Legislative Assembly of Alberta

Title: **Wednesday, March 1, 2006 8:00 p.m.**
Date: 06/03/01
head: **Committee of Supply**

[Mr. Shariff in the chair]

The Deputy Chair: Hon. members, it's 8 o'clock. We shall call the committee to order.

Before we proceed with the estimates before us, may we briefly revert to Introduction of Guests?

[Unanimous consent granted]

head: **Introduction of Guests**

The Deputy Chair: The hon. Member for Edmonton-Manning.

Mr. Backs: Thank you, Mr. Chairman. I'm very pleased to introduce to you and through you to the members of the Assembly a group of Cubs. I used to be a member of the Cubs. I was a sixer back when. This is the 160th Latter Day Saints Cub group, and with them today are Christine McCaw and Marilyn Borely. I'd just ask all the members of the Assembly to give them the usual warm welcome.

Thank you very much.

head: **Supplementary Estimates 2005-06**
General Revenue Fund, No. 2

The Deputy Chair: As per our Standing Orders the first hour is set between the minister and members of the opposition, following which any other member may participate.

Health and Wellness

The Deputy Chair: The hon. Minister of Health and Wellness.

Ms Evans: If I may. I know that the hon. Member for Edmonton-Centre would like to proceed, but if I could just give a couple of responses to the questions that were posed in the afternoon session.

First of all, the hon. member is quite right that the regulations in our standards stated 1.9 hours. However, the position of 3.1 hours came into effect in the 2004-05 year, and over the past year we have been endeavoring to reach 3.4 hours per patient on average for staffing. By August the varied authorities and varied facilities in some authorities had achieved that level. By January it is my understanding that all of the authorities reported that all of their facilities had achieved a staffing mix equivalent to 3.4 hours. However, in doing so, some reported that their targets, though they may have been met, were met with some difficulty to the overall budgets of the regional health authorities. So when this supplementary estimate provided additional dollars for the long-term care hours, it did so knowing that we were topping up what was already spent by the health authorities in transfers to the long-term care centres.

Now, why not 3.6 hours? That might well be something that comes as part of our new budget year. It is not something that is part of this. We knew that we had to be realistic in how we reported and spent money towards the end of this fiscal year, and that's why the announcements that have come out in the third quarter cover simply that.

The other point I want to make is that the intent of the lifts that have been installed was not to reduce staff but, rather, to boost staff morale because of the very grave difficulty – and I've been there and done that in long-term care facilities – where if you're one person and you're managing somebody who is not able to help themselves into a chair or into a bathtub or into a bed or in any other place, you can't manage that even with a lift as a one-person activity. We knew from what we'd heard from the staff in these facilities that the expenditure of these ceiling lifts would help us to at a minimum give them some assurance that we would make their lives easier in managing the patient, and in turn the patient would be able to relax better in a lift.

It was with no thought that they wouldn't still need the staffing complement at all. In fact, I think that that would give them some extra assurance. If it was possible for somebody who was fully lucid to manage with a staff member and one person operating the lift, presumably another staff member would still be managing other care and treatment for other patients on the ward or in the facility.

The lifts of their own accord were never installed with the thought that we were going to be reducing staff. It was strictly to make it safer for the patient and to make it a simpler procedure for people that are providing care to folks who need long-term and continuing care. Not once did anybody ever raise the point: well, then you can use fewer staff because you're having a lift. It might be a simpler situation, but for safety reasons for the largest part, if you have somebody who really needs to have a lift – and I know that in a couple of the long-term care facilities that I'm most familiar with, people are not able to be fully connected to their environment either because of their own state of dementia or because of their physical lack of well-being and so on. For many of the people it's still going to take two people even to manage that lift properly.

I don't know if there's another point I can respond to on that, but I look forward to the rest of the questions. I just thought I'd clarify what I'd heard up till now.

The Deputy Chair: The hon. Member for Edmonton-Centre.

Ms Blakeman: Thank you very much for the remarks that the minister made in response to the questions that I put on the record at the end of the afternoon session. I appreciate that the minister believes that the intent of funding the lifts was not to reduce the staff complement. I can tell you that I watch this every week, and there's one person there. There are not two people; there's one person there operating the lift. I've never seen two people there, actually, in all the time that I've been there. So that's the effect. That's the long-term outcome of what happens. If you've got just one person to operate it, that's what happens.

My illustration with the story about the woman trying to be positioned appropriately in the wheelchair: that's the result of it. When you've now got just one person operating the lift, you are unable to have a second person there that can help position the person appropriately. So you end up with someone who's not positioned properly, and they're slowly sliding down over the four or five hours that they're in the wheelchair during the morning or during the afternoon when they're back in the chair. There are outcomes as a result of choices that are made, and that's one of the places where I see it. I've already said that there are dedicated professionals there, and they're all working very hard, but that's what happens.

It was interesting to me that the physiotherapists that were working in the sit clinic were unaware that that would be the result. To give a very crude example, it's like going to the hairdresser's or barber's and getting a wonderful haircut which you are never ever able to repeat on your own. So it only happened in the sit clinic that they were able to position the person appropriately, and that's

unlikely to ever happen again because they don't have two people on in the actual facility to help them get in the position they're supposed to get in. That's the outcome of some of these things, whether they're intended or not.

The $3 million to accelerate the implementation of the continuing care system, especially around availability of information used in decision-making: could we please get some details? I'm looking specifically for timelines, whether they're incremental or not. What are the points you're trying to hit with this, and what performance measurements are in place to allow you to look back on this and decide if it was in fact useful and an efficient project?

I'm looking for the same kind of information for the $600,000 to support the implementation of the new standards for medication management, and if we could also get a layperson's description of exactly what's being anticipated there. Is this around a new charting system? Is it around computerization? Is it around some kind of robotic packaging, bubble packaging of pills in single dosages for individuals? What exactly does that mean?

There's an awful lot of money in here: $114.8 million to accelerate the expansion of Alberta's electronic health records. Oh, boy. I think that we are all looking at the electronic health records with great anticipation and optimism that this will make the system better.

8:10

However, there are some huge pitfalls involved there, and the minister has been warned about these. There were several very good sessions at the minister's symposium in May 2005 in Calgary, in which they clearly said: you've got to know what you're doing here because there are a lot of examples out there of people rushing off and getting systems in place and then finding out that they don't interface well with other systems they need to interact with. Then I look in Alberta and go: "Great. We've got the Capital health authority developing one kind of electronic health record system and the Calgary health authority developing a completely different system."

Now, I've asked about this before, and I've been told: "Oh, yeah, they're going to interface well. They're going to communicate. This will be seamless. We're working on this." At that point I just have to pause and go: what were you thinking? Basically, each region could potentially develop their own electronic health records. How is that going to work, especially when we start bringing in all the other components that are involved there, the pharmacists and diagnostics and everything else? I'm noticing that more and more money is going off into this.

There were transfers of money in the third-quarter update around this. Now, this may well be the money that was in the third-quarter update, but I thought: wow, we're just pouring money into this system. Are we really watching? I'd like to know what the benchmarks are for checking that this stuff is working because we can pour literally hundreds of millions of dollars into this and end up with a system that doesn't work. We have examples elsewhere in the world of exactly that situation happening, so I'm not talking about the sky falling here. I'm talking about studies that the minister should be aware of.

I am interested in the explanation of why the regional health authorities were allowed to develop independent systems. Who is it that's supposed to knit these systems together and get them all to talk to one another electronically? I think there's a real issue there. I understand that we're in a hurry for this, but it strikes me that we were out front to begin with, and now we're behind. So what's the problem here? I'm getting reports that we're now behind on the electronic health records implementation.

The other issue around that is what we're seeing happening, and we got a little taste of it with the debacle over the privatized registries. This has been the point I've maintained all the way along. You can have lots of different levels of security in these electronic databases, but it's always going to come down to a human being deciding that they're going to do it anyway. That's where we really need to be watching the system because, obviously, if we've got certain parts of our system like the drivers' licences and vehicle registrations privatized, through private companies, and they pay their staff minimum wage or slightly better and somebody rolls in and says, "I'm going to give you $25,000," well, duh, yeah, they're going to take the bribe. No, they shouldn't, but how do we set up the system, aside from all the electronic blockers and alarm systems? There's a description of these levels of security that are in it. What systems are we looking at to deal with human nature and human behaviour? Because that is where our system is actually failing.

You know, we get the journalist shot in the parking lot in Quebec because the girlfriend of the Hells Angels biker gets his licence plate number out of the private registry there. That's exactly how they got it. They had his licence plate number. They walked around in the parking lot, found his car, waited for him. He walked out there, and bang, they shoot him. So that's where the problem is, and we don't seem to be looking for any kind of systems that are dealing with it.

When we've got electronic health records and we're shipping X-rays to India overnight and then shipping them back again and all kinds of information is being accumulated on someone, access to that information by sources that aren't supposed to get at it, frankly, I think, can have deathly consequences for people. I'm just not seeing anybody being alive to this and quick on the uptake.

