Legislative Assembly of Alberta

The 27th Legislature
Second Session

Standing Committee
on
Health

Department of Health and Wellness
Consideration of Main Estimates

Monday, May 4, 2009
6:31 p.m.

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Standing Committee on Health

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6:31 p.m. Monday, May 4, 2009

[Mr. Horne in the chair]

Department of Health and Wellness
Consideration of Main Estimates

The Chair: Good evening, colleagues. I'd like to call this meeting of the Standing Committee on Health to order, please. I'd like to welcome Minister Liepert and his staff.

Minister, in just a moment we'll give you an opportunity to introduce your officials. We'll begin this evening by introducing members of the committee, beginning with the deputy chair.

Ms Pastoor: Thank you. Bridget Pastoor, Lethbridge-East.

Mr. Weadick: Greg Weadick, Lethbridge-West.

Mr. Fawcett: Kyle Fawcett, Calgary-North Hill.

Mr. Denis: Jonathan Denis, Calgary-Egmont.

Mr. Dallas: Cal Dallas, Red Deer-South.

Mr. Olson: Verlyn Olson, Wetaskiwin-Camrose.

Mr. Quest: Dave Quest, Strathcona.

Dr. Swann: David Swann, Calgary-Mountain View.

The Chair: I'm Fred Horne, MLA for Edmonton-Rutherford and chair of the committee. To my left is Erin Norton, committee clerk. We are expecting some additional members this evening, so they may be joining us within the first few minutes of commencing our deliberations.

Minister, if you'd care to introduce your officials.

Mr. Liepert: I would like to do that. Thank you, Chair. It's our pleasure to be here this evening. To my immediate right is Linda Miller, Deputy Minister of Alberta Health and Wellness. To her right is Martin Chamberlain, acting assistant deputy minister of corporate operations. To my left is Charlene Wong, executive director, finance and administration.

Do you want me to carry on?

The Chair: I'm just going to make a few comments regarding procedure and then turn it over to you. Thank you very much, Minister.

Colleagues, just a few reminders. I know you've all been through this a number of times. The vote on the estimates is deferred until Committee of Supply, which will be held May 7, 2009. A vote on any amendments which may be tabled at this meeting is also deferred until Committee of Supply. Any amendments that are to be proposed at this meeting must have been reviewed by Parliamentary Counsel no later than 6 p.m. today.

I believe you're all familiar with the speaking order as cited in the standing orders. Just a reminder that only committee members, the minister, and any other members of the Assembly present may participate in the discussion. Department officials and members' staff may be present but may not address the committee.

Speaking time is limited to 10 minutes. Alternatively, a minister and a member may combine their time for a total of 20 minutes. In that regard the chair would appreciate, if you do elect to combine your speaking time to 20 minutes, that you just so indicate to us so that the clerk and I can keep track of the time accordingly. Members are asked to advise the chair at the beginning of their speech, as I just said, if they plan to combine their time.

We have a total of three hours to consider the estimates of the Department of Health and Wellness. If the debate is exhausted prior to three hours, the department's estimates are deemed to have been considered for the time allotted in the schedule, and the committee will adjourn. In any other event we will adjourn at 9:30 p.m.

Just a reminder that points of order will be dealt with by the chair as they arise, and the clock will continue to run during any discussion of points of order.

I think that's about it. The Official Opposition will have the first hour. The subsequent 20 minutes will be allocated to the third party, and the remaining time will be allocated to all members of the committee. As we have done in the last consideration of another department's estimates, I will alternate between government and opposition members in the final time period.

By mutual agreement among all parties represented, the committee will take precisely a five-minute recess following the 20 minutes allocated to the third party.

Are there any questions regarding the process?

With that, then, I'd like to invite Minister Liepert to speak for the first 10 minutes.

Mr. Liepert: Well, thank you very much, Mr. Chair. It's our pleasure tonight to bring before this committee the estimates for Health and Wellness. As you all are well aware, the estimates of this department far exceed any of the other departments of government. However, I think that we would also all agree that the provision of health care to Albertans is probably the most important thing that we as government do.

I wanted to sort of step back a bit before we look to the next year. Just over a year ago we commenced a health action plan. It was a nine-month plan, which concluded on the 15th of December. We periodically reported out on the progress of that health action plan every three months. At the conclusion of the nine-month plan I committed to bring progress reports twice annually to the policy field committee. Tonight as part of our discussion I want to circulate to the committee members, Mr. Chair, our health action plan progress report, the first report of this year. So if we could do that, I would appreciate it.

It's been a busy year, and as you can see by the report that you'll soon have in front of you, a lot has been accomplished, but sadly a lot more remains to be done. Hopefully, as part of our 2009-10 budget year we can continue to make strides in meeting those goals.

Probably the most important decision that we made as a government in this past year was the governance structure with Alberta Health Services, that is now well under way. Our board was appointed in December, and they are working diligently to pull the workings of the previous 12 entities together under one. Our new CEO commenced his duties in late March. There have been some very significant strides made, including the release on Friday by Alberta Health Services of their three-year strategic plan. With your permission I would also like to distribute to members the three-year strategic plan as put forward by Alberta Health Services.

Some of the other accomplishments in the past year were the introduction of Vision 2020, which sets forward our vision for health care in the province, and also the continuing care strategy document. The release of the children's mental health plan was a very important step in the past year. We brought forward legislation to deal with a couple of areas, including before the House today the Drug Program Act, which is the governing legislation to deal with our pharmaceuti-

cal strategy. Finally, the Public Health Amendment Act, 2009, has now received third reading.

One of the key initiatives under the Public Health Amendment Act is the appointment of our new chief medical officer of health. Dr. Corriveau commenced his duties, again, in late March, and it didn't take very long before he was thrown into the middle of our worldwide H1N1 influenza, I think it's called. I would just say here and now that he has done an absolutely terrific job over the last couple of weeks. As of today members of this committee will know that we have, I guess, just about the most number of cases identified in the country. We also have the only individual, unfortunately, who has required hospitalization. Dr. Corriveau has handled this extremely well, and we've made some great progress in the area of public health.

6:40

I'd like to just take a minute or two and highlight some of what I would suggest would be our priorities in this budget that's before you today. You're well aware of our, as I said, Vision 2020 and our pharmaceutical strategy, which we've brought forward.

We have as part of our 2009-2012 business plan seven goals for the department. I'd like to read them off, if I could, for the record. Number 1 is effective governance for the health system; number 2, a sustainable and accountable health system; number 3, healthy people in healthy communities; number 4, strong public health capacity to mitigate risk and enhance population health; number 5, enhancing workforce collaboration, development, and capacity within health; number 6, increasing access through effective service delivery; and number 7, improving health service efficiency and effectiveness through innovation and technology.

We will be achieving these goals through our budget allocation this year of $12.9 billion. That's consistent with our budget from last year, but I do believe it needs clarification. The $12.9 billion is almost entirely in operating and is an increase of $558 million, or 4.6 per cent, from our '08-09 forecast. Alberta Health Services will receive $7.7 billion in operating funding for the delivery of health services. This will include an increase of some 550 million dollars, or almost 8 per cent. But it does include $122 million to provide emergency medical services going forward. As you know, the responsibility for EMS was transferred from municipalities effective April 1, and already early reviews of this change have been very positive.

The Alberta Health Services deficit for the year just concluded is estimated to be around $500 million, but those final numbers won't be available until the financial statements are received at the end of June.

I just want to touch very briefly on a couple of the allocations in our budget going forward. Physician services is being allocated $3 billion. That's an increase of $365 million. It'll include funding to support physician compensation, on-call programs, and a number of other areas, including the alternate relationship plans.

We're going to spend some 42 million dollars of our budget on the safe communities initiative. That will deal with a lot of preventative measures and also the areas around mental health and addiction. We've allocated $41 million to implement the continuing care strategy, and it includes significant increases in such things as home care for our seniors.

I think it's important to note also that cancer therapy drug funding is receiving $94 million, which is a 20 per cent increase, and a large chunk of that is due to the approval of Avastin for the treatment of advanced colorectal cancer.

I won't go into too many other details, Mr. Chair. Actually, I wanted to just very briefly cover our capital budget. This year, as you are well aware, our capital budget is only $238 million, but what needs to be emphasized is the fact that beginning this fiscal year, '09-10, Alberta Health Services had approximately a billion and a half dollars in cash reserves for capital. Then our projected increases over the following two years are in excess of a billion dollars in each one of those two years.

As I said on budget day, considering the challenging economic times that we find ourselves in, I believe that this is a good-news budget for Alberta Health and Wellness. Clearly, we are going to have to do things differently going forward. I think there is a willingness on behalf of those involved in health care delivery. There's a renewed understanding by the public that we can't continue to do what we've been doing, so that's our challenge in the year ahead.

With those opening comments, Mr. Chair, I would turn it back to you.

The Chair: Thank you very much, Minister.

The next hour will be devoted to discussion with the Official Opposition. Dr. Swann, the floor is yours.

Dr. Swann: Thank you very much. Thank you to the minister and to the staff for attending tonight for this important debate and discussion on the health budget. For the record I want to provide a series of questions which may or may not have immediate answers, but I would appreciate the written answers. I will attempt to be as constructive and respectful as ever, Mr. Minister, and hope we can address some of these issues very substantively and move forward together.

Let me begin by saying that everyone wants the health care system to work, and I believe, having had 30 years of medical practice, that everyone wants to be healthy. There is a very tiny proportion of people in the population that are psychiatrically or psychologically unable or unwilling to make choices in their own health, but the vast majority of people do intend to be healthy and reach their potential. What I think all of us want to see is a health care system with a clear plan: short-, medium-, and long-term goals for infrastructure, for professionals, and for programs that actually address preventive, diagnostic, treatment, rehabilitative, and palliative services.

Albertans have said to me since I became elected that they see some problems in the priorities that the government is taking around the health care system, the priority services being front line, primary care, family doctor, nurse, provision of public health and ancillary services, home-care services, early intervention services for children and adults and seniors, and a more, I guess, focused system that isn't quite so dispersed and trying to do all things for all people all the time, including some of the most advanced research and high-tech medicine, that is clearly impossible if one is going to provide the basics to the extent that we need to.

A second value that Albertans have expressed to me over time is the need to demonstrate outcomes. When we take decisions and make new programs or expand old programs, we want to know that the outcomes are worth the investment and that, as compared to other investments of those dollars, we're getting good value for the money.

A third aspect has to do with the management issues and the question of whether we have the right level of management or are overwhelmed by too many cooks, as you might say, and not enough front-line workers and where that balance is. There has been a question in the last while that needed to be looked at, and that certainly has to be an ongoing evaluation, whether or not we're getting the value from the management sector. Efficient and equitable services are clearly a priority.

A fourth has to do with the decision, then, more specifically, to consolidate the nine regions into a single health board, which, indeed, might reduce some levels of management. That remains to be proven, especially given the cost overruns in the past year. But as important to Albertans, I think, is that they have input into the system, and by centralizing all the authority and control and spending into a single Health Services Board, we see a reduced flexibility, a reduced accountability, a reduced transparency, reduced representation from the regional and local levels, and a disrupted communications strategy.

