget, we do not provide any indication of what that report is going to hold. I would question why that is, why this department is not being more transparent about their initiatives with respect to the future of public health care in this province.

Just a couple of concluding questions with respect to children's services. In terms of the increase in the overall budget or within the RHAs, I would ask how much of that is being targeted for the provision and co-ordination of children's services? Also in relation to children's issues, is the money in relation to vaccines and sera that has been increased in fact going to provide for equipment costs and additional manpower costs to provide vaccinations in this fiscal year? That has not been the practice of the department in the past, so I would raise that question again this year.

Further, what money is being designated for the treatment of special-needs schoolchildren requiring speech and/or hearing diagnosis and treatment? Will school boards and parents continue to have to wait and dip into their own wallets for services that used to be funded through the education system? That is a high area of concern and has not been adequately addressed.

Further, we've seen some initiatives around fetal alcohol syndrome. I don't see any designated funding with respect to the interventions and diagnosis of attention deficit disorder. What if anything is the department planning to provide in that respect, including alternatives to drugs like Ritalin, the utilization of which appears to be on the increase?

With those comments I would thank you, Madam Chairman, Mr. Minister, and I will look forward to some response at some point before the estimates are voted on in the Assembly.

Thank you.

THE CHAIRMAN: Go ahead.

MS LEIBOVICI: Thank you. A couple of points of clarification on the minister's remarks and also a clarification on one of the items I had mentioned as well. When I asked about the funding formula, what I was asking was whether within the regions the hospitals are funded differentially. That was the question I had. I look forward to receiving the manual and being able to sit down with the departmental reps to help interpret what the manual says as well.

If I can just also mention that I don't think it was the Lakeland region that I said had a funding problem. It was the WestView region that had an historical funding problem. It's my understanding that it was not just one single RHA that was grandfathered but others. I think Aspen may have been one of them as well that was grandfathered. I understand what you indicated in terms of bringing all the resources from the various hospital boards together. The question still remains whether the communities were given credit in a sense for having hospitals that were functioning and had surpluses as opposed to carrying debt. That still is an issue that citizens would like to know about.

A correction that I'd like to make. I think I indicated for the Capital health authority that the backlog of out-of-date equipment was $30 million. It's $130 million with ongoing annual replacement costs of $45 million. The information systems, amounting to approximately $63 million, will require replacing over a four- to five-year period.

There has been a fair amount of discussion around Wellnet and information systems, Y2K. The question is whether or not there is consideration within this budget as to the increase that will be required for the operating expenditures for information technology and whether in fact we are getting the best bang for our buck out of those technologies.

If I can just refer the minister as well to recommendation 24 from the Bonnie Laing report, that was alluded to by the government members I believe, that indicates that "a rigorous cost accounting and cost benefit approach be taken with the Wellnet project prior to substantial dollars being invested." I'm not sure that the deliverables the minister was talking about do in fact address that particular point. Given the limited budget that is available and the requirement for those dollars to go to frontline care, the question still remains: is this the best place to put our money?

Another clarification that I would appreciate from the minister. There have been some very good questions that have been put forward not only by the members of the Official Opposition but by members of the government as well. Traditionally what happens is we only get answers to our questions. I would put forward the request that we could receive the answers to all our questions, so I would be able to receive not only the answers the department provides for the Official Opposition but the answers to questions the Member for Calgary-Montrose put forward, the Member for Grande Prairie-Wapiti, et cetera. It would be more efficient. If, I guess, we need to do it in another manner, I would echo all those questions the members of the government put forward to the minister and would like answers to those questions. So if that solves any problems you may have in providing that information directly to me, just consider all those questions asked by myself as well.

I will continue with the list of questions that I have. Again, some of them are under program 2.3. Some will be under program 1.0.7, health strategies, and 1.0.5, health information and accountability. As there is no way in reading these single line items and my knowing which area they come from, I am sure the department will answer them out of the appropriate program areas.

With regards to public health - and the Member for Edmonton-Riverview touched on a lot of concerns that we do have with regards to public health and the whole perspective of health in the broader sense. Does the minister or the department have information by region which services have increased with regard to public health, which services have decreased, and which services have been deleted as a result of the reforms in the health care system?

10:51

This is a very specific issue but has some broad-ranging implications. Can the minister provide the level of sterilization that occurred prior to the reorganizations with regard to certain procedures and the level of sterilization that is now occurring with regard to - equipment I don't think is the right word - surgical implements that are being used? You might want to take three or four or five hospitals across the province to do this. It's my understanding that whereas before there was a high level of sterilization for certain operations, now what is happening is that there is less sterilization occurring. Does that in fact have any implications with regard to increased infections and readmissions as well? Has that been tracked?

Can the minister provide by region, unless they are all the same across the province, a list of services that have been excluded for provision by the regional health authorities - for instance, canes, slings, cervical collars, casts, tensor bandages, et cetera - the method of payment that is put forward within each region, if they are different, and the cost of those items, whether they are the same across the regions or not?