Now, the minister had gone through the various transfers, how there was more revenue than expected and that that money was transferred inside the department to pay for other things. What I would like to do is get a breakdown of details – and you may wish to supplement this in written form after the fact and just send it over to me, Madam Minister – of the $27 million for the access and wait time projects. There was an additional amount of money that was transferred internally for that. These access and wait time projects: exactly how does that break down? Who's getting cheques cut to them? What's the line-by-line breakdown on how those projects actually worked? We don't get very much information from the government financially. We tend to get sort of everything rolled up into one big vote line. I'm interested in: what is the detailed breakdown on this one?

I know that my colleague from Lethbridge-East is going to talk, I'm sure, about the progress that's not being made on establishing the standards of care, so I won't spend a lot of time on that. I will note, in fact, that that Member for Lethbridge-East is bringing forward Bill 205 with some excellent recommendations on standards and monitoring and enforcement through an ombudsperson, and I hope that the minister will give that very strong consideration. I'll leave the continuing care questions to her because she has a real passion for it.

Okay. I'm going back to the medication management. I asked for the details on the implementation of the standards. Could I also get information on what the standards are, please? In addition to that, are these going to be province-wide, and will they apply in both public and private facilities? The additional breakdown to that one is: how small a facility will the standards still apply to? You know, we've got some of these day homes now where people can take people into their homes and take three or four or five or six seniors into their home, but the standards are usually not applied to them, so we're getting somewhat concerned that there's an unlevel playing field out there with security.

I'm wondering overall why this money was not in the original

budget. I'm increasingly concerned about the amount of off-budget spending that this government is doing and the efficiency of this off-budget spending cycle that the government gets into. It is, in fact, inefficient. I wish we could see a budget that really was exactly what we needed to provide excellent health care to Albertans rather than this sort of A version and then the supplementary supply we get in the fall and then an additional supplementary supply that we get in the spring and, frankly, always after the fact. I'm sure this money has all been spent. It's not an efficient way to do things because people are not able to incorporate it in their planning from the beginning.

We talked about the breakdown on the electronic health records. What are the additional plans for these electronic health records? I've already noted that I'm seeing a lot of extra money being plowed in there. What are the plans going forward? Again, are there sort of incremental points, targets, or benchmarks that the ministry is trying to hit as they develop these? I know we're on an accelerated timeline. What is that timeline now, what points are they trying to hit, and how much money do they think it's going to require? I know that some of that will be in the budget, but I would like to hear what the overarching plan is here because I'm beginning to feel that it's a bit piecemeal. I would like to be reassured that there was, in fact, a through-line plan.

8:20

There's some interesting wording in here in the last bullet under the reasons the supplementary estimate is requested. This is around this additional money for "higher-than-budgeted health care insurance premium revenue on additional health services." Could I get an explanation of what the additional health services are? It's saying: "including $27,000,000 for Access and Wait Times projects." What else is included in that? The $27 million for the access and wait times projects: I don't think that's the full amount of money for that project. So when I asked for a detailed breakdown, a line-by-line breakdown of that before, I was meaning the full amount of money, including this particular injection of the $27 million. But I'm interested in what the additional health services are for that.

When will we get the final results and evaluation of the access and wait times projects? I'm also interested in when we would hear the final evaluation of – I'm not going to get the name right now – what's essentially the hip and knee project, that just announced its results, its quite spectacular results actually, about a month ago.

So those are the specific questions that I have. I look forward to hearing from the minister. I understand that some of this is quite technical, and I've asked for a line-by-line. I'm happy to receive that in writing because I don't expect the minister to particularly have that off the top of her head.

I know I've got a couple of colleagues that would also very much like to ask questions of the minister in this department. Thank you very much.

The Deputy Chair: Hon. minister, would you like to respond, or would you like to listen to the others?

Ms Evans: Well, I will give a response. I will perhaps be more cursory on the matter of some of the continuing care hours and staffing hours just to enable further questions to come later.

Let me just go back for one minute to the safe lifting practices, that have been referenced once again by the hon. member. Injuries related to lifting and moving patients account for considerable lost-time claims and costs. For example, in 2004 the Workers' Compensation Board of Alberta accepted 3,493 lost-time claims from health service workers. Long-term care facilities had the highest lost-time claim rate of all the health service areas, at a cost of $2.9 million in 2004. Back, neck, and shoulder injuries, Mr. Chairman, resulting from the lifting and the lowering of patients, the holding, pushing, and pulling of patients while assisting them in their daily activities, and inappropriate patient lifting may have contributed to falls, strains, and safety issues for the residents.

Unsafe manual lifting of residents in long-term care facilities can be significantly reduced by the use of mechanical lifting devices such as the ceiling lifts. I will take under advisement the hon. member's comments that in her experience on a weekly basis there's only one person operating the lift. It has not been my experience, but under the circumstances I believe it's important for us to take a look at it. Clearly, the driver for this, in my view, was the safety of the workers as well as the patients, and I think that some of the statistics I've cited relate to that.

Now, about the continuing care system management project, I'm very pleased to report that it involved the implementation of standardized assessment and care planning tools for continuing care clients and residents. The totals include the interRAI MDS 2.0 for nursing home and auxiliary home residents, the interRAI MDS-HC for home care clients, including clients in supportive living residences, and the electronic submission of client, resident, and service information to Alberta Health and Wellness. These new tools and the data that results from the use of the tools will facilitate standardized comprehensive assessment and care planning for all residents and clients receiving continuing care services and will provide quality indicator and resource utilization information for use by health regions in the department.

Right from the time that we first heard from the Auditor General on the intake procedures and on the assessments when patients came in, I have been very concerned about that type of assessment and intake process as well as being able to have the proper tools in place for a plan that's easily understood not only by the resident and their loved ones or guardians but also by the staff that are using that plan.

Nine point five million had previously been allocated to the health regions for the project: $3.3 million to each of Calgary and Capital and $2.9 million to the nonmetro health regions. It's our belief that with the additional funds that are being provided, we will be able to complete the project and have the proper tools in place.

Now, the hon. members also asked about the plan for the $600,000 for immediate action on medication management. Naturally, we were as a government highly concerned about the Auditor General and the MLA task force reports of overuse of psychotropic drugs to restrain long-term care residents and by the general problems of managing complex medication issues, especially for seniors in care. The funding will support the work of a multidisciplinary expert review panel. This panel will have to do not only the work of assessing the complaints that have been provided but make sure that we have accountability from those who are dispensing medication so that we know, for example, they're not simply left at the bedside or that there's not overuse or overprescription of certain psychotropic drugs and so that the charting and the use of these drugs is very clear in the purpose of them and how the patient has responded to those drugs.

The panel will conduct a comprehensive review of current medication management practices in all of our long-term care facilities and assisted living spaces receiving publicly funded health services; for example, nursing homes, the auxiliary homes, designated assisted living, et cetera. It will review the current practices here in Alberta and internationally and develop a medication management practice standard for implementation in our continuing care system during this coming year of 2006-07.

I want to talk for a few moments about the Alberta Netcare project

charter, and I swear that the hon. member in her speech has been collaborating with some of my colleagues who would pose some of the same questions because of the significant investment we've made both in information technology and in the electronic health record.

Let me back up to the starting point of the discussion, and that is: why is it that various regions have been enabled to develop their own processes and procedures? Well, I think, simply put, it's because they were quicker off the mark than we were. They were able to identify a need on the ground running, seeing the very disparate needs of some physicians, some who wanted to get involved and quickly embrace the notion of the physician office system management and get their own electronic health records in place plus the additional tools that were available. Some were receiving that information from various vendors who would approach them and give them that opportunity, and the health regions themselves of necessity found that in order to make proper links not only between their facilities and their providers of care but in terms of the accountability for the system, they developed systems that were put in place in a way that was generating information for those various regions.

What we are looking at now is a portal system that utilizes the advantages in these already-built systems. Some, yes, have been in place for a considerably long period of time, but I looked very carefully at what had been done, and if you eradicated everything and started fresh, we would not have been in any better position than we are today, in fact much worse. We are better now to look at the advantages of advanced technology and with the portal system build with the capacity that's already been generated and try to make those connection points.

Although it may have seemed like an impossible dream, it is advancing quite well because for the very first time the governance group of the providers – the Calgary health authority, the Capital health authority, and the rural regional health authorities – are working together with the Department of Health and Wellness in establishing protocols for how monies are spent, how initiatives are undertaken, and how we are advancing in the gathering of information and connecting with one another.

Alberta Netcare requires the ability to share information across disparate systems to achieve its objectives, and that has been accepted. It's not one system but a group of projects guided by the provincial IM/IT three-year plan, which will achieve the common goal of a provincial electronic health record.

8:30

Here I must thank my hon. colleague the Minister of Restructuring and Government Efficiency because we have been working in close partnership with his ministry, knowing that we have the SuperNet in place in Alberta and knowing that we're trying very hard to be cost-effective in the systems that we deploy but being very conscious of other systems that are being built around us.