Particularly at a time when this outbreak is occurring, I'm hearing serious concerns from people who feel they can no longer speak on issues that matter to their community and to their well-being. Timely communication has now become difficult and, in fact, in some cases increases risk because timely communication is having to be routed through the Alberta Health Services Board, and that's a serious concern.

Ultimately, with decreased responsiveness at this provincial level, there becomes a sense of disconnect and a loss of sense of responsibility at the local level. We see the paradox or the contradiction of wanting to have more efficiency while we see, because of the centralization of power and authority, a sense at the periphery that: well, we don't get to make any of these decisions, so we won't even speak up and make the kind of changes that need to be made and would have been made under a regional system, where people would have immediate response and debate and a decision would be made and improvements would be made.

6:50

A fifth element has to do with the workplace health and the professional quality of life in the workplace. My impression is – and I don't have statistics to back this – that there is an increased level of stress and burnout and absenteeism and perhaps injury. I would look forward to any data that might be available on this from any of the staff. It's clear to me from talking to many professionals over the past year that job satisfaction has certainly declined even if health status in measurable terms or absenteeism hasn't.

Finally, I'm pleased that the Health Quality Council is alive and well and doing its job. It's identified as important the recognition of satisfaction in patients, job satisfaction in professionals, rates of complaint from the public, and confidence in access to primary care networks, some key measurements. I don't know how up to date they are. In the budget the last measurement I see on some of the serious complaints about the system is from 2006. In addition, 60 per cent confidence in access to primary care is from 2006, with a 60 per cent satisfaction. We have some challenges with gathering the data and reporting the data, and I have no doubt that they'll be working on this.

The other concern I have about the Health Quality Council is that they appear to be muzzled. They appear to be, again, not very free to speak to their objective evaluations and make very clear recommendations about what needs to be done to improve access, to improve quality, to improve the cost-efficiency of the system. The reports I've seen appear to have a very limited freedom to criticize and to challenge, even in constructive ways, some of the decisions that are being made.

Having said that, I'll move then to specific questions, Mr. Chairman, and leave these for the record. With respect to this budget in particular, almost a $13 billion budget, I guess the question we on the opposition side continue to raise to the government is that we're given 80 minutes, at least as the Official Opposition, to debate a budget of $13 billion. This breaks down to $161 million a minute and raises questions about just how effectively, I guess, we are able to look in significant depth at where we're spending the money, why we're spending the money, and what some alternates might be to improve the effectiveness and efficiency of the system.

Moving on, then, to the health system governance. My questions for the minister and staff: what is the total cost for restructuring the health care system? Will the minister provide the complete amount of what this has cost in the past year and include some of the severance packages from former regional health authorities? What is the explanation of the one-time financial assistance to Alberta Health Services? According to line 5.0.2 on page 243 of the government estimates it was $297 million. In '07-08 that figure was $68 million, so a sixfold increase.

Another question to the minister: what does the minister project the final deficit for Alberta Health Services to be? We understand that this won't be available perhaps till June, and that's obviously something that people are watching very closely. Has the minister performed a comparison of the deficits when there were nine regional health authorities to now? Under the nine authorities it was an accumulated $97 million deficit. Now the deficit, of course, is between five and 10 times higher than that. How does the minister explain this, and in the name of sustainability and efficiency when can one expect to see those figures turn around?

If Alberta Health Services is supposed to be sustainable, what is the $558 million increase in the operating budget, and how is that being distributed throughout the province? What accountability will there be as far as certain areas of the province knowing how much funding they receive? For example, will the annual report for Health and Wellness break down the funding by cities and towns or regions? How is the minister going to deal with the issue, including the money spent by Alberta Health and Wellness?

Strategy 1.3, page 161 of the 2009 business plan, refers to the capital planning process. Will the minister table the evidence and documentation used to prepare the complete business plan case analysis of each health care facility that's currently under review by the Alberta Health Services Board? What is the explanation for the $386 million reduction in the capital plan according to page 92 of the fiscal plan? Will the minister commit to a timeline for reporting the status of the facilities either completely under review or that the scope is under review, as indicated in the project-by-project breakdown of the health capital plan? Finally, is Alberta Health Services performing a review of the capital plans, or is it an outside consultancy firm? What are the projected costs of that review?

In relation to strategy 1.4 on page 161 . . .

The Chair: Dr. Swann, excuse me for interrupting. I just wanted to indicate that a signal indicated that 10 minutes of the first 20-minute segment has passed. You didn't indicate, but I'm assuming that you're electing to combine your time with the minister.

Dr. Swann: That's correct.

The Chair: I just thought I'd point that out to you. There are about 10 minutes for your questions and then for the minister to have an opportunity to answer.

Dr. Swann: I can proceed, then?

The Chair: Yeah.

Dr. Swann: Thanks.

Strategy 1.4 on page 161 refers to implementation of a single health authority and clarification of roles and responsibility. Will the minister explain the areas where there is a lack of clarification on

roles and responsibility between the Health Services Board and Health and Wellness, and will the minister support the Ethics Commissioner looking into issues that arise from the Health Services Board? I'm also aware of the Provincial Health Ethics Network and concerned that that health ethics network is an objective voice for health ethics issues in Alberta and would hope that we could hear some comment about the future of that body as I think it has served Alberta very well and certainly helped health professionals feel confident that the ethical issues being raised by our modern system are being addressed.

Page 242 of the 2009-2010 government estimates, line 3.0.2, allied health services received a reduction of $40 million, more or less. Will the minister explain what made up that $40 million reduction? What programs and services were reduced?

In the 2008 business plan there were two additional performance measures not included in the 2009 business plan. On page 160 of the 2008 business plan performance measures 1(b) and 1(c) mark the percentage of health program spending with regard to total government expenditure and the average of all the health authorities' annual operating surplus as a per cent of total health care authorities' revenue. Could the minister give us a reason for excluding these two measures from this business plan, and will there be additional performance measures created for the goal of effective governance for the health system?

Performance measure 2(a) on page 162 of the 2009 business plan shows the percentage change over prior year actual in ministry operating expense. The last year actual was 10.4 per cent, and the target for '09-10 is 4.7 per cent. How does the minister propose to reduce the expenditures by 5.7 per cent? Is this where the minister has plans to delist 30 to 40 services? Why is the information about delisting services not included in the budget documents for this year?

The Chair: Excuse me, Dr. Swann. Again, I'm sorry to interrupt you, but pursuant to the standing orders I believe there's a limit of 10 minutes of speaking time per member. We've exceeded that considerably now.

Dr. Swann: Oh, I thought I had the first hour. That's my misunderstanding.

7:00

The Chair: You do, but the time is divided into 20-minute segments. At the conclusion of this segment, then we would start again, and you'd be free to continue.

Dr. Swann: Oh. Fine. Sorry.

The Chair: Minister, would you care to . . .

Mr. Liepert: I'd love to, actually. I'm not going to be overly critical, but I am going to say that a good number of the questions that were asked obviously were written out for the member, and I answered them in my opening remarks. I'll repeat them again, but I don't think that's terribly good use of our time. If we need to just continually repeat things, we will.

Starting off with a plan, I'm not sure where the Leader of the Opposition has been, but in the last year, as I said in my opening remarks, we have released Vision 2020, which is a plan for health care in this province. We can go through it, but it's there for everybody to see. Tied into Vision 2020 we released the children's mental health plan, a continuing care strategy, a pharmaceutical strategy. So to leave the impression that somehow there is no plan is clearly not either acknowledging what has been done or is not being prepared to acknowledge what has been done.

Now, there were some comments made around early intervention. I happen to agree with the hon. leader, and it was one of the reasons why one of our first priorities in dealing with mental health issues was to ensure that we had a children's mental health plan. It is there, it is funded, and to me that's the best example of how you can have early intervention.

There was also a comment made relative to providing more home care for seniors. As I said in my opening remarks, one of the priorities in this budget is additional monies for home care for seniors.

Now, you did raise the issue around the need to demonstrate outcomes. I couldn't quarrel with that because I believe very strongly in our health care system today. If there's a huge weakness in it, it is that we continue to put money into a system, and we have no ability to measure what it achieves. There's a very good report by the Health Council of Canada that talks about the amount of dollars that we put into health care in this country and that there's no measurement. We have to do a lot better in that area. I certainly wouldn't disagree with that.

Some comments were made around the management of the Alberta Health Services. I would ask all members of this committee to give the guy a chance. We have brought in one of the leading health care management officials in the world in Dr. Stephen Duckett. Anyone who has met Dr. Duckett comes away incredibly impressed. I had certainly some long discussions with the mayor of Edmonton after the creation of Alberta Health Services and his real concern about what the loss of Capital health was going to do to this city. I can tell you that he is one of the strongest advocates today of what is happening, and a lot of it is around the leadership of Dr. Duckett. So I really believe that we need to give this individual a chance to put in place some of the changes.

I would like to respond relative to your comment around the decision to consolidate. There was a comment by the leader about something to the effect that it was intended to reduce management, save money. My notes are kind of thin here on that. The decision to consolidate was never about saving money in administrative and management costs. We hope that there will be. We believe there will be. In fact, I think it's clear there will be. The decision to consolidate was so that we had one health care system for all Albertans, so that we didn't have nine competing health care systems, didn't have duplication in so many areas. All the indications that we've seen to date are that we're streamlining in that manner, and it's coming together very nicely.

Some comments around the health in the workplace. There were some broad-based assertions by the Leader of the Opposition. If he has specific examples that he can give us, we're more than happy to look into it, but I'm not going to start chasing ghosts by somebody saying that they've talked to somebody who had talked to somebody who said something. Give us something to follow up on, and we'd be happy to. Just saying that somehow you're hearing about concerns about workplace health I don't think is good enough to start chasing down.

I would absolutely disagree with the Leader of the Opposition that somehow the Health Quality Council is muzzled; those were his words. The Health Quality Council undertakes initiatives. It reports. It reports publicly, and to leave that kind of assertion on this table is not right.

Then we get to the questions, the cost around the change in governance. We have made public the senior management severance packages. They're there in black and white. I don't know how you can, beyond the severance packages, actually put a cost around

consolidation. There are potential savings in the area of staff at the management level. There are savings around IT. But to come forward with any kind of cost around the governance changes is, frankly, impossible.

I made mention in my opening remarks and, again, the question came up about the final deficit. I said it was estimated to be around $500 million, but we won't have the actual numbers until the audited financial statement around the end of June.

I don't think I've spent my 10 minutes yet, Chair. Is that right?

The Chair: No. What's happened, Minister, is that we've completed the first 20-minute segment. We'll restart the clock for the second 20 minutes.

Dr. Swann, this time if I could just ask you not to exceed the first 10 minutes of the 20. That was my error. I'll interrupt the next time, and that will give the minister some additional time to respond.

Dr. Swann: In the interests of fairness, I'd be happy to give the minister his extra two or three minutes.

Mr. Liepert: Great.

The Chair: I'll start the clock. Let's continue, please.

Mr. Liepert: There was mention made by the leader about the $97 million accumulated deficit of the previous year, that somehow the projected deficit in the year that was just concluded was going to be five to 10 times higher. You know, what we need to do is compare what the final deficit will be at the end of March 2009 – as I said, it's estimated to be in the range of $500 million – with the projected deficits in the business plans of the previous health regions as they entered into the '08-09 year. Those projected deficits accumulated were somewhere in the range of just under $400 million. Keep in mind that the new Health Services Board did not officially take over the operations of this entity until into that budget year, clearly had to operate largely in this past year under the previous health regions' business plans.

In addition to that, there was a settlement with the Alberta Union of Provincial Employees that added about an additional $250 million onto the costs. It was not part of the previous regions' projected business plans. I would say that all things being equal, the final deficit for the just-concluded year will be in the range of what was projected in the business plans for the previous health regions.

The $558 million increase for the Alberta Health Services budget clearly is simply cost increases. You've got wages. You've got the cost of providing services. If you pull EMS out of the budget for '09-10, which wasn't a cost that Alberta Health Services previously had, their operating increase is about 6 per cent. You've got an AUPE settlement, as an example, that is closer to, I believe, 7 or 8 per cent across the board. Just increased costs in health care are clearly going to be at least in the range of 6 per cent.

7:10

The question around accountability: how is this money going to be spent in regions, cities, and towns? I can only say to you what I answered in the Legislature today. We're not going to try and say that the Capital region gets so much versus the Calgary region or the former Northern Lights region. We want to ensure that as one health board we are providing health services equitably across this province, and we're not going to get bogged down about who got more and who got less. It's going to be important to ensure that we provide health delivery across this province. That's why the alignment of EMS with health was such an important decision.

Capital planning costs. I'm struggling to remember exactly what the question was on that. There is a project review under way. Relative to timelines we are trying to get meetings set up with the affected communities within the next 30 to 60 days, and that is taking place now. There are no outside consultants that are being hired, so there are no costs associated with that for the project review on capital.

Clarification around roles and responsibilities between Alberta Health Services and the Department of Health and Wellness I would say is a work-in-progress, but let me tell you what Dr. Duckett said to me. He said: I'm not going to spend a lot of time worrying about roles and responsibilities; collectively we're going to work together to ensure that we deliver the best health care system we can for Albertans.

Your question around allowing the Ethics Commissioner to deal with the Alberta Health Services Board. I don't believe the Health Services Board is in the purview of the Ethics Commissioner by our legislation. I will stand to be corrected on that, but I don't believe that that applies.

The health ethics network is one of those areas that was transferred to Alberta Health Services to make a determination going forward, and they will.

The reduction in allied health care is primarily around some 50 million dollars that will no longer be paid to partially cover chiropractic fees.

You asked about measures around regional surpluses. Well, it really doesn't apply anymore because we no longer have regions.

Your final comment was around other services that will be, in your words, delisted. There is nothing in this budget that is an indication that any of that is going to take place. We as a department had to meet some tough guidelines that were set out by our caucus, and we have dealt with them as best we could.

The Chair: Thank you, Minister.

Gentlemen, there are about 14 minutes remaining. Dr. Swann, I'll ask you both to share the time accordingly.

Dr. Swann: Thank you. Well, thank you to the minister for those. Since you began to address some of the questions of delisting, I wonder if you could comment further about what your list comprises, how you came up with it, why, for example, transgendered surgery and chiropractic rose to the top and on what evidence you feel you're going to save money there when these would certainly continue to cost the system money over time.

On a question related to page 158 of the 2009 business plan I want to talk about preventive services. As your business plan states, "it is easier to prevent health problems or minimize the complications . . . than to treat them once they emerge." Apropos of this is the quote from page 243, line 4.0.3. Community-based health services received a reduction of $12.6 million. So we're again, I guess, raising the question: what is the evidence that you're going to save money? It may be true that you'll save money in this fiscal year by cutting some of these services, as you would with the delisting of some services. The question is: what's the longer term vision for health services, and how are we going to make these decisions in a longer term time frame and a more holistic picture if the government is downloading greater responsibility for health on individuals? This appears to be to some extent the case with respect to seniors' pharmaceuticals as well. Surely there should be an increased support to prevention and community-based services.

On page 159 of the 2009 business plan under Integration of Delivery Services and Policy there's a statement that "health services will be more effectively delivered throughout the continuum

of care." Perhaps the minister could explain a little more about what evidence is being used and what changes will be made to improve that continuum of care.

Strategy 3.5 on page 163 of the 2009 business plan states: "Realign the delivery of provincial public health programs between the Ministry and Alberta Health Services." Will the minister explain what this means? Will more public health be done through Alberta Health Services or through this ministry? Will there be an increase in funding for Alberta Health Services if they take on more of the public health programming?

Under the Pharmaceutical Strategy, page 160 of the 2009 business plan, strategic priority 8 refers to implementation of the strategy. What was the total cost for the five government ministries who provided drugs under the old system, and what is the projected new cost of combining these under the ministry of health?

Because of the increase in Blue Cross premiums the government will take in an additional $18 million and $27 million in fiscal 2010-2011 and 2011-2012 respectively. Government estimates also show that the revenue from supplemental health benefit premiums will increase by $8 million from the 2008-09 forecast, an increase of 31 per cent. What was the status of Blue Cross with regard to surplus or deficits in the past five years, and will the minister table the documents for us? If Blue Cross did not increase premiums for 15 years, why was that, and why is there a necessity now to double and triple the Blue Cross premiums?

How can the minister explain the need for a 200 per cent increase, then, in the nongroup coverage for Blue Cross and the need, as he has expressed it, to bring into alignment employer insurance and private health insurance? Will the minister admit that raising the premiums can be perceived by Albertans as being some return for the cuts to premiums in health care? Are we giving at the same time as we're taking from Albertans?

Strategies 2.4, 2.5 on page 162 relate to the implementation of the pharmaceutical strategy and exploration and implementation of common procurement systems. Will the minister tell us when there will be one consolidated government drug plan and provide the information on any changes to what is covered under this one plan, what those changes will be, and similarly to the Alberta Blue Cross plan? How far along is the minister in implementing a common drug procurement system with other provinces in the country, a very positive initiative, I would say?

Under continuing care will the minister table the average cost for an acute-care bed per day, the average cost for a long-term care bed per day, and the average cost of home care and projections for savings that we will see with the changes the minister is projecting over the next five years for long-term care and assisted living?

Could the minister also table how the proportions of public, private, and nonprofit continuing care facilities have changed over the last 10 years, and will the minister explain his reasoning for changing the focus and priority from long-term care to a greater assisted living designation with greater cost being passed on to the senior? Will the appropriate levels of care still be available for those seniors who need significantly more than what is available through assisted living?

The Chair: Dr. Swann, excuse me again for interrupting. I think that at this point we're about even here in terms of the time allocation, so I'm going to turn to the minister now to reply to some of the questions you've raised.

7:20

Mr. Liepert: Okay. Let me just reassure the Leader of the Opposition that there is no delisting list. I've said before that there were some tough decisions that had to be made in preparing this budget. I have also said that we are working on having the establishment of an expert panel which will be the body that would look at programs and services and whether or not they should be funded. These could be both programs that are already funded and maybe some that aren't.

Under the preventative services budget line you asked about the $12.6 million reduction. There were five pilot projects involving children's mental health that had concluded. The funding has simply moved over to the children's mental health file; therefore, the funding for the pilot projects is no longer part of that budget item.

Now, you used the term "downloading" seniors' pharmacare costs. I don't know how many times I need to say this publicly, but let me say it again. Under the current plan that seniors have, government pays 80 per cent of the drug costs for seniors. Under the proposed plan that we've announced, government will continue to pay 80 per cent of the cost of drugs for seniors; however, what we have done is shift some of the responsibility. Currently every senior pays exactly the same amount for drugs, and we were running into situations where it was a real struggle for low-income seniors. That was the reasoning behind the change.

You ask about evidence around continuing care. Clearly, we have a number of situations in this province in the old regional model where they've gone out and they've tried different things in continuing care. We're going to take the best of what works and ensure that we offer that to Albertans. We don't need a bunch of consultants to come in and study it. We've got our own projects that are operating well, and we can see what works best for which particular group of seniors.

Total cost of combining the drug programs within the various departments. I'm not so sure we're looking at saving money by combining the various programs within the five departments of government. It's simply to have one consistent program across government because they are different today, and it doesn't make any sense if you move from the department of seniors and were on AISH to Alberta Health and have a different program. It's the same person, the same patient. Why can't government get its act together and provide a consistent drug program whether you're in jail under the Solicitor General or you're in the health care system?

Now, I need to take a minute, Mr. Chair, and explain Blue Cross because obviously the leader, by his questions, does not understand Blue Cross. Blue Cross is not an arm of government. There was a request if we could table the surpluses and the costs of Blue Cross. Well, we have nothing to do with the bottom line of Blue Cross. Blue Cross is an entity that operates independently from government. What government does do is contract with Blue Cross to administer our subsidized programs. Blue Cross on its own offers a significant number of programs that Albertans can subscribe to or not.

Now, you asked about the 200 per cent increase in Blue Cross premiums. Well, it's a 200 per cent increase in the premiums that we have in our program. It isn't that Blue Cross hasn't increased the premiums in the last 15 years; it's the fact that the government of Alberta has not increased the premiums of its plan that Blue Cross administers on our behalf. Just to be clear, the nongroup drug plan for those under the age 65 is a government-run drug plan that any Albertan can subscribe to. Under the current premium of some 20 dollars a month for a single individual they are paying about a third of what they would pay if they were part of an employer-driven plan. We can delve into that further if you want, but I'd like to try and cover off the other questions in my seven minutes, Mr. Chair.

We are working currently on the second phase of our pharmaceutical strategy, and I'm hopeful it will be public at some point in time

this calendar year. We want to ensure that we've had good consultation with all of the stakeholders before we bring it forward. It will deal with such things as procurement, although in order to have a common drug procurement program for the three western provinces, we need two other partners to that dance, and some of them are otherwise preoccupied these days.

The average cost. We can provide you with some numbers, but for seniors' care let's just say off the bat that acute care is double what it costs in long-term care, and long-term care is a whole lot more than home care. That's why we have placed a high emphasis in this budget on increasing our dollars for home care. We recognize you're still going to need long-term care facilities, you're going to need designated assisted living, you're going to need through our seniors' department assisted living accommodation, but it has to be a combination of all of the above.

I don't have any number relative to the right proportion of public-private. I want to see the right facilities built at the right cost. Keep in mind when you talk about passing on the cost to seniors that those seniors who cannot afford it are subsidized by government through my colleague's department of Seniors and Community Supports. Again, our overall policy is to look after those who don't have. Those who can afford to pay typically have to pay a proportion of their costs.

The Chair: Thank you, Minister. There are about 20 seconds remaining in this segment.

Dr. Swann: Under the continuing care strategy, then, line item 3.0.12, the $40.7 million budgeted, how much of it is for supportive living? How much is for caregiver support and enhanced respite? How much is allocated to enforcement of standards and monitoring of standards in long-term care facilities?

The Chair: All right. That concludes that 20-minute segment.

Mr. Liepert: I think my answer is that we're going to have to get you that information. I don't have it right handy with me.

The Chair: Thank you.

Just before we go into the final 20-minute segment, colleagues, the intent of the opportunity to combine speaking times is to facilitate an exchange between the member asking the questions and the minister. So if I could suggest, perhaps, an approach whereby three or four questions or five questions, perhaps, are asked and then the minister gets a chance to respond, that will allow the chair to ensure probably a more equal distribution of time. In the event that doesn't happen, at the conclusion of 10 minutes, if no one else has spoken, I will interrupt the member who holds the floor at that time, and then the remaining 10 minutes will go to the minister to reply.

Final segment. Dr. Swann, will you be continuing or another member?

Ms Pastoor.

Ms Pastoor: Thank you very much to my colleague for allowing me a few minutes. As a member of this committee I'm allowed to do this amendment, so I'd like to give notice that I am bringing forward an amendment, and I'll have that passed out. Thank you. Yes. I would like to move that

> the estimates for corporate support services under reference 1.0.7 at page 242 of the 2009-2010 main estimates of the Department of Health and Wellness be reduced by $51,000 so that the amount to be voted at page 239 for expense and equipment/inventory purchases is $12,962,420,000.

Thank you. I would like to now return it to my colleague.

The Chair: Excuse me. I'm afraid that pursuant to the standing orders members may not divide their time. Ms Pastoor, you have the floor for the 20-minute segment if you wish to continue. We had this issue at the last meeting of the committee, and I made it quite clear then as well that members may not divide their time. If you choose not to continue, I can turn the remainder of the time back to Dr. Swann.

7:30

Ms Pastoor: Yes. I would like to turn the remainder of the time over to Dr. Swann. Thank you.

The Chair: Please proceed.

Dr. Swann: Thank you, Mr. Chair. With respect to strategies for staff retention I wonder if the minister or staff could comment on what strategies and programs the minister is using to retain staff. How much money is allocated to retention strategies, how much specifically to retention of nursing staff, and what performance measures does the minister have to show whether these retention programs are working? I'd also like to know what retention investments are being made in physician recruitment and retention programs and how indicators are showing results there.

Under strategy 5.3 on page 166 of the business plan, "Develop and maintain compensation models and a fair labour relations environment to support effective and efficient ways to offer . . . services," and under strategy 6.1, page 166 of the 2009 business plan, who will be performing the workforce efficiency review to optimize workflow practices in the health care system? How much will that be costing, and when will the results of this review be known? Will the United Nurses of Alberta be involved in that review?

Page 242 of the government estimates 2009-10 shows that line 2.0.5, academic alternate relationship plans, received a $40 million increase from the '08-09 forecast. However, the budgeted expense for this program was actually $129 million in 2008, with only $85 million spent. Can the minister explain why the line item was unexpended by such a large amount? Seeing as this program was unexpended by such a large amount last year, does the ministry believe that there will be an increase to this program and that that increase will be used? Why were fewer physicians than expected opting into this program?

Moving to emergency medical services, there's no line item in the 2009-10 government estimates that shows what the projected cost is for delivering ground ambulance services to Albertans. Will the minister give us an estimated cost for the transfer of the emergency services to the province, and what relationship, if any, does it have to the $55 million previously allocated to the program shift?

On page 159 of the business plan under strategic priority 2, emergency medical services, there's reference to "include a policy review on standardization of user fees for Emergency Medical Services." I'll just finish up these questions on the emergency services, and the minister can respond.

In a news release the department of health on May 29, 2008, indicated that when the transition was first proposed, it stated that users of EMS services would only have to cover 10 per cent of the cost rather than the 33 per cent of the services from before. Is this going to be changed? Are the fees charged going to be different?

Finally, strategy 1.1 on page 161 of the business plan states: "Provide leadership and support for the transition of Emergency Medical Services to Alberta Health Services." My question is: how much oversight of the emergency medical services will the Ministry of Health and Wellness have now that it's transferred to the Health Services Board? Will it be the minister of health or the Health

Services Board that will determine protocols and response time targets?

I've heard anecdotal reports from two rural areas that they are being asked to increase their staffing by a very substantial number of emergency medical workers, and obviously they will be receiving an increased budget. But they were operating at a much more efficient level before this transition. Now they've been asked to take a very substantial increase in staff numbers, and they feel that they were providing a much more efficient service prior to this.

Those are some questions on the emergency services.

Mr. Liepert: Okay. I'd like to just start off. I cannot let this particular amendment pass by without making a comment.

Mr. Mason: It's not for debate here.

Mr. Liepert: I have my seven minutes, Edmonton-Highlands-Norwood, and if I want to comment on an amendment, I can.

The Chair: Gentlemen, excuse me. I think the minister is aware of this. The amendments are not debated or voted at committee, Minister.*

Mr. Liepert: I understand that.

The Chair: If you choose to make some general comments pertaining to it, fine, but it won't be considered a debate on the amendment.

Mr. Liepert: That's right. What I would like to say is that I would expect more of the Member for Lethbridge-East. This is a stunt. Fifty-one thousand dollars out of a $12.9 billion budget, quite frankly, doesn't deserve comment.

Okay. We go to the questions about retaining staff. I think one of the key indicators that this particular government wanted to keep the staff we had was the fact that we negotiated and settled very generously with our Alberta Union of Provincial Employees so that we could retain our LPNs and our aides because we were starting to see that there were other opportunities out there. Now, clearly the economic situation in this province has changed since then, but I would suggest that's one good indicator that we take staff retention very seriously.

The only measurement we have relative to physician recruitment is that I believe the statistics are that we have more physicians working in Alberta today than at any time in the past. Physicians are not government employees. They can come and go. Obviously, our contract that we signed with the AMA last fall was, I think, again, a very fair contract. If you look at the economic situation today, it's probably, some would say, a generous contract, but we want to ensure that we have the framework within that agreement so that we can ensure we recruit more young people into family medicine. If we can recruit family doctors from elsewhere in the country or offshore, we're going to do it, and it's within the framework of that agreement to do that.

A question around the workforce review: is the UNA going to be involved? I can't answer that, but we would want to involve not just the UNA but all of those involved in the workforce. We need to ensure that it isn't just one particular union or profession that we concentrate on.

Questions around the academic physician program. Basically, I'm informed that the uptake has been slower than we would have liked. That is the sole reason for the underexpenditure. We'd be happy to try and ensure that going forward those dollars are all allocated.

Some questions around emergency medical services. On the $133 million the member is right. The reason why there is nothing in the Alberta Health and Wellness budget is because, as I mentioned in my opening remarks, we have committed an additional $133 million to Alberta Health Services to operate and ensure that emergency medical services are provided across the province. Again, the member talks about anecdotal comments he has heard. I'm not going to comment on anecdotal comments. If he can tell me specifically who's concerned about what issue, we'll inquire into it, but I'm not going to start chasing ghosts.

I guess the final comment on emergency medical services. The member asked to compare this expenditure to previous years'. We have to keep in mind that in previous years municipalities picked up – what? – 40 per cent of the cost of ambulance services. Our cost in the previous year was only $55 million. We've made a substantial increase in our commitment to funding EMS services through Alberta Health Services Board.

7:40

Dr. Swann: Well, to be more specific, then, Mr. Minister, Red Deer has said that they've been asked to hire 40 more staff than they needed last year. I'm just going on the basis of those comments that were made, and I think they deserve careful examination.

The other questions, then, relate to your comment that academic alternate relationship plans were underspent very substantially. Why, then, are we freezing the hiring of some of these academic positions? We're short of family practice staff, short of a dean. I understand that there are one or two people that came over to this province already guaranteed a job, and in spite of uprooting themselves, they're now being asked to go back home because they're not needed. These are, you know, real people that have been disrupted by a promise of employment and then a reversal of that. I know for a fact that some of these academic institutions are lacking teachers, and it's clear to me that we are not even spending the budget that we have committed to that, so there's some inconsistency there that I think we need to look at.

Under addictions and mental health and cancer, those three separate entities that were merged into one under the Alberta Health Services Board, according to page 251 of government estimates AADAC received $160 million in transfers from the department of health in 2008 and '09. The question is: will that funding be used for AADAC-type services and addictions treatment or not? How committed are we to continuing that resource for people with addictions? Can we be clear, I guess, as health providers that our commitment to addictions remains the same? There is some concern and uncertainty about that commitment.

With the integration of mental health, addiction, and cancer services under the health services framework we need to be assured as Albertans that we'll receive the necessary and appropriate care. Will there be separate reporting of those three specialty health services, and if not, what type of accountability will we be providing? Will the minister tell us if what used to be AADAC, the Cancer Board, and mental health will be replaced by community health councils, which were discussed at some time in the past – it's not at all clear to me where the health councils fit into our system any longer – and if so, what kind of authority would these have?

Strategy 3.4 on page 163 states: "Increase the engagement of government, community, stakeholders and employers in initiatives to prevent and reduce the harm associated with substance use and gambling." Will the minister provide a list of other ministries and stakeholders that he's working with in order to fulfill this strategy?

Performance measure 6(a) on page 167 shows the wait times for

*See page 275, right column, paragraph 6

children's mental health. The last date for which a measure is given is 2007. Can the minister provide an estimated measure of children's mental health wait times in 2008? Why was the information not included if it is available? Is this related in any way to the elimination of the Mental Health Board?

In relation to that, the Auditor General made the following recommendations: that the Department of Health and Wellness create provincial standards for mental health services, that Alberta Health Services encourage mental health housing development and provide supportive living, and that Alberta Health Services reduce gaps in mental health service delivery by enhancing mental health professionals, co-ordinated intake, specialized programs in medium-sized cities, and transition management between hospital and community care. How are we addressing those issues?

Thank you.

Mr. Liepert: Okay. I will follow up on the Red Deer situation. Again, I think that what the member has heard is anecdotal information, but I will follow up on it.

I really have to take exception to the comments relative to our academic so-called hiring freeze. I have told this particular member on two occasions in the House that there is no hiring freeze relative to physicians. If he can tell me a specific individual who had a contract, came over here, and we sent him home, then I want to know about it. I'm told by Alberta Health Services that for all of those individuals where there was a contract in place, they've been honoured. There were some discussions with some individuals about potentially looking at moving to Canada. There was never any guarantee with any of those, and while there is not a freeze, we have asked through Alberta Health Services that those discussions be put on hold until we have a more streamlined approach to what it is exactly we need to be recruiting. We're not going to go out there and recruit particular individuals who don't fit the direction that Alberta Health Services needs to go in the future. If that member can provide me a name and show me that that individual has a contract that we did not honour, I will commit here tonight that we will honour that contract. But if he doesn't, I need to know about it.

We have provided global funding to Alberta Health Services to continue the addictions, mental health, and cancer work, and that is continuing unabated. The member asked that the commitment to addictions remain the same. In fact, we're doing better than that. We have allocated through this budget significant extra dollars either through the safe communities program or through this budget for mental health. We don't want it to remain the same; it's got to get better.

There was a commitment, and we will follow through on it, relative to the establishment of advisory councils for these three former boards, but they will not have boards of their own.

There was a question around community health councils. We will be bringing forward very soon through Alberta Health Services a new initiative on what used to be the community health councils. I'd ask the member to just wait for probably another month or two on that, and we'll have something to announce on that.

I will get a list of the other departments and stakeholders relative to the gambling. I mean, they're the obvious ones, but we'll provide a list to the member and also an answer around wait times for children's mental health. Clearly, one of the things that prompted the development of our children's mental health strategy was that we needed to do better in that area, and that's part of that overall plan.

With respect to the Auditor General's recommendations around standards, those are currently being developed, and hopefully we'll have them fairly soon.

Dr. Swann: Thank you.

The Chair: There are about 45 seconds remaining, Dr. Swann.

Dr. Swann: Under models of care "new and innovative models of care will need to be developed," from page 159 of your business plan, will the minister tell us what direction the new models of care will take? What will be the cost of creating the change? How has the minister decided to evaluate such new models of care? Does he have any funding estimates and timelines for these new models of care, and exactly how does it translate as far as quality, access, and cost-efficiency are concerned?

Mr. Liepert: We'll provide those answers, Mr. Chair.

The Chair: Thank you, gentlemen. That concludes the first hour for the Official Opposition.

Before we move to the leader of the third party, I'd just like to first of all note for the record that Mr. Brian Mason, Edmonton-Highlands-Norwood, has joined us. I don't think we had that on the record.

Colleagues, I just want to correct myself for the record. There was a discussion about the amendment that was put forward by the deputy chair. Just for your reference, pursuant to Standing Order 59.01(6) "when an amendment to a department's estimates is moved in a Policy Field Committee, the vote on the amendment stands deferred until the date scheduled for the vote on the main estimates." Debate on the amendment is not prohibited under the standing orders.* Perhaps in the future it would be helpful, if members wish to speak to an amendment, to have that discussion at the time the amendment is tabled, but I'd remind you that the clock continues to run while that process is going on.

In this case there would not be a point of order, and my apologies for not providing the adequate clarity about this at the time the point was raised.

Mr. Mason, the floor is yours.

Mr. Mason: Thanks very much, Mr. Chairman. Mr. Minister, I would prefer to go back and forth rather than 10 and 10, provided that we can agree that both questions and answers will be concise.

Mr. Liepert: Go ahead.

Mr. Mason: Otherwise, I'd just list them off.

Thanks very much. I'd like to start by asking about the waiting times in our emergency rooms. These have increased to the point where they're almost at 24 hours, I think a few hours short of that, in both Edmonton and Calgary hospitals. The question I have is: what's the department's strategy for dealing with that?

7:50

Mr. Liepert: I wouldn't want to leave the impression that the member left, that somehow in Edmonton and Calgary the average waiting time is 24 hours for emergency. That is clearly not the case. There are extreme situations. Again, sometimes it depends on the severity of the patient's illness but also other situations, like if it happens to be flu season or whatever.

There is no one magic bullet that's going to fix the emergency wait time issue because it is exactly what it says, "an emergency," and you can't predict emergencies. But there are some things that we do need to do, and I will absolutely admit here that it's not acceptable right now, the wait in our emergencies on many occasions. I think you're going to see the alignment of emergency medical services over time be a significant contributor to clearing the backlog. Secondly, we need to implement our continuing care

*See page 274, left column, paragraph 7

strategy to ensure that beds are made available for those who need it in hospitals. Those would be the two areas.

Actually, if I could very briefly. We hosted just recently a conference here in Edmonton with the emergency docs from, frankly, around the world. There were a number of recommendations that were made out of that that certainly we need to look at acting on. It will be a multifaceted approach. But it's not good enough right now.

Mr. Mason: Thanks very much. One of the figures in your business plan on page 167 is the number of persons waiting in acute care for hospital placement. That number for '07-08 was 645. This kind of brings me around to the whole question of the long-term beds, because I think this is at the root of a lot of problems in our health care system. As far as conversations we had with at least one of the physicians from that conference, he referenced some changes that were made in the United Kingdom. The problem seems to be that because there's not enough long-term care beds, long-term care patients occupy acute-care beds, and then they can't move people out of the emergency rooms into an acute-care bed. This cascades back on the problem. Of course, long-term care beds are less expensive than acute-care beds.

I guess, a concern of mine is that the government strategy on long-term care beds and filling that gap seems to be based on getting the private sector to do it – and you can correct me if I'm wrong – and that the private sector has indicated that in order to build these beds, they need a very significant increase in the fees. I just see a whole bunch of problems emerging from that strategy. My question is: why doesn't the government just tackle the question of long-term care beds head-on? It would clean up a lot of problems. I'm concerned that your private-sector strategy is going to create great financial difficulty for many seniors and then problems for the government: how do you help people pay? All of that kind of stuff. Why not just build the beds and focus on clearing up the wait times in emergency rooms?

Mr. Liepert: I wish it were that easy. First of all, whether they are private or not-for-profit or government-run long-term care facilities, we've had a real challenge with the workforce. I don't think the member would disagree with that. That being said, there's a significant number of beds under construction in Alberta right now. I think it's numbering in the range of 300 or 400 that are currently under construction. I know, as an example, that in the city of Calgary the Garrison Green one is . . .

Mr. Mason: Those are long-term care?

Mr. Liepert: Those are long-term care beds, yes. Garrison Green is a long-term care facility. I think it's a couple hundred.

I've had the same discussions, I'm sure, that the member has had with practising physicians who have said: you know, not all of the patients who are taking up acute-care beds need to go to long-term care; they may not even need to go to assisted daily living. If that attending physician could be assured that the patient had adequate care in whatever living accommodation they were in through appropriate home care, they would discharge that particular patient. It really is a combination of things. Number one, we are building long-term care facilities. Number two, we are not discouraging the private sector from building long-term care facilities, but the reality of it is that we do have a cap on the amount that any provider, whether you're public or private, can charge an individual per day for accommodation fees.

The member has raised the issue a number of times relative to one particular long-term care provider – one long-term care provider. Then others have tried to somehow extrapolate that into being government policy. What I read the long-term care provider had said was: when you take in the cost of capital plus the provision of services, we really need a hundred bucks a person for accommodation rates. We've had that discussion before, and it's simply not going to happen.

However, it should be known to members around this table that every time we as government increase the daily rate for long-term care, it actually costs government more money because we subsidize a substantial amount of that differential for low-income seniors. So there is a fine balance there, and it would be for that reason, if none other, that we would never go to that kind of an accommodation rate: because the costs to my colleague's department of Seniors and Community Supports would go through the roof.

Mr. Mason: Okay. Thanks. Just one quick follow-up. You said that we are building long-term care beds. Is it not more accurate to say that there are some private-sector long-term care beds? What's Garrison Green?

Mr. Liepert: That's government-funded long-term care.

Mr. Mason: Okay. And who's going to own and operate it?

Mr. Liepert: Carewest, which is a division of what was formerly Calgary health region. In Edmonton it's Capital Care. I should also make it known, because this is in this city, that there are several projects that if they aren't about to commence, they're certainly close to it, where the former Capital region, now Alberta Health Services, is working jointly with I think it's two or three different nonprofits to build several facilities in this city. So there are some things that are happening there. Are they happening fast enough? Probably not.

Mr. Mason: Okay. Thank you very much for that.

There's been a lot of concern lately, of course, about the flu. I forget the order of the letters and numbers.

Mr. Liepert: H1N1.

Mr. Mason: In order not to offend the pork industry, I'm going to try and start using that.

There have been no expenditures for pandemic flu supplies in your budget since '07-08. I'm wondering why not.

Mr. Liepert: I don't think that's correct, but let me do some checking and come back to it, if I could. I believe we've got $30 million budgeted somewhere in it for supplies. I think it's in capital, actually, surprisingly enough. Influenza actually shows up in capital.

Mr. Mason: Okay. If you can get back to me because when I looked at the numbers, there were a bunch of zeros there for the last couple of years.

Mr. Liepert: Yeah, we will.

Mr. Mason: Okay. Now I wanted to ask about one of my pet projects, which is the bulk buying of pharmaceuticals, something we've been advocating for, you know, four or five years. It seems to me that you're starting to move on that. Can you let us know where it stands?

8:00

Mr. Liepert: We will be bringing forward phase 2 of our pharmaceutical strategy, which will deal with that. But I need to make it clear. I've heard the member say on several occasions: well, if you just did what New Zealand did, you could save yourself a hundred million dollars. I've had our folks look into that, and it's not quite as simple as what the member tries to have the public believe. For one thing, New Zealand has a substantially narrower number of drugs that they provide as part of their program for their citizens.

As everyone around this table knows, I think you've all received letters as MLAs from your constituents about a newer, better drug that's on the market, and there's a lot of pressure to put some of these drugs on. We have set up our expert panel around the approval of drugs. Some get approved; some do not. I guess I'd just say to the member: it's part of our coming forward to the phase 2 strategy, but there's some work to be done on it yet, and we will certainly be looking for any opportunity on the drug side where we can get a better deal for Albertans because it is the one single area where costs rise dramatically.

Mr. Mason: Okay. Thank you very much.

I want to ask about the consolidation of the health regions. You know, this might be a dumb question, but it certainly occurred to me and it has occurred to other people, including some of my constituents, so I want to ask it. There were, I suppose, reasons for the regional health authorities having boards. It had evolved from the point where there was this hospital – it was a city hospital; this was a Catholic hospital – and they appointed their own people, but there was some element of regional representation in the old system. If you're going to centralize it all, then why do you have a board with a separate administration to manage the health system and then have a whole separate bureaucracy – sorry for using that term to your officials – a separate administration for the health department? Isn't that an incredible duplication? Why do you even need a board if you're going to eliminate the health regions?

Mr. Liepert: I think that where I'd like to try and draw a line is – think about our department. If everybody was doing exactly what I believe in the perfect world they should be doing, our department would be doing a set of things that would be more aligned with policy development, and your board with its management team is delivering the health care that Albertans need underneath that policy umbrella. In addition to that, there are a number of things that our department will continue to do in the areas of public health. The whole physician contract still resides within the department of health, but we need to work hard to ensure that there is not a duplication of services.

With this budget, as an example, we realized in going through it line by line that our department was still involved in too many delivery programs. As a result we believe there are a number of programs that – you know, how many times have you as the MLA had a constituent come to you and say, "Well, if I could get a grant from government there, I can match it and complete this project"? Well, as soon as they get approval from government for this grant, they run over to another government entity to get the matching grant. We need to ensure that we are not delivering duplicative programs, one out of the department and one out of Alberta Health Services. That was the reason for the transfer of a number of these programs. I think that ultimately we need to ensure there is not that duplication, but we do not want to deliver health care out of the government department.

Mr. Mason: But it's essentially a government structure. It's another department, and instead of the minister being the boss, he appoints a board to be the boss. I'm having a hard time understanding why we even need this superboard at all.

Mr. Liepert: Well, I believe that we have been successful in attracting some of the best people that we could to sit on that board. I know that the member and I probably disagree. Delivering health care in this province has become a $7 billion business, and we need to run it like a $7 billion business and not run it like a $7 billion welfare program. You know, government is good at delivering programs – many of them would be considered welfare, social assistance type programs – but we've got to ensure that if we're delivering health care in this province, we're delivering it most effectively, most efficiently. I don't believe that that happens when it's being delivered by government.

Mr. Mason: Okay. Well, I mean, we're getting into a philosophical thing, so I'll break it off there. Just one parting shot: I don't think oil executives know very much about delivering health care.

I want to ask about the settlement for the doctors and what you are anticipating for the nurses. Now, it's my understanding – correct me if I'm wrong – that we're looking at about a 14 per cent increase in overall compensation for physicians. Is that correct?

Mr. Liepert: Yes, but I think it's important to point out that that doesn't necessarily mean that every doctor is going to get a 14 per cent increase in pay over the next three years. There are a whole bunch of incentive-type programs in there. We need to try to ensure that there is incentive and encouragement to deliver health care in a different way than we have in the past; in other words, to ensure that our physicians are being encouraged to work in team environments. There are a number of, I guess, opportunities to work together with the Alberta Medical Association to ensure that we're continuing to improve the delivery of health care.

And I'm not going to let you get the last shot. An oil executive is not delivering health care. I don't even know that there's an oil executive sitting on the board, but Dr. Duckett is delivering health care.

Mr. Mason: Okay. And he just answers to oil executives.

I want to come back to the nurses' settlement. There has been some suggestion – and maybe you have been misquoted – and some anticipation that we're going to be finding some cost savings or at least preventing significant cost increases when the United Nurses' collective agreement comes forward. You've made certain comments, and I think there were some changes today in terms of the assignment of overtime to nurses in a part-time position. I want to get to the point, which is that it hardly seems fair to allow an overall increase in physician compensation of 14 per cent and then turn around and look at reductions or constraints in increases for nurses. It just doesn't seem fair.

Mr. Liepert: There's no secret that the contract between Alberta Health Services – and let's be clear: it's Alberta Health Services – and the United Nurses of Alberta expires at the end of March in 2010. What I said was – and this is what I have consistently heard from those even before the merger and after the merger – that the contract that currently exists significantly ties the hands of management in effectively scheduling nurses. I'm not going to say any more about it than that, but that is clearly the message that comes back. I think what we need to ensure as we move forward is that all of our professions are given the opportunity to work to the full scope of their abilities, and I would hope that contracts going forward would allow that to happen.

Mr. Mason: Okay. But just to conclude on that point, are you actually setting expectations for the board that there be a hold-the-line or even reduction in terms of compensation for nurses?

Mr. Liepert: I'm not setting any expectations. This particular board, made up of individuals who have lots of experience in this sort of running of large organizations, knows what their budget is, and they will have to operate accordingly.

The Chair: Okay. Thank you, gentlemen.

As agreed, we'll take a five-minute break. We'll reconvene at exactly 8:15 on this clock, and then we'll commence again. Thank you very much.

[The committee adjourned from 8:10 p.m. to 8:16 p.m.]

The Chair: Colleagues, we'll come back to order, please. We'll now enter the final. The remaining time will be divided equally among members, so any member may speak. We'll proceed in the rotation that I described at the outset.

We'll begin with Mr. Denis.

Mr. Denis: Thank you very much. I just have a few questions for the minister. One thing that I've seen just from the estimates is that you want to go to a static budget, but at the same time we're increasing funding to Alberta Health Services by about 8 per cent. Do you want to comment on that?

Mr. Liepert: Well, yeah. First of all, I think we have to be clear that we need to compare apples to apples, so I think that in fairness you need to pull out the EMS, of which a good chunk used to be in our budget. We've transferred it over to Alberta Health Services. If you compare apples to apples, it's about 6 per cent. There's no way that Alberta Health Services, in the rising tide of health care costs, could even contemplate anything less than a 6 per cent increase. In fact, it's going to be a real struggle at that, but hopefully, going forward, we can start to level that off and bring it down.

Mr. Denis: Okay. Now, dealing with the budget itself, over the next year what type of performance measures does Alberta Health and Wellness have in place to ensure that the budget is held accountable?

Mr. Liepert: We have some measures in place that are outlined in the business plan, but I think the most important thing is working with Alberta Health Services to put measures in place for the delivery of health care because they're the meaningful measurements. If you look at the three-year strategic plan, they have a number of first goes at performance measurements on wait times, those sorts of things. There are a number of others that they want to develop with input from the public. You know, as I've said many times, we're not going to turn this around quickly, but clearly we have to do a better job at measuring outcomes.

Mr. Denis: Just further along that point, the government often talks about the importance of healthy living. I'm referring to page 241 of the estimates, a budget of $96,571,000 being reduced to just over $90 million. Why is there a reduction in this area, and what does it represent to Albertans as users of the system?

Mr. Liepert: Well, I guess the easy answer to that is that as we prepared our budget, we had to look at every line to make sure that if we were able to deliver services at less cost in some area, we could do that. I think, as an example, that a chunk of your heathy living budget is in promotion and in advertising, and maybe it's in brochures. You can always say: we can't do all of those things right now. I can't be specific on that, but I think it's fair to say that we need to do whatever we can to do a better job. I know the Leader of the Opposition in his comments had remarked about something to the effect that it was a very small percentage of people that didn't do a very good job of looking after themselves. I think it's more than just a small percentage. It's, unfortunately, far too many.

Mr. Denis: I'll remember that next time I go for a run in the Leg. gym.

Finally, the last question. Earlier you had talked about Avastin coverage for colorectal cancer. I'm wondering if you could comment if over the next year there are any plans or any investigation about covering Avastin for brain tumours as well.

Mr. Liepert: I guess I don't know the answer to that. That would be something, obviously, that we need to discuss with the medical community. Clearly, the representations that came to us were around colorectal cancer. It was a well-received decision, but we're always, constantly reviewing what drugs we cover and for what. I guess it would be something we'd be considering going forward by our expert panel.

Mr. Denis: Thank you very much.

The Chair: Thank you.

Dr. Swann, followed by Mr. Mason, please.

Dr. Swann: Thank you, Mr. Chair. With respect to transgender surgery, Mr. Minister, what exactly are the criteria for continuing with those who will qualify for payment for transgender surgery and those who will not? There's certainly confusion within that community about who's in and who's out.

Mr. Liepert: I'm not sure if actual letters have gone out, but it's my understanding that anyone that would be eligible for surgery – let's be clear. There will continue to be health care coverage for all Albertans if it's around, you know, consultation, if it's around areas of health care. What we have discontinued are the actual surgical procedures beyond those that were on the two lists that I made clear earlier. As I said earlier, we had some tough decisions to make in this budget. That was one that we were funding, out-of-province surgery at a private hospital in Montreal, that we chose not to continue funding going beyond those that we had already entered into the program either surgically or in preparation for surgery. We will honour those commitments.

Dr. Swann: That is the question, though, Mr. Minister. Those that have been in the system for a couple of months heading towards surgery: are they in, or are they out?

Mr. Liepert: Well, I don't have the exact numbers in front of me, but my understanding of the situation was that there was – and I'm going from memory here – a list of some 26 or 28 that were already within surgery and a secondary list of 20 that were waiting for approval and had been taking hormonal drugs in expectation of being approved. We said that we would be covering those. I don't know how much more explicit I can be.

Dr. Swann: Under models of care, page 159, there is a description of innovation that includes: "New and innovative models of care will need to be developed." Would you be prepared to talk about what

that means, what direction these new models of care will take, and any estimates of costs or cost savings under these different models of care and where they originate from?

Mr. Liepert: Yeah. I think I'd sort of touch on one area. We have real challenges in many of our rural communities that have an H on the side of a building. There are certain expectations that come with an H. As we're all aware around this table, ensuring that we have the professionals that can deliver the services that the community expects from a hospital is a challenge on occasion. We want to ensure, through our commitment to provide equitable health care to Albertans, that we look at all models of care. It might be that in some communities an urgent care centre relying on such things as ambulatory care, relying on larger regional facilities might very well in fact deliver better health care to that community than a small hospital that is understaffed and can't meet the needs of the community. We're not close-minded to any model that works better for a particular community than what exists today.

8:25

Dr. Swann: Thank you. Under the community health program we described a $13 million cut over last year. I've been concerned, particularly coming from the prevention side of the system, that we don't have the commitment to prevention that we used to have in this province. Certainly, the loss of four health officers, the long delay in getting a provincial health officer in place, and these cuts haven't added to my sense of comfort in our commitment to prevention. In looking over your annual report, 2 per cent of the health budget is committed to prevention, promotion, and protection of health. What does the minister have to say about the appearance of having less commitment to prevention?

Mr. Liepert: Well, I would absolutely take exception to that because, you know, we can sit here and look backwards all we want, but this department, this minister, and this government are going to look forward. As I said at the outset, we have attracted, in my view, in the last two years two of the leading professionals in health care delivery. First of all, we've talked to some extent about Dr. Duckett heading up Alberta Health Services, and if anybody wants to challenge his ability to do this job, go ahead and do it. I would throw the same challenge out there to Dr. Corriveau, who has led our public health initiative in the last few weeks through this world situation. We have some of the best public health officers in this province. I can think of Dr. Predy in the Edmonton region, Dr. Musto in the Calgary region.

There are all these things within public health care that you can do better, and to just look at a line number comparing this year to last year – programs change. I mentioned earlier that we had the five mental health projects where we have moved funding into a different area, so our commitment to public health is as strong as it ever has been.

I guess that if there was a guarantee that spending a dollar in prevention was going to save you $10 in treatment, if there was some way of justifying that or documenting that, it would be a lot easier to sell an increased budget in public health care, but at the end of the day, unfortunately, public health care and prevention tend to always lose out to crisis health care delivery, whether it's emergencies, whether it's cancer or any of those other dreaded areas of health care. There is a limit as to what our budget can manage.

Dr. Swann: The area of diagnostics. In cost increases and particularly based on whether it's public or private diagnostic services, our experience in Calgary was that there was concern about rising costs, so the lab service was privatized in the '90s. When the costs began to peak again, the lab service was taken over by the public system again. What is happening to diagnostic services, and to what extent are they contributing to the significant increase in costs to the health care system?

Mr. Liepert: Well, if you're referring specifically to Calgary Lab Services, I think that Alberta Health Services has to take a look at all of the provision of services that they have today and if they are being delivered in the most effective way and then make a decision going forward. I do know that we have a good model in terms of public and private delivery of health care when it comes to everything from MRI delivery to other areas. That's something that Alberta Health Services' management is going to have to review, and I trust they'll make the right decision.

Dr. Swann: Do we have any sense over the last decade what contribution or increases have been experienced in the diagnostic services relative to other parts of the system? Do we have any figures on that?

Mr. Liepert: Well, one of the difficulties in trying to get those kinds of figures is that when you had the nine regions, there were varying ways of documenting costs. I think that until we have Alberta Health Services with a year or two of a track record, you're using kind of a disjointed past experience, and I'd like to, I think, get a real good sense of a baseline. We are probably going to need a year or two.

Dr. Swann: Well, with respect, Mr. Minister, this has been the problem for the last 15 years in this province. With three restructurings we can compare nothing with nothing in this system. We have a bunch of apples and oranges, and we have a system that's costing increasing amounts of money, and nobody can tell us why or how to stop it. This latest experiment doesn't give us any more confidence that we are going to be able to answer those questions, unfortunately.

I have had a question from one citizen in the province about whether we would not follow the British Columbia example and sue tobacco companies in this province for millions and millions of dollars of health care services that are the result of misrepresenting and lying about the effects of tobacco on the population and inciting and inducing addictions in children and adults. What is your position on suing the tobacco industry in Alberta?

Mr. Liepert: We will be coming forward soon with a decision around that, and I can't add anything more to it other than the fact that I'm not going to let you lecture me in your first comments without coming back to you. The creation of Alberta Health Services is not an experiment. It is a model that is going to deliver effective, efficient, accessible health care in this province. If you're going to keep running around this province downgrading it, calling it an experiment, then you're going to pay the price at the next election, Mr. Leader.

Dr. Swann: No more questions. Thank you, Mr. Chair.

The Chair: Thank you very much, Dr. Swann.

I apologize. I just misspoke the speaking order the last time I reviewed it. As you know, we're alternating between government and opposition members. The next member to speak will be Dr. Sherman, followed by Mr. Mason.

Dr. Sherman: Thank you, Mr. Chair. How many minutes do I have?

The Chair: Ten minutes on your own or a combined total of 20 with the minister.

Dr. Sherman: Maybe I'll do some comments, and then we'll go back and forth a bit.

The Chair: So you're going to combine your time for a total of 20 minutes?

Dr. Sherman: If that's okay.

The Chair: Go ahead.

Dr. Sherman: Thank you. Health care is a very complex issue. Just to educate all of my colleagues here on all sides of the political spectrum, after 17 years on the front lines access to health care across the nation has gotten worse. In order to go forward, we have to look backwards to where we were at. The ability to supply health care was up here, and the demand for it was down here in the '80s and early '90s. A report came out, the Barer and Stoddart report, portions of which were implemented by every health minister across the nation: reduce the number of doctors and nurses and beds, and you'll save health care costs. That's what everyone did.

A couple of things happened along the way. I do remember that at that time I was an emergency doctor. The emergency department wait times are a barometer of how the system functions. It's not an emergency problem; it's a system problem. I remember we had a physician who every Saturday morning would bring in a hundred patients and run his office through the emergency department because we actually had the capacity to deal with it. Our waiting rooms would be empty, people would be in and out, and there were no admitted patients in the departments, no long-term care patients waiting upstairs.

A lot of staff left the country from every province. Then we made, I think, an error across the nation in training less staff. It was a primary care based system run by family physicians who had a good relationship with all the patients, and most of them gave up their privileges. Then all of a sudden internists, specialists, who didn't know the patients, started doing all the admissions. Therefore, they ordered more tests and did more consultations. The family doctors would order one or two tests and consult one consultant because they had a relationship with the patient.

Then another thing happened. From the early '70s you know Mr. Marlboro. In the '70s everybody ate a lot, drank a lot, smoked a lot, and those folks now are getting sick. Previously the social determinants of health – everyone couldn't afford a car, processed food wasn't around, and people lived healthier lives. They worked on farms. They had labour jobs. All these sitting jobs weren't around.

Then, lastly, in this generation, when I started working 17 years ago, I was the lazy kid on the block. I only worked 27 shifts a month, 10- or 11-hour shifts. I was the laziest doctor at the time when I started. Because there are so many jobs and the supply and demand shifted, this generation doesn't have the same commitment to work. Not to say that they don't have a commitment to work, but I think the previous generation had an overcommitment to work, an unhealthy overcommitment to work.

8:35

The other thing that sort of happened is that men weren't really nice. You know, women weren't recognized as people until 1917, and we discovered that women are actually either harder working or brighter than men. A lot of the physician workforce – in Quebec I believe 62 per cent are women; here I think it's about 54 per cent – has a better work-life balance. In fact, even the men have that same work-life balance. Unfortunately, as you know, I ended up divorced, and so did a lot of my colleagues, and I cut back to three days a week to look after my children and coach their teams. This generation, I think, has a wiser work-life balance.

In essence, what's happened is that we have a whole bunch of patients because of the lifestyle in the '70s and the fewer staff that we trained, and then they're working less. That's really the issue. The challenge in access is access to primary care to see a family doctor and access for elective surgery and then access to emergency care. In our world – as you know, I was a spokesperson for the emerg docs – the world's problems come to where we work, whether it's homelessness, poverty, violence, addictions, you name it. If you don't have a family doctor and you call after 5, it says: go to emergency.

The biggest problem isn't actually the sore throats and runny noses. The biggest problem is actually that people across this nation do not get any primary care, and by the time they show up with a heart attack, they have four different problems that they didn't previously know that they had because they haven't seen a doctor for four or five years. Usually I ask people, "Do you smoke?" They say no. I say, "When did you quit?" They say, "Yesterday" because they've been really sick for the last few days.

Those are the issues in health care. As emerg docs we've been saying: "Look, it's not an emergency problem. We actually have to fix the system." Yes, long-term care is an issue. The problem is that people aren't looking after their grandparents. They're not looking after their family members. I'm going to say that a lot of people abandon their seniors in the emergency departments, in the hospitals. Most of them aren't people that necessarily need medical care. They need home supports. In fact, they need their children and grandchildren to look after them. But in this country the populations are so mobile. You know, we had a whole city show up in the last 10 years. Health care went through a tough time in the '90s, and we were actually okay for a few years there until a lot of people showed up, and then those end up in the emergency departments.

To answer some questions on emergency wait times, in the emergency department we have two groups of patients. One group is the ones that we discharge and one group the ones we admit. The wait times of an acceptable standard of care: I think everybody would like that as low as possible. The U.K. standard of care for ED wait times is four hours in and out. They accomplish that by massive investments in health care and community care, long-term care, and community supports from $60 billion to $100 billion. In Australia they are eight hours, and as you know if you read the papers not too long ago here, in certain facilities – you can't translate that across the system – the hours are 27 to 34 hours for admitted patients. With admission the patients are older, they're sicker, and they're more complicated.

When I first started, they had one problem, and we would admit them. Now they actually have four or five problems when we admit them. The evidence now is that we actually kept people in hospital too long in the olden days. We kept them so long, in fact, that they actually got a complication, and then they got another problem sitting around in a hospital bed. We don't need to keep people in hospital that long. Technology has improved health care. Laparoscopic surgery has decreased length of stay. Appendixes are done by laparoscopic surgery. Technology has done amazing things for reducing the need for patients to stay in a bed. As well as medication, we've reduced the need for cardiac surgery and angiograms with the advent of the statin drugs, and medical management is equal to if not superior to surgical management. So these are all good things.

Health care, I've always said, is easy to fix. For us in the acute-care system it's an input-throughput-output issue. We've concentrated a lot on input. Throughput and output need to be a priority.

Staffing. We need the right type of staff. We need more staff. What's happened is that across the nation only 23 per cent of our students go into family medicine. It's a tough job. To create more family doctors, you need to give them the supports, and then you need to pay them properly. It's not just money; it's a good system to work in.

The same with the nurses. We have a lot of highly trained, highly skilled, intelligent, bright nurses. You know what? I work with 600 of them. They're busy cleaning beds, pushing patients around, and doing work that they probably don't need to do for the level of training they're getting. So either we're overtraining them, or we should get them the support so that they're not doing work underneath their scope of practice.

The good thing that I have seen is that we're the first medical school, Dean Marrie was telling me, where 50 per cent of our students are going into family medicine, here at the U of A. Partly it's because of co-operation with the Alberta Medical Association, wherein the family docs actually got the big bump in pay, and we emergency guys only got a 2 per cent pay raise, I believe. For us guys on the front lines and the higher income docs, we need a system to work in. We need doctors to send the patients back to, which are family doctors. So that's a good thing.

On the nursing end the nurses need more LPNs, more nursing aides, cleaning staff, hospital support staff. I believe it is reassuring to see that the LPNs and nursing aides got a significant bump in pay. I think that'll be very reassuring for the nurses. To many of the nurses that I work with I say, "What do you want: more money, more staff, or more support?" They all tell me: "Raj, it isn't the money. It's the staffing and the support that we urgently need more than the money."

Then there's the issue of the efficiency of the health care system. I've always heard: where's the evidence? The evidence is that we actually used to have one board. The board was the ministry, and there were 142 individual hospital boards. The hospitals got paid to perform, but the problem there was that across the nation the minister of the day built hospitals for political reasons where there weren't staff and there weren't patients. In fact, Mr. Romanow closed 52 hospitals next door. I don't think politicians should be interfering and making the decision on where the hospital goes. The boards have made some very good decisions. There were successes across the province.

The Chair: Excuse me, Dr. Sherman. I'm sorry to interrupt you. You've now exceeded 10 minutes of the 20-minute allotment.

Dr. Sherman: I'll narrow it down really fast.

The Chair: No. I'm sorry. In fairness to all, I'm going to turn it over to the minister and ask him if he wishes to respond. You'd have up to 10 minutes, Minister, to respond.

Mr. Liepert: I always listen intently to the sage advice of my well-educated adopted son Raj. He can talk for the next 10 minutes if he wants.

Dr. Sherman: May I continue?

The Chair: No, I'm afraid not. I'm going to try to explain this again if you'll just indulge the chair for a moment. We didn't have this problem in the last set of estimates that we considered. You may elect as a member to speak for 10 minutes, after which the minister may speak for 10 minutes, for a total of 20, or you may elect to combine your time for a total of 20 minutes in the form of an exchange, such as was demonstrated by Mr. Mason earlier this evening.

With that said, Dr. Sherman, I'm sorry; you've exhausted your portion of the time. I don't think the minister has any further response, so it'll be over to Mr. Mason, followed by Mr. Fawcett.

Mr. Mason: Thanks very much, Mr. Chairman. First, I'd just like to make a comment with respect to the comment of Dr. Sherman that people are abandoning their parents in emergency rooms. I do take exception to that. My experience is that because elderly people or very ill, chronically ill people can't get proper long-term care, they're in assisted living beds or similar types of accommodation, and their families are actually taking shifts around the clock to provide the additional care that they need. My experience is that families are giving up other parts of their lives in order to care for elderly parents because they can't get into long-term care. We saw an example of that when the facility in Hinton that was built by a community – it was a long-term care facility – was converted by I think it was the Good Sam into assisted daily living. Lots of patients that were in there could no longer get the care that they needed. So I just have a difference in my experience from what Dr. Sherman said.

Now I'd like to go back to some exchanges with the minister.

8:45

Mr. Liepert: I liked it better the way you were doing it.

Mr. Mason: What's that?

Mr. Liepert: With you and Raj.

Mr. Mason: You'd love to be off the hook.

I have a question about mental health beds now. You know, we were discussing in the House last week a report on mental health, and it indicated that we had relatively few mental health beds compared to the national average. One of the concerns that also arose out of that was that, once again, people who needed mental health care beds were occupying acute-care beds, which are more expensive. Now, obviously, putting everybody in a bed or in an institution is not what I'm advocating, but I think it's a reasonable assertion that we need more dedicated facilities, where there are mental health care beds not in big institutions but located where people are so that they have their family's support and so on. I want to ask the minister what plans they have to provide the additional number of beds; if you've assessed, you know, how many additional beds, approximately, would be appropriate; and then, also, how you deal with people who require mental health care but not necessarily a bed.

Mr. Liepert: Well, first of all, I think that – and I've said this publicly – if there has been an area of health care that probably hasn't received the level of attention that other areas of health care have over the past number of years, it's the area of mental health. It's health that – I need to be careful how I say this – it seems like it was easy to sort of avoid, unlike cancer or something that was obvious. I think that with a lot of situations relative to homelessness and addictions and all these other things, if we would have done a better job over the years in identifying at an early age mental health issues, the numbers today would be better than they are.

That being said, last year, as I've mentioned on a couple of

occasions, we brought forward the children's mental health plan because we want to start to identify at an early age those youngsters who are showing signs of having mental illness. We also believe, however, that you can't identify, that you can't treat mental illness in a silo. It involves a number of departments of government. So we have purposely put a significant amount of our effort and initiative through the safe communities initiative that the Justice minister is leading. In fact, I think it's Friday of this week that we're making an announcement jointly in Calgary relative to some additional mental health beds. I don't know if we can specifically put a number on it, but my recollection is that we're somewhere in the range, even just in the past year or two, of an additional 80 mental health beds that are now on stream. Beds are part of the solution, as you've identified, but they aren't, on their own, the only solution.

Mr. Mason: I certainly appreciate that. I hope that the department will come up with a plan that addresses the various aspects, but I would like to see some specific targets for the number of mental health beds as part of that as well.

I'd like to switch now, if I could, to the question of rural health and the potential closure of some of the smaller hospitals. I was up a few weeks ago in Beaverlodge for a public meeting there about their hospital. There's a great concern there. I know that there is in Athabasca and other communities as well. Of course, it's not terribly far from Grande Prairie, but Grande Prairie was hoping for a new hospital, and that isn't happening right now. I think that the smaller communities have made the case that some of these facilities perhaps could be better utilized but certainly are necessary and that the commensurate pressure on a facility like the Grande Prairie hospital should Beaverlodge be closed would compound the problem. Mr. Minister, maybe you can outline for us what you have in mind for some of these rural hospitals and what you see their role is going forward.

Mr. Liepert: Well, first of all, let me commend the member for getting out of Edmonton at least once to travel to Beaverlodge. I have heard the Beaverlodge story many, many times, and I haven't heard any other story, so I suspect it's the only part of rural Alberta that the member has visited in the last year and a half.

That being said, I would come back to some of the comments I made earlier relative to doing a review of all of these facilities. You know, I want the member to be very careful in terms of this hospital closure stuff, because I know it creates really nice headlines. Our intention is not to be going out there closing rural hospitals. The Member for Edmonton-Meadowlark talked about the former NDP Premier of Saskatchewan, who closed 52 hospitals. Well, we're not going to do what the NDP government of Saskatchewan did. What we are going to do, though . . .

Mr. Mason: You can't resist. You just can't resist.

Mr. Liepert: Well, it's a fact. I mean, I'm only saying the facts.

We need to ensure that we do a real thorough review of the facilities that we have, ensure that the services that we can provide out of these facilities meet the needs of the community but ensure that for the kinds of health care delivery that we promise, we have the people in those communities to deliver it. So it is something that Alberta Health Services is doing a thorough review on. We're not just going to rush out there and close 52 hospitals. In fact, we're not going to rush out there and close any hospitals. There are a few facilities that are four-bed hospitals that really are being operated primarily as long-term care centres. We have to see whether or not they should be long-term care centres versus hospitals because, as I said earlier, there's a certain expectation of what a facility that has an H on it can deliver.

Mr. Mason: Okay. Thank you.

One of my other journeys into Alberta's hinterland was to the town of Empress, where there's a boarded-up, closed hospital that served for a while as a long-term care facility. I'm just wondering if we can't find some productive uses for some of these facilities that have been closed by Progressive Conservative governments here in Alberta in the past.

Mr. Liepert: Well, the member has this one on me because while I've been to Beaverlodge, I have not been to Empress to see the closed-up former hospital. I've been in this Legislative Assembly long enough to know that you'd better go visit yourself. Don't just take the word of the Member for Edmonton-Highlands-Norwood because you could be led down a path that doesn't always have the same ending as he has seen. So I will take that under advisement. I will discuss with the MLA who represents the community of Empress, and we'll find out why that facility is, in the member's words, boarded up.

8:55

Mr. Mason: Okay. Maybe I can save you the trip. One of the problems was that it was converted to a long-term care facility, but families objected to having to travel to visit their seniors. I think that that was the reason. Nevertheless, it's contributed not only to a deficiency in rural health care but in terms of long-term care.

I want to ask about the question of getting the right balance between being able to construct a facility, the capital side, and being able to staff and operate it. One of the things that Dr. Sherman referred to was the building of health facilities, hospitals, for political reasons. That's certainly the rap that the Lougheed government has received. I want to ask about the Mazankowski heart centre. I'd really like to know what happened there because it was announced with great fanfare, and it stood vacant. Why can't we co-ordinate better between the construction of new facilities and the ability to adequately staff them? If we couldn't staff it, why did we build it, or why did we open it when we did?

Mr. Liepert: It is my understanding that the situation in the delay of the actual opening of Mazankowski was not a staff issue. It was a combination of issues relative to the construction and the contractor. This is a facility that has a high degree of technology involved in it. It is a research facility. There was a desire to ensure that before patients were in the facility, it was operating without error.

I cannot and will not comment on why an official opening was held by the former Capital health region. That was not an event that this minister organized or this department organized. We participated in it on the presumption that the former Capital health region, which was responsible for the construction at the time, was at the stage where it was appropriate. Maybe, in fairness to those who organized it, they felt they were at that stage. I'm not laying blame on anybody. I just can't answer the question as to why an official opening was held before it probably was ready to be held.

Mr. Mason: Can you rule out the theory that Capital health received pressure from the government in order to have the opening so that there would be a grand announcement on the eve of a provincial election?

Mr. Liepert: No. It was after the election.

Mr. Mason: Was it after the election?

Mr. Liepert: Yeah, because I was already health minister. It was last spring. I was already the minister, so it was held after the election. So I can rule out that this minister had anything to do with having the grand opening in place before the next election.

Mr. Mason: Okay. I want to ask about ambulance now and the reorganization of the ambulance. The question that I have, talking to some officials with the city of Edmonton over the weekend about the consolidation, in particular issues around the ambulance dispatch in Edmonton and the northern region, is: how is that going to be handled? How long will it take to put in place a fully functional provincial dispatch system, and how much will that cost?

Mr. Liepert: I need to refer to some notes here, member. I'm told that within the next two years the EMS dispatch will be consolidated, and the cost will be somewhere in the range of – I don't have the cost for the dispatch. But we need to ensure that we're looking at dispatch not from a cost or a cost-savings standpoint; we're looking at dispatch from an efficiency standpoint. We previously had somewhere up to 30 different dispatch operations.

We have already had real, live examples of efficiencies that have been created. One that comes to mind is a patient who was transferred from Olds to Red Deer. Normally that patient would be dropped off, and they'd go back empty to Olds. Dispatch happened to identify a patient that was waiting for transfer home from Red Deer to Olds. That same ambulance was able to transfer that patient. There are several other examples that I won't bore the committee with. But there are small examples of efficiencies, and that can only happen when you've got a co-ordinated dispatch approach.

Mr. Mason: Thanks for that. I'm certainly not questioning the strategy or the decision. Certainly, you know, municipalities have felt for a long time that ambulance service was part of the health care system and should be taken over. The question is whether it's being done effectively and cost efficiently. So can you give me a figure for the all-in cost for creating the provincial ambulance system?

Mr. Liepert: Well, as part of our total funding for Alberta Health Services this budget year it's about $130 million. Now, that compares, I guess, to what we previously had allocated for ambulance services on an annual basis. The most recent was $55 million, I believe. But you've got to remember we were only paying 60 per cent of the ambulance costs at that time. We believe that we have funded Alberta Health Services appropriately to ensure that there is a smooth transition and an ongoing funding commitment. All indications at this stage are that it has worked incredibly smoothly.

Mr. Mason: Okay. Thanks very much. The last question has to do with the capacity in the public health system. You know, I'm beginning to get a sense that we really dodged a bullet here with this . . .

Mr. Liepert: H1N1.

Mr. Mason: Swine flu is just so much easier. I'm going to echo Dr. Swann's concern here. It really strikes me that after years and years of economizing in our health system and particularly in public health, we don't have the redundancy that we need to handle a major health care crisis. It looks like H1N1 is neither as virulent or as severe as first feared. We don't know that for sure. But in the event of a very severe and virulent outbreak, I am very concerned that we don't have that redundant capacity in order to accommodate that. I'd like to know what your view is with respect to that and if there's any evidence that we do have that capacity for a situation where, basically, our emergency rooms and our health care system could be swamped by something that most public health officials feel is inevitable at some time.

Mr. Liepert: I'm not going to deny that our health system today isn't stressed. That's what we're working to fix. [Mr. Liepert's speaking time expired] Am I being cut off? I wouldn't mind answering the question if it's okay with the committee.

The Chair: Would you do so very quickly?

Mr. Liepert: Thank you. You know, we could never build a health system capacity for every eventuality. I've got great confidence that this – I happen to believe this was kind of a really good trial run because our plan worked. We now have one pandemic plan, not nine regional plans. Our chief medical officer of health, who's new to the province, was very impressed with how everything unfolded. We can run around expressing fear and concern, but I'm expressing incredible satisfaction with how we handled this particular situation.

9:05

The Chair: Great. Thank you very much.

Mr. Fawcett, please, followed by Dr. Swann.

Mr. Fawcett: Yes. Thank you, Mr. Chair. I think we'll do a back and forth, and we'll see how long it takes us. I just want to, first of all, commend the minister. I appreciate his direct and honest answers. Actually, I find it a little refreshing. I also want to suggest that he's got a very tough job that he has taken on, and it remains to get tougher as well.

One of the challenges that I believe makes the job so tough is that sometimes when it comes to health care, we don't see the forest for the trees. We spend a lot of time asking questions about specific services, one group's issue, whether it be, you know, health care professionals or a particular group in society that feels like they're being treated unfairly.

One thing that struck me is a recent report out of the University of Calgary that suggests that by the year 2030 health care costs could take up anywhere between the 36 per cent of the provincial budget it takes up now or 87 per cent of the provincial budget. That's a little over 20 years from now, and that concerns me. It concerns me greatly. When we talk about the issues of the day, I think we all need to keep that in mind. That being said, they've said in between what it is today and I believe it's 87 per cent. I think that the point of the report was that depending on the decisions you make today, you can be in that range. I, like many other Albertans and Canadians – and I hear this from my constituents all the time – really appreciate the public health care system that we have today. However, when it comes down to some of the opportunity costs in the future, when it comes to education, the environment, all the other issues that we need to deal with as a province, the 87 per cent becomes a little worrisome.

My first question is regarding the minister's Vision 2020 document, the sustainability report. We've seen a 7.7 per cent operating increase in this budget, which is substantially higher than the overall government budget increase and substantially higher than many of the other departments'. I know that the minister has made some very tough choices in this year's budget. How are we going to know as a government what the markers are that we're going to be able to

identify over the next short term going into the long term as to whether what we're doing is going to stem that curve on the cost expenