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The Honourable Kenneth R. Kowalski, Speaker

Legislative Assembly of Alberta
The 27th Legislature

First Session
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[Errata, if any, appear inside back cover]

Legislative Assembly of Alberta

7:30 p.m. Tuesday, May 13, 2008

Committee of Supply

[Mr. Cao in the chair]

The Chair: Hon. members, I would like to call the Committee of Supply to order.

Main Estimates 2008-09

Health and Wellness

The Chair: The hon. Minister of Health and Wellness has the first comment.

Mr. Liepert: Well, thank you, Mr. Chair, and my pleasure to be presenting the estimates for the Department of Health and Wellness tonight. I should make all members aware at the outset that I am currently a product of the health system because I have been having this back situation, so if I don't get up quite as quickly and if I have to lean on the table as I speak, it's not because I'm inattentive; it's because sitting is rather agonizing these days.

Before we begin, I would like to introduce officials that are accompanying me here tonight. We have Paddy Meade, our deputy minister, to my right. Martin Chamberlain is acting assistant deputy minister of corporate operations, and Charlene Wong is acting executive director of finance and administration. It should be noted that after the election when the new cabinet was appointed, the deputy minister of Executive Council chose to find two new deputy ministers out of our executive team. That's why we have a couple of acting assistant deputies at this time, but I think it speaks well for the talent that exists in our department.

Our work in the year ahead will be guided, as all departments are, by the mandate given by our Premier. In my mandate letter the primary responsibilities of our department are to increase access to the health system and improve the efficiency and effectiveness of service delivery, and what I've said since the appointment is that everything we do will be built around the pillars of accessibility and sustainability and around patient care.

We introduced a health action plan about a month ago now, and that plan outlined a wide range of initiatives that we intend to accomplish and achieve over a three-, six-, and nine-month time frame. The reason those were chosen is that there are some initiatives that can happen rather quickly, there are others that are going to take longer to accomplish, and others that will probably actually lead into budget '09-10 and the legislative session of a year from now. Together these initiatives will help us create a health system that better meets the needs of Albertans.

An example of one of the initiatives that we'll be taking immediately will be the introduction of a patient navigator to help Albertans quickly and easily access programs and services that are required. We also intend to continue to expand the role of pharmacists to include preventing and managing chronic diseases. Through these and other steps we hope to build a system that is focused on the patient and not on the system, a system, as I said earlier, that's accessible, efficient, and sustainable.

In addition to work stemming from the ministry's mandate, Health and Wellness will continue its efforts in a number of critical areas. Addressing workforce shortages, improving infection prevention and control, and increasing access to long-term care are a few examples of the ongoing and important work of our department.

The 2008-2009 budget provides for our immediate and future-focused efforts as well as ongoing work. This year the ministry's budget increased by $1.1 billion. That's an incredible amount of money when you think that probably in our estimates in Committee of Supply in this session a lot of our departments don't even come close to $1.1 billion in total expenditures let alone the increase in one year. It's a 9.1 per cent increase and brings health spending in this province to $13.2 billion.

Out of that $13.2 billion health authorities receive the largest proportion, about 54 per cent. This year authorities will receive $7.1 billion, or an increase of $524 million. The increases range from 6 per cent to 8.7 per cent for our two largest health authorities, and I'd like to emphasize that every health authority in the province is receiving at least a funding increase of 6 per cent. Each authority is being provided with more dollars in the coming year, hopefully with the sufficient funding to address inflation and population growth. Government's funding allocation is designed to be fair and equitable. To achieve this objective, a number of factors are considered when determining each region's funding, factors like the number of elderly in the area.

It's true that Capital health received $110 million more than the Calgary health region this year. I'd like to explain that just a little bit. Capital health serves a much larger population from outside its regional boundaries than does Calgary. It is estimated that Capital health's net cost for providing services to nonresidents in the current year will be $162 million more than Calgary. In addition, the Capital region has a larger population of seniors and disadvantaged, all of whom tend to have greater health care needs.

Each region's needs are considered in a similar way to ensure that government provided appropriate funding. In turn we expect the regions to work within their funding allocations and undertake initiatives that will reduce their costs and improve productivity. I'd also like to note that funding to the authorities has increased every year since 1999-2000, and it has more than doubled in that time period.

There is no provision in this budget for health authority deficits. Audited financial statements are due by June 30. At that time we'll know if an authority has a deficit position. If that's the case, health authorities are required by legislation to submit a three-year deficit elimination plan.

I'd like to move on briefly to physician services. This accounts for the second-largest portion of our budget, at 19 per cent. In '08-09 two and a half billion dollars is budgeted for physician services. As most members are aware, we are currently in the negotiation stage under the eight-year trilateral agreement. The dollars are renegotiated and expired at the end of March, and we're currently into that right now. This budget also includes an increase of $20 million for salaries and benefits for medical residents, funding for the Alberta international medical graduate program, and funding for the postgraduate medical education program. We'll continue to work with other ministries through the health workforce action plan to address our province's shortage of physicians and other health professionals.

Infrastructure is another major component of the budget, accounting for more than 9 per cent. This year $1.2 billion is provided for new and previously approved capital projects. This includes $109 million for capital maintenance and renewal costs. I don't have time to detail some of the major projects, but they include the cancer corridor in Lethbridge, Red Deer, and Grande Prairie; 600 new and 200 replacement long-term care beds; and also significant dollars in the Northern Lights region under the Radke report.

We also in this budget have $749 million for supplementary health benefits. This includes everything from prescription drugs to ground

ambulance services and other benefits such as prosthetics and orthotics.

It should be noted that in the past 25 years total drug spending in Alberta has increased three times faster than either physician or hospital spending and six times faster than Alberta government revenue. We will be introducing a pharmaceutical strategy as part of our three- to six-month plan.

We've got a number of initiatives on protection, promotion, and prevention, and I'd be happy to discuss those during the estimates. I won't go into a lot of the other numbers. We can talk about those as we proceed through the evening.

I guess I'd just like to conclude by saying that I expect this to be a busy year for Health and Wellness. We've promised action, and our business plans reflect meeting that action.

I do want to conclude by saying that this portfolio is incredibly complex. I've had a short period of time to grasp as much of it as I possibly can. I want to ensure, however, that members' questions are answered thoroughly. If I'm not able to answer them tonight, we will provide written answers to any member's questions within, I would say, the next two weeks. With that, Mr. Chairman, I'd be happy to hear comments and take questions.

7:40

The Chair: The hon. Member for Calgary-Currie.

Mr. Taylor: Thank you, Mr. Chairman. It's my pleasure to rise and join the debate tonight on the estimates for the Department of Health and Wellness for the fiscal year 2008-2009. We are debating over the course of the next three hours or thereabouts $13,229,837,000. I'm not sure I've ever said that big a number in my life.

To the minister: thank you for committing to get written answers to our questions within the next two weeks if you don't have the answers to the questions we ask here on the floor tonight. That will be helpful, unquestionably. This is, as I well understand, a very challenging portfolio because I believe I've had the shadow ministry or critic responsibility for the portfolio exactly 24 hours less than the minister has had the portfolio. I often think it's easier to be the critic than the minister when it comes to health care, but don't get too comfortable. I'm not giving too much ground tonight.

Look, let's start with the big stuff. The big stuff is health regions, obviously: 54 per cent of the ministry's total expenses going to the nine health regions. You have noted that each region will receive at least a 6 per cent increase, and Calgary and Capital will get about 8.7 per cent. Really, though, when you take into account what the cost of living has been in the province of Alberta in the last 12 months and add to that the population growth, that's pretty much a break-even saw-off: 6 per cent up; 6 per cent up on the other side as well. I will use these words for now to establish the point, and then I'll explain myself. I think the argument can be made that the regions are no further ahead in this budget.

However, the regions are considerably further ahead of where they were in 2003. I am looking here at a research paper prepared – and I believe this will actually come up tomorrow, probably, in Public Accounts Committee – for the Public Accounts Committee that indicates that overall funding for regional health authorities grew by nearly 62 per cent between 2003 and 2007 while the population of Alberta increased by 9.28 per cent. Wow. They're well ahead of population growth and well ahead of the inflation rate in that area.

I guess that's a starting point for my questions, Mr. Minister, and it comes directly to your review of the health regions. It doesn't matter how I turn the paper. We don't seem to be getting good value for our money when regional health authority budgets are going up that rapidly relative to either the inflation rate or the rate of population growth. I'll be very interested to hear what the minister has to say about it.

Now, there has been a great deal of speculation, and I suspect that the minister is not prepared tonight to reveal what he is going to do to reform or rejig regional health authorities. I would merely point out to the minister that bigger does not always equate to more efficient. We went from 200 and some health and hospital boards to 17 regional health authorities, and the cost of health care went up dramatically. We went from 17 to nine, and the cost of health care went up dramatically again. If we're going from nine to even fewer than nine, I sure would like some assurance that we're not just going to put the price up again.

We've always said on this side – well, I shouldn't say that we've always said on this side of the House, but certainly for the last two or three years that I have been involved as an elected member, we have said on this side of the House that we think we're spending enough on health care in the province of Alberta. We are spending more per capita, I think, than any other jurisdiction in the nation. The issue is that we're not spending it tremendously efficiently, or to put it another way, we're not managing the system terribly well.

My first questions to the minister really turn around that. Does he think that there is cause for concern here when we see health region funding going up so dramatically relative to the inflation rate and population growth? Is he prepared tonight to speak to that in terms of shedding any light on what he intends to do about that, and is he in agreement that bigger does not always mean better in terms of more efficient, more effective?

I'll take a break at this point and allow him to answer those questions first.

Mr. Liepert: Mr. Chair, I'll try and make some comments in a general sense. I won't go any further than what I've said previously relative to our review of governance. I believe that if we want to have a more efficient, more effective health care delivery system, the foundation has to be right. You cannot try to change the system if the foundation is wrong.

I think the hon. member raises some very good questions about: are we getting value for money? Clearly, one of the observations I have made in the short period of time here and I guess even before is: have we as elected officials provincially lost accountability for that 54 per cent of the dollars that we spend? I think that that's a question we all have to ask and try and answer as we move through the governance discussion.

I was interested to hear the hon. member talk about some of the observations of the opposition caucus relative to a drastic increase in funding to health regions. I don't want to be confrontational, but I did see the hon. member quoted in the Calgary newspaper as saying that we should just write a cheque when we're talking about the Calgary health region deficit. We are not going to just write a cheque. We need some accountability, and I suggest that as we move forward, we will see changes take place that will provide more accountability.

But I think it's more than that. I think we have to look at the governance model. Is this the right model to deliver health care in the 21st century? I believe the government of the day determined I guess it was back in the early '90s that having hospital boards, long-term care boards all responsible for their own budget was not the way to deliver health care in the '90s. So the change was made to health regions. The question can be asked: is bigger better? I don't think there is a set answer that bigger is better. You cannot say bigger is better; you can't say it's worse. It all depends on how it's managed.

It's really about how to best deliver health care as we move

forward. We saw the evolution from hospital boards in the early '90s to health region boards. We saw the evolution from 17 to 9. We're now considering whether the evolution should move to something other than 9 or stay at 9. That's the discussion we'll be having, and we should be, I believe, in a position to make a decision fairly soon.

I'm not sure if I answered all the questions or not.

Mr. Taylor: Well, I think you did. But even if you didn't, you certainly gave me fodder for my next set of questions.

With reference to the quote that you attributed to me in – was it the *Calgary Herald*?

An Hon. Member: One of them.

Mr. Taylor: One of them. Okay.

I'm not sure if I said precisely that. I do have two points to make on that. Number one, something has to be done about the deficit that the Calgary health region is running because it's simply not sustainable. Point 2, there is another envelope of funding, and relative to a $13 billion health ministry budget and a $37 billion provincial budget it is relatively small change. It's $25 million, and that is what is required immediately. I certainly have said that the minister should just cut the Calgary health region a cheque for this, $25 million in immediate funding to open the new beds in the Sheldon Chumir urgent health care centre, that replaces the old 8th & 8th clinic, and the 200 or so beds coming on stream here at the expanded Rockyview general hospital. To me it simply makes sense; operating funding needs to follow and tie into capital funding.

7:50

Now, the ministry of health, wisely and several years late, finally came to the realization that Calgary lost 1,500 beds in the reorganization of the mid-90s. Calgary continued to grow, and nothing was done to replace those beds until very recently. About two or three years ago an expansion of the Rockyview and an expansion of the Peter Lougheed, a major rebuild at the Foothills hospital, and the construction of the Sheldon Chumir centre were all approved to help expand capacity in Calgary's acute care system and bridge the gap, if you will, to 2011 when the new hospital on the south Calgary health campus opens up. Those facilities are all needed. However, brand new beds are no good if there are not operating dollars to properly staff them, and I certainly would proudly be on record as saying that the minister should immediately cut a cheque for $25 million to make that so.

Now, that comes back to his review, which he has said will be thorough. I hope it will be, and I hope it will come up with some innovative recommendations. That review needs to find out why the Calgary health region continues to run a deficit, I think now for the sixth year in a row, something like that, and what can be done to change that. I'd call it a systemic problem.

He made mention of the governance model, and perhaps we should be talking about the funding model. Acknowledging that the population that the Capital health region serves covers a wider geography, is older, is sicker, contains more aboriginal people with very unique health issues than what Calgary does, it just doesn't work to say, "Well, Calgary's population is younger and healthier; therefore, the Calgary health region should get less money," if the end result of that is that the Calgary health region cannot look after the people of whatever age who are sick enough to need acute care.

So what plans does the minister have to re-evaluate the health region's funding formula as it is not adequately addressing the financial needs of the regions? What provision has been allocated, if any, or will there be to help the Calgary health region get that $25 million in immediate funding to open those much-needed new beds? What provision will be allocated, if any, to help the Calgary health region cover its current deficit of about $125 million, or is the Calgary health region, whether or not it continues to exist, going to simply be required to find a way in the next three years to pay that off?

Mr. Liepert: Well, first of all, Mr. Chairman, we won't deal with the deficit until we know for sure that we have a deficit, and that's why you submit audited financial statements. They're due by the end of June, and we will deal with those.

I do want to talk about the $25 million, however. You know, it really doesn't matter whether you're writing a cheque for $25 million to open beds over here or you're writing a cheque for $25 million to cover a deficit over there. It's, you know, one pocket or the other. I recall a fellow one time who was ranting on about city council. Every time city council had a budget crunch, what was the first thing they decided to do? They said that they were going to close down the swimming pool, and the reason they said they were going to close down the swimming pool was because they knew damn well that that is what the public would be the most irate about. I'm not implying anything along that line here, but I would suggest that the $25 million that the member suggests is $25 million that is well-leveraged to get additional money to ease what is seen as a funding inequity in Calgary today.

I think I mentioned in this House on a couple of occasions that we have had several reviews of the funding formula in the past, and I can tell the hon. member that I did travel the province shortly after taking this portfolio. I met with all of the health regions. When I was in Grande Prairie meeting with the Peace Country health region, what was the first thing they told me? The funding formula penalizes their area. When I was in Lethbridge meeting with the Chinook health region, they told me that because of their high senior population the funding formula penalizes their area. I think that you can make an argument, regardless of which region you are, that in some way or another the funding formula is unfair. So it is not my intent at this time to do any further review of the funding formula.

The bed issue. While I certainly acknowledge that Calgary, compared to every other region in the province, has fewer beds per capita, we need to look at health care in this province in a different way. Putting people in hospital beds is not the only answer to health care. Just because they have fewer beds doesn't mean that there is poorer care happening in that health region. We can show you statistics that show that there are areas of the province that have a higher number of beds per capita and hospital stays end up being longer, and a whole bunch of other costs are incurred simply because the beds are there. It's, you know: build it; they will fill it. So I guess there's kind of a happy medium that you attempt to meet in the Calgary region. One is that clearly on a per capita basis they have fewer beds than any other region. But we want to ensure that we don't simply build beds and put nurses beside the beds because they will be filled rather than looking at alternative ways of treating patients.

Mr. Taylor: Agreed in principle. There are much better ways to go about this than putting everybody in the hospital. The minister, I'm sure, will agree with me that the most expensive place to care for a patient is a hospital. So this brings up a couple of points: one, bed blocking, and two, the need to go to the hospital because you don't have a doctor. I'm not going to just talk about the family doctor shortage, although it is real. I know the minister has said before that not everybody needs to go to the doctor all the time either, and that's

true. But there is, I think, some wisdom to the notion that you're far better off and we're far better off as a system, as a province if sick people can go see their doctor or their health care practitioner, whether it's a doctor, a nurse practitioner, whatever is appropriate, in that – I'll use the term doctor – doctor's office rather than having to go to emergency and wait and ring up the bills.

It's getting tougher and tougher and tougher for doctors, whether they be family doctors or, you know, specialists, surgeons, whatever, if they have their own practices, to keep the old proverbial roof over their heads. Expenses are going through the roof for overhead. I talked to a doctor just last week whose office expenses increased I think – I'm going from memory here – by 17 per cent last year and 21 per cent the year before that. We are looking at some pretty dramatic cost increases.

In a recent Calgary health region study of family doctors 70 per cent of the doctors who reported leasing office space – and it was a small sample survey; let's be up front about that – will be negotiating their rental contracts within the next 12 to 14 months. Nearly half the doctors in the survey who were facing lease renewals, 46 per cent, are telling the survey that they plan to quit their local family practice, retire, or move their offices outside the city. The report concluded that operating a family doctor's office in the city of Calgary is not sustainable as significant overhead increases of 30 per cent or more are being reported thanks to the city's overheated real estate and labour markets. That is a quote from an article in the *Calgary Herald* and the *Edmonton Journal* from Tuesday, April 8, of this year.

Again I mentioned Calgary, but I mentioned Calgary because the Calgary health region did the survey. I mentioned Calgary because it's a well-known issue there. I don't for a moment think that the situation will be much different, and if it is different right now, it will remain much different in the city of Edmonton because the city of Edmonton over the last few years has had a tremendous capacity for . . . [Mr. Taylor's speaking time expired]

8:00

The Chair: Proceed, hon. member. The second 20 minutes.

Mr. Taylor: Thank you, Mr. Chairman. The city of Edmonton has had a tremendous capacity for catching up to the city of Calgary and sometimes passing it in terms of real estate values and rent increases and all the rest of that. So we have a real issue here – a real issue – and it's not just family doctors, although that's obviously a concern when you're short family doctors as we are in the province of Alberta. I wonder what the minister has in the way of firm plans, vague plans, anything in between for addressing this issue by making it easier for doctors to remain in private practice as opposed to going into the hospital system, where they get paid the same amount as they would to see that patient in their office, but they no longer have any overhead. Obviously, working as a hospitalist is a defacto significant raise.

What plans does the minister have in terms of – well, I'm not going to tie your hands on this one – addressing that issue of doctors' overheads in their own practices? Because even if it means an investment and perhaps a significant investment up front, we can reasonably predict, I think, that we're going to get that investment back and more in terms of the savings relative to seeing the patient in the office as opposed to having the patient go to a hospital.

Mr. Liepert: There's very little the member raised that I disagree with. I think it's important to try and answer the last question in this way. We have been making very good progress in what are called primary care networks or clinic environments. The new doctors and many of the doctors coming here from other countries are less interested in being sole practitioners/small businesspersons than they used to be. Doctors today, from what I'm told, are mostly interested in being medical doctors, not businessmen, and that's probably a good thing because it takes care of a lot of the issues that the member raised.

In addition to that, one of the difficulties that we had encountered in the earlier years in attempting to get the electronic health record up and running was the fact that you needed the buy-in from the doctor at the front end. It's easier to get a buy-in from a group of doctors that operate within a continuing care centre that may even in fact have a full-time office administrator, a full-time technology person that works for that clinic or that primary care network.

Chinook health region was a pretty good model until just recently, when one clinic pulled out of their primary care network. All of their doctors were on a primary care network. Capital has, I would venture to say, probably been more progressive in moving their doctors into primary care practice rather than sole practitioners. That is part of getting away from some of the overhead costs that the member raises.

I think we also have to look at our physician incentive. In some of the discussions we're currently going through with doctors, it's my personal view that we incent doctors in exactly the wrong way. We pay for them to have sick people come through their doors. We should be paying them to keep people healthy and not coming through their doors. I've sort of casually said that the highest paid doctors should be the ones that are on the golf course all afternoon because they've kept all their patients healthy and have kept them out of the health care system. So we have to really look at how we incent doctors as well.

We've talked a bit about the shortage of doctors. I want to be assured that we as users of the system are prepared to look at accessing health care in ways that aren't always walking through the doctor's door. The Member for Edmonton-Centre raised questions the other day about midwives, and I think it's a classic example of how we can be better utilizing our professionals. We've taken initiatives with pharmacists to prescribe and to actually start to treat. There are a whole variety of ways that we can meet the needs of Albertans' health care that may result in there not being the shortage of doctors that we've heard about.

I want to talk very briefly about the first issue that the member raised around bed blocking. We have in this budget, as I said in my initial comments, committed to some 600 new long-term care beds and some 200 refurbished facilities. I've already made arrangements. We're going to meet with my colleague the minister of seniors. We have to look at: how do we ensure that the private sector in long-term care can provide the facilities? Government doesn't have to provide them all. The long-term care facilities can be provided by the private sector, but we also have to look at other ways. Again, I'll refer to my visit to Chinook.

A few years ago Chinook health region on its own initiative determined that all patients that crossed that line – they no longer could stay in a lodge accommodation – had to move into long-term care, but if they provided a small assistance to hire one or two staff in that lodge environment, that senior could stay in the lodge environment, which was a lot less cost to the system. The lodge patron was happier in that environment rather than having to move to long-term care.

There are a whole bunch of ways that we need to look at ensuring that we have patients in the right environment, and clearly, as the member said, acute care is the most expensive for them to be in a bed.

The Chair: The hon. member.

Mr. Taylor: Thank you, Mr. Chairman. I'll come back to long-term care in a minute, but I want to bring the minister back to doctors in practice in their own offices and his comments about primary care networks and the clinics that make up those primary care networks. My understanding is that when a patient checks into a hospital for acute care, of the fee for service paid for that patient, a portion of that fee is, in effect, a facility fee for the hospital. I'm wondering if the minister can clarify for me whether a facility fee of any sort is paid to help defray the overhead costs of these primary care networks, these clinics, and if he would be willing to consider a facility fee, quite possibly separate from the fee for service that the doctor gets for seeing a patient if that's the payment model that particular doctor is using, to help defray the overhead costs of a doctor's own office.

Mr. Liepert: I'm sorry. I'm going to have to respond to that.

Mr. Taylor: A written answer to that? That's fine. Thank you.

Just while we're with physician services, since it is the second biggest chunk of the budget, a couple of questions for the minister around that. The goal is that by 2012 we will be graduating 68 more physicians, 625 more RNs, 441 more LPNs, I believe, if I have the numbers correct. If I don't, I'm sure the minister can correct me on those. How will these numbers be achieved given that members of the health industry have called into question those goals and wondered whether they're realistic? Will this money be put towards faculty or funding to increase student intakes substantially or a combination thereof? How will the minister address the fact that RNs can make more money nursing than they can by teaching at either Mount Royal or Grant MacEwan or the universities? In a situation like that, what incentive is there for them to teach to help meet the minister's graduation targets? You know, money is an incentive whether we like to admit it or not. Even if the minister is able – and I think this is a key one – to meet the graduation targets that have been set, what incentives are in place to keep medical graduates in Alberta to practise? The College of Physicians and Surgeons reported that last year 128 doctors left the province, and only 97 new medical graduates from the U of A and the U of C registered to be physicians in the province. That's a net loss. If that keeps up for very many years, it can reach endangered species proportions. So what incentives are in place to keep MD graduates in Alberta to practise, and what's being done to ensure that growth pressures don't force doctors in Alberta to leave the province because of the cost of doing business here?

8:10

Mr. Liepert: I'll try to deal with the question around incentives. We have to remember that we do have a mobile workforce. We attract as many or more doctors to this province than leave, if my recollection is correct. I don't want the member to leave the impression that somehow we have fewer doctors today than we had last year and last year we had fewer doctors than the year previous. We have, as I say, more doctors coming into the province than leaving.

I had a good opportunity yesterday to spend some time, as I believe many members of this House did, with the residents' group. I think there is more that we could do there. In many ways the residents are probably our lowest cost provider of health services in the system, so we'll take a look at that.

For many of the questions at the beginning that the member raised, it's unfortunate that they weren't raised with the Minister of Advanced Education and Technology the other night when his estimates were up because while the benefactor of much of that is the health care field, those are really questions that my colleague would have to answer. What I will do is take a commitment to get written answers to those questions for the member.

The Chair: The hon. member.

Mr. Taylor: Thank you, Mr. Chairman, and thank you to the minister for that. I think it would be key in any review of the health care system in three, six, nine months, whatever the timeline is going forward, since we are all in agreement that recruitment, retention, and training of additional health care professionals – be they doctors, nurses, lab techs, whatever – is a key component. The ministry of health and the ministry of advanced education and their ministers need to become awfully good friends over the next few years, I think.

Mr. Liepert: We have offices next to each other.

Mr. Taylor: The minister just said that he and the minister of advanced education have offices next to each other. Perhaps they should get adjoining rooms at the Holiday Inn. I don't know, but I hope that they're travelling back and forth frequently.

On the subject of the net increase in doctors, then, year over year, if we're losing more Alberta-trained doctors than we're turning out year in and year out, it only makes sense that we're making up the difference by importing doctors, whether that's from British Columbia, Ontario, South Africa, Lower Slobovia, wherever they're coming from. That brings up, of course, the question of foreign-trained doctors. The minister mentioned at the outset that he's going to be working to speed up the accreditation process for foreign-trained medical professionals of all sorts, if I recall. I'd like him to talk a little bit more about that. Also, what systems are in place to help foreign-trained health professionals once they're here, whether they're fully accredited to practise or whether they're practising while they're awaiting their accreditation under the mentorship of Canadians, to help them with such things as finding housing and dealing with some of the growth pressures that are putting up the cost of, quote, doing business, unquote, as a health care professional in this province?

Mr. Liepert: There is some assistance through the regions for some of the doctors, certainly in rural areas, to try and encourage them to locate outside of the major centres. The accreditation and registration, of course, is handled through the College of Physicians and Surgeons, as the member would know. You know, there's always a question about why a particular foreign-trained doctor is not registered or not accredited through the college. I think that generally, though, the college is very diligent in how it ensures that doctors that are accredited to work in our province are legitimately trained and meet our standards.

I did want to put on the record that between 2003 and 2007 – those are the most recent statistics we have – we in this province saw a net increase of 1,049 registered physicians. So just to be sure, our increase is over a thousand physicians in that four-year period, and as of a year ago we had almost 7,000 physicians registered in Alberta.

The other thing that we should not lose sight of is that we do have medical graduates that leave our province, but in some cases they actually leave our province to get advanced training and come back. So they may in fact register on the scale as leaving the province, but

we have to make sure that we're tracking them because several years later they may very well be coming back.

I'm not sure if that answers all the questions, but I'll leave it at that.

Mr. Taylor: Okay. It doesn't answer all the questions, but we have other ground to cover as well.

If I could refer the minister to page 242, line 2.0.3, the physician office system program. Almost had a slip of the tongue there: I said symptom program. It budgets $34 million for the physician office system program. Last year the same amount was budgeted, and it appears that nothing was spent in the last fiscal year. Zero. I'm wondering what that means. Was the program not implemented? Or was the portion of the program that was supposed to be implemented not implemented? What's going on?

Mr. Liepert: If I'm looking at the right line, member, just look one line over: '06-07 actual was almost double that. What actually happened there was the commitment was made probably just near the end of the budget year, but it got accounted for in the year previous. I'm told that the spending was actually one year in advance and then was a catch-up in the year '07-08.

Mr. Taylor: So the budget for this year coming up will be spent this year?

Mr. Liepert: Yeah.

Mr. Taylor: Okay. Good.

I think we can move on now to long-term care because I said I had some questions there. I know that one of my colleagues would like to talk in a little more detail about home care, so I'm going to leave that for the Member for Calgary-Mountain View if I can. When we talk about the difference between assisted living and continuing care – forgive me if I'm not using all the right terminology. I've had some personal experience over the last year dealing with the system in Nova Scotia, and I do tend to mix up the terms a little bit. But what I'm really meaning in, sort of, classic terms is nursing home versus assisted living versus a retirement home for seniors who are, you know, just choosing to live in a facility like that, but they're still perfectly mobile, et cetera, et cetera, et cetera.

I understand in theory what the minister is saying about wanting to keep seniors in a sort of lodge kind of environment if at all possible, and if it's therefore possible to add a little bit of assistance to that in many respects, that often is preferable to uprooting them and moving them into a higher level of care, one step closer to the Pearly Gates, if you will. But how does the department make that determination? How does the department determine, or who determines, who is eligible for continuing care and who can make do staying put in the lodge with a little bit of assistance? I'm sure the minister understands that if you make the case that grandma can stay put in the lodge, grandma is going to cost the system a whole lot less than if you have to move grandma into continuing care.

The Chair: We're now in the last 20 minutes of the first hour.

Mr. Taylor: Thank you, Mr. Chair. Okay.

The Chair: Proceed.

8:20

Mr. Taylor: I'm not clear as to how the decisions and how the determinations are made because it's also equally true that there's a powerful incentive in a system and a ministry that has ever-increasing budgets and ever-increasing pressures on the broader provincial budget to keep the cost down. That may not be in grandma's best interest.

Mr. Liepert: Well, just to be clear, it's not the department who would do that assessment. It would be the health region that does that assessment. There are professionals that deal with patients, whether they're in a lodge environment or a long-term care environment. It would be the judgment of a health care professional, with some assistance and some financial assistance to that lodge, to hire the nurse or whatever was required. The health care professional would make that judgment, probably, I would suggest, with some consultation with family members to ensure that that is the environment that they would want their parent or elder to be looked after in. It's done in the same way that you would be assessed by a doctor outside the system would be my answer.

The Chair: The hon. member.

Mr. Taylor: Thank you, Mr. Chairman. I just got a request from *Hansard* for an earlier quote, so I was looking for where I got that. Just bear with me for a second while I turn back to the page on the notes where I was at.

My understanding is that these decisions are often made by panels within the health region – or it could be individuals; whichever – but that the processes are not particularly open, that they are susceptible to administrative and bureaucratic pressures and influences, maybe even political, that the panel members are regional health board employees in many cases. They're bound by confidentiality regulations, so they're not really accountable to anyone for that decision. The panel meetings happen in private; they're not open to monitoring or review.

Now, I could be wrong – it wouldn't be the first time, and it won't be the last – but I hope the minister can assure me that there's some sort of accountability process here that is open and accessible, not to me, not to members of the opposition, but to members of the public whose own relatives may be going through this process so that they can quickly check and see what the rules are, what the parameters are, how the decisions were made.

Mr. Liepert: Well, yeah, I think it needs to be clear that we do have within the department a monitoring group. The care in these facilities has to meet certain standards, and that's their job. We also have the Health Facilities Review Committee, that visits these homes.

You know, there's no question that we had the review several years ago by the Auditor General, and it was critical of some of the care that was in these lodges and in the long-term care facilities. But I think it should also be noted that the Auditor General in his follow-up report very recently was actually quite complimentary to a number of the changes that he had recommended that had taken place, and we were actually quite pleased with the progress that had been made.

I guess that if there's a specific instance that the member has, I'd be more than happy to have our officials look into it. I don't want to sort of have it left hanging out there that there are some situations that, without identifying what they are, are somehow not following the standards that we set and monitor. If there's something specific, I would ask the member to draw it to our attention.

The Chair: The hon. member.

Mr. Taylor: Thank you. Being cognizant of the time – I know that there are other people who wish to join the debate tonight – I'm going to choose to talk about wait times next, if I could. I may not get to the other topic that I wish to discuss, but I'm sure somebody else will. I need the business plan. If I could have a quick look at that. Page 165, I believe, is what we're looking at, Mr. Minister. Goal 5, health service quality and innovation. It kind of looks like we're missing some of the targets here. Heart surgery. I think we nailed heart surgery last year. Cataract surgery. The target was 16 weeks last year, and the actual was 40 weeks; the target again this year is 16 weeks. Hip replacement surgery. The target was 26 weeks' wait time; the actual was a little over 40 weeks. Knee replacement. The target was 26 weeks; the actual was nearly 50 weeks.

I guess I need to know why those wait times didn't meet their targets and why they missed their targets as dramatically as they did. Since these targets were not met, what is the minister going to do about that? If I'm reading the documents correctly, I don't see any additional funding provided to specifically address these wait times. I'm perfectly willing to concede that there might be a better answer than just throwing money at it, but I do want to hear that answer.

In the estimates, page 242, line 3.0.13, patient wait times guarantee, there's about $31 million budgeted there for this coming year. I'm wondering if that's the same funding for the cancer radiation wait time initiative, which had been allocated at about $31 million. I'd like to know some details, plans, timelines, goals, et cetera, involved with the $31 million allocation to reduce cancer wait times. I'd like to know that I can sit down with some degree of confidence that this initiative will actually reduce wait times to – I can't come up with a better term for it than acceptable standards, you know, given that you set targets given the failures of last year's performance measures. I think, by way of comment, that the targets were not only missed; they were in some cases missed by a mile, and we need to do better than that. I'm interested in hearing the minister's response to that.

Mr. Liepert: The member is correct. The $31 million is the federal money that just came through, and that, we are hopeful, will go a long way to meeting some of those wait time targets that have been set.

I think it's fair to say that we are going to have a difficult time meeting targets, and I'll come back to my view on targets in a minute. In our current workforce environment we're going to have a tough time meeting what I would consider to be even acceptable targets.

I guess to me the ultimate vision that we should be shooting for in health care is that service is there when and where you need it. I believe that – and I've said this publicly – establishing wait time guarantees is a simple way of saying: "Well, it's the Canadian way; you have to wait. We're only going to make you wait just a little bit less than what you normally have to wait." We should be striving for a system that does not have a wait time for anything. Now, I recognize that's probably not going to happen and certainly not going to happen in the short term, but to me the wait times that are listed are unacceptable, and we need to work to improve them.

Mr. Taylor: Well, then, if the ultimate target, the ultimate goal is that the service is there when and where the patient needs it, even respecting what the minister just said about wait times, I have to ask: what's his targeted wait time to achieve that goal?

Mr. Liepert: Well, I think we have to be open to different ways of providing health care, and I'm sure we'll have some of those debates as we move forward through the next four years. We need to be open minded, and we'll see where it leads us.

You know, I think a good first step in what we've attempted to do to meet some of these wait times and ensure that the federal dollars are going where they were targeted is our initiative to build a cancer radiation corridor in Lethbridge, Red Deer, and Grande Prairie. It's not going to happen this year, and then probably some of the wait time guarantees aren't going to be met, but it's a first step towards getting there. It's only one step, and I'm sure we'll have many discussions over the budget estimates over the next few years on this.

8:30

Mr. Taylor: I'm sure we will, and I understand the need to keep an open mind.

Sometimes it strikes me that the debate over health care in this province and this country has become a little bit like the abortion debate, which back in my past life was always a topic you wanted to avoid in talk radio because there were two polarized positions: either adamantly pro-choice or adamantly pro-life. No matter how you tried as the facilitator of that discussion, you couldn't bring the two sides any closer together. It sometimes seems to me that we're in much the same boat in regard to privatized versus public health care, that the argument in favour of public health care as expressed by some seems to at least be perceived as an argument that's totally wedded to preservation of the status quo without any open mind whatsoever. On the other side of the equation there are those who are pushing a privatized health care system or a health care system that contains an element of privatization who argue that if you could just let the people who could afford to go and pay for their medical needs, somehow that would make lines and wait times and all that magically disappear and that that's the only way that you can do that.

I'm going to ask the minister, within the context of that open-mindedness that he spoke about: does he believe that he can pull this off within the context of the public health care system, the single-payer health care system? It does seem to me that he got a pretty clear mandate to do that from the Premier.

Mr. Liepert: Well, I think, Mr. Chairman, it's fair to say that we have made a commitment to a publicly funded health care system. You know, there are a lot of scare tactics out there about private delivery of health care, and we have significant private delivery of health care today. The question is: how is it funded, and how is it accessed? I believe that we are going to do harm to patient care if we aren't open to a debate on how best to deliver health care to Albertans. That's all that I would say on that at this stage. I'm open to debate.

Mr. Taylor: But not particularly tonight, not at this time on that subject. We will come back to that.

You know, one way to approach health care is to keep people from getting sick in the first place. With that in mind, I noticed that – where am I here? – on page 241, line 6, assistance to the Alberta Alcohol and Drug Abuse Commission, AADAC, increases about 5 per cent, or $4.7 million. Total funding is $99.6 million. That doesn't seem like a huge investment in addictions counselling and addictions prevention.

I'm noticing as well that on page 164 of the business plans, under 4(c) and 4(d), the performance measures for the prevalence of teenagers who smoke and drink heavily remain stagnant, and I wonder why. As smoking and drinking cause serious health concerns, as the minister well knows, particularly the younger that

those behaviours start, why is the government not planning to do more to address this performance measure? Surely the minister isn't satisfied with the fact that 1 in 3 teenagers is reported as a heavy drinker.

On page 243, line 6.0.2, the Alberta tobacco reduction strategy is budgeted again this year at $9.1 million, the same as last year. Why haven't you increased funding for this strategy? Why does the ministry business plan not have a statistic for teenage smokers for 2006 and only lists one for 2005? Are you tracking this to the extent that you should? We must know by now that tobacco use is one of the worst things you can do for the sake of your health over the course of your lifetime and that tobacco cessation or the prevention of tobacco use are probably two of the smartest strategies in terms of health promotion, wellness promotion, and disease prevention that we can undertake. Why not more of an effort on that? Have we solved the problem? I still see teenage smokers on the street. I still see adult smokers on the street. I have to conclude we haven't.

Mr. Liepert: Well, I want to deal first with the dollars allocated for – the member talked about the AADAC dollars. We have to recognize that there is a significant chunk of money – I think it's some $29 million – that comes out of the allocation from the safe communities task force report, and that is aimed directly at addiction treatment. I absolutely agree with the member that we should be doing more in terms of prevention. It's way less costly and obviously way more beneficial to society if you can prevent an addiction from happening in the first place rather than treating it after. In many cases the young person becomes addicted.

We have statistics that show that smoking and heavy drinking in young adults have actually declined. I will express a personal opinion here: I think that we have to do more. I believe we have an economic situation where young people have considerably more disposable income than they've ever had in the past, and it's difficult sometimes to try and ensure that they make the right choices. We have, the member is well aware, taken initiatives on the antismoking campaign, and as of July 1 the so-called power walls will no longer be permitted.

I certainly agree with the member when he talks about the damage. I happen to have a number of family members – my father was a heavy smoker. I used to hear him cough every morning, and I'd swear to God I would never start smoking because of that. But I also have family members that currently smoke, and as much as I try to tell them how bad it is for them, it almost works in reverse. I think you can do as much as you can to try and encourage young people not to take up these bad habits, but it's probably easier said than done to bring in government policies that somehow are going to fix all of those problems.

The Chair: The hon. member.

Mr. Taylor: Thank you, Mr. Chairman. Yeah, it is easier said than done. I'll agree with the minister on that.

The Chair: One minute, hon. member.

Mr. Taylor: One minute? Thank you.

We've been fighting the war on tobacco for over 40 years now. It is a war that we're winning, though. I guess my only encouragement to the minister on that is: don't give up on that one. We're spending $9.1 million on the tobacco reduction strategy, $7.1 billion on the health regions. I'd like to bring those two numbers a little more in line if I could.

My time, Mr. Chairman, is very close to being up. I think I'm leaving a few seconds left over, but I know that there are many others in the House who would like to join the debate on the Health and Wellness estimates. I thank the minister, I look forward to his written answers, and I look forward to the rest of the debate.

Thank you.

8:40

Mr. Liepert: Can I answer that very briefly?

The Chair: Quickly.

Mr. Liepert: Okay. I don't want to leave the impression that the $9 million that's spent on tobacco reduction is all that's being done. There are a number of programs spread throughout the department, whether it's in AADAC, whether it's in the cancer legacy fund, that are geared towards prevention.

The Chair: The hon. leader of the third party.

Mr. Mason: Thank you very much, Mr. Chairman.

The Chair: Hon. member, do you want the 20 minutes?

Mr. Mason: Yes. I'll go back and forth if that's all right.

The Chair: Okay. Go ahead.

Mr. Mason: I'll start with a few questions. Mr. Minister, thank you very much for your comments so far. I managed to catch at least part of the questions. If I'm repeating things that were said before I arrived, please just let me know, and I'll check the *Hansard*.

I'd like to start off with the question of health regions, which has been fairly topical in the last little while. I don't expect the minister is going to sort of reveal his hand in terms of plans for the total number of health regions in Alberta, but I would like to know what he thinks the advantages and disadvantages are of more or fewer health regions and what role he thinks the health regions currently play. What do they really bring to the table in terms of improving the quality of care or the availability of care in our system?

I'd like to ask about drug costs, which are one of the drivers of increased health care costs. As the minister knows, we've put forward a proposal for a number of years now for doing some bulk buying of drugs on a system-wide basis. It's based on a model formulary used in New Zealand, which has about the same population as this province. Now, in the past I've addressed this question to two ministers previous to this one, and in each case the answer was: we're looking at this sort of on a national basis. Of course, it would make more sense because you've got bigger buying power nationally, but in fact, as I've learned, there's precious little actual progress on this, at least as far as the currency of my information. I really would like to know why we just don't try and tackle this thing. The calculations we did showed that it could potentially save $150 million. Now, in a huge multibillion-dollar budget that's not a huge amount, but $150 million is $150 million. It always struck me that one of the things that we should be looking at is whether we're paying large pharmaceutical companies too much from the public purse for drugs.

It relates to a second piece, which we've also talked about, and that's the whole question of seniors' Blue Cross coverage. I think we have a good system to a point here, where seniors are limited to I think it's $20 a month per prescription. As the minister knows, many seniors have multiple prescriptions, and we actually in the course of our research found, you know, in some cases up to 20, but

a dozen is not uncommon. That adds up to a considerable amount of money every month. I wonder if the minister is prepared to consider capping the monthly fees. According to our calculations savings from bulk buying of drugs could fund a cap on Blue Cross so that seniors pay $20 a month regardless of the number of prescriptions they had. So I'm wondering about that.

I wanted to ask also about doctors. I did hear some of the conversation about the shortage and so on. There was a report today in one of the newspapers about patients being surveyed, and a significant percentage felt that they didn't get enough time with their physician. That's probably due, I'm guessing, to the shortage of physicians, and they're trying to cover more. It also raises the question of our fee-for-service system for paying physicians. I'd be interested in the minister's views on the fee-for-service system and whether or not it's time to start pushing a little harder to have doctors on salary.

That also, then, is a segue towards the question of rural health care and whether or not we ought to consider establishing public clinics in many of the smaller centres around the province where there are doctors that are on salary. Maybe some of that is already done, but it seems to me an idea worth looking at in terms of improving access to physicians across the province but with a special emphasis on rural areas and smaller centres.

Mr. Chairman, that's my first. It's kind of a grab bag, but it's a set of questions for the minister, and I'll let him respond.

The Chair: The hon. minister.

Mr. Liepert: Yes, Mr. Chairman. First of all, with respect to the health regions we did cover that off somewhat before your arrival. I think it's fair to say that we have made it very clear that we are planning to review the governance structure of health care and how it's delivered in Alberta. We will be taking some options to caucus fairly soon. It's not about whether there should be more or less or whether bigger is better. It's all about delivering health care differently in the 21st century than we delivered it in the '60s and in the '90s. That's what we have to arrive at: to ensure that whatever the governance model we have in place, it's one that can deliver health care better, more efficiently, more effectively into the 21st century. I'll leave it at that.

With regard to drug costs the hon. member mentioned some total dollars that his arithmetic came up with in terms of bulk buying. I don't have the calculation that he used, but I do know that he and I disagreed immensely on the calculations he used around royalties. So I don't want to justify the numbers that you're using, hon. member, because if they come from the same source that your royalty numbers come from, we're going to have a major disagreement right off the bat. There's no question that we can do more around drug costs. They are our fastest increasing cost in health care. We have committed to a pharmaceutical strategy as part of our three-, six-, and nine-month action plan.

The member mentioned a national buying authority. I don't think we're pursuing that strategy, but I do believe we need to pursue a strategy at least with the three western provinces. Manitoba may have different ideas because they have a different philosophical government in Manitoba than they do in Saskatchewan, B.C., and Alberta, so it may be harder to work on that kind of a strategy with Manitoba, but we certainly are going to try to work at least with the three western provinces. But it's not just drugs. We can be looking at large equipment purchases as well, procurement of large equipment, and maybe it's even procurement of large equipment that is stationed in one location that serves all three provinces. So we need to not only start to look at the delivery of health care on a provincial basis, but we have to look at it on a western basis.

The member talks about senior Blue Cross coverage. I would want to look at our Blue Cross coverage in maybe a slightly different way than the hon. member is looking at it. He mentioned a $20 cap, sort of, for all drugs. I think we have to start to look at whether or not a number of our seniors should be on the senior drug plan and have to pay only $20. Seniors today are in a very different income bracket in many cases than they were 20, 30 years ago, when some of these universal programs were put into place. We need to start to look and see whether we can continue to afford some of these drug plans.

8:50

Relative to physicians the member raised the issue about a survey that he referred to, that patients felt they didn't have enough time with their doctor and putting doctors on salaries. We've made some very good progress in our primary care networks. While it may not be on salaries, it's the same concept. I guess I would have asked the question in that survey in a slightly different way. I would bet the answer would be quite different if you asked it in a different way. If you asked that same question of those same patients of the doctor and said, "Did you spend enough time with your physician if you were paying by the minute?" they might have a very different answer. It's very easy to say, "I didn't have enough time with my doctor" when it didn't cost you anything. But if you were paying some of that cost – I'm not suggesting you should be – I would venture to say that your answer would be quite different. If the first five minutes were free and then after that you had to start paying by the minute, I would venture to say it would be quite a different opinion.

The Chair: The hon. member.

Mr. Mason: Thank you very much, Mr. Chairman. I want to return to the question of bulk buying. The minister talked about his disagreement with my position on royalties, which is interesting but really not exactly answering the question. I guess I would ask the minister this: has he had his department look at doing bulk buying of pharmaceuticals, and does he have numbers that are, perhaps, different than mine, and would he share those numbers? I'll just indicate that we basically took the savings that New Zealand found and just applied the same reduction to the Alberta drug budget. That's how we got ours. It's very simple math. It may not be the right math. The question is, really: is the minister looking at it? Does he have his department looking at this? If so, does he have some numbers that he at some point can share with us?

Mr. Liepert: That would clearly be part of our pharmaceutical strategy that we'll be unveiling over the next few months.

Mr. Mason: So that's a yes?

Mr. Liepert: Well, we'll see.

Mr. Mason: Okay, Mr. Chairman, we'll see whether or not. We will, I guess.

I want to ask about wait times. The hon. Member for Calgary-Currie talked about the issue of not hitting targets on wait times. I appreciate that the minister said the wait times weren't good enough, but he also talked about – he hinted at, I guess – how you might deal with wait times.

Economically, Mr. Chairman, there really are two ways of dealing with scarce goods or services. One is to put people in a queue, which is, of course, what they used to do in the old Soviet Union for

bread and food. You had lineups for basic commodities because those prices were subsidized and very low and there was a shortage relative to the demand. The other way to do it is to use a price mechanism. You can make the lineups disappear by just letting the prices rise. I'm interested to know if that's what the minister has in mind: eliminating wait times using a market price mechanism.

I do know that Alberta Health a few years ago had what I thought was a wonderful program for managing wait times. I think it was with respect to heart if I'm not mistaken, where they basically pooled all of the doctors that were available and had a combined waiting list, and the reductions that were projected from that were dramatic. The minister at that time talked about extending that system to other surgeries and other procedures.

Ms Blakeman: It was bone and joint, and they talked about extending it to heart.

Mr. Mason: Yes. Thank you very much. It was bone and joint, and they were talking about extending it to heart. That's right. I appreciate that.

I'd like to know if that's been done and if the results that we're seeing and the figures that we're seeing here are a result of doing that or whether or not something changed and they didn't go ahead with that.

The Chair: The hon. minister.

Mr. Liepert: Yes. The member is correct on the bone and joint – I don't know if you'd call it a trial because it was significantly more than a trial – the model that was put in place. I actually just met with Dr. Cy Frank and the group a week or so ago, and they now have had the opportunity to compile the data. The numbers are very impressive. You know, some of this is not necessarily rocket science. It's saying: how can we streamline the system so that the patient is receiving almost like a continual care mechanism through the system rather than sort of going in here, getting kicked out; coming back there, getting kicked out? I would say that there are good indications that we can take the model and make it a model for a number of other, similar kinds of processes through health care. That will obviously require a buy-in province-wide from all of the providers. That's the one thing that the bone and joint folks have had, a very good buy-in from all of the surgeons, and it's a model that we should be working towards, implementing other care in that way.

The Chair: The hon. member.

Mr. Mason: Thanks, Mr. Chairman. Well, I'm pleased to hear that. I am a firm believer that change has to happen within the context of a public, single-payer system and that innovation can in fact save a great deal of money and improve efficiency, improve patient outcomes, and that we haven't yet begun to scratch the surface about the innovations that can make our public, single-payer health care system more effective. That was an example where I thought Alberta led the country with some very impressive results, and I'd like to encourage the minister to go further with that.

I want to come to the Mazankowski report, which the minister has talked about. Now, there are some good recommendations in the Mazankowski report, certainly preventative health, reducing the factors that lead to disease, healthier lifestyles, and so on. There are lots of things in the Mazankowski report that are very positive and we would certainly agree with. There are some contentious items. There are three in particular from that report. I'd like to ask the minister his views on these things and whether or not these will comprise portions of the various plans that he's tantalizing us with as he talks about unrolling them over the next months and year.

The first thing is an increase in the use of user fees, which was something that Mazankowski talked about and the minister hinted at, suggesting that perhaps people would feel that they were getting more of their money's worth if they were actually paying for the service. That implies user fees. That's the first question. What does the minister intend with respect to user fees in the plans that he's rolling out over the next months and year?

Second – and this was very contentious, Mr. Chairman – was the question of delisting of existing services. Does the minister think that we have to look at delisting services that are currently covered, and what mechanism would he use to do that? What criteria would be used to delist services?

9:00

Of course, the last and most contentious is more private delivery. We all acknowledge, as the minister has said, that there's a significant private component in our health care system as doctors operate on that basis, and that's an accepted part of the health care system. Nobody that I know of in this House is proposing to change that. But the provision of private hospitals, private clinics, and clinics that would give, for a fee, preferential access to services that are covered under our health care system . . .

Ms Blakeman: Executive access.

Mr. Mason: Executive access. Thank you.

. . . is a very contentious issue. There is a clinic, of course, opening up in Calgary that will provide those kinds of things. Inquiring minds would love to know the minister's position on those. Perhaps, Mr. Chairman, he can respond to that in writing since we're out of time.

Thank you.

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

Ms Blakeman: Thank you so much, Mr. Chairman. I'm delighted to get some time with the Minister of Health and Wellness tonight. A couple of areas I'd like to cover in my 20 minutes with the minister, just as an overview: midwifery, ambulance funding, mental health, cancer legacy fund, a bit more just drawing on your comments on the regional health authorities, and also some additional debate on seniors and seniors' health.

You know what, Mr. Minister? I'd like to start out by thanking our staff person Kristen McFaden, who was here supporting my colleague the MLA for Calgary-Currie in his role as critic for Health and Wellness. We are very lucky to have some exceptional young people that work for us, and I actually am supported by Kristen as well in my role as Finance and Enterprise, Treasury Board, and Culture and Community Spirit critic. So Kristen has her plate full. I think she's actually the researcher on about five different portfolios. We were very pleased to have her join us tonight, and I'm very grateful that she was willing to put in yet another 12-hour day on our behalf. Our thanks to Kristen.

My thanks to the staff across the way and, I'm sure, joining us in the gallery from health, who've also got to come in on their evenings. We appreciate that extra work that you give us all very much, because we don't want to be alone here by ourselves late at night, so we appreciate you coming out.

Okay. I was very interested to hear the minister – while he didn't react to my question about midwifery funding, he did go outside of

the House and talk about it to the media. If I can perhaps draw him out on what he anticipates happening there and where it fits into his – it's not a 30, 60, 90 days; it's a three-month, six-month, nine-month. Where does that one drop in? Which of those does it drop into? Can I sort of get on the record confirmation that you are looking at funding the payment to midwives inside of the insured health care service? Let's just have that exchange now. If I could draw you out a bit on that.

Thank you.

Mr. Liepert: First of all, my apologies if I said something outside the House that I didn't say inside the House. I believe that what I said outside the House was that I believe there was a role. It was part of what we envision, having more service providers working to a scope of practice that they're capable of working to, and midwifery certainly fit into that.

One of the things that I'm not going to be able to say more on at this stage – because I feel very strongly that when we bring forward initiatives in health care, I want to ensure that I've got 71 salespeople selling it for me. The way that you have that happen is to involve our caucus in decisions. It hasn't gone to caucus yet. I have some ideas about it. I believe that it's the kind of decision, because there will be some parameters, where we have to ensure the training, the safety of patients. I want to be able to take a package to caucus that caucus is comfortable with. I just can't expand anymore on it at this stage, but I really strongly believe that within the course of this summer we will see something come forward that will start to recognize that profession.

Ms Blakeman: Okay. That's good. That sounds like we could be in the six-month or nine-month range for that. The minister is nodding in agreement, so that's good news. Thank you very much for that. Nineteen years it took me, but I'm really pleased to see it. I honestly did start to work on that in 1989, when I was with the Advisory Council on Women's Issues, and that was one of the key set of recommendations that that council made. So you can change public policy if you just hang in there long enough. Okay. Thank you for that.

I'm going to move on to ambulances. Now, the funding for the municipal ambulance program has been one that has gone around a couple of times and is a source of frustration for the municipalities because, you know, there was a move under a previous minister, two I think, to take over the funding of that completely. The municipalities were told to reallocate their funding, which they did; then they got it back again. But the government having found out how expensive it was going to be, in fact, is not funding to that amount. It was over a hundred million I think, and what's being funded has remained stagnant at $55 million. I'm pretty sure we're talking four years' worth of funding at that level.

I'm wondering whether this is one of the things that is under review for this minister. I mean, clearly it's in as $55 million again this year, so the anticipation is that it would stay at that for this year. But I'm wondering what direction the minister thinks he's going to go with this funding in the future. Is it likely that it would increase to give the municipalities some hope of some relief with that?

The second piece of that is how it actually works. We're all struggling with that. We've had some rules or some legislative regulations that are in place about handovers. I know civically there's great frustration because the ambulance personnel are not allowed to just bring people to the hospital, dump them off, and they're out of there. They actually have to officially and legally transfer the person over, which means that we can have ambulance staff standing, waiting in the hallways along with their patients on a gurney for four or five hours sometimes depending on how it's going along. So the ability to change that system, whether it's putting in an intermediate body that is sort of a paramedic in the hospital, where people get transferred from the ambulance people to an intermediate group who can then get them officially admitted to the hospital, and therefore it's off the emergency personnel's plate or whatever: where is the ministry looking at going around that?

So there are the two aspects to it. One is around the funding, and the second is around the minister's sort of vision of what possible legislative regulatory or service delivery changes could be anticipated coming through it and not all actually done or implemented by the provincial government, a good deal of it more likely by the health authorities or by the municipalities, but everything flows from you. What's the shape of it as you see it?

Mr. Liepert: The member is correct that in this budget again there is $55 million to cover – I hate to use the word "subsidy" – some of the costs for ambulances. I can assure the member that within a short period of time we will have in place the governance model that will deliver health care in this province going forward. First of all, I believe strongly that ambulance is more closely linked with health care than it is with municipal services, even though there is the interaction between fire and police, but that's more of a dispatch mechanism than it is the actual provision of services. Some of the issues that you alluded to could actually be easily rectified if it was more closely linked with the health system.

It seems to me that this needs to happen in step. If there is going to be a change to our governance model, let's ensure that the change is in place first before we talk about any changes to the ambulance governance. It is part of what I believe we had in our three-month action plan, so I would suggest that within the next month the whole issue around the provision of ambulance services will be much clearer to the member.

9:10

The Chair: The hon. member.

Ms Blakeman: Okay. Thank you. I'd like to talk about mental health, which, of course, is an issue that is important to my constituents here in Edmonton-Centre, and I think just as important to me as I've found myself somehow in the role of an advocate for people with mental health issues overall. Twenty-nine million dollars are allocated to mental health, essentially more beds, residential treatment beds, and mental health services for inmates. The minister may not have this as a breakdown. Perhaps you can give it to me in writing, but I'm wondering where these new beds will be located. Yeah, it's $29 million to provide more mental health and residential treatment beds and inmate treatment, so where would those beds be located? If I could get a breakdown even by regional health authority, that would be helpful. That tells me which hospital or clinic they're located in and which region they're in.

I'm also wondering, of course, how much of that money goes to community, not-for-profit, charity/volunteer-based delivery of mental health services. So Canadian Mental Health and then you end up with some group homes that should be getting funding. These are funded already through your budget, and I'm wondering whether they're getting any kind of an increase or a reallocation in any way, shape, or form out of this additional funding. I sure hope they are because, boy, they need it.

Of course, the whole issue of not-for-profits' retention and recruitment of staff is key here. I mean, one of the areas that we're hearing about, Canadian Mental Health, I think more than a year ago, probably 18 months ago, was telling me that they had five staff

positions they couldn't fill, and that was back then. They are way beyond that now. Their ability to continue to deliver the service that they deliver in such a cost-effective way – if the government had to take back all that service delivery, it would cost you guys a whole bunch more money. So is there recognition of that from the minister? Is there any plan to allocate additional funds as part of the contract that you no doubt have with those not-for-profit organizations delivering mental health services and specifically targeted to staff retention and recruitment, and what's the timeline involved on this? Again, if we're looking at three, six, nine, 12 months, when could we be looking at this money actually coming out of the bank and being delivered to these groups if it is new money?

Now, I also note on the same subject of mental health, if I can just group this all together, that there doesn't seem to be any funding to assist in the implementation of the provincial mental health plan. This was something that the Auditor General had noted, that the delays in implementing that seemed to be attributed to a lack of financial resources. So I'm wondering if anything is changing there.

The next question is more about philosophy. We've had mental health always with other health delivery, but it tends to be off to the side. We've had it under a separate board. It's moved around quite a bit. It was directly underneath the minister. What is this minister's vision of that? Is there an integration that's expected for mental health services into the overall health care system, regional health care, regional health authority delivery? How is that mental health expected to fall out? Where's it going to go? I mean, we had all these resources taken away from Alberta Hospital. We were going to put people into the community and support the community. Then we went back and invested a whole bunch more money in Ponoka, and then we talked about having it integrated under regional health authorities. Where are we? What's happening with that one now?

I just want to close again hoping that there are resources that have been reallocated here and directed specifically to those not-for-profits and to individuals for mental health. We know that people can do very well on their own with additional support. That additional support may seem silly to us, that you would need to have someone come and knock on your door in the morning and go: "Laurie, have you taken your medication yet today? Do you need any help grocery shopping? What's in your fridge? Ah. Popcorn. Hmm. Probably need to go grocery shopping, there, Laurie."

That may seem odd to many of us, but those little reminders and that additional assistance is all they need, and they will be able to cope from there. Or perhaps have someone manage their money a bit for them, maybe drive them to the grocery store, and in doing that, they can stay on their own rather than being in a group home system, which again costs more money, or reeling backwards and ending up in acute care in a mental health care bed in a full-service hospital, which is very expensive.

Again, I'm looking for how those resources are going to be divided between services you're delivering inside of the institutional beds, including the hospital, with the not-for-profits that deliver the service, and individuals. That's the mental health piece.

Mr. Liepert: First of all, I need to make it clear that the delivery of services continues to be integrated through the health regions. While we still have the Alberta Mental Health Board from a policy development standpoint, the actual service delivery is in the regions. Now, is it being done as well as it should be? That's a good question. Of course, the member mentioned the Auditor General. We've met with the Auditor General specifically on this issue. He continues to do work to see whether or not those dollars that have been allocated to health regions for mental health are actually being committed to mental health.

The member raised a very important issue, I believe, and that is around not-for-profits. We will be developing a children's mental health strategy over the next six months. I happen to be a big fan and believer of the CASA initiative in Edmonton, Child and Adolescent Services Association. They do wonderful work with children in children's mental health. They are a good example of a not-for-profit. I believe strongly that it should be as often as it can be the not-for-profits that deliver these services in the region rather than government or the health regions, where it tends to get lost a lot of times. I would concur with the member that the not-for-profits should be playing probably a larger role in overall mental health, but certainly one area that we can work towards is in children's mental health with groups like CASA.

The Chair: The hon. member.

Ms Blakeman: Thanks. There are no additional funds being put into the cancer legacy fund. It got its original injection of $500 million, and nothing more ever happened. I'm just wondering whether that's just been set aside for a long period of time – five years, 10 years – or whether there's going to be a reallocation of what's happening. I notice that there is money being withdrawn from it I think to Health and Wellness or maybe directly to the Cancer Board, but that means that it's not inflation proof, so as an investment, then, it is drawing down. I'm wondering what the plans are around that.

The second question is around the regional health authorities. Part of my frustration as the previous critic was that we had never looked at the regional health authority system and really evaluated it. Did it work? Did it work better than what we had before? We'd never re-examined it, which was a frustration to me. It sounds to me like the minister is now going to follow through on that, but I'll look for confirmation.

9:20

The final piece I'm picking up here is based on what the minister was saying about seniors and universal health coverage for seniors and that perhaps we'd move beyond that. Is the minister, then, anticipating or seriously considering a means test or an asset test for seniors to receive both health care and Blue Cross or just one or neither? If I could get an answer for that.

Also, what statistics was he using to underpin his assertion that, in fact, seniors were in a different economic bracket now than they were in the '60s when the program started? Can he give me what statistical reporting background he's using to make those statements?

Thanks.

Mr. Liepert: Well, I just want to clarify my comments to the Member for Edmonton-Highlands-Norwood. Just to be clear, I wasn't advocating means testing. The member suggested that we should be moving to a cap and, in fact, more subsidization. I'm suggesting, in my view, that seniors today across the board have more disposable income than they did 20, 30 years ago. I wouldn't see us moving that way. I'm not suggesting that we're moving the other way, but I wouldn't see us moving the way that the member suggested.

The Chair: The hon. Member for Calgary-Mountain View.

Dr. Swann: Thank you very much, Mr. Chairman. It's a pleasure to rise and discuss the health budgets for this year. I appreciate many of the comments from the minister and the presence of his staff and the level of discussion tonight. I guess one of the key

questions for me, having lived through the 15 years of restructuring and reform, is: what do we know about what's happened as a result of the restructuring? What have been the cost implications? What has been the differential between administration and front-line working staff? Have we evaluated the changes we've made at least twice over the last 15 years?

I think we have a lot to learn from the changes that were made. They were well-intentioned changes. They were changes intended to bring more accountability, more regional focus on services, an attempt to see where we could best improve and streamline and focus some of the differences between the regions and address unique needs in each region. How did we do? I've never seen any evaluation of these changes. I think that would be an important basis on which to make future decisions. More specifically, do you envision putting in place some monitoring to establish exactly that? How are the costs and effectiveness going to be measured over the next 10 years after the changes that you're recommending, some of which I'm very encouraged by, frankly.

Maybe you could just respond to that. I have just a few others that may not have been touched on.

Mr. Liepert: Well, I think the member raises a good point in terms of evaluation. I would say that if there's been a weakness over the years, it's that we haven't done a good enough job in terms of performance measures by our regional health authorities. I don't think we've held them as accountable as probably they should have been. But in saying that, we have to also acknowledge that there have been some very good successes. There has been some terrific innovation.

Again, it's not about looking at what is wrong with the system. It's saying: is it the right system to deliver health care in the 21st century? That's the discussion we're having right now.

The Chair: The hon. member.

Dr. Swann: Thank you, Mr. Chairman. Could the minister, then, given that primary health care has been a major focus and a positive focus and an important contribution to the new realities that we face, comment on why there was no increase in funding for primary health care in this budget? Related to that and how we might keep more people out of institutions, what is happening to home care budgets and the importance of trying to keep people in their homes for longer periods of time?

Mr. Liepert: Relative to home care, that isn't a specific line item for our department. Home care is contracted through the regions. Regions have to make decisions as to whether dollars spent on home care save dollars elsewhere. I happen to believe that regions are not allocating enough dollars to home care today. I think that we could be doing way more with home care than we currently are, but there may be good and valid reasons why we're not. I met just a couple of days ago with the home care association, and they made some strong suggestions on how they could be better utilized. I think that it's, again, another one of these situations where I'm not sure we're using all of the various professions to the best of their abilities.

The Chair: The hon. member.

Dr. Swann: Thank you, Mr. Chairman. I didn't hear a comment on primary health care networks and what we're doing there, why we're not increasing support for those.

Mr. Liepert: The member is correct that the total budget hasn't increased, but there is significant progress being made on primary care networks. Not increasing the budget doesn't mean that there aren't going to be continued initiatives in primary care. The dollars are the same as last year. It doesn't necessarily cost more money, would be the way I would . . . [interjection] Yeah, that is a good point.

We are in negotiations currently with the AMA, and it may come out of the negotiation process that dollars will be moved around and reallocated, but we aren't able to budget for that in the absence of having a contract with the Alberta Medical Association right now.

The Chair: The hon. member.

Dr. Swann: Well, thank you, Mr. Chairman. Again to the minister. It's my understanding that the health regions get a budget, and out of that budget they may choose to fund or to not fund long-term care facilities. As a result, the pressures being what they are on the health regions, increasingly they are cutting the transfers to long-term care settings, meaning that long-term care settings are coping with a rapid turnover of staff, less qualified staff, and more demands that are not being met by existing staff in these long-term care institutions. They point the finger at the health regions for cutting their budgets to the point where they can't provide safe and sustainable services. Is there any talk about trying to direct specific envelopes to long-term care as separate from the health regions?

Mr. Liepert: The short answer is that, yes, we are very much in the midst of coming forward with an initiative in that area. We recognize that the long-term care providers are under tremendous pressure in the workforce. We also have to look at whether or not our fee structure for long-term care is appropriate. There may be some adjustments that are required there. That would allow long-term operators a little more flexibility in terms of a revenue stream. I don't get the sense that there is resistance by regions to not be contracting with long-term care. I think it really comes down to capacity. I would remind the member that we have a pretty significant allocation in this budget for capital for new long-term care facilities. I think that if we took some of the other steps that I referenced, there would be more capacity from the private operators as well.

9:30

Dr. Swann: Well, prevention, obviously, would reduce demands on the system. There's been a lot of talk about social determinants of health and other factors that are profoundly important to people's opportunity for health. It's hard to see that reducing the promotion, protection, and prevention part of the budget by almost 20 per cent is going to help us to reduce the demands on the health system. Can you talk a little bit about how prevention got the lowest priority in this budget?

Mr. Liepert: It needs to be noted to the member that the reduction in the budget is because of the one-time purchase of pandemic supplies in last year's budget. So it's not really a reduction in preventative; it's that one particular purchase item.

Dr. Swann: Compare the prevention budget to two years ago, then.

Mr. Liepert: I'm told it's slightly higher than two years ago.

Dr. Swann: Okay. Thank you.

The Chair: The hon. member.

Dr. Swann: Thank you, Mr. Chairman. In relation to the prevention programming that I'm thinking of, I note that there's no funding specifically targeting sexual health when we have problems with sexual disease and sexual abuse. Is there any consideration being given to looking at a significant investment in sexual health education and prevention as opposed to funding the treatment? The department has been very good at funding treatment, but surely we can prevent a lot of this with better education.

Mr. Liepert: Well, we do have initiatives in that. We fund to some degree those initiatives through the health regions. I would like to take the opportunity to provide a little more detail in writing to the member on that if I could.

The Chair: The hon. member.

Dr. Swann: Thank you, Mr. Chairman. Just one final question. I gather from your first comments that the evaluation of the changes that have been made in the system you put on the health regions, that there's been a lack of evaluation. I would ask you, respectfully, to look at the province's responsibility for evaluating what changes they have made to the health system and how those have impacted quality, access, and cost efficiency.

Mr. Liepert: If I left that impression, that was not the impression – I was saying that I don't believe that provincially we have put in place proper performance measurements, proper evaluation. No. I would not suggest that that's up to the regions to evaluate themselves. I will accept responsibility that we haven't done a good enough job in that.

Dr. Swann: Is the staff aware of any reports that would put some kind of an evaluation on the changes that have been made in Alberta in the last 15 years? Have there been any studies to try and compare these results?

Mr. Liepert: I will respond to the member and see what we might have that would be even remotely tied to what he's looking at. I'm trying to think of anything that the Auditor General has done, as an example. There have been various parts of Auditor General's reports that have come forward. We will see what we can get for the member that would help him in that area.

The Chair: The hon. Member for Calgary-Currie.

Mr. Taylor: I'm back up again. Imagine that. Thank you, Mr. Chairman.

One area that I did not get to when I was speaking to the minister before is an area that he certainly noted as, I guess, the fastest growing cost centre in health care, which is prescription drugs, pharmaceuticals. The minister gave kind of a generic indication that going forward there's going to be something to be announced about that, but I'm going to probe a little bit here and see what I can get out of the minister right now because pharmaceutical costs are going up dramatically.

It seems to me and to many of us on this side of the House that it really is time to talk about co-operating with other provinces and co-operating with the federal government as well and establishing a national purchasing plan that would allow bulk buying of drugs and more consistent coverage across the province. Is the minister or is the ministry prepared to move in this direction? Is the ministry prepared to take a look at a full pharmacare program? What are the minister's thoughts on that area?

Mr. Liepert: Well, the member may have been out when I answered a similar question for the Member for Edmonton-Highlands-Norwood, but it is a pharmaceutical strategy. I don't want to use the term "pharmacare program," but a pharmaceutical strategy will very much be coming forth in the next six months. I mentioned to the member as well that I believe there are some opportunities, certainly, as a western block to be looking at some initiatives like this. It's not just drugs; it's also procurement of equipment, maybe specialized services.

I think that it needs to be put on record, however, that not all drugs are a cost to the system. There clearly are drugs on the market today that, while they may cost a lot of money, may very well be keeping patients out of an acute-care facility or potentially even out of long-term care. We need to ensure that we're looking at pharmaceuticals in a way that it's the right prescription, I guess, for the patient at the time. If it, in fact, may save the health system money, we shouldn't just look at it as a cost.

Mr. Taylor: Okay. In principle I certainly think I would agree with that. I think we saw an example of that within the last day or two in the case of 17-year-old Trevor Pare with Myozyme, right? I do have the name of the drug correct. In that case we're looking at a drug that's phenomenally expensive, $773,000 a year I believe. But the prognosis for Trevor with that drug is, as I understand it, very good for a near normal lifespan as opposed to the very real possibility that he could be dead within months without it. Here we're looking at a 17-year-old future productive adult member of society who may be able to in fact give back to the system, whether that's monetary or otherwise, in a number of ways that will be very good for society. I commend the minister, by the way, for agreeing to pick up the cost of that treatment.

It would seem to me that going forward from there, whether it's this minister and this ministry or other health ministries somewhere else, ultimately all health ministries and people in health care are going to have to come to grips with some generally agreed upon parameters. This may involve a province-wide or national discussion among all citizens, too, as to who qualifies for these sorts of things.

Not to keep coming back to Trevor as an example, but here's the case of a 17-year-old boy with potentially a pretty decent future ahead of him now. Obviously, some treatments that may extend life, prolong life, improve the quality of life for a 20-year-old or a 30-year-old or a 40-year-old might be well worth the expense given the benefits that accrue both to the individual and to society over time – I don't mean to sound as though I'm, you know, trying to boil it down into actuarial dollars and cents terms; that's not what I'm trying to get at, but I need to express it in some form – whereas perhaps for somebody who's older or sicker or whatever, it's not so worth the system's while. In addition to being business cases, those are tricky, thorny ethical dilemmas.

9:40

Yet when we look at a 13 billion, 200 and some-odd million dollar health care budget for 12 months, when we look at the cost of pharmaceuticals even given what the minister said – and I'm not arguing with you here about the need to look at some drugs as not a cost to the system – when we look at the various issues in health care today, I think the minister would agree that somehow this is a discussion our society needs to start having probably sooner rather than later.

I'm taking the opportunity to put the minister on the spot here because we are now talking about things that may very much be in

the public interest but may not be in either his political interest or mine specifically, but would the minister share some of his thoughts on this issue?

Mr. Liepert: Well, when it comes to the drugs for rare diseases, we have to ensure that we remember that what we're talking about are rare diseases, drugs that are on a clinical trial. I can assure you that we had a very good discussion in caucus relative to this particular issue. We are going to move forward with the development of a policy because doing these on a one-off basis where, in essence, the minister makes this kind of a decision is not right. I think that I can speak for my caucus when I say that there is a high degree of agreement and understanding that these become moral decisions. We have to ensure that we also understand that while it is a large amount of money, there are many other situations involved in health care today, whether they're at the start of life or at the end of life, that are also significant costs to the system. We just don't happen to hear about them because they're not sort of one-offs like the rare disease drugs.

One can go to an ICU and see patients that, frankly, are costing the system $10,000, $20,000, $30,000 a day. You know, we have a health care system today that does everything possible to preserve life, and that's the right thing to do. Clearly, as we move forward, there are going to be some of these end-of-life kind of decisions that, I think, with families we have to have discussions whether or not I want to have something at end of life that is different than keeping me alive for as long as I possibly can. That's a discussion that crosses all members of this Assembly.

The Chair: The hon. member.

Mr. Taylor: Thank you, Mr. Chairman, and thank you to the minister for those thoughts, for that answer.

Now, back to more immediate issues around pharmaceuticals. The business plan, page 161, line 2(a), public expenditures per capita on prescribed drugs in dollars. It's expected to increase by almost 15 per cent in the next three years. The explanation given in the notes – let me just find my place here – says that the increase is from higher use and also "the entry of new drugs into the marketplace (typically at higher prices)." Now, there are two ways of looking at that. Some are actual new drugs entering into the marketplace, and because they're new and because they cost a lot of money to research and develop, they cost a lot of money and they cost the system a lot of money. But there's also these drugs that are new versions of existing drugs where the cost seems to go up.

I wonder if the minister is prepared to say that his pharmaceutical strategy is going to, for lack of a better of word that comes to mind right now, crack down on that. It seems as though sometimes what's going on here is that pharmaceutical companies with patent protection that's about to run out find a way of taking, you know, brand X and changing it into brand X, version 2.0, with a little bit of the formula changed so that they can extend that patent protection and, if it's a popular drug, put the price up.

Mr. Liepert: I think it's important to put on the record that whenever a new drug comes on the market, the federal common review process takes a look at it to see first of all whether it's better than what's already there and then whether or not – there's a word for it – the cost benefit is there and then will make the recommendation. We have our own expert drug review panel in Alberta, which is arm's length from government, which also takes a look to see whether or not those drugs should be part of a plan. I think we have a pretty good system in place to ensure that if a new drug comes on the market or a newly improved old drug is coming back on the market, the cost benefit has to be there or else it is not a recommended drug.

Mr. Taylor: Mr. Chairman, I have just a couple of other questions, and they get us back to workforce strategy. I have to come back to a comment that the minister made earlier this evening when he was talking about paying doctors. I'm not sure that I'm quoting him exactly here, but he suggested that essentially in the perfect world we would pay doctors to keep their patients well rather than to treat them once they've gotten sick. I believe he said that in that scenario, that kind of fantasy scenario, the best-paid doctor would be the one on the golf course because he'd have the fewest sick patients. Well, yeah, it was a fantasy scenario. I know the minister admitted as much at the time, and I'll acknowledge that.

However, we don't want to come up with a system of payment that incents doctors or any other health care professionals not to see as many patients as they were before if there are patients needing to be seen. Now, sometimes patients go to doctors not because they're sick but because they want to stay well, whether it's the annual physical or whatever it is. I'm all for the idea of encouraging a new kind of doctor-patient relationship that sees the patient going to the doctor for preventative maintenance, if you will, rather than waiting until the patient needs fixing.

I certainly had some doctors express to me the concern that moving away from a fee-for-service model encourages doctors to see fewer patients rather than more. I think that when we initially envisioned an alternate payment scheme to fee for service, we thought: well, wouldn't it be great if we could come up with a scheme that paid the doctor essentially to look after the patient for a year, see the patient when the patient needed to be seen, take the time that's needed with the patient to answer the patient's questions, fully diagnose the patient, and not feel like he has to rush them through on an assembly line because of the fee-for-service-model?

On the other hand is if we've got a shortage of doctors. Now, the minister tonight has denied – well, I shouldn't say that he has denied that we have a shortage of doctors, but he has certainly strongly suggested that the shortage may not be as bad as reported. On the other hand, he has made reference to the fact that we really can't effectively tackle the wait time issue with the workforce issues that we have right now, which I think is a tacit admission that we do have some serious shortages in the system. If we've got a doctor shortage and doctors ought to be seeing – I don't know – 20 patients in a day and suddenly there's no incentive to see any more than 10 because you make the same amount of money whether you see 10 or 20, that's a problem. I wonder what the minister is thinking in terms of alternate fee arrangements, that sort of thing, and whether they're really working as well as we envisioned they would when we first started thinking about them.

9:50

Mr. Liepert: Well, I think there are several ways of looking at that. You know, I would encourage the member during his summer vacation to maybe travel down to the Chinook health region. We've got a number of alternative payment arrangements that are in place in that health region for a number of reasons: one, it's the right size; two, it has sort of the right demographics; and three, it has a very good buy-in by all of the stakeholders in the region. They've got several alternative payment arrangements with doctors. Doctors seem to like it. Patients seem to like it. It seems to cost the system less money.

I just feel strongly that if it's a new model that works, we should be striving to see where else it can work as well. It's not a matter of

necessarily being paid to do less. It's a model of triaging patients to the service that they most need at the time. There are many patients that come into a doctor's office and, quite frankly, there are probably some seniors that come into a doctor's office that simply need to be listened to. It may not be a doctor that needs to listen to them; it might even be a social worker. I don't want to leave the impression that somehow an alternative payment arrangement means that we're paying to do less and that thereby there's going to be a longer lineup out the door.

The Chair: The hon. member.

Mr. Taylor: Thank you. By the way, I'll take the minister up on his offer. Almost any excuse to go to southern Alberta in the summertime is good enough for me.

However, you mentioned that the Chinook health region is the right size, with the right demographics, that it's a good model for doing this. The thought that comes immediately to mind is: "Okay. How transportable, how transferrable is an alternative payment plan that works in Chinook to Calgary or Capital or Northern Lights?" Maybe this is what the minister is thinking about in terms of reorganizing the governance of the health care system in the regions in the province. I don't know. But I don't think we can just cookie-cutter this thing and say: "Okay. We're going to make every health region the same population and demographic makeup as Chinook no matter how weird the geography gets." Right?

Mr. Liepert: What I was trying to get at is that the Chinook health region has a total buy-in, but there are similar kinds of arrangements in Capital health, as an example. It's just that Capital health is – what? – 10, 15 times the size of the Chinook region, so it's harder to kind of get the total buy-in of not only the physicians but of the patients. It just seemed like it worked well in the Chinook model. Clearly, it's being transplanted around the province. I think it's some 50 per cent of doctors that are now in this primary care network system.

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

Ms Blakeman: Thank you so much. While the minister spoke to others, a few more things came to mind. Some time ago a number of individuals from the department and from the community were working on a blood-borne pathogens report. What happened to that report? It may have gotten rolled into a different report, which is fine. Just tell me. I also want to know what the outcome was. There were a number of opportunities there, and of course those that are working with people with hep C or AIDS or HIV are very interested in what would roll out of that report.

Somewhat connected to that but on a slightly different topic are harm reduction strategies. Directly or indirectly things like the needle exchange that happens here in Edmonton through Streetworks get funded through either the Capital health authority or through the government, and I'm wondering what vision this minister of health has around supporting those front-line initiatives around harm reduction. Is there any consideration for a safe injection site in Edmonton? I know that the Vancouver one has been controversial, although I don't know why because the stats have been very positive. Is the minister considering anything like a safe injection site, or can we expect better support or the same support or different support for those organizations that have been receiving health funding to deliver those front-line services around harm reduction? So two things: the blood-borne pathogens report and harm reduction strategies.

Mr. Liepert: Well, we will be bringing forward initiatives, certainly, in some of these areas. The member referenced the Vancouver project. That's a federal pilot project. I have no plans at this stage to be bringing something similar to that through to our caucus members, but the other issues that were raised are part of what's going to be coming to caucus very soon.

Ms Blakeman: I've got to admit, Mr. Minister, that it's tough to have a sort of discussion around budget allocation when almost every answer you've given me is: well, it'll go to caucus, and you'll hear about it eventually. The next opportunity I get to question you about this will be a year from now, at which point these things will already have been implemented. So the "just wait for it" or "stay tuned" responses are a bit frustrating.

Okay. The next question. Smoking cessation products are not covered under health care. Why is that? You know, I had an employee who managed to get himself prescribed Wellbutrin as an antidepressant or something in order to get it because it would be covered by his Blue Cross or by his health care. By the other brand name of exactly the same drug, which was Zyban, which is a smoking cessation product, he couldn't get coverage for it. I would have thought that for a government that had adopted a strong smoking cessation policy across the province, those products would be covered under health care. I think it's an ongoing frustration because let's face it: the ones that are still smoking are pretty diehard at whatever it is, 10, 11, 12 bucks a pack. Boy, they're serious. I was a serious smoker, and certainly I don't think I could have successfully quit had it not been for drugs like Zyban that were available to me, and that was in 2001.

Now, I'm on an enhanced prescription service, and therefore it was covered for me. But it's frustrating for me to see those people out there that are still smoking, that are interested in quitting, and the fact that the drug is not covered under their health care is enough to make them hesitate. As you know, when you've got somebody close to quitting smoking, you really want to grab them and bring them along, and to have them wander off because of that little barrier is pretty frustrating. I'm wondering if under this minister the province is looking at making some of those smoking cessation products available, covered under regular health care, under the regular Blue Cross, so that they would be available to people.

Again, connected to that, I had asked the question earlier about why there were no additional contributions to the cancer legacy fund. I think that the clock ran out on us, and I wasn't able to get an answer, so I'll just remind the minister of that. It is being drawn down, but it's not even inflation proof now, so what's the plan? Are you going to inflation-proof it, add to it, leave it alone, let it die? What? So those two questions around cancer and smoking.

10:00

Mr. Liepert: Well, I guess the answer to both of those questions comes down to whether you want a budget that has increased by 9.1 per cent or one that has increased by double-digit numbers. There are limits as to what we can afford in a health care budget. I think it's fair to say that we could have brought a budget in that was at a 17 per cent increase in expenditures, and it probably wouldn't have covered all of the demands and asks of Albertans.

I would say that 50 per cent of the letters that I sign are to Albertans who have written to the minister asking why certain things aren't covered. We simply have to start to become more responsible in this province for some of these costs. The system cannot continue to grow at the rate it's growing. It becomes a matter of whether or not we're going to increase the budget by 9.1 or 10.5 or 12.7 per cent. You draw a line at one place, and some things are in and some are out.

I do not want to let the earlier comment of the member go, expressing her frustration about not having some of the answers. This particular caucus is going to work where the caucus makes the decision, not the minister. This minister has had two months in this role, and we have a number of issues that are going to be rolled out over the next year. It may be frustrating to her that she's not getting the answers tonight, but this caucus will be making decisions on some of these controversial issues and very important issues. If they're not made at this point in time, I regret that, but she's going to have to be frustrated.

Ms Blakeman: Well, you know, that's about decisions that the government has made overall because the government controls the timing, absolutely, when the budget comes in. If the minister needed more time to get this through his caucus in order to be able to come before us and spend this three hours, which isn't a lot of time to talk about all the complexities that are in the minister's budget, I mean, this is a choice that the government has made. We are trying to hold you accountable for something. For most of the questions that we've been asking you tonight, we're told to wait and see, that it'll be coming. My point is: this is our chance to talk to you about that, and then it's over, and it's a year later.

I guess my issue is with the timing of this, and of course government is in absolute control of that timing. If the minister didn't have time to run his budget through his caucus for their decision-making process to kick into play, which is what he prefers, fine. You know, maybe there needed to be an adjustment on the budget process, which in itself has a whole other series of repercussions there. I would challenge both the minister's and the government's timing on this because what we end up with is not very fulsome answers as we try to hold the government accountable. In other words, the government is not very accountable.

As far as, "Well, the budget could be this high if you paid for every single thing this first time out," that's true. But does the minister not recognize the offset costs? Are there not comparable reductions in the costs brought into the system by people with COPD, with lung cancer, and with various other problems associated with smoking that cost the health care system an awful lot of money? Doesn't it save the health care system to get some people to quit smoking, and isn't that an offset cost? Yeah, it may be, you know, a couple of thousand or $10,000 more to pay for smoking cessation products, but is there not an offset cost in the improved health and therefore lower acute-care costs in the system from that? Isn't that part of the investment strategy around a prevention and wellness approach to health care? Isn't that the point?

I mean, I take what the minister is saying about, well, you can't get everything the first time out. Frankly, these are the same people I'm looking at in front of me, for the most part. This is the same government that's been here for 37 years. You guys didn't come in a month ago. You've had an awfully long time to decide on this strategy. Does the minister not recognize that there are these offset costs, or does he not incorporate that into the way he looks at how the whole budget works over time?

Mr. Liepert: This minister recognizes that there are personal responsibilities that people need to take care of for themselves, and government should not be taking care of everybody's personal responsibilities.

Ms Blakeman: Well, actually, Mr. Minister, that doesn't work. This government knows that. Over the last 20 years or since '93, when there was the last big change in philosophy from the same government and there were a number of cuts made, we've seen the effects of those cuts. There were a lot of reductions in income support, called welfare, and then it was called supports for independence, and now it's called income support, I think. What we ended up seeing was a corresponding rise in child welfare rates and children that were turned over to be wards of the state. That cost the government almost as much, if not more.

You know, this idea that, well, we'll just tell everybody to take care of themselves and that they should pay for everything themselves: I understand that this is a political philosophy that this government and this minister clearly feels very strongly about, but I will rebut that in that we have enough examples now of where, in fact, that attitude will end up costing the system a lot more money and cost taxpayers more, cost the government more in the long run. Saying, "Everybody, just smarten up and take care of yourself" doesn't in fact work, and you guys have got the stats to prove that. You've got it from close enough to that minister's own time, certainly in his close association with the party, what the actual effects of that are.

You know, we want to say, well, the homeless should just smarten up and not get into trouble and get themselves a job. But you all know very well that that doesn't just happen. If the investment isn't made to help individuals to do that, they're not able to do it. It's tough that you can't just say: smarten up; quit being homeless. But you know what? It doesn't work. If you're going to persist in saying that, then you end up with people who truly do become a cost to the system with ambulance pickups, with an encounter with the judicial system, with the police, with EMS, with the court system, and possibly with incarceration, which in the long run costs the system a lot more money than if that smaller amount of money would have been put in in the beginning.

Am I hearing from this minister, then, that he prefers that philosophy of, you know, "Do it yourself; pay for it yourself" without recognizing the costs that have come back on the government from having implemented that since 1993?

Mr. Liepert: Well, I'm not sure, Mr. Chairman, how this particular member can stand here and talk about cuts, how she can stand here and say that this is a philosophy of the government, everybody has to take care of themselves, when we have a 9 per cent increase in the health care budget. We have a $37 billion budget in this province, which is the highest per capita of anywhere in this country, and she stands there and says that it's a philosophy of this government that everybody is on their own to take care of themselves.

Ms Blakeman: Well, I think that if the minister looks at the *Hansard*, he will see that he said it. That's exactly what he said.

Mr. Liepert: I said about smoking cessation.

Ms Blakeman: Oh, I'm sorry. And so the "everybody should take care of it themselves" is specific to smoking cessation?

Mr. Liepert: It's an example.

Ms Blakeman: Well, perhaps the minister would like to take the time to expand, then, on where he applies that particular philosophy and where he doesn't, because I took it and he said it and it's in *Hansard*. If he wants to limit that particular philosophy to smoking cessation, you have the time to get up and put it on the record. If you're expanding it to other things in the health portfolio, please, again, take the time.

Mr. Liepert: Mr. Chairman, this particular member was asking about why we don't cover smoking cessation products, why we didn't contribute more money to the cancer legacy fund. What I said at the time was that there comes a point in the budget where you have to draw the line and say that we can only spend so much money. She then extrapolated all of that to say somehow that we don't care about people and we let people take care of themselves. I would ask her to check what she said in *Hansard*. I was only referring to her two comments on why we don't cover smoking cessation products and why we haven't contributed more funds to the cancer legacy fund. There has to be a limit as to how much we can spend.

10:10

Ms Blakeman: Well, I'm sure the minister or his staff will check the *Hansard*.

Okay. Let's look around seniors and prevention programs for seniors through health care. Is the ministry continuing to fund or to direct the regional health authorities to continue the same amount of funding that has been flowing through to, for example, some of the seniors' centres that offer health and wellness programming, or is the ministry going to deliver that flow of money directly?

Mr. Liepert: Well, Mr. Chairman, we provide health regions with a global budget, and we expect that they will deliver health care to their constituents in their regions in the best way that they see fit. If it means using innovative funding models, as I mentioned earlier, like Chinook has taken relative to lodge care versus long-term care, that's clearly a decision that the regional health authority would make. We don't direct them how to spend those funds.

Ms Blakeman: Okay. I take it, then, that the money continues to come through the regional health authorities and that it's not being redirected or augmented.

There's been some discussion about the global funding model for the regional health authorities, and I notice there was quite a bit of discussion in some media clippings that Calgary MLAs in particular were feeling the need to pressure the minister to change the global funding model specific to Calgary. I know he has touched on that in the context of some other discussions around funding, but if I could get him to direct his comments to the global funding model specific to changing it to Calgary.

Mr. Liepert: Well, the funding model is global with respect to population base and then adjustments, as the member well knows, for other things like demographics. I said earlier in estimates that there would be no adjustments specific to Calgary because, as I said, when I travel to Grande Prairie, the Peace Country believes that the funding model is not fair to them for particular reasons in the Peace region. If I travel to Chinook, the same argument can be made because they have a high seniors population. The funding model is not perfect – I will acknowledge that – but we haven't come up with a better one. We have had it assessed by external companies, including the Auditor General, who had a look at the funding model and concluded that it was for all intents and purposes fair, so it is not our intention to revisit that.

Ms Blakeman: Okay. Thanks very much. That clarifies that.

My last question was around the funding deficits. I know that he already had that conversation with my colleague from Calgary-Currie, so that concludes the additional questions. Thank you very much.

The Chair: The hon. Member for Calgary-Mountain View.

Dr. Swann: Thank you, Mr. Chairman. I'll be brief. I just have a few quick questions to round out the discussions on this very important file. Over the years I've watched the health laboratories go from public ownership to private ownership, and now they're back to public ownership. Can the minister talk about the rationale behind the laboratory services in the health regions and what we've learned from these changes in the laboratory services?

Mr. Liepert: It's my understanding, Mr. Chairman, that we actually have a pretty good mix of public and private. I would challenge the member that it has gone from public to private and now back to public. My sense is that there's a pretty good mix. I stand to be corrected, but that's my understanding.

Dr. Swann: Perhaps it's my experience in the city of Calgary that we've gone back and forth, and it's not clear to me what we've learned from that and whether we should be evaluating that and seeing where we are with that.

Generic drugs. I heard you speaking about drugs before. Clearly, a generic plan would help us to reduce costs and make drugs more accessible, and obviously a provincial purchase plan would help it to be more affordable. I'm not sure if you mentioned that specific issue in your discussion of drugs – I might have missed it – pharmaceuticals particularly.

Mr. Liepert: Well, generics are an important part of the drug plan and will be an important part of the pharmaceutical strategy coming forward. They clearly are not the only answer, and I guess we have to ensure that what we're talking about is a bigger picture pharma strategy. Again, I can only say that we will be bringing that forward.

I think I may have misunderstood the member's question around the labs. Was he referring to the Provincial Lab? No. Okay.

Dr. Swann: One of the controversial issues that I remember reading about in the '80s was the Oregon model for health decision-making and examining the limits to services that are able to be provided by any particular jurisdiction of government. Has the government looked at all at the Oregon Health Decisions model and how some of that difficult decision-making was made through public polling, through public forums, through trying to evaluate: where monies are limited, what the priorities are for spending?

Ms Blakeman: Do you mean like end-of-life care?

Dr. Swann: I don't mean end-of-life care in itself. I mean, what are the realistic services that must always be provided through a public system? Then another category of services would be the nice to have, and another category of services would be unachievable for the general population. That's the Oregon Health Decisions model that had some bearing on this.

Mr. Liepert: Well, I'm not that familiar with it, and I will actually get the member a written response relative to some of the work that we may have done in analyzing that in the past. If it's as the member describes, I think that it needs to be examined because clearly the origin of health care was to save individuals from catastrophic financial cost. We've evolved to a health care system that is pretty all inclusive. The demands continue to ask for more all-inclusive coverage, and at the rate we're going, we're not going to be able to potentially even keep what we've got, let alone expand,

so I think categorizing as the member suggests would be a good exercise to look at.

The Chair: The hon. member?

Now I recognize the hon. Member for Calgary-Currie.

Mr. Taylor: Thank you, Mr. Chairman. When I ran out of time in my last segment with the minister, we were talking about some workforce issues, and I want to come back to that if I can, please. This turn is around family medicine.

For a number of years now it's been difficult to encourage medical students to choose family medicine as a specialty. I think there are a number of reasons for that. You know, the debt load that a typical medical student will incur through all those years of postsecondary and medical education is pretty significant in any event. It becomes a little more significant in the event that you go on to a specialty, but I know and I'm sure the minister knows from talking to medical residents and medical students, whether it was earlier this week or in years past, that many students feel it's worth taking on that added extra debt to become a specialist because at the rates of pay that you can make as a specialist, your chances of actually paying your medical debt off in a timely fashion are better than family medicine. So the debt load coming out of school is one issue.

10:20

The high cost of the overhead for the family practice in an office environment is another, as we spoke about before. I think generally there's just kind of a Rodney Dangerfield component to family medicine that's developed over the years, where family doctors don't get the respect that specialists do. The question is very simple. What incentives are in place or is the minister contemplating putting in place to encourage medical students to choose family medicine as their preferred line of practice?

Mr. Liepert: Well, as I mentioned earlier, we are just in the process of negotiations with the AMA. One of the things that we did well in the last set of negotiations was that we worked out an arrangement with the AMA where, actually, the family doc received compensation that was more equitable, let's say, than some of the past agreements with the medical association.

I was quite encouraged in the meeting yesterday – I guess it was yesterday – with the medical residents by how many of them actually were planning to go into family medicine. I thought that was very encouraging. It is a challenge. It's difficult to incent other than to do it in ways that you can incent family doctors to relocate to specific areas because our basic compensation package is negotiated through the AMA. We have, you know, some flexibility in there to try, should we say, to compensate certain parts of the profession, but it's a negotiated agreement.

Mr. Taylor: The other area around this, of course, is rural physicians and rural practice and the ongoing shortage of rural physicians, which, obviously, predates the shortage of family doctors, family practitioners now in the cities.

Page 242, line 2.0.7, if I have it correctly. The rural physician action plan has an increase of only $664,000, to just a little under $8.7 million. Given that recruitment and retention of rural physicians and health workers is a major challenge, is that enough? Are we paying enough attention to the rural physician action plan? Should we be doing more in that area? Can the minister tell us how the additional funding that is in there is going to be distributed this year? What is the minister doing to address the issues that prevent doctors from choosing a rural practice?

Mr. Liepert: I'm going to commit to getting the member a more detailed written response. Some of the additional incentives are part of our workforce strategy plan as well. I think that it's important, as we recruit foreign doctors, to try and see if there is a desire – and in many cases there is – for them to work in an environment that is outside the major metropolitan centres. From my visitation to Palliser and Chinook regions specifically – well, actually, Peace as well – a high proportion of foreign doctors work in those regions, and that would certainly tell me something.

Mr. Taylor: Well, just one more question. I'm asking the health minister because it has just come to mind now as we've been discussing this. If he wants to punt this off to the advanced education minister, that might be exactly the right thing to do. I'm not sure, but I'll try this out on you anyway.

In our medical schools does the minister think that maybe we need to adjust the culture that we're teaching in our schools along with the technology and the science of medicine that we're teaching in the sense that maybe the culture that we're passing on to our medical students is that Calgary and Edmonton are where all the action is, where the exciting stuff and the innovation is happening, that it just really isn't much fun being a rural physician? You'll work harder; you'll work longer; you won't have as much support around you: that sort of thing.

I'm asking an opinion here of the health minister. It's really the purview of the advanced education minister, I think, so I'm going to leave it up to the minister to decide what he wants to do with the question. But the next opportunity that I get, I'll put it to the advanced education minister as well.

With that, if I can get the answer from the minister, I think my questions for the evening are done.

Mr. Liepert: Mr. Chairman, I will respectfully decline. I have my hands full with health regions and 32 colleges. I'm not going to start to wade into the faculty of medicine.

Thank you.

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

Ms Blakeman: Thank you. I'm just wondering if the minister could close by talking a bit about what we can expect to be coming up with the Health Professions Act. As all of those groups start to come underneath that, what are we expecting to see? I know that there's a great deal of talk out in the communities. I'll leave the last couple of minutes for him to talk about that.

Mr. Liepert: It is our plan to bring forward legislation in the fall sitting. It wasn't ready to be introduced this spring. As I try to work my way through meeting with the various professions, in almost all instances there are changes that are requested. I think all of them are the kinds of changes we need to address in many ways the shortages that we're talking about. So it would be our plan to bring forward legislation this fall.

The Chair: The hon. member.

Ms Blakeman: That's good. Thanks.

The Chair: There is no other member who wishes to speak, so I will now invite the officials to leave the Assembly so that the committee may rise and report progress.

The hon. Deputy Government House Leader.

Mr. Zwozdesky: Thank you, Mr. Chairman. I would move that the committee now rise and report progress.

[Motion carried]

[Mr. Cao in the chair]

Mr. Johnston: Mr. Speaker, the Committee of Supply has had under consideration certain resolutions for the Department of Health and Wellness relating to the 2008-09 government estimates for the general revenue and lottery fund for the fiscal year ending March 31, 2009, reports progress, and requests leave to sit again.

The Deputy Speaker: On the report, does the Assembly concur in the report?

Hon. Members: Agreed.

The Deputy Speaker: Opposed? So ordered.

10:30

Government Bills and Orders
Second Reading

Bill 1
Trade, Investment and Labour Mobility Agreement Implementation Statutes Amendment Act, 2008

[Adjourned debate May 12: Mr. Hehr]

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

Ms Blakeman: Thank you very much, Mr. Speaker. I know I'm one in a long line of people who wanted to speak to this bill because I think it's one of the most important bills. Not that I agree with it, but I think it will have a profound effect upon our province, and to my thinking it's probably the bill with the most far-reaching effects that we will be doing this spring.

Let me just talk a little process first. I think what has bothered people the most who have expressed objections to me is the fact that this Assembly never got to actually debate the agreement itself, and they certainly did accord that respect to their members in British Columbia. They actually debated what was in the agreement.

What we are doing here – and I can hear the squawking from the other side already – is dealing with how this government is implementing that agreement, not the agreement itself but how the implementation of that agreement is necessitating changes in our laws. In this particular one this actually says, "Trade, Investment and Labour Mobility Agreement Implementation Statutes." We're not debating the original agreement here. We are debating the implementation statutes, and that, I think, is what has offended people the most, that this Assembly and the people we represent did not actually get to participate in that debate, that we had a group of caucus members from the Conservative caucus who went on a little road trip to B.C. They made an agreement, they signed it all, they took the photos in the photo ops, and the Alberta contingent came home. And then, whenever it was, two years later we start hearing that this agreement is now going to be implemented in Alberta and in B.C.

Well, in B.C. they actually did debate it, and I'm trying to work my way through the *Hansard* debate because it was significant. I mean, here in Alberta 10 hours of debate is looked upon with horror from the Alberta government, and they start making loud rumbling noises about the need to bring in closure because, well, good heavens, that's enough, and they're all talking about it. Oh, horror. But they spent – I'm sorry; the number's not springing to mind – I think it was 60 or 70 hours in their Assembly debating this agreement. We're not even going to come close to that. That's the context of the process that we're dealing with with TILMA, and in fact we're going to have a number of bills that are going to flow through from the government probably in this year and next year to fully implement this agreement. I know there's another one coming shortly or that we've already got up that's on the insurance portion of TILMA, aligning the insurance portions.

What I find really interesting about TILMA is this stated desire that we need to break down these barriers, that there are these terrible things that are stopping us from trading and making money between these provinces. Oh, no. Yet I've crossed the B.C. border a number of times. Never once have I been pulled into a customs office, been made to declare what I was importing or exporting between Alberta and British Columbia. You know, it's fair trade here. You look at the Constitution, and in fact mobility rights are enshrined in the Constitution. So the very idea that Canadians, Albertans, people in B.C. are free to live wherever they want; they're free to move back and forth across those provincial barriers; they're free to invest anywhere they want in the country. You want to invest on the Toronto Stock Exchange? Go right ahead. You want to do Vancouver? Go right ahead. We have our own Securities Commission here in Alberta. If you want to put your money somewhere else, in a Dairy Queen in Kitchener, go right ahead. There's nothing that restricts you.

From the get-go I started saying that the whole premise that this is based on is, I believe, false. There are no barriers as such. There are no customs stations set up that we have to pass through. There are no tariffs that we have to be wary of and to pay on that are set up on the border between Alberta and B.C., so I challenge the very premise that this whole debate is based on.

A second part of this is what I consider an imbalance in that we are giving over our ability as legislators to make public policy that we believe would enhance the lives of our constituents, our citizens. And we are. With these agreements we are limiting our ability to make those changes. We're limiting our ability to make land-use bylaws, to have municipalities make certain restrictions on recycling or the height of buildings. It's very interesting what's been included in TILMA and what's been excluded from TILMA. Even when it's excluded, it very clearly says: it's off the list right now, but we very clearly want to work towards having it on the list, and you shouldn't impose anything that makes it harder to invest in this and have it as a profit-making situation.

I think the underlying fear – and I'll admit that we haven't test run this. We don't know how this is going to work. So am I absolutely certain that the concerns that I have are going to come true? No, I'm not. But neither can any of you tell me with any degree of certainty that what you also claim is true will come into being. None of us know what's going on here. I wish that we were not going to test drive this because I think the outcome will not be as good as what the government is hoping for. Frankly, neither can you guys prove to me at this point that what you claim is going to be true will in fact follow.

We have an agreement that is shadowing, flowing down from the free trade agreement, NAFTA. Some time ago there was an agreement that was signed called – let me get the exact wording here – the agreement on internal trade. This was negotiated by the provinces and the federal government more than a decade ago. This TILMA is substantially expanding the scope of that agreement on internal trade, and what's new to it that was not in the other parts of it is this idea of a dispute procedure that can be invoked.

That, I think, is going to have pretty far-reaching effects because the dispute procedure can be called into play repeatedly if someone is found guilty of contravening this TILMA by anyone who chooses to bring it forward, by any individual, but I'm expecting mostly by companies who will be claiming that somehow their investment opportunity, their profit-making opportunity, their mobility rights, and their profits have been contravened and that, therefore, they should receive compensation for this. They can sue repeatedly for essentially the same incident, and each one can be a fine of up to $5 million.

That, I think, will have a farther-reaching effect because of the chill that it will eventually place on local authorities, even provincial governments, on trying to change public policy or move public policy along because if you get hit with a couple of – you know, one $5 million fine is okay. But if that was for everybody that was in the queue that day, and that company or individual is able to sue on every single one of those, those $5 million fines start to add up. I think it will create a self-censoring, if you will, a chill upon doing things that I would regard as good public policy if it is helping, protecting our citizens, if it's enhancing their lives but which, frankly, someone, a private individual or a corporation, may regard as a lost opportunity to make money.

I've watched this in a very small way around the city of Edmonton's decision to put in place an exemption around property tax and how they were going to organize that. They struck a committee which had citizens appointed to it. They spent quite a bit of time looking at this. Where the challenges came up was really interesting.

10:40

For example, they looked at extending an exemption to property tax to specialized seniors' residences and the services that they had in those residences. That got challenged by someone. One seniors' residence that I'm thinking about had a cafeteria on the main floor. Nothing swanky, but it was a cafeteria. It got challenged by a local restauranteur, who said: "Excuse me, but that is a distinct business disadvantage to me. This group is not going to pay property taxes. Now they'll be able to offer their services at a reduced or subsidized rate, in effect, and that's not fair competition with me. I insist that that group should not be granted this property tax exempt status because we're both serving food. We're both charging for it. We're both restaurants. They shouldn't be allowed to have that tax exempt status."

The group had to look at that and go: okay, is that really the case? In the end they determined that it wasn't because the seniors' group was offering additional benefits that the restauranteur couldn't. Part of what they were offering was that the proximity was important in that the cafeteria was in the base of a multistorey, high-density seniors' apartment complex. What they were trying to do in that cafeteria was draw people out. They were trying to get the seniors to leave their apartments and to come out to socialize with other seniors to improve their mental health, their socialization skills, and a number of other things. So there was something else going on there besides just grilled cheese sandwiches. Based on that, they did allocate not-for-profit status to that group. That, I think, is a very tiny example of what we're looking at overall here with the decisions that will likely flow from TILMA.

When we look as legislators at how we can make life better for our citizens – and the exchange that the minister of health and I just had around smoking cessation products is a perfect example of that. You know, if we believe that quitting smoking is going to lower costs in our health care system, help make a healthier population, I would argue – the minister may not – that the subsidization of those smoking cessation products will have a longer term effect that's very good for society, good for health, and a lower cost to the system. It's worthwhile to do that. That's exactly the kind of thing that could start to get us into trouble by putting in that kind of public policy that could then be challenged by a private entity who feels that this is interfering with their profit. It's a possibility. It's exactly the same as the restauranteur who felt, you know, that the grilled cheese sandwich was the same in both places.

I'm sure you've heard from a number of my colleagues about the different parts of TILMA that are particularly egregious. I think that TILMA is, as I've been discussing, essentially a tool for deregulation on a number of fronts. Yet that's exactly what we're here to do as legislators is to protect our public, to enable good health and good public policy decisions. We may well be hampered in that.

AUMA, I know, has looked at this. I think individual municipalities are not as confident as AUMA and a little nervous about how that is going to affect them. When we look at some of the things about trying to balance economic growth and the environment or the effect on the health of our people, when we look at things like recycling and placing a return fee on our bottles because we want people to bring them back, and we want that recycled in a certain way because it's better for our environment, it's less wastage, and it's less use of a nonrenewable resource, all of those things start to come into this mix.

I'm really curious about why the government felt that it needed to take this very large step in putting this particular series of agreements into place because, as I said, we don't have any barriers in trade between our provinces. There are no formal barriers or tariffs in place at this point in time.

I look forward to continued discussion, and I would like to adjourn debate. Thank you.

[Motion to adjourn debate carried]

Bill 2
Travel Alberta Act

[Adjourned debate May 6: Mr. Chase]

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

Ms Blakeman: Thank you very much, Mr. Speaker. This act is a fairly straightforward one. I'm aware that it does follow recommendations that were done from a review of Travel Alberta that took place a couple of years ago, I think, and also that this is in fact mirroring changes that I think we saw come into place in some of our sister provinces, B.C. and Manitoba. Essentially, it's made into a Crown corporation or an arm's-length agency in which to be able to operate in a more efficient fashion.

We have done a review of stakeholders. The Strategic Tourism Marketing Council certainly endorses this. We have spoken to some of the other stakeholders in the group, and they seem to be supportive as well.

At this point on behalf of my colleague the Member for Calgary-Varsity and on behalf of my colleagues in the Liberal opposition I am happy to support second reading of Bill 2, and I'm happy to call the question.

[Motion carried; Bill 2 read a second time]

Bill 3
Fiscal Responsibility Amendment Act, 2008

[Adjourned debate May 12: Mr. Snelgrove]

Ms Blakeman: Well, it's just my lucky night, Mr. Speaker. [interjections] You know, this late at night I always get really

inspired if there's a lot of support for me from the backbenches, and you'd be surprised at how long I can talk or how many possible amendments I have under my desk. That means that I can talk more than once on the same bill, so you probably just want to all tuck in and listen carefully.

I am happy to be able to bring forward some of my comments in response to second reading of Bill 3, the Fiscal Responsibility Amendment Act, 2008. What we have with this act are a couple of changes, a couple of minor ones and one major one.

I have to say, Mr. Speaker, that one of the things that I always find a little amusing about this government is how, for all of its protestations about what incredible money managers they are, they can't do it without passing a law. What's always struck me as very interesting is that this government cannot stop itself from spending wildly without passing a law to rein itself in. Then does it stick to that law? Well, not really, because the next year it comes back and changes it again.

Now, I was here when this act was first brought in, because I can remember the then Member for Red Deer-North, I think, bringing it in when he was Treasurer, I believe. Since then, I think this act has been amended every single year. This government has to have an act that restrains it from spending money and makes it illegal to have a deficit. Of course, it's got all kinds of deficits. It's got an infrastructure deficit, a social deficit, a human sector deficit. Good Lord. But then it also goes and changes the rules on how it's restricted every single year. Here we go: 2008, and we have it before us again to be changed again.

10:50

The small changes that are being made are that they're dumping the sections that allowed them to do what was fondly called the Ralph bucks but was called the 2005 resource rebates and that allowed them to be allocated out of the sustainability fund. There were a couple of sections which are basically deleting that, so I think that tells us that we won't be seeing those come around again unless they're going to change the act, well, next year so that they can do it again.

The big change that we're seeing here is that the government is in effect giving itself the ability to go into debt. They're giving themselves the ability to not only put themselves in debt but school boards, hospitals, regional health authorities, the Cancer Board. Postsecondary institutions under all of their respective acts will also now be allowed to go into debt. Essentially, this is to enable P3s and to get into P3 spending. How do we know that? Well, we know that because we've seen the Treasury Board minutes that outline doing this, and the government has followed right through on doing that.

In fact, you know, in those Treasury Board minutes from November 14 of 2007 it said, "The Fiscal Responsibility Act should be amended to allow debt to be incurred to people to provide capital infrastructure to school boards, health authorities, and post-secondary." Then the sort of massaged version of that, the Public Affairs Bureau version of it, comes out as, "The Fiscal Responsibility Act should be amended to allow various alternative financing methods to be used for capital infrastructure for school boards, health authorities, and post-secondary institutions." You've got to credit that Public Affairs Bureau for creative writing – you really do – to make "debt" turn into "various alternative financing methods," but that's what we have. That's, in fact, what's happened here.

Why do Albertans care? Does anybody really care if we get schools and hospitals and cancer clinics through one kind of infrastructure? Do Albertans really care? I mean, big deal, right? It gets paid for one way or another. What's it all about? I think we do care. I think we care on a number of levels, and I think they divide out into about four areas that I've sort of written out in my notes. I think the first area is around transparency and accountability. The second area is reliability, the third is additional cost, and the fourth is assets for all Albertans. I'm just going to go back and kind of group my thoughts around those four areas.

The transparency and accountability part. Well, admittedly, it's not very sexy. It doesn't get on the front page of the paper. Yet when the chips are down, this is where it really matters. My issues around P3s: there are a couple of areas that have proven to be problematic in a number of other examples of P3s. Really, that's what this is about. Bill 3 is about P3s. It's about allowing this government to get itself into P3s but also to get school boards, health authorities, hospitals, schools, postsecondary institutions into P3s. The interesting part of this is that the government always says: "Oh, no. We'll be totally transparent. Absolutely anybody can know anything." Actually, none of us ever find out anything, and that has been proven over and over and over again in any example of a P3 that you want to give me.

What happens is that the negotiations themselves are secret because they're negotiations, and there's always concern about business product getting out and that you can't let, you know, your business competitors know what your bid is and all of those kinds of things. That process is always very secret. But then the contract gets signed. "Well, great. Can Albertans see what we signed?" "Oh, no. No, no, no." "Can we FOIP it?" "Oh, absolutely not." Horror, shock, and dismay. No, no. Now this is a contract with a third party. You can't FOIP that, and the FOIP laws protect it.

So we the public, we the opposition members, even you the backbenchers never get to see what's in those contracts unless you were on the negotiating team. Now it's a contract that has been signed on behalf of Albertans for 25 or 30 years, 60 years, whatever it is. Most of them are in that 25- to 30-year range. There's no transparency in this process. It's negotiated behind closed doors, the contract is signed, and then we can't see the contract.

What we found in looking at the other P3s that have not gone well is that mistakes are made in the contracting, and the whole idea of the risk and the transfer of risk, in fact, doesn't happen. The risk for the most part is staying with the governments, and they are paying six ways from Sunday on these projects. There's no transparency, and there's no accountability. For us to be able to say to the government, "How are you implementing that contract?" or "Can we see what the terms of the contract are?" or, you know, "How much money have you spent so far?" – we can't get any of that information either. So there's no transparency and there's no accountability under this process. It all becomes thrice removed, to quote good old Bill.

The second category I was talking about was reliability. When I first heard about P3s, you know, I'd hear the government go, "Oh, these are wonderful things" and "This was a great idea" and "That was a great idea" and "New Zealand has done all of their hospitals that way, and it's just terrific." Then I started to hear about all these things that weren't so good. I remember the international health symposium that was sponsored by two times ago previous ministers of health in May of 2005 and a great speaker from New Zealand, I think he was. I was very interested in his presentation because he was the chair of a board of a hospital, and he, in fact, had had to get his hospital out of a P3 contract and literally had to buy them out of 25 years of stuff because things had gone so badly for them.

I thought, well, okay, that's the only one. Well, no, actually, it isn't. It didn't take me very much looking – I didn't have to look very far – to find a hundred examples of P3s that were either abandoned because they had gone so badly, and a couple of those are from Alberta, or that had had serious and ongoing problems,

especially around risk transference, around the terms of the contract, around the maintenance, and around how the asset is actually turned over. In most cases it ended up costing the government either more money or substantially more money than if they had just built it themselves in the public sector.

Let me just give you an example of what I'm talking about here because, you know, I like to do my homework. Here's an example. It's example 21: long-term care facilities, 13,000 private beds in Ontario, page 20 there.

> In three rounds of bidding from 1998-2000, the Ontario government contracted with for-profit companies to build over 13,000 long term care beds as profit-seeking ventures. For the first time, taxpayers are paying for beds to be owned and operated by for-profit companies.

So the taxpayers actually paid for this, but the not-for-profit companies get to actually own them.

> In contracts that span 20 years, the province will pay $10.35 per bed per day for 20 years for the capital portion of the costs.

Now, just for comparison, folks, here in Alberta in long-term care the individual Albertan is paying $44 a day. So here's the government paying $10.53 – this is between '98 and 2000, so figure in inflation there – per bed per day, per day, for these beds to a private company. Who signed this contract?

> At the end of the deal, Ontarians will have paid over $900 million for beds which the companies will own and can convert for their own uses.

Now, please. I'll have anybody in this room explain to me how this was risk transference. Hardly.

> The end of the deals, at approximately 2020, coincides with the time period in which the biggest crest of baby boomers will reach age 80. Ontarians will then have to pay again for the beds [which they've already bought] or build new ones.

That wasn't a very good deal, was it?

11:00

So there's one example. Let me give you another one. This is from the William Osler Health Centre P3 in Brampton, Ontario.

> Costs for the P3 hospital deal grew from $350 million to over $550 million during the lease negotiation.

Not even over the terms of the contract, guys. During the lease negotiation.

> In this period, the size of the planned hospital was reduced and the new hospital is now to be opened in stages. The higher private borrowing rate and premium on equity mean that capital costs are $174 million more than they would be if the hospital was built publicly.

One hundred and seventy-four million dollars more than if they had just built it themselves.

> All other financial information pertaining to the service privatization regime is considered a "commercial secret" shrouded from scrutiny by taxpayers, along with the Value for Money report and many other documents. Ultimately, the deal was over a year late.

So another example of not doing so well in all of these examples.

Then there are a number of truly horrifying international ones. Let me just give you this one. No. 69: East London and city mental health trust P3, East London. What were the problems here? Long delays, serious design and construction problems, problems in relationship between the public and the private sector.

Here we go. The following problems:

> . . . the bidding and the negotiating went on for 2 years beyond deadline, even after which the contract did not adequately specify the obligations of the private companies; the architects were not paid, did not inspect works or certify completion and there are no drawings of the final buildings . . .

Now, for any of you with an engineering degree in this Chamber or anyone who has ever done project management, I can feel the fear running up and down your spines at the thought there are no drawings of the final buildings.

> . . . the original design provided no office space at all . . .

In a hospital no office space at all.

> . . . a redesign to squeeze in offices is extremely poor; gender segregation in the wards is impossible due to design flaws; the water supply totally failed upon the building opening; a number of toilets were not connected to drains leading to "obvious problems"; floor coverings are defective; alarm and call systems unreliable; emergency systems non-functional; staff were ill-informed and alienated; and the contractor was deemed uncooperative and adversarial.

Okay, that was in East London.

Guys, you know, there are a hundred examples here. If I get some more time, I'll come back and read some more into the record because it just starts to give you a feel for how badly wrong this can go.

The risk transfer doesn't happen, we don't really save the money on the cost of borrowing, there are a number of problems that go wrong in the contracting about who's responsible for what, and in the end the public who has paid for this asset in a lot of cases doesn't get it. Or they get it back in such crappy shape, they have to start over, which is the other very common problem in this.

The third thing I was talking about were the additional costs. You've all heard this argument, so I won't spend a lot of time on it. It is that obvious argument about why on earth when we have a triple-A rating here in Alberta – we have $70 billion worth of assets that are being currently managed by AIMCO, so, you know, we could borrow from ourselves at a pretty good rate to build these hospitals and schools. But, no, we're going to get into having a contract with a private firm who's going to go out and borrow this money from the banking system. They're going to be paying prime plus whatever.

So right there is an additional cost in doing these P3s, right off the bat. That's obvious to anybody that's walking down the street to look at the difference in that. It costs those private companies more money to borrow the money right away. The difference is that the debt does not appear on the government's books right now. It appears as a series of annual payments, which can be written off as an – watch the quotation marks – expense, but it's not seen as a debt. But it is a debt because they've got a contractual agreement to pay it over a long period of time, far beyond in many cases what it's actually worth.

The fourth thing is assets for all Albertans. What do we get back? Well, in the P3s that I've looked at, in a lot of cases it's as I've already mentioned. What they get back, especially if you get into the agreements where the P3 contractor builds it and they maintain it – and that's in a lot of cases where the corners get cut, where the maintenance did not happen or was postponed. So in some cases, yeah, you get that building back into the public sector after 30 years, but guess what? They never did the roof repairs and regular maintenance that they were supposed to do at the 25-year mark, so now you've got a building back at 30 years that's five years overdue on having its roof done, and now we're paying for it again. We've paid the contractor for this building, they made the money, they made the money on the maintenance contract, they didn't do the maintenance, and now we're going to pay for it again. That's where it's a rip-off for Albertans.

Ultimately, I think this is around an ideological difference between the party that forms this government and, certainly, the background that I come from. I think there are certain things government should be doing. Some of those things are: building hospitals, building schools, building postsecondary educational institutions. I do not see an advantage for Albertans in having a private sector do this. That's not to say that the private sector isn't

a valued part of our society and that it doesn't give us many wonderful things and that we don't have some real crackerjack entrepreneurs out there who have really contributed to this province not only in the businesses they've built but also in the philanthropic work that they have given back to their community. You know, be very careful about that. This is not to be slagging entrepreneurs or businesspeople in any way, shape, or form; this is a question about public policy and choices that we make.

The other, sort of, outflow that comes from this one is around union work. No surprise to anybody in here that I'm pretty keen on unions. I think they're a safer – well, I don't think; I know they're safer workforces, safer work sites. I like the idea of that collective bargaining process, but you don't get very much union work through these P3s. You know, with union workers you know the money's staying here, right? They live here. They pay their mortgages. They buy their groceries here. But I'm expecting that what we'll see is P3s that start to not use union workers but bring in – wait for it – temporary foreign workers, who will then be shipped off again. They don't stay in this community. They don't contribute to it, and they take their money away. That's one more thing that does not contribute back into and benefit our very own people.

Now, I'm aware that my – yeah, there's my time.

So, no, I'm not going to support this, and I would like to adjourn debate.

[Motion to adjourn debate carried]

The Deputy Speaker: The hon. Deputy Government House Leader.

Mr. Zwozdesky: Thank you, Mr. Speaker. It's been a riveting evening of debate and a great exchange of information from contributing members. On that note I would move that we now adjourn until 1:30 tomorrow.

[Motion carried; at 11:09 p.m. the Assembly adjourned to Wednesday at 1:30 p.m.]

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