The major provincial projects and 2008 targets by the project charter include a P viewer, a provincial portal which will be ready for provincial rollout by May of this year and which will provide access to patient information through one common provincial tool, the PHIE, the health information exchange, which is integrator technology to connect more data sources such as the lab reports, which will be added with software selected and contracted this month, and phase 1 implementation will be ready by the fall of 2006.

The drug information or the pharmacy information network. Most drugs dispensed by retail pharmacies and by the Alberta Cancer Board can be viewed across the province, and I see that most of that is in place. By this coming year, 2006-07, 50 per cent of physicians prescribing medications online will be able to check for possible drug allergy interactions. For 2007-08 our targets are for two-thirds of physicians frequently using the electronic medical records to document care, prescribe medications, and view lifetime health records of patients. It has been amazing to me over the last several months to listen to physicians tell me: I wasn't too enthusiastic, but our Premier said that we would be there by 2008, so we know that we must be there.

The laboratory test information. Eighty-five per cent of all lab test information is available province-wide for physicians and pharmacists who have access to laboratory results, and this coming year 95 per cent of all lab test results will be available for physicians. So we're closing the loop on that one, and we expect to have a hundred per cent available by 2007-08.

Our diagnostic images and tech report information. In 2005-06 they were available from Calgary and Capital for physicians, and in 2006-07 the filmless and shared electronically from Calgary and Capital regions for X-rays and MRIs for the diagnostic image and tech reports will be available from all regions and health boards. This will be an enormous cost saving. Most diagnostic images and tech reports will be completely available by 2007-08.

I want to comment briefly about registries and security. This past year every patient accessing the health system has at a minimum a record that includes their name, address, and personal health identifier. This coming year health care providers will have a secure single sign-on access to appropriate health care based on the principle of need to know. In 2007-08 health care providers, planners, and policy-makers will be able to track health services by provider, location, and type of event. Mr. Chairman, along with our wait-list registry and the use that we've made of that so that people all over Alberta can see the wait times across Alberta, I think there are maybe subtle but certainly clear signals that we're making some advancement on the use of information technology and our Netcare project. Our project charter now has tripartite sponsorship, as I've indicated, with the CEOs being involved. RSHIP has done a remarkable job.

If I may talk about the benefits of Netcare that we see, enhanced patient safety and more effective and efficient use of our health resources. We feel that we'll be better able to facilitate team-based care. Clearly, with the primary care networks we're able to track that in a much better way for multidisciplinary providers, and we believe that we will be able to improve access. This Assembly knows that the EHR will reduce medical errors dramatically; 18,000 Albertans requiring hospitalization due to improper medication use is just one frightening statistic of circumstances where Albertans have been either unintentionally overdosed but accessed medication from more than one provider and, as a result, have taken ill. Principally, this affects seniors because of medication-related problems. It's my belief that as soon as pharmacists and physicians alike can check that electronic health record of the patient, we will be able to curtail significant amounts of those circumstances, which will not only reduce costs but increase patient safety.

We've talked about reducing the duplication of data entry and the reduction in the lab tests and the paper production and, finally, the legacy system savings which will be achieved with discontinued use of expensive-to-maintain older legacy systems with the introduction of the new systems. The 10-year cost for the acquisition of an EHR in Alberta is estimated to be $1 billion and can range from $0.8 to $1.6 billion. The 10-year cost of ownership, including both acquisition and recurring costs, for an EHR in Alberta is estimated to be $2.3 billion. The total gross savings over a 20-year period are estimated to be $8.7 billion and can range from $6.6 to $10.4 billion.

Now, these are incredibly huge numbers with a significant

magnitude, but let me break it down with one of my favourite examples. There was a forensic report done in Ontario just a few short years ago where 15 per cent of the physicians' records were examined in terms of determining the accuracy of their coding and billings to government. When that was reviewed by a team of professionals, forensic accountants, they determined that of the 15 per cent sample they were looking at, there had been some $800 million worth of errors made, and that particular amount of errors were made in billings that went to the government that were billings over and above what those dollars should have been based on the procedures that were actually done to benefit the patient. It is not for me to suggest that any one of those billings was done with any malice or deliberate intent, but it shows that the lack of familiarity sometimes with the medical language, sometimes with the codings that should be used, sometimes with the business planners or practitioners that operate on behalf of physicians and manage the course of events in their office, perhaps even their reading of the procedures or the handwriting of the physician, resulted in some $800 million that was spent that didn't need to be expended.

So when I look at an electronic health record, I look at it as not only a useful tool for patient safety but as an opportunity to create a much healthier and safer environment and a much more efficient system because we will be able to track the costs that have been billed to us and we will be able to check much more easily what we have done.

If you look at Canada Health Infoway's 10-year investment strategy in the Pan-Canadian electronic health record report prepared by Booz Allen, dated March of last year, our benefits in Alberta were assumed to be proportional to Canada's total public and private health expenditures; in other words, 10.5 per cent of Canada's total health expenditures. Canada Health Infoway's 10-year investment strategy estimated Canadian gross savings over a 20-year period to be $82.4 billion; 10.5 per cent of this amount was assumed to be representing Alberta's savings. Over a 10-year period this amount is reduced by 50 per cent to $4.35 billion of which two-thirds, or $2.9 billion, is assumed to be savings realized by the public health care sector. In other words, the duplication that today clutters up our health care system is part of what we'll be able to achieve a savings in.

8:40

I can speak here of my own mother, who has had batteries of tests and never really realized the benefit of the results of those tests and who challenges me almost every week about why she has these tests when she's not feeling any better. I believe that ultimately an electronic health record and a patient care record that we would be able to access on behalf of our parents would tell us not only what the test was, what the benefit of the test should be, what the outcome should be, and what we could expect from the expenditure of those dollars, but more than that with the kind of suffering and discomfort they go through while they go back and forth to the doctor to get those tests. So, in my view, this is one of the best ways that we can make the health care system not only more accountable but more cost effective.

I think the hon. member also asked about the additional health care as written in the report where it states that "in addition to the Supplementary Estimate request, the Ministry will spend $28,117,000 of higher-than-budgeted health care insurance premium revenue on additional health services." The additional health services were services that were acquired by additional individuals who came to Alberta and purchased the health insurance plan, or bought into the health insurance plan. There are more Albertans, so we had a total of $28 million more collected in health care premiums. So that is what we're talking about.

Of that, we spent $27 million for the access and wait-times project and then put the $1.1 million into the other portion dealing with the – I believe it was the electronic health record. I'll just check back on that, and I'll have that answer prepared. But certainly the first part of it was put towards the access and wait-times project, and then the rest was moved into the amount of money that was spent on the electronic health record. That total expenditure is $116 million. [Ms Evans' speaking time expired] I've talked to the limit for now.

The Deputy Chair: Thank you, Madam Minister.

I have the following three individuals who've indicated that they want to speak on this subject: the hon. Member for Edmonton-Highlands-Norwood, followed by Edmonton-Ellerslie, followed by Cardston-Taber-Warner. The hon. Member for Edmonton-Highlands-Norwood.

Mr. Mason: Thank you very much, Mr. Chairman. I appreciate the opportunity to rise and speak to the supplementary estimates for the Department of Health and Wellness. I would like to start with the $26.3 million increase to long-term care, and I want to talk a little bit about some of the things that have been said in the past.

As we know, Mr. Chairman, the Auditor General did a report in this area that was quite scathing about the conditions that many of our seniors lived in. The Premier at that time stood in the House and committed to implement every single recommendation that the Auditor General had made, but subsequent to that an MLA committee was created to study the thing. This was a curious development because the Auditor General had done a fairly comprehensive job in his study. So the rationale behind creating an MLA committee to further study the issue was something that was questionable in our view. Sure enough, when the MLA committee completed its report, its recommendations were considerably less rigorous than the Auditor General's report. So it raised a question about which set of recommendations the government was going to implement and whether or not it meant that if they simply implemented those recommendations of the MLA committee, they would not fully implement the Auditor General's recommendations.

Now, the government had admitted at the time that the cost for carrying out these recommendations was much higher than the amount here. These are supplementary estimates, so I'd really like to know from the minister if she intends to bring forward in the actual budget the remainder of the money that's necessary to meet this. It was admitted by the government that between $150 million and $250 million would be needed to properly implement the changes proposed by the Auditor General and committed to by the Premier on behalf of the government. So my question is whether or not this expenditure is going to be forthcoming outside the supplemental estimates in the upcoming provincial budget.

Mr. Chairman, I want to talk a little bit about some of the government's claims about costs in our health care system. It's interesting that the document that has been released, highlights from Alberta's new health policy, indicates that today one-third of Alberta's budget goes towards health care, and it goes on to say that if current spending trends continue, health care will consume Alberta's entire budget in 25 years. Now, I'd like to know what the underlying assumptions are in making that statement because it's interesting if you go back to the Mazankowski report. Back in the year 2002 he makes a similar claim. Mazankowski says in his report on page 4, "If health spending trends don't change, by 2008 we could be spending half of the province's program budget on health." This is in 2002. Clearly, that's not acceptable.

Now, there was an attempt there, in our view, to do what's being done today, and that is to create artificially a sense of crisis in the

growth of spending. It's not to say that spending on health is not growing, and it's not to say that steps have to be taken to constrain cost increases in the health care system. This can be done through innovation in the public system.

It's interesting. I've got a report here, Mr. Chairman, that was prepared on behalf of the leader of the New Democrat opposition at that time, the Member for Edmonton-Strathcona, and the report indicates that the assumptions in the Mazankowski report are incorrect. They use 1996 as the base year to begin tracking increases in health spending, and that's misleading. It conveniently overlooks that health spending was cut by over 17 per cent between '93 and '96, and some of the increases were simply making up for previous reckless cuts in health care spending. It also assumed that revenue growth would only be about 4 per cent a year. Of course, despite substantial tax cuts government revenue has increased by an average of 10 per cent annually since 1996, roughly matching increases in health spending. Vastly underestimating revenue growth as the Alberta government has done consistently might be seen as a virtue in other contexts, but it leads to erroneous conclusions in this context.

Mr. Chairman, not very much has changed in the last four years, when this response to the Mazankowski report was put forward. The government is still attempting to create a false sense of crisis about growth in health care expenditures and at the same time rejecting practical solutions that would in fact control costs within the context of a public health care system. The clearest example of that is the NDP bill that was defeated in the fall, calling for the creation of a pharmaceutical savings agency.

8:50

Now it's interesting, Mr. Chairman, that while it's true, as the Premier has said, that New Zealand is a country and that Alberta is a province, they both have the same population more or less. In New Zealand it's 3 million people not including sheep, and in Alberta it is 3 million people not including Tory backbenchers. Since 1993 New Zealand's pharmaceutical expenditures have only risen 3 per cent annually compared to the OECD average of 14 per cent and the Alberta average of 10 per cent. In fact, some observers argue that New Zealand saved $624 million on its drug subsidies in the year 2002-03 alone, and that comes from the Conference Board of Canada. Clearly, the government has turned its back on the single most effective way to control health care costs. Why have they done that? Well, in our view they've done that because it falls entirely within the public system. It takes away the growth in health expenditures and therefore takes away the sense of crisis that the government needs to engender in order to create public support, they hope, for bringing in the third-way health care proposals that they have in mind.

I said at the point when I was concluding debate on the bill, Mr. Chairman, just before it was defeated, that we had two objectives in bringing forward the bill. The first objective was to show that substantial savings can be found by innovating within the public system, and the second objective of the bill was to show that the government is not interested in doing so. I think that's exactly what happened.

Mr. Chairman, I just want to conclude by saying that the suggestions that have been made both inside the House and outside the House by the Premier and the Minister of Health that we are now entering a consultation phase on these proposals is absurd in our view. These are clearly defined objectives that the government has had for some time that they are intent on carrying through, and the so-called consultation that is taking place in our view is a sham. There is no opportunity for broad public input. There has been no public consultation since the provincial election, when the Premier promised that it would take place. All of the work has been done by the government in putting forward proposals to implement what they've long sought to do, and that is to create a second private tier of health care and to fund it through private insurance. It will allow queue-jumping, it will allow enhanced services, and it will inevitably increase waiting times, reduce the quality of care received in the public system, and according to Dr. Herb Emery, who is an economist at the University of Calgary and a senior fellow of the Fraser Institute, it will not save the government any significant amount of money and may in fact cost more.

I just want to say in conclusion that I don't believe that Albertans want to see private, two-tier health care. They have not asked for it, they have not been calling for it, nor have they been given an opportunity to provide any significant feedback to the government on this. The government does not intend over the next month to provide meaningful ways for them to do so, so I have to say that it is being driven from somewhere else than either the costs, which we've already dealt with, or public demand. It is not designed to control costs. Quite the contrary. It will increase them simply by adding additional middlemen. It is not being demanded by the people of this province.

The question then comes, Mr. Chairman: where is this idea coming from? Where is the pressure and the impetus to bring in private, two-tier health care in this province? Quite simply, it's coming from a number of corporations who provide private health care services, drug companies, and some physicians who stand to make very, very significant financial gains if the government system is put in place. That's where it's coming from.

It comes at the expense of people. As Dr. Emery has indicated in his paper, at most about 28 per cent of the people of Alberta will be able to afford the more expensive private tier. In order to get them to be willing to pay very substantial amounts of money in order to access that system, it must provide much higher levels of service than the public system, and it will inevitably result in a declining level of service in the public system and increased waiting times rather than shorter waiting times as the government has indicated.

On that note, Mr. Chairman, I'm happy to conclude my comments with respect to the Department of Health and Wellness supplementary estimates. I call upon the minister to provide clear rationale for the cost increases in the health budget that they are projecting and give us their assumptions. As one of my math teachers was fond of saying, "Show your work."

Thank you.

Ms Evans: Well, Mr. Chairman, one of the things that all the members of this Assembly will be pleased to note is that the comments from my learned colleague across the way very eloquently addressed the view of the advancement of the health policy framework which we have just delivered. Not one cent of this supplementary estimate is carved in any way towards any part of the private care that he has so eloquently decried. He attributed motives to this government and to the corporations, I know not of whom, that have advanced the case that they may benefit from it. I've never heard this. What I've heard, in fact, is people wanting choice. What I've seen in the expenditures of the supplementary estimates is an opportunity to advance efficiencies, to improve the nursing hours in long-term care, to provide patient lifts and supports for medication and assessment tools.

Mr. Chairman, in answer to the colleague from Edmonton-Centre's previous request about where the $1.1 million extra was going to, it is in fact on point 2, as I suggested, the electronic health record, for work done on the systems management there.

I would just simply state that in due course, pending the outcomes of the consultation with Albertans, we will be providing more detailed estimates of costs. I think that we've been quite clear that on that subject, we haven't defined so much cost savings on the policy number 8 or 9, but several of the other policies, in fact, will lead to cost savings with a more efficient system.

With that, I'll conclude and wait for others to comment.

The Deputy Chair: The hon. Member for Cardston-Taber-Warner.

Mr. Hinman: Thank you, Mr. Chair. I appreciate the minister of health being here this evening and taking these responses. I guess there are a few things that I'll just run over quickly. First of all, the people in the long-term care facility are very grateful for the money that is being added to these different areas. One of the problems, though, with the people that I've been talking to down there is that it seems like all of a sudden we're just doing a political pressure thing here, attending to long-term care when, in fact, home care and DAL and enhanced care are facing these same shortages and problems. I wonder if the minister is aware of that and if there's something possibly coming in for those.

The extra home care really does help seniors stay in there a longer time. I've had two or three seniors that have called and talked to me about the problems of their home-care people not coming in the morning. They're sitting there saying: well, I guess I'd better get back and get into a different system and get out of my home here. I had a 90-year-old senior who fell a month ago because her home-care person didn't come in the morning. She tried to shower on her own, and then the complications went on. I'd like to bring that to the attention. I think home care has been an excellent program, and perhaps we need some additional looking in that area there.

With the $15.2 million that we're spending on increasing it from 3.1 to 3.4 hours, I'm just wondering if you could give an actual number of additional workers that we're talking about. When my constituents and people come and ask me, these numbers don't mean a lot to them. To be able to say that 5,000 more are going forward or what the numbers are would possibly be helpful.

I have some concerns with the lift devices. In the one facility that I went into, the power went down. All of these lift devices that they're putting in now are electronic. There are a few of them. If the thing burns out or something else – it seems like the old hand pumps worked. They were functional, worked well. The $7.5 million just seems like an incredible price to pay. I'm wondering how many extra lifts that is putting in or whether we're buying cadillac lifts. I agree with all of the points that the minister put out on helping our seniors as well as the workers and not hurting them by two people struggling and pulling and trying to lift them, but I have to wonder about it.

9:00

The question that I have on that is that I'm going to go to an electronic wheelchair that I was helping a senior with that reclines so that she can rest. She's got MS, and she's stuck in this wheelchair, so in order to take the pressure off, it reclines. Anyway, it's got an electronic actuator on there – a screw jack is what it is – and it allows her to tilt her machine back, but it was not functioning well. Myself being a jack of all trades, I took it apart to look at it to fix it for her, and the cotter pin was coming out. I was able to fix it.

I went into the local farm dealer – it was a Timken activator – and I said, "Can you get me one of these?" They're the Timken dealer. They looked at it. "Oh, absolutely." I said, "Well, can you give me a rough estimate as to what this is going to cost?" He looked at it and said, "Well, it shouldn't be more than $150, but I'd say $125." I said: "Please order me one in. This came off a wheelchair, and the senior told me it cost $1,500 to get this." Being a jack of all trades I thought, "Well, I'll get it, and I'll adapt it for this senior." Anyway, two weeks later the farm dealership calls me back and says: "I can't believe it, but we're not allowed to bring those in. It's a medical device, and therefore we can't get it." The point that I want to bring up on this, with the health records and some other areas: it seems like as soon as medical is attached to something, we take a fleecing on the price.

I had another senior whose wheelchair axle – it was a rubber-tire device with actual plastic rims instead of steel, and the plastic had broken. She took that in to get it fixed, and the facility said: "Oh, that is outdated. You can't use it anymore. You've got to get a new wheelchair. We don't have those." There was a half-inch axle bolt that went through it. They wanted her to spend $750. I told that senior: "Look, we'll find one. Those wheels have got to be around." I found her two steel axles for $50 apiece and put it on, but the facility said: "Oh, no. That's outdated, and we can't get the parts for it."

It just seems like we've got a major problem in the medical system where we take an incredible fleecing on these services because they can and will take advantage of it. I wonder if the province has done any looking at where we're getting our sources from and if we can get a more reasonable rate and change the attitude of: this is government funded, and it's okay to charge $600. So I have concerns in those areas.

When it comes to the different drugs now, I believe that we announced awhile back $10 million to cover some drugs for cancer patients. We're picking areas again. Different physicians that I've talked to say, "You know, Paul, we've got seniors, whether they've got degenerative disease or other areas, and too often we're playing politics again." We're saying, "Well, here's $10 million for these drugs." But other people, whether they've got MS, Lou Gehrig's, or something else, aren't entitled to those drugs. They're feeling that we need more global programs, that if these drugs are going to be accepted, it doesn't matter what the tragedy is or the health problems, they need those drugs. Why we would say that a cancer person needs the drug and we'll pay for it, but for someone with Lou Gehrig's we won't. It seems like we're playing politics here and going for the bigger groups, and some of those smaller groups are feeling left out and very much concerned about the decisions that are being made and how it's coming forward.

The $114 million to accelerate the expansion of the Alberta electronic health records: another area that there's some question on and whether we're getting value for our money. But the biggest question, I guess, that some people outside health care are wondering, you know, is: are these totally going just to enhance the records and to enhance our evaluation and our treatment of people, or is this going so it's transfers of costs and other analyses? How much of that money is really being targeted to help with the evaluation and client care, like you were mentioning, with allergies and those types of things that come up?

I guess the other two things that I want to talk about are our lineups and our backups that we're dealing with. Quite often it seems like the shortage that we have is beds. We're saying that we've got these doctors, and you're talking about allowing them to go into private practice because they don't have the ability to do all the surgery they want in the public system. The question has to be asked: are the beds available there, and how could they possibly be working part-time in our public system, yet somehow be able to go to the outside and work and utilize their time there when, in fact, if we had the beds available, they'd stay in our public system and continue operating and putting people through? So I have questions on that line of thinking and where we're going.

The last area I'd like to cover is actually when, you know, this whole supplementary budget said it's under expense and equipment and inventory purchases. There are many things that the different health regions want to provide. I've talked to you before about angioplasty down in the Chinook health region, the MRI equipment down there. They had to raise the money. Currently there's a doctor that is trying to come back and is interested. He does colonoscopies, but the hospital is going to have to raise $150,000 to get the equipment to allow him to come back and work here if, in fact, he gets accredited to work here in Alberta again.

It seems like if we were to put some of this enormous amount of money into some actual equipment like for colonoscopies and into an angioplasty room and some of those things – we've got an enormous amount of money, and I guess I wonder how much is actually being spent on equipment and beds so that we can actually get people through and shorten the list down and do the best we can with the dollars that we're spending.

I'll look forward to the minister's response in writing or however. Thank you very much for the time.

Ms Evans: Mr. Chairman, I'm pleased to say that I am quite enchanted with the hon. member's observations across the way. It occurs to me as I listen to him that I've heard some of the same remarks and frustrations from people like yourself, hon. member, and several others in this audience that would probably wonder if there are ways that we could find an orchestrated response to making sure that we get those professionals in appropriate places at appropriate times.

Maybe what we need to establish – and I'll take a very sincere look at it – is some kind of central appeal mechanism for MLAs of all sides of the House to go through and say: this is your contact person if you've got somebody you believe should be working at a greater involvement in the health care delivery system and these are the barriers. Perhaps if I kept a registry of that, I would see some clearer way of unraveling and untangling these issues with members of the public.

I want to just give an answer to your first question on the number of staff. We will provide an analysis of how many staff were added, but I want to make clear that I will define it in two ways: the number of staff that we believe were added not so much as a result of the move to 3.4 hours of care per patient but equivalents so that we're comparing apples with apples and not just looking at the numbers that have been inflated because people have moved into long-term or continuing care residence. The other part, though, I should tell you is that in some cases dollars that were provided for long-term care were provided to increase the salary levels of people who were advanced either by merit or by some other agreement with their institution, so it not only provided more dollars for increasing the number of hours of staff care on that patient ratio but increased the number of dollars that individual providers received for the work they did interfacing on the front lines.

9:10

In terms of medical devices and alternative supports I think this is one of the areas that intrigues me most, Mr. Chairman, probably because as a woman living alone, I have suffered with not knowing what prices should be for repairing the simplest of implements and finding myself quite vulnerable because of my lack of mechanical capacity to evaluate that. Your comments about whether or not some of these substitutions would be acceptable, whether we should be entitled to importing other devices, or in fact are we being exclusive because they are, quote, unquote, medical? Are we being exclusive because someone has a lock on the market? I'm not sure, but I'm going to undertake to do some analysis of that.

If we could hire handymen or get people to do some kinds of replacements or repairs to equipment rather than replacement of equipment or just completely cancelling one chair that might have some use – we ship literally hundreds of pieces of equipment that we deem unfit to use any further for our own purposes to Third World countries. Perhaps some economies could be achieved if we would undertake to do the kind of repairs you have.

Mr. Chairman, I'm delighted. I'll sit down. I find now that if I've got something that needs help, I know exactly who to call.

The Deputy Chair: The hon. Member for Lethbridge East.

Ms Pastoor: Thank you, Mr. Chairman. I do realize that the time is running out and we have other departments that want to be discussed, so I'll try to be very brief. A lot of things that I'd like to say have already been said. I'm not sure that I actually need a reply from the minister. I think if you would just consider what I'm saying, it'll probably suffice for tonight.

One of the things that you mentioned – and I'm not sure if it was a misspeak or not on your part. You referred to the lifts as ceiling lifts. I'm wondering if, in fact, that was correct: they're ceiling lifts. It comes out of capital accounts. Now, ceiling lifts, in my mind, are totally useless. We need mobiles that will move around the rooms and down the halls and into other rooms, so it may just have been a misspeak.

Certainly, speaking about the injuries, in my mind it's partly because of inappropriate training, but I would venture to say that it's probably because people are working short. They can't wait for their partner to come, and they just do the job because they've got to get in and do it. I would suspect that a lot of those injuries lead toward that. Certainly these lifts will help, but I'm not going to bother going into it. I think it was pretty well described this afternoon what can happen.

The hon. Member for Cardston-Taber-Warner sounds exactly like the maintenance person that we had at our nursing home. We were so, so fortunate. He could feed his mother. He could do anything. He could repair them, but once we started getting into a more sophisticated way of having wheelchairs, he was told that he couldn't repair them because then the insurance companies wouldn't accept what he had done. So we often had things just sitting for no reason because of insurance. Perhaps that's something to look at.

The interRAI tool. I think that you explained it in a fairly comprehensive manner. Part of my problem with that, though – and I was given some education on the use of the interRAI when I was fortunate enough to sit on the MLA task force with my other two colleagues. It's my understanding that it's to establish a care plan, and that care plan has been made: three assessments with multidisciplinary people on that thing. The most important people that are often missing are the families, and they should be a crucial part of it, and I do know that they aren't in some areas.

The other thing is that that tool in my mind is supposed to be a care plan. It is not supposed to be used as a placement tool for where people will live. In essence what is happening is that they say: this is the care you get; therefore, this is where you're going to live. They're using it as an excuse not to put people into long-term care because they're trying to downsize long-term care. I'm really opposed to that because I have horrific stories that, of course, I'm not going to go into about people being very inappropriately placed for housing.

Another thing with the interRAI tool. It has to be used – again I'm back to my mantra of provincial standards – absolutely the same across the province. People have to understand the use of it and also the definitions. I would like to see at the bottom of that interRAI

tool the care plan. The care plan, then, equals the hours required to deliver that care plan and the number of staff that would be required for it. It would average out, I'm sure, but I think it's a better way of figuring out what actual staff hours should be, based on the actual care plan that the interRAI had come up with.

The medication. There are some excellent studies, as you know, that have been done and have identified a huge problem. Part of what I see as a problem is the downgrading of our professionals. I'll go into a little nursey talk here that I'm sure both you and I will understand, and it's just a very short story. I have a file on my desk where a woman came to me and said that she had actually been paying somebody to make sure that her mother got her medication. The mother suffers from Parkinson's. She came to me and said that sometimes she comes in and the medications are on the floor because, of course, the mother is shaking. I said, "Did you check the chart?" She said yes. The chart had said: medications given. Now, had it have been a nurse, like you and I, you would have assumed, because as a nurse and as a professional it is assumed, that when you say "medications given," they're also taken. However, if you're the cleaning lady for 50 bucks a month and you say "given," what you have done is given them and left them at the bedside. That is a huge problem, in my mind.

The electronic records. My fear for that is that I think that I as a patient would like the choice of what goes onto that electronic record. For one thing, I fear insurance companies getting it. I honestly don't believe that anything is secure in this day and age. There are just too many clever hackers out there. My fear is that insurance companies would get it and hold it against you in terms of pre-existing conditions for jobs or whatever. As I said, I really think it's important that patients have the right to say: "No. You will not put these in the electronic records. I want that between you and I." I'm thinking perhaps of some kinds of psychiatric records that may hit that because it comes in under a medication. It's a medication that starts the record, and then the rest of it would hit it.

You also had mentioned the report that I had also heard about with these huge mistakes in terms of the codings and dollars not being spent. It went both ways; the mistakes were made on both sides. You were talking about the dollars, and I'm talking about the mistakes that can be made in terms of the privacy. In computer-speak, not that I'm computer literate, the one thing that I did learn was garbage in and garbage out. If people can make mistakes in the filing of the billing, they also can make mistakes in the filing of the privacy or in actual fact of what they're supposed to be putting in in terms of: it was the left leg and not the right leg and whatever. Those sorts of little mistakes could be made. So I question that as well.

I think that if you would just consider all that, that would be fine. I don't need a reply tonight. Thank you.

Ms Evans: Well, I stand corrected on the – I've always called them ceiling lifts – safety lifting devices. I agree, and I would be very pleased to look into the kinds of things, and I'll get the Blues later to check.

I just want to make one point. I'm not sure that we can ever agree to the patient agreeing to what is placed on the electronic record for the simple fact that some patients, although I recognize that there is a risk always with information – one of our grave problems today is the management of those with psychiatric problems that choose not to take their medications, community treatment orders, et cetera. We have to have some kind of way of keeping that kind of record for the medical professionals and making sure that the patient record that they may be able to have access to isn't fettered with so many descriptors that could be in the hands of somebody else in the home, perhaps, given to the patient in a way that somewhat compromises their dignity.

I think there are a couple of things we can look at here, but I will make sure that I look at the Blues, and I'll give you a response later. I do look forward at another time to the opportunity to talk to you about the continuing care standards. I agree with you that interRAI should not be used as a placement device, but we should be careful to use it as an assessment tool. I always – always – believe that a patient should have a guardian or a family member as part of their care plan.

9:20

The Deputy Chair: The hon. Member for Lethbridge-East.

Ms Pastoor: Yes. Thank you. It's just really a personal comment, I guess. The fact that I recognized that you used "ceiling lifts" I think probably dates us both, so thank you.

The Deputy Chair: Okay.

The hon. Member for Calgary-Varsity.

Mr. Chase: Thank you very much, Mr. Chair. One of the concerns, an ongoing concern that was brought to me over a year ago from a constituent, is gastroparesis. I talked with the hon. member very early on last year about this concern, and it has to do with information accuracy. At the very beginning the mother of the two children who were suffering from gastroparesis had had a great deal of difficulty with receiving misinformation or the province was misinformed that a device was available. It had been approved federally, and the cost was, I think, relatively small. It was the equivalent of the cost of a pacemaker, basically, under about $5,000, but the technology and the medical expertise did not exist in Alberta at that time. Hopefully, the minister can update me as to whether she's found out whether Alberta has finally recognized that the device has been approved and if there are any steps towards being able to implant that device within the province.

In this particular case, the family was forced to mortgage their home and go down to the States, where fortunately the teenage children had the devices implanted. It made a significant difference to their daily lives – they were able to return to school – but at a great cost to the family, approximately $60,000.

There are a number of patients, both older and younger, who are so debilitated by gastroparesis that they have to be fed through a tube, and the minister is very aware that one of the greatest ways to increase the cost of care is to institutionalize a person. If this person who is being fed in the Foothills hospital through a tube and requiring this kind of care had had this device implanted, based on the percentages of success there's a good chance they would have been able to return home, return to work, and contribute.

This is just an example where we need to have updated information, and we need to have the specialists on hand in Alberta. Failing that, I gather that since this family had to travel down to the States, there is the capability in Quebec at this point, and hopefully the minister will consider that the travel costs associated with going down to Quebec, until we can deal with the problem here in Alberta, would be considered covered by the department of health.

Another concern I have has to do with cancer drugs. The province refuses to recognize federally approved cancer drugs, and by this failure cancer sufferers are suffering the financial costs of drugs that in some cases, I gather, are up to $15,000 a month. With these drugs having been proved effective in arresting the development of cancer, I would like to see that money being spent right now to improve the patients' treatment because without it they're not necessarily going to be around in the future for the research to have kicked in.

A second concern I have. I met recently with directors of the Calgary health region, and I was asking about the Children's hospital, which is going to be opening later this year in the Calgary-Varsity constituency. I asked: would the hospital be fully operational? I was told: no, it wouldn't. In fact, while we're going to have state-of-the-art, wonderful operating facilities within the Children's hospital itself, they're basically going to be kept in cold storage because we don't have the individuals to perform the operations within these rooms.

When we're talking about achieving efficiencies and having to contract out operations – granted, they're hip and knee, and there are not very many children that are going to require that type of surgery early on in their lives that would be attending this hospital – it seems to me a terrible waste when we have operating facilities within our public system that are being mothballed or at least underutilized.

Likewise, in terms of achieving savings, in talking to a radiologist with the Calgary health region, the individual indicated to me that there was absolutely no need for contracting out such things as MRIs and a whole variety of ultrasounds, scans, and so on. They could be done within the public system because this is one area where we're doing well in terms of having the equipment available. But because we only have a single shift, this work gets contracted out at a much higher expense. Yes, it's paid for under the public system, but if we were performing these scans, et cetera, within our own public system, which we have the capability of – we also have the trained individuals to do the testing. This is just an example of a greater efficiency that would be considerably less costly.

Another concern I have is with regard to the security of health records. This didn't happen under the current minister's watch, but we can remember that at one point we had a population of 3.2 million, but there were 5 million health cards out there. Based on the fact that it's not nearly as secure a form of identity as the driver's licence, which the minister of government affairs pointed out, we're still talking about a piece of paper. Yet that piece of paper can be used to apply for a passport. It's got the equivalent significance of a social insurance card. If you have to show ID at a police station because you had the misfortune of getting a ticket or you're looking for a police clearance, you can use this card as a statement of your identity. I would like to think that at some point in the not distant future we would have a more secure card system and that that would be part of the entire record system.

An ongoing concern of mine that comes up on a very frequent basis at the constituency office is patients falling through the gaps, whether they're supposed to be funded by seniors' care, whether they're supposed to be funded by health care, whether it's a community living concern. It seems that no one necessarily takes the responsibility, so a question I would have for the minister is: would you like to see anything to do with health, whether it's persons with disabilities, whether it's seniors, under the health care umbrella? When I've talked to people, for example, at the Bethany care homes, they would like to see anything to do with seniors – health, recreational programs, et cetera – under Seniors because they felt that they wouldn't have to go to three ministries, necessarily, to get support. It would be one-stop shopping through seniors' care. I'm just looking for a reflection if you think this is potentially a good way to focus on seniors' care.

9:30

With regard to the lifts, I'm glad that the difficulty was cleared up as to whether they were stationary or mobile. One of my constituents had the misfortune of basically going through nine years of frustrating denial from the Workers' Compensation Board because while working, again at a Bethany care centre, the lift that she was using to take a senior out of her bed broke. So this very dedicated registered nurse intervened and, in so doing, ripped the muscles out of both her shoulders and failed to receive appropriate compensation and was put through a series of very demeaning, frustrating reviews of her circumstance. She went to see an endless stream of different doctors, who didn't seem to have records from the previous visit. So she basically was unable to work, being put through a series of "Lift this box; lift that box," which she wasn't able to do. So I'm so glad to hear from the minister that more lifts are being put in place.

I do believe, as the hon. Member for Cardston-Taber-Warner pointed out, that there are possibilities of greater efficiency within the system. Sometimes the types of devices that we're giving to patients are of such a complex, built-in computerized nature that the ability to repair them no longer exists. So while I want the best for people, maybe we have to look at what is also very practical in terms of wheelchairs and power chairs and so on.

Thank you very much.

Ms Evans: Mr. Chairman, there have been a couple of points relative to follow-up on certain correspondence and discussion that the hon. member provided me with last year. I will have to examine the Blues and follow up on them, and that goes for some of the other points as well.

I think that overall what I hear here is genuine concern that we get it right in dealing with both the electronic health record and the hours of support for particular patients, and I appreciated his interest in some of those particular cases. I'll follow up and correspond directly, and I have my staff member Mr. DeBolt here that will make sure that we follow up on his questions.

The Deputy Chair: You're ready for the vote, I presume, after considering the 2005-2006 supplementary estimates, No. 2, for the general revenue fund for the Department of Health and Wellness for the fiscal year ending March 31, 2006.

Agreed to:
Expense and Equipment/Inventory Purchases: $141,183,000

The Deputy Chair: Shall the vote be reported? Are you agreed?

Hon. Members: Agreed.

The Deputy Chair: Opposed? Carried.

Solicitor General and Public Security

The Deputy Chair: The hon. minister.

Mr. Cenaiko: Thank you very much, Mr. Chairman. It's indeed an honour to be here this evening to discuss the supplementary estimates for the Department of Solicitor General and Public Security in the amount of $4,982,000, which is requested. The spending pressures are due primarily to policing costs and salary settlements. The three significant incidents that have resulted in spending pressures that must be addressed as part of the third-quarter update: $2.1 million for the Lakeside Packers strike in Brooks earlier this year, $2.3 million for the RCMP settlement, and $582,000 to provide policing services to the municipality of Crowsnest Pass.

Mr. Chairman, I'd like to comment briefly on each of these spending pressures. With regard to the Lakeside Packers strike the cost from the strike at Brooks was $2.1 million, representing 70 per cent of our costs as part of the provincial policing service agreement. This labour dispute was unexpected, but additional manpower was

required to diffuse any possible conflicts that might have occurred. In fact, there were some incidents that had the potential to escalate had it not been for the additional officers that were on scene. The strike lasted approximately three weeks and required support from the Edmonton and Calgary police services, the RCMP K Division municipal police service, the RCMP K Division provincial police service, and the RCMP F Division tactical team from Saskatchewan.

Mr. Chairman, regarding the RCMP salary settlement, funding is required to address $2.3 million in RCMP manpower costs resulting from the salary settlement impacts this fiscal year. The 2005-2006 provincial policing service agreement estimates included a salary settlement forecast of $2.1 million, which is consistent with historical increases. However, the total settlement amounted to $4.4 million, based on a federally negotiated increase for the RCMP.

Finally, Mr. Chairman, the Crowsnest Pass policing issue. An additional $582,000 is required to assume responsibility for policing the municipality of Crowsnest Pass. This is a result of the government's decision that the population of Crowsnest Pass be calculated as if it were five separate communities under section 604 of the Municipal Government Act.

Mr. Chairman, that's a brief look at our budget pressures and program review. Thank you very much.

The Deputy Chair: The hon. Member for Edmonton-Manning.

Mr. Backs: Thank you, Mr. Chairman. I'm very pleased to rise today to speak to the supplementary estimates on behalf of my colleague the Member for Edmonton-Glenora. Looking at these some-millions of dollars and all of the millions of dollars that are debated here under supplementary estimates, I just have to put in the point that I think it is shocking that we spend so little time and have so little time left to deal with many, many millions of dollars for each department. There should be more time allocated to debate these matters.

Just a couple of questions on these particular matters. On the Lakeside Packers strike and the cost of RCMP for that were any of these offset costs to communities that lost police personnel for short periods of time because of that strike? Were they compensated in other ways, or were they asked to be short of police for that period? I see that you've broken it down in your comments, Mr. Minister, through the chair, but why were they lumped together in the supplementary estimates document?

A minor question. Can the minister explain what he means by the costs of the RCMP salary settlement? Are these funds going to be used to adjust the salaries of police officers in Fort McMurray? If so, are the funds provided enough to allow these RCMP stationed in Fort McMurray an adequate standard of living given the extremely high cost of housing there? You might also look at Fort McMurray. If we're looking at urgency, the need to help those communities and, indeed, those personnel in those centres is very pressing. You know, if not, why aren't more funds being diverted to assist these officers?

9:40

As to the Crowsnest Pass: is this a reverse of the position that the minister took in the spring of 2005, when he actually denied the extra funding to the municipality of Crowsnest Pass? Is he now honouring the provisions of the Crowsnest Pass regulation, which stipulates that the government provide for funding for policing based upon whatever way that delivers more money? Why is there now a reverse in that position, and are these monies going to continue?

Another matter is in terms of the RCMP salary settlement again. Are there any training costs or extra training costs involved in that or any extra monies involved in the preparation for the training facilities that will be coming up, in the police academy or whatever we want to call that facility that's coming up? Just to speak to the potential siting of Edmonton: it is again, I think, in the primary position for that because of the siting of the Edmonton maximum institution there. Of course, we've also heard that another primary site might be the city of Drumheller because of the site of the institution there.

Thank you.

The Deputy Chair: The hon. minister.

Mr. Cenaiko: Thank you very much, Mr. Chairman. Some very interesting questions, and I'll respond to each of them as briefly as I can.

Were municipalities short of policing resources when the strike at Lakeside Packers in Brooks was taking place? What the RCMP do throughout our province: they use a concept called a post system, where the officers in a community – for example, let's use the community of Brooks. They have a number of officers that work in this municipality, in the city of Brooks, that are paid for by the municipality. The provincial government provides the RCMP officers that work in the surrounding community or in the rural communities around Brooks. In a post system officers can work, actually, in the municipality or can work in the rural area. So they can actually cover each other, and that's the "post" term that's used by the RCMP.

Because of the issue that this was 24/7 coverage for the strike, some RCMP officers had to be transferred in from various parts of the province to ensure that sufficient resources were there to ensure the safety of not only the employees of the plant but the safety of those that were on strike at the plant as well as ensuring the safety of the community of Brooks. Officers were brought in from various parts of the province to ensure that the number of resources that were required were there. That's why resources from Edmonton and Calgary police services were brought in, to ensure that, again, the right number of resources were in place, just to ensure that the police were there to provide a safe and secure environment for both those that were on strike and those that were not on strike.

In the supplementary estimates the hon. member asked a question about why both amounts were lumped together. The reason both amounts were lumped together, the $2.3 million and the $2.1 million as $4.4 million, is that they both fall in line with the provincial policing programs within the ministry. It's separated out for information purposes, but it's still in the same line item in the business plan and in our budget totalling $157 million. It's a small portion of the larger picture. It all ties in with our provincial policing service agreement that we have with the RCMP as well as some of the other smaller programs for the provincial policing programs that are provided.

The RCMP salary settlement, Mr. Chairman, is determined by the federal government. The RCMP are in a unique position where they do not have an association or a union that negotiates for them. Normally what occurs is that the finance department looks at the policing contracts throughout Canada, and it tries to keep the RCMP in line in the middle of, I believe, the top six police services throughout Canada. So they'll usually be in that number three position.

We don't have any say regarding what type of salary increase they get at all. Historically over the past number of years it's been roughly about 2.1. A 3 per cent increase would be roughly around that $2.1 million which we budgeted for. This past year they received substantially more, nearer the 5 per cent mark, and that, of course, created some issues for us, obviously, coming back to this

Assembly asking for additional funding to ensure that the RCMP officers got the raise that was given to them by those in Ottawa.

The member also asked, though, regarding the issues in Fort McMurray, which is a very good question: are those funds there to assist those officers at Fort McMurray? These funds are not. These funds are strictly for the salary. He raises a very good point, a very interesting point, in fact. We've been working with Commissioner Zaccardelli in Ottawa, the commander of the RCMP. There are some real issues regarding the fact that we have recruits coming out of Regina that are going to Fort McMurray. Their starting earnings are in the $40,000 range or close to that. Obviously, the cost to live and to provide for a family in that community can be very expensive, so we are working with the RCMP to look at being able to supplement their salary for the provincial positions. I know that the city of Fort McMurray is looking at working with the RCMP from that aspect as well. We're hopefully going to come to an agreement very soon.

I met with Commissioner Zaccardelli about three weeks ago, and he reassured me that it's on the table in Ottawa and that it's moving forward. There is a real concern for us with those officers because, obviously, we want to ensure that they have a quality of life in Fort McMurray that provides them with a salary that can provide the necessities for themselves as well as for their families.

The hon. member, Mr. Chairman, as well asked regarding the Crowsnest Pass legislation. Have we changed our position regarding the Crowsnest Pass legislation under the Crowsnest Pass amendment act? No, we haven't changed that because the Crowsnest Pass amendment act wouldn't allow us to split those communities up. The hon. Minister of Municipal Affairs and I met with the MLA from that area and discussed this at length with the mayor. It was an agreement that under section 604 of the Municipal Government Act the five separate communities in the Crowsnest Pass area could then be continued five separate, thus allowing them to be funded provincially under the provincial police service agreement, being that they were each a municipality of less than 5,000 population versus the town of Crowsnest Pass having a population of 6,700 individuals.

Training costs for Lakeside Packers, I believe, was one of the last issues the hon. member spoke of. Training costs are always an issue that we want to deal with year-round. Training costs of any type are not included in these estimates. This is strictly for salary, overtime, and the costs of the strike: food, lodging, which was done, I believe, at the armed forces to the south and west of Brooks on highway 3. Training costs, though, are provided in their normal budgets that we provide to the RCMP throughout the year in the lump-sum negotiated budget that we have with them, which is near the $135 million, $140 million a year. So training costs are included in there.

9:50

Did we learn from issues at the Lakeside Packers strike? Yes, we did. There are opportunities that we have to learn from. Obviously, one of them was very simple and very clear regarding communications at the site between the Calgary Police Service or the Edmonton Police Service and the RCMP. Our radios are not compatible. So we have to work on issues such as that as well as some of the techniques. The techniques in training for the RCMP are different than the techniques that the Edmonton Police Service and the Calgary Police Service use, for example.

There are some differences between municipal policing in this province and federal policing provided by the RCMP. Those are things that we've been reassured by the RCMP and the Alberta Chiefs of Police Association that they are going to continue working together on in the future to ensure that those training practices are going to come together. As we move towards integration in the province, as we move towards collaboration with our policing services, as we look at sharing services and sharing responsibilities, along with that will come, obviously, the training capabilities to in fact train together as one.

I'm not saying that one service has a higher standard of training than the other, but they do have different techniques, whether this service uses riot control techniques and this service on occasion uses bikes at a strike or a lockout. So there are a number of different techniques that are used. In our province we've been fortunate to have more training than other provinces. From the fact that with the WTO here about six years ago, with the G-8 here a few years ago, there were opportunities for us to work together in collaboration in a larger picture but, as well, bringing officers from throughout Alberta from all of our police services to one location and actually working together. So it's actually very interesting to watch because it is an opportunity to see a seamless police service work together with officers in different uniforms.

I think I've answered all the questions, Mr. Chairman. Thank you.

The Deputy Chair: The hon. Member for Edmonton-Highlands-Norwood.

Mr. Mason: Thank you very much, Mr. Chairman. I appreciate the opportunity to address the supplementary estimates for the Department of Solicitor General and Public Security.

The large majority of the funds that are being requested were included in the Lakeside Packers dispute, which the minister has talked about. The difficulty I have with this is that I think these expenditures were unnecessary and would have been avoided if the Minister of Human Resources and Employment would have worked towards bringing the parties to a resolution prior to the strike.

I attended at the picket line on several occasions, Mr. Chairman, and I found that the police presence generally was very positive. They were even-handed, by and large, and worked I think fairly effectively to defuse tense situations that developed from time to time. So I think it was a positive use of the police in that case, but the potential for violence was clearly there. It certainly wasn't violence restricted to one side. In fact, some of the tactics used by the employer were, in my view, deplorable.

But the question is why we have to pay this. This is a great deal of public money for a policing presence that might not have been necessary. The cost to the workers, the cost to the plant, the cost to the town's local community, and the cost to our agricultural producers were tremendous as a result of this strike. I believe that that strike could have been avoided, and we needed to see more action from the Department of Human Resources and Employment. Opportunities to head off the strike, in my view, were not taken.

So I guess I'd just ask the question. Before we make a decision that might involve extra expenditures in another department, in this case the Solicitor General and Public Security, is there some consultation when another department takes certain decisions that may in fact result in a dramatic increase in costs for that department? It might be in the agricultural department, or it might be Economic Development. I don't know. Clearly, the extra costs in Solicitor General and Public Security were caused not by that department but by another department, and I'd just like to know whether or not these things are discussed or worked out in advance and whether or not the Solicitor General has an opportunity to express his view with respect to decisions of another department that might substantially affect his budget.

The Deputy Chair: The hon. minister.

Mr. Cenaiko: Thank you very much, Mr. Chairman. The hon. member makes some interesting comments, and I'll try to answer them as best I can. The police presence. I think they were very kind remarks. I think they were very professional comments made, and I know that the police service members and RCMP members that read *Hansard* will appreciate the comments that you made regarding their presence being positive in that community and their presence being there to diffuse serious situations. Obviously, the potential was there, and the hon. member was at the site.

The question that the member raises was: could the strike have been avoided? That's a tough question to answer. I think we in this province have had very little unrest with our labour unions and associations. The labour atmosphere and environment is very good. When this strike did take place in Brooks, it was one that was unusual in the fact that we had not seen a strike of that magnitude in a long period of time. But from a policing point of view we did have the resources that we wanted to ensure that the residents of the community of Brooks as well as those that were striking and those employees that were not striking were all protected in that community.

The. hon. member also suggests that costs related to our Ministry of Solicitor General and Public Security may have increased due to the Ministry of HR and E possibly creating the problem. That's another good question. First of all, I'd like to thank the hon. member for supporting this budget request. That's what I thought he was inferring, but on the other hand it's always something that we have to deal with when we work in cross-ministry initiatives. Obviously, legislation is in place regarding strikes and lockouts. I had the fortunate ability in my previous career to be the strike lockout co-ordinator for the Calgary Police Service, and I know that going to the front line on a daily basis at various strikes in our industrial areas was very tense, but it was very interesting to talk to both sides because both came from different points of view. It was a matter of getting down to the table and being able to negotiate a contract fairly and in a reasonable frame of mind.

The last question: did the Ministry of HR and E create an increase for my ministry? No, I can't say that it did. The Ministry of HR and E is there to assist with employment standards throughout the province, to ensure that unions have rights out in the workforce but as well to ensure that management has the right to manage. Therefore, the strike itself was something that we have to live with and did, and I'm just thankful that no incidents of major occurrence occurred other than one incident where an assault took place, but nothing of a more serious nature occurred.

So thank you for those questions.

10:00

The Deputy Chair: Hon. members, we have two minutes left.

Mr. Hinman: Wow. That's a good time constraint. Well, I guess I'll have to be really brief and efficient. For the strike: $2.1 million. I guess I'd be interested in the breakdown on that on whether that was for the number of officers, the salary, or the resources that you had to bring in for that.

I wish that this supplement would have had recognition of the inequity for small towns throughout the province that have over 5,000 and are not receiving any funding as causing a major strain on those mid-size communities. Mr. Chairman, I was hoping that that would have come in there. On behalf of Mayor Irwin from Crowsnest Pass, he's grateful for the money that's come in for the policing there. But, as I say, the province really needs to take a look and realize that those small towns over 5,000 need a stepped approach where they're funded. It puts a tremendous strain on those small communities.

The other quick thing to mention is the training costs. These small towns that have had their officers come in, they often lose them to larger towns because of the salary inequities that they can't pay. Perhaps we should be looking at some sort of compensation when a small town loses a trained officer.

I also want to talk briefly about the police training facilities and to remind the Solicitor General again about LCC in the south and the facility that they have there and that we don't need to be necessarily looking at a whole new facility in the province but perhaps funding those that we already have and getting the best tax dollars for the number of officers that we can train and put out there.

Because of the shortness of time I guess that that's where I'll leave it.

head: Vote on Supplementary Estimates 2005-06 General Revenue Fund, No. 2

The Deputy Chair: Hon. minister, I would have liked to recognize you, but pursuant to Standing Order 58(1) and Government Motion 5, agreed to February 28, 2006, I must now put the following question. Those members in favour of each of the resolutions not yet voted upon relating to the 2005-2006 supplementary estimates, No. 2, for the general revenue fund, please say aye.

Some Hon. Members: Aye.

The Deputy Chair: Opposed, please say no.

Some Hon. Members: No.

The Deputy Chair: The motion is carried.

The hon. Government House Leader.

Mr. Hancock: Thank you, Mr. Chairman. I would move that the Committee of Supply rise and report the estimates of Community Development, Education, Health and Wellness, Human Resources and Employment, Infrastructure and Transportation, Justice, Municipal Affairs, Solicitor General and Public Security, and Sustainable Resource Development.

[Motion carried]

[Mr. Shariff in the chair]

The Acting Speaker: The hon. Member for Airdrie-Chestermere.

Ms Haley: Thank you very much, Mr. Speaker. The Committee of Supply has had under consideration certain resolutions relating to the 2005-2006 supplementary estimates, No. 2, for the general revenue fund, reports as follows, and requests leave to sit again.

The following resolutions for the fiscal year ending March 31, 2006, have been approved.

Community Development: expense and equipment/inventory purchases, $30,200,000.

Education: expense and equipment/inventory purchases, $11,000,000.

Health and Wellness: expense and equipment/inventory purchases, $141,183,000.

Human Resources and Employment: expense and equipment/inventory purchases, $6,100,000.

Infrastructure and Transportation: expense and equipment/inventory purchases, $39,900,000.

Justice and Attorney General: expense and equipment/inventory purchases, $3,720,000.

Municipal Affairs: expense and equipment/inventory purchases, $39,850,000.

Solicitor General and Public Security: expense and equipment/inventory purchases, $4,982,000.

Sustainable Resource Development: expense and equipment/inventory purchases, $15,700,000.

Mr. Speaker, I wish to table a list of those resolutions voted upon by the Committee of Supply pursuant to Standing Orders.

The Acting Speaker: Does the Assembly concur in the report?

Hon. Members: Agreed.

The Acting Speaker: Opposed? So ordered.

The hon. Government House Leader.

Mr. Hancock: Thank you, Mr. Speaker. In light of the hour I move that we adjourn until 1:30 p.m. tomorrow.

[Motion carried; at 10:06 p.m. the Assembly adjourned to Thursday at 1:30 p.m.]