Can the minister also provide the actual number of beds in each

region that will now be open as a result of the 1,000 staff that are being hired, provided there are 1,000 individuals available to be hired in the health care system, both short- and long-term beds within that system?

What are the appeal mechanisms within regional health authorities for decisions that are made by regional health authorities that affect individuals who are providing care? There is at least one example that we are aware of with regards to physiotherapy services in Calgary. What is the process of appealing decisions that are made by regional health authorities? Are they decided individually, or is there a standard across the province as well with regards to those appeal procedures?

Is there any tracking of admissions to hospitals as a result of procedures completed or performed within the private health care sector? What are the admission rates, if any, that occur as a result of procedures happening in the private health care system? Are there any standards and performance levels, expectations of private clinics that are providing care based on public dollars? And specifically with regards to the long-term private operators, is there any breakdown of what the profits are of those long-term private operators and what the salary is of the individuals who are providing care as caregivers and as rehab professionals within the long-term care sector?

The Member for Calgary-Buffalo had mentioned the aboriginal health strategy. I think it was about $650,000 over a three-year period that was supposed to be provided for that particular strategy. I've seen no mention of it either in Intergovernmental Affairs, in the Health department, or in Family and Social Services. I've looked through whichever budgets I thought it might be under and haven't found it as yet. So if the minister can provide that information and let us know what happened with the dollars, what the outcome was, and what the next steps are with regards to that particular program.

Let me skip a little bit to mental health, 2.3.19. If the minister can - and this builds a little bit on what the Member for Edmonton-Riverview had asked as well. Under what circumstances would a fatality inquiry be held, particularly when it comes to suicides? What is the Provincial Mental Health Advisory Board's business plan and strategic direction? What is the future role of nonprofits in the delivery of mental health services? What do the minister and the department see as a favourable mix? Is it the current 70-30? Is that what it is? Is it 60-40? Is it somewhere in between with regards to the provision of institutional mental health services versus community mental health services? What does the minister see as the actual role of the Provincial Mental Health Advisory Board? Is it to be a deliverer of services as we're seeing it become with regards to crisis lines, or is there another role for the board?

It's my understanding that last year, I believe it was, the board had a $20 million surplus. What has happened with that $20 million surplus? How in fact can service providers, if this is the case, provide service when their contracts are only from year to year? Are there any plans, or do the nonprofits have contracts that are in fact more than on a yearly basis? If not, why not? What is the breakdown of dollars that are given to the mental health board or for that function right now with regards to the community versus institutional, and what's the breakdown within those categories within community? What is the breakdown for crisis intervention, for instance? What is the breakdown for the different services that are provided on the institutional side?

Can the minister explain the concept of clubhouses? How they are going to be integrated within the delivery of mental health services? If the individuals do not wish to access the clubhouse concept, will in fact there be other options available in Calgary and Edmonton? I believe Ponoka and Claresholm are also potential sites, if they are not already sites, for the clubhouse concept.

I had asked originally about a $3.4 million allocation to the Calgary regional health authority for the deficit in the mental health services, I believe is the way that flow of money went. Where did those dollars go? If they were in fact moved into the general budget of the Capital regional health authority, what is the government's position on the designation of funds? Are funds designated or are they not designated? This has implications for the current budget as well.

In terms of health strategies, I'd like to briefly touch on that as well. It's under 1.0.7, and the funding for it, I believe, is under the Broda committee. I have some questions along long-term care as well.

My colleague from Edmonton-Riverview had touched on the need for studies of the effects of industry, oil and gas, livestock, et cetera, on air/water and the need for long-term epidemiological health studies. Is this the branch of the department that this would occur under, and how do you co-ordinate your work with the department of the environment and other departments as well perhaps that may be affected?

The Provincial Health Ethics Network receives $370,000; 77 percent is from Alberta Health, 16 percent is from the RHAs, and a small amount from other sources. I'm curious to know what the overlaps are with the ethics network, other areas within Alberta Health, and other ethics committees. Every time I turn around there seems to be another ethics committee that is popping up around the province. There may be a need for it, but I would like to know if there's any co-ordination from the ministry with regards to these committees and how they in fact work with each other. What in fact is the Alberta taxpayer getting for the $300,000 that the department is providing for the Provincial Health Ethics Network? They are supposed to be an arm's-length group. Are they addressing issues of genetic manipulation, cloning, decisions of implications of government policy that say we can only afford perhaps a certain number of lifesaving operations? Are they looking at ethics with regards to decisions made to split families apart when it comes to placing them in long-term care? If they're not looking at those kinds of ethical decisions that are being made on a daily basis within our health care system, then who is?

Where do their reports go? Are they filed in the Legislative Assembly? I don't believe I've ever seen one, but perhaps they are and I've missed it. If they are a nonpartisan, nonprofit organization, why do they in fact need permission from the government to review public policy initiatives or initiate a process of public consultation? If they are in fact independent and arm's length, they don't need government permission, I would imagine, to do that. So what exactly is their mandate?

When I look at the long-term care committee, I have some questions with regards to what is occurring there. I believe that also would come under 1.0.7. I don't know; there may have been an actual budget allocated for that particular committee. It's interesting that the minister says there is no interim report, but on page 261 it states very clearly that the interim report from the Broda committee stated there should be some dollars provided for long-term care and drugs for palliative care, I believe.

Just as an aside, with regard to the drug issue, how is it decided who will be able to access that medication? It's the "$6.2 million to address drugs for short-term acute care clients outside a hospital setting." How are those dollars going to be provided? What kind of drugs are those for? What happens when you run out of the $6.2 million in the year? Is there a cap in each regional health authority providing those dollars?

11:01

With regards to long-term care, will nurses and other professional groups who daily work with long-term care be specifically consulted? This is not part of the large group. Are there specific meetings held with those health care providers who deal with those individuals on a daily basis? If not, why not? How many meetings have the chair and vice-chair actually gone to and attended that are happening throughout the region? What is the province's actual target with regard to long-term beds? I've seen a number of different figures, and that's why I'm asking what the actual target is and whether that decision has been made.

Does the province have right now the number of individuals in each regional health authority who are termed "bed blackens"? In other words, those are individuals who do not have the ability to leave a setting where they need long-term care. They are in acute care beds and are waiting for a long-term care bed. What is the average length of time spent in an acute care bed, and how long does it take to actually move and find a bed for someone in long-term care?

The health workforce. Under 2.1, practitioner services, some specific questions there as well. What is the average length of time for repayment of billings from Alberta health care? What is the number of billings that have been refused and the reasons for those billings to be refused? How long does it take for a new procedure to be listed, to be reimbursed from Alberta health care? If the government truly means what they say about teamwork with the health care professionals, why was the AMA not consulted before Bill 7 was introduced into the Legislative Assembly?

I have other questions around the health workforce with regards to the knowledge we have that it is an aging workforce, with the average age, I believe - and I would appreciate some clarification - for nurses somewhere in the neighbourhood of 45 to 47 and for doctors somewhere in the neighbourhood of 47, 48 to 50, 51. So it is somewhere in that neighbourhood, depending on region. What's the actual average across the province for physicians as well as for nurses? What is the government's plan to address the retraining, the retaining, and the recruiting of health care professionals in this province? I would assume that there is an overall plan somewhere. I know the province of Ontario has just finished their plan. Is there something specific that this province is doing with regards to ensuring that there is a plan as well?

Y2K. I don't quite remember if the Member for Calgary-Buffalo had asked for the Y2K compliance challenges that the regions have. Can we have a list of what those are, how they've met them?

If I can just reinforce the issue around pacemakers. Every once in a while there seems to be a question as to whether pacemakers - and this is not just a unique Alberta problem but across the world, I would guess - are in fact compliant. I have read a number of differing opinions on it. I would like to know whether the government has looked at that, what the experts to government are saying around the issue of pacemakers. If in fact there is a certain brand of pacemaker that is not Y2K compliant, then we need to be aware of that. We need to let those individuals know who have that particular pacemaker that there may be a problem and ensure that around that time period when there may be some problems, there are enough facilities available to replace them if required. I don't have the expertise, quite frankly, to know what is and what isn't, but I would hope the department has that at their disposal and would like the answer for that.

The audit of the HAS. I had asked for some information with regards to org charts, what in fact their plans are with regards to capital improvements, with regards to equipment and programs. Also, it would be helpful to know what the outcome focuses are, what evaluation the government is using to say, "This is what the inputs are, and this is what the outputs are," and to know what those are as well.

I talked a little bit earlier about the nursing shortage and the need for a template for effective manpower managing. Where is that template? I think we used to have a workforce planning council. What exactly is the mandate of that?

I had asked earlier, but just to clarify as well with regards to the sick leave and overtime provisions: does the government actually have a ratio that they use of the effective paid hours as a percentage of total paid hours? What would the government see as being an effective and efficient workforce with regards to that particular ratio?

If I can just add a question also to the question from Calgary-Buffalo with regards to death certificates. There is a concern that when an individual dies of AIDS, that is the only notation on that particular death certificate. Is the government in fact looking at perhaps indicating what the other causes of death might be, as it is not only AIDS but usually some complication of AIDS that causes death, whether it's pneumonia or some other kind of complication?

The Cancer Board. The Member for Edmonton-Riverview had touched briefly on that. Can the minister indicate what the current wait lists are for procedures from the Cancer Board and what the procedures are that are backlogged, if any, with regards to accessing treatment from the Cancer Board and the clinics throughout the province? Also, if the minister would be able to provide where the outreach clinics are of the Alberta Cancer Board. I know in some of the tours across the province I have seen some of those clinics, and the model seems to be a good model. I would be interested in knowing how many of the regions have that particular model.

With regards to dialysis, I know that is a concern as well and that there is some outreach to some of the communities with regards to that. I'd like to know what the plans are for moving that program out to the communities. I don't know that it's helpful to an individual who needs dialysis two or three times a week to have to, for instance, travel from Lethbridge to the Calgary regional health authority. That's the information I've received, that needs to occur, and if not, then I'd appreciate that information as well.

11:11

Acupuncture and acupuncturists. Again, just to build a little bit on the Member for Calgary-Buffalo, if the minister could provide the information as to which and who has the services paid through Alberta Health. It's my understanding that there seems to be a dual approach to receiving the services of an acupuncturist or someone who is trained in acupuncturing - if there is such a verb - and that some are funded through Alberta Health and some are not. Is it in fact regulated by the Health Disciplines Board or not?

The department has talked a fair amount about silos, as has the Minister of Family and Social Services and, a little bit, not as much, the Minister of Education. In this particular budget can the minister indicate where those silos are being broken down and how the department is being moved towards ensuring that those silos do not occur? On the vaccination and sera side, has there been a study done on the effectiveness of the flu vaccination program in Edmonton versus Calgary? It seemed that the flu is one of the reasons in the wintertime that there are blockages within the health care system. Does the flu vaccination program actually work, and are there differences between the two major regions?

Ambulance fees. Can the minister provide what the cost is to Alberta Health of nonpayment of ambulance fees and to private providers of not receiving, potentially, payment of ambulance fees? Are the private providers out of pocket if they're not able to collect,

or does Alberta Health then provide the private operators with the dollars from individuals who do not or cannot pay? Then is Alberta Health out, and what is the amount of dollars that Alberta Health is out?

Probably some clarification around the large number of accounts, that one-quarter of the population who have not paid their medicare premiums. It seems that the onus is on the doctors perhaps to collect those premiums. What in fact is the government going to do if this is a growing trend? As one of the last provinces that do collect medicare premiums, there may be a better way to recoup those premiums.

The summit has been talked about a whole lot. The blue-ribbon panel, interestingly enough, I don't believe is mentioned within the budget. The province seems to have made a commitment for continued consultation after the summit and ongoing consultation. Where in the budget are those dollars for ongoing consultation if in fact that is to happen? Is there anything in the budget for consultation with the public after the blue-ribbon panel has put their submission in to the minister? I believe that either has happened or will be happening in an extremely short period of time. Given the huge amount of interest in that particular area, what in fact is the government planning to do in the form of consultations?

THE CHAIRMAN: Karen, your time is up. Thanks.

We go to the government members.

MRS. SLOAN: Pardon me, Madam Chairman. Is that the full exhausting of our hour?

THE CHAIRMAN: Yes.

MRS. SLOAN: I only had by our clock 50 minutes.

THE CHAIRMAN: Well, you're wrong.

Denis, please.

MRS. SLOAN: Okay. Thank you.

MR. HERARD: Thank you, Madam Chairman. There is a question that I had on factors that are increasing the cost of health care. There are some new things that are happening in health care that haven't happened before. One of them is that . . .

THE CHAIRMAN: Excuse me, Denis.

MRS. SLOAN: We still have questions, so I'm assuming you're putting us on the list in the event that government members don't have questions.

THE CHAIRMAN: That's correct.

MRS. SLOAN: Thank you.

THE CHAIRMAN: Go ahead, Denis.

MR. HERARD: Okay. I'm saying that certain things are currently happening in health care that never happened before. I'd like to understand them a little better. I'm not sure if that would be repeated throughout the province in most urban centres, but I'm told that in the city of Calgary we have something like 800 family physicians. Approximately half of those, from the information I'm getting, currently do not take on any hospital work whatsoever. I would like to understand the impact of that from the point of view that it has reached the state where the regional health authority has had to hire a particular new classification of doctor called hospitalists. I'd like to know if the remuneration of those doctors comes out of the AMA pool or if that comes out of CRHA. Is that additional costs with respect, you know, to what we're spending on physicians in this province?

I'd also like to know with respect to the operation of these walk-in clinics, because I understand that that's primarily where the doctors who don't take on hospital privileges work. In other words, there must be motivation, and there must be reasons for that. Has the centralization, for example, of the lab services had an impact on the ability of doctors to provide diagnosis rather than sending people to the emergency room, which of course is what we're finding more and more of. So if you've got half the doctors in Calgary, the general practitioners, the family physicians, sending their patients to the emergency area, then I can see why the lineups and the delays and so on are occurring day in and day out in emergencies.

I'd like to understand that problem more. What is it that can be done to attract physicians back into the hospitals rather than working strictly out of their walk-in clinics? Then the attendant costs that that creates with respect to having to hire other people, other doctors, to look after those patients in the hospitals: does that come out of their overall pool? Just exactly how is that going to get solved? This is something that's never happened before in health care. It's one of the factors that I believe is increasing the cost overall. I'm told that in the city of Calgary it was probably to the tune of $50 million last year, which is significant in terms of health care costs. I would just like to get some background information and the thinking of the minister and the department with respect to how we're going to solve that one.

Thank you.

THE CHAIRMAN: Mr. Minister, go ahead.

MR. HERARD: Oh, excuse me. I had a second question that I forgot to ask.

I have a number of constituents who tell me that when they go see specialists, they have to pay certain fees. Some of them are fees for setting up appointments. Some of them are fees that deal with specific medications and so on that certain specialists are prescribing that may or may not be available through our normal pharmacies and so on. So I would just essentially ask that question as a point of clarification. Is it really in keeping with the Canada Health Act or any other legislation or rules that Albertans would have to pay up front for the privilege of seeing a specialist? I would just like to know what there is in place to monitor that kind of thing if it is happening. If it is, then under what legislation or what lack of it or whatever do they have the ability to do that? That was my second question.

Thanks, Madam Chairman.

11:21

THE CHAIRMAN: Mr. Minister?

MR. JONSON: First of all, with respect to the issue of general practitioners and their not assuming or not taking on hospital privileges, I think there are two factors. One is general; one I think to some degree is specific to Calgary. It has been a slow but steady trend in health care that a certain portion of the doctors that are trained and graduate or perhaps are getting into their later years of practice increasingly opt out of having hospital privileges. It may be because they're working part-time raising a family, or it may be because they've just decided they are not going to have what we

might term a full general practice career out there. So I think that's just part of the modern trend perhaps and how people look at the job of being a general practitioner in some cases.

The other thing, however - and I've certainly spoken with the Calgary regional health authority on this, and I would hope they're taking measures to address it. To some degree some general practitioners want to be able to identify with a particular admitting hospital as opposed to having to link up in perhaps all three hospitals at different times to get their patients admitted to the hospital. You can see that if you have three patients in hospital and they're in three different hospitals, it becomes quite a challenge for a physician. So I think the Calgary regional health authority is working on smoothing out that whole issue of admissions and convenience of access for general practitioners. But it is an issue.

The cost of hiring those hospitalists is partly borne by the medical services budget, because the hospitalists, for the specific services they provide in hospital, are topped up - pardon me; I'm getting to the second stage. They charge for their basic billing fee, but then there are some cases with the hospitalists, particularly with respect to the 24-hour service, where there's a topping up, or I guess you'd call it a standby rate, that is paid to the hospitalists by the regional health authority. I don't know what the portion is, but both the AMA pool and the hospital - the region is paying for those.

With respect to fees being charged by specialists, I would like to know if you know of any specific cases. We have a process for following that up with the College of Physicians and Surgeons. However, there are cases where it is quite legitimate. For instance, I am familiar with one area where we did follow up and found that there was nothing untoward about it. Let us say that you have a specialist working in the whole area of laser surgery and a person comes to that particular clinic and wants perhaps an examination. They have a noncancerous blemish, but with modern laser surgery and stuff you can take that off and look better. Perhaps the specialist initiates this or suggests it, or the patient. So they have this blemish or this wart, whatever it is, removed, and they pay for it. It would go under the category of cosmetic surgery. Nevertheless, they have entered that office, and the procedure, as I understand it, would be that the physician, because the person came in for an examination, would bill for the examination, but if the patient elected to have that non medically required surgery, they would charge the patient.

THE CHAIRMAN: Is that everything, Mr. Minister?

MR. JONSON: One other item I'd just like to respond to in the area of health care premiums. Total health care premium revenue, just to put things in context, is $687 million for 1998-99, of which approximately $22 million is uncollectible, about 3 percent. This $22 million that is deemed to be uncollectible is largely due to people moving out of the province and not advising us.

THE CHAIRMAN: Thank you, Mr. Minister.
Mr. Pham.

MR. PHAM: Thank you. I have two more questions for the minister. Presently WCB pays a number of selected doctors more than the regular schedule fee so that they can provide service to the workers faster. I'm wondering whether that practice is in violation of the Canada Health Act. If WCB can do so, can a private organization, be it an insurance company or a private citizen, go to a group of doctors and offer to pay them more than the regular schedule fee to acquire faster service? That's my first question.

The second question. I want to focus on the access to the health care system by new Canadians, especially senior citizens who may have language problems. The language barrier is a serious hurdle for them to access the health care system. I represent a constituency where we have a very high ratio of new Canadian immigrants. A lot of these people rely on the services provided by the doctors who speak their same native language. In Alberta the ratio is one doctor per 500 Albertans, but in those communities it's really one to 5,000 people. I went to many of their clinics in northeast Calgary, and presently it takes on average about three hours of waiting time to come in to see a physician. That poses a serious threat to those people and also to the general public at large, especially during the flu season. Is the department developing any program to deal with that issue at all, or do they even recognize that as a problem? What is the long-term solution for it?

THE CHAIRMAN: Thank you.
Mr. Minister.

MR. JONSON: First of all, with respect to Workers' Compensation Board, the workers' compensation system in Canada is specifically referenced in the Canada Health Act as being an exception. So the answer is that it is quite possible for WCB to contract with a doctor or group of doctors for services and have an up-charge or a bonus involved in it, and that we talk quite a bit about. It's used over and over again, and our critics say: well, you must comply with the Canada Health Act. But then when the WCB issue comes up, they complain about it. That's part, ladies and gentlemen, of complying with the Canada Health Act, because there is that exception written right into the legislation. Also, by extension, in terms of application although not used too often, the Royal Canadian Mounted Police, the armed forces, and I imagine the coast guard would be in that same category.

With respect to new Canadians, we do in terms of overall - and I think that to a degree, although perhaps it's very modest, particularly through this being identified by our community health councils, both Edmonton and Calgary in particular have been working on and I think do have in place services for immigrants, quite frankly, not physicians that can speak the language necessarily but at least community workers who can help with the communication between the patient and the physician when the two do not speak the same language.

THE CHAIRMAN: Thank you. Is that everything?

MR. JONSON: Yes, it is.

THE CHAIRMAN: Mr. Jacques.

11:31

MR. JACQUES: Thank you, Madam Chairman. I was wondering if you could refer to page 260 in the government estimates. At the top of the page it says Business Plan Summary. This is under Health in the total government estimates. Under Major Strategies you'll see some various bullets there. There are three bullets in particular I'd like to have your comments on. The first one is about halfway down, and it's referring to the development and the implementation of the "health workforce planning for Alberta, which supports the goals of People and Prosperity, in consultation with health authorities and others." The second issue is the one right below that, which refers to "enhance access to front-line services by increasing staffing levels." Then the very last bullet on that page: "Enhance services for lodge residents in collaboration with health authorities, Municipal Affairs and lodge providers."

What I would like, more in terms of your overview kind of

comments, is what you see as perhaps specific issues that are in each of those, what you see as kind of the process, if you like, as to how each of these can be approached. You may not have defined processes, but perhaps some of the alternatives you're thinking about as to how you'll approach these. Again, conceptually, what do you see as, if you like, the outcomes starting to identify specific measurements? I recognize you may not have those today, but in terms of what you're thinking about, maybe the possible outcomes or possible measurements in terms of those outcomes.

In more specific terms with regard to the second bullet, which is to "enhance access to front-line services," your news release of March 16 provides an overview in terms of some of the dollars that have been provided to the regional health authorities. It then goes on to make specific reference to hiring at least an additional 1,000 full-time frontline staff in the coming year. You then go on to say, "Front-line workers are defined as . . ." et cetera, et cetera. Then you go on to give examples of the type of occupations that would be hired with that additional funding, and there's something like - I don't know - eight or nine bullets or examples. Then the news release goes on and talks about, again, more specifically, some savings, what Albertans have told us. Then the backgrounder information starts to get into very specific allocations of 1,000 positions and breaking that down by each of the regional health authorities.

A couple of questions in regard to this. Number one, in terms of the number that is identified, what is the process you're going to be using with the regional health authority in terms of their commitment or their plan, that yes, this is the target - we acknowledge that - and this is how it's going to be implemented? I don't know what the process is between the regional health authority and the department in that regard.

Secondly, in terms of the 1,000 positions and particularly as it pertains to the Capital health authority and the Calgary regional health authority, which obviously have the bulk of these, do those numbers purely reflect the funding, commensurate with the funding targets that were shown on that earlier list at the time of the budget, or do these also include commensurate numbers that might be associated with the additional funding for provincewide services? Are provincewide services more of another plan that has to be developed in terms of just what's going to be done in Calgary and in Edmonton, or is there some association tying back into the frontline staffing?

The other question associated with that. If a regional health authority for whatever reason - let's assume it's a bona fide reason - cannot meet the target that's been established and they come down, say, two or three positions below that, would you consider transferring funding from that regional health authority that's been allocated and which they say they really cannot utilize in frontline staffing to another regional health authority that would make a very good case saying, "Yeah, we could not only utilize the $18 million that you've targeted, but we have a good business plan and a good reason here that says we should have $20 million"? If that regional health authority is going to spend the dollars, what are the chances of getting that funding over? Is there a process that might even envisage that? Is that something you're thinking about or you still have to address?

In terms of that last bullet, when you're responding to that one, I was wondering if you could just indicate at this point, in terms of the "lodge residents in collaboration with health authorities, Municipal Affairs and lodge providers," where do you see that going in terms of what discussions have taken place to date versus what process for more discussions? Particularly in terms of the lodge providers, have they been a major player to date, or is that something that's been, if you like, filtered through Municipal Affairs and, in turn, discussions with the minister and the Department of Health?

Thank you, Madam Chairman.

MR. JONSON: First of all, with respect to the lodges, in some parts of the province the lodge/Health relationship I think is going well, particularly where, yes, you have an aging population in place in the lodges but they're being served through home care. So the health care system is moving in to support their longer tenure in the lodges. Also, in the budget we have a modest amount of money to give some recognition to lodges who do provide that service: some administrative assistance with dispensing prepackaged pharmaceutical products or pills.

In other cases the lodge boards, which have a certain amount of autonomy, have I think still maintained that the role of the lodge is the same today as it was in 1963 when they were started by the Social Credit government of the day, and that is that they do not want to see those services in the lodge because they feel that will detract from the nature of the lodge as being more of an apartment type of service, in their minds, rather than one for an aging-in-place population. It's a variable matter right now across the province, and we are trying to work with Municipal Affairs and ourselves and the lodge foundations to have this situation where home care can support and people can stay in their lodges longer, and that helps with the overall situation.

Your question, hon. member, through the chair, was: if there is some money left over after hiring or not perhaps for legitimate reasons being able to hire your complement of frontline staff, can someone else make a bid for it? No. The way we look at is that we're going to monitor it very carefully. We do expect the regional health authorities to report on it, and if they cannot find, for recruitment reasons or whatever, that additional frontline staff, then we want them to make their case. But I think in most regions, let us say in an isolated part of the province, say, the northwestern region, if they cannot find a particular additional dietician, let's say, because that's a high priority with them, then we're not going to take the money away from them. We assume they have other priorities, and they've made a sincere effort to fulfill that frontline staffing need, because it's all in the same budget package.

11:41

With respect to the frontline staffing and how this fits in with the other initiatives that were identified, basically what we're doing in our workforce planning exercise, which is a multistakeholder effort, is we're looking at the health workforce this way: where do we have a need for additional staffing? Secondly, we need to define the number, have some estimate. We're talking here about more long-term planning, because we're looking at the whole need for training and so forth. So within the system we look at defining the need, defining the number, defining the particular competence that we want to see those people have in the future. Then having calculated that or having recommendations with respect to that, we of course need - and it's all in the same process - to define the educational needs that are going to be there in the system for the postsecondary sector and determine what can feasibly be done at university, college, or technical school levels to tool up our capacity, if it's lacking, to get those people in place.

We also are looking in the health workforce strategy at the need for refresher courses or for in-service education, as we would say in Education. We're also in that health workforce planning process looking at possible reward strategies or perhaps location incentive strategies if they're relevant to some of the particular needs. So there's a set of steps that that group are going through with respect

to the overall health care system: first of all, the big picture and then what the sections are within it that have to be followed up on in terms of planning through postsecondary and, hopefully, back into our workforce.

A third area that had been raised, Madam Chairman, was with respect to workforce planning, this first general provincial effort, and how it relates to the way that we look at determining staffing levels within the regional health authorities and our other delivery systems. Yes, this is certainly related to workforce planning. I think there are increasingly good sources of data as to what the proper staff mix should be for different sites within the health care system. Sometimes these are more or less set for us by certain collective agreements that might be in place, but I think there is an increasing body of knowledge being developed to provide us with some good information as to what the right mix of staff is for a particular level of service. That's something else we want to follow through on, to the extent that we're able to, in the health care system.

Long-term care, of course, is one of the areas of particular attention because of the need to track how you need to adjust your staffing ratios. In a way it's what you might call aging acuity. As you get older and older and older and perhaps have more and more difficulties, you need to have a larger team or a more complex number of services available to you, even in long-term care.

THE CHAIRMAN: Mrs. Fritz.

MRS. FRITZ: Thank you, Madam Chairman. I'm also going to refer this morning to the larger booklet, the government and lottery fund estimates, Mr. Minister. On page 260, under the Business Plan Summary, I too am very interested in the major strategies and the way that you have outlined some of them. I did have a couple of questions about the definition of some of the terminology that was utilized. For example, there is the strategy, almost halfway down, to "develop options for paying health professionals that encourage ongoing improvements in health and the performance of the health system." I'm interested in what you're looking at as options. Is that a reward system that is monetary? Are you relating it to time, that kind of thing?

Also, I'm interested in the next bullet: "Enhance access to frontline services by increasing staffing levels." We often hear about frontline services being inclusive of RNs, RNAs, et cetera, but I'm wondering if you're including occupational therapy, rehab. Is it just in the acute care system? Could you please comment on the terminology "frontline" and, further to that, "Enhance support for drugs for short-term acute care clients in the home"? I'm interested in what the definition of "short-term" would be. I know that it is looking at acute care, and I think that you've certainly been very accommodating over last year's budget, when we had talked about palliative care and medication for palliative care and how that's incorporated. With this being acute care, I'd like to know what "short-term" refers to.

Then further to that, the other strategy you have is: "Enhance organ and tissue donation and distribution." I noticed that you also have it in the other booklet as well. In The Right Balance on page 187 you also have there: "Enhanced tissue and organ donation and distribution." So it's outlined in both, but then when I look at the budget line item, there had been what appeared to me a significant change in the moneys, from $110,000 to $66,263, so if you could comment on how you're relating that budget to what this major strategy is.

I'd also like to make a comment in regards to women's health, that you do have here: "Improved co-ordination and enhancement of cervical and breast cancer screening." I'm very pleased to see that, because I did notice, too, in the same booklet that you had increased - and I'm sorry I don't have it in front of me, but I was reading this on the weekend. I think it's on page 190. You had increased the current performance rate by 10 percent, which is a significant increase in the breast cancer screening rates, and I'm hoping that within that you are collecting the data which we know previously wasn't as well co-ordinated as it could have been and that the Alberta Cancer Board is working in that area with the radiology.

Also, I know that I've asked this question before in other budgets, but I continue to be very concerned about the area of suicide, the provincial rate of injury deaths including suicide. I've noticed that the target performance rate is at 15. I'm hoping that you could take that number down significantly from 15, because we know that the suicide rate has increased, especially among our young people, our youth, and if you could comment on what you are doing in that area.

I also would be very interested in what is happening - and I know we've talked about this previously as well - for people with bulimia and anorexia because of the services that had been offered here in this region compared to the southern region and more along the lines of the acute care system. Families are accessing the service outside the care system because it doesn't seem to be as readily available as it could be, especially in the southern part of the province. I know that's a concern of yours as well, Mr. Minister, so if you could please comment on that.

11:51

MR. JONSON: Madam Chairman, very, very quickly. First of all with respect to the last issue of anorexia and bulimia, yes, we do hope to make some progress this year in addressing that, particularly as it's a need in southern Alberta.

With respect to the references to the overall budget for blood, as I recall, there's an amount there of $110 million approximately. It decreases in the coming year, because $60 million was committed to deal with the hep C proposed settlement that was arrived at initially among all 10 provinces and territories, and now we'd have to say it was arrived at with one province sort of changing its mind. The agreement is still being worked on at the legal level. So you take $60 million out of that amount, and then you have an amount which applies more specifically to blood services. As I recall, there's something in the neighbourhood of $17 million by way of an increase in terms of ongoing blood services here for the province and for paying for our services from the Canadian Blood Services.

MRS. FRITZ: So it's actually a $17 million increase overall; is that what you're saying?

MR. BHATTI: Yeah, on human tissue and blood services. This is what we pay to the Canadian Blood Services committee. There is a $17 million increase. But your question specifically relates to organ donations, and we have $300,000 set aside in our budget specifically to deal with organ donations.

MRS. FRITZ: Okay. Thank you.

MR. JONSON: Madam Chairman, to the member. Then with respect to your questions on frontline staff, yes, it would include occupational therapist, rehabilitation therapist. When we talk about frontline staff, we're talking about a person the majority of whose attention and workday is dealing directly with the patients or the users of the system, not all patients yet. Hopefully they don't need to be.

MRS. FRITZ: And in regards to the suicide and injury prevention, with the strategy that's in place, if that has changed.

MR. JONSON: Well, with respect to the whole area of injury prevention, we have taken a couple of initiatives. One is that we have provided funding assistance to the injury prevention institute, I think it's called, newly opened here under the leadership of Dr. Francescutti of the University of Alberta. We work with other departments such as Alberta Agriculture. You'll have noticed that right now there's quite a bit of publicity over the media with respect to this whole area of farm safety, which is important. So there's a wide variety of injury prevention initiatives that we either do ourselves or work with others on.

With respect to suicide prevention, that is something that I certainly acknowledge we need to make a greater effort in. It is, though, a component of the whole community health - not the public health; that's usually given a different definition - and prevention effort that is part of the health authorities' mandate. We have a type of incentive grant or program in the formula for RHAs. It's called Partners in Health. This is about $4 million which is allocated among the regions which is only paid on the basis of their having proactive preventive health programs such as these.

THE CHAIRMAN: Mr. Minister, thank you. We've run out of time. If we could please have a motion.

MRS. FRITZ: Thank you, Madam Chairman. I'll move that under Standing Order 56(8)(b) the designated supply subcommittee on Health conclude discussion on the 1999-2000 estimates of the Department of Health and rise and report.

THE CHAIRMAN: All those in favour?

SOME HON. MEMBERS: Agreed.

THE CHAIRMAN: Opposed?

SOME HON. MEMBERS: No.

THE CHAIRMAN: Carried.

[The subcommittee adjourned at 11:57 a.m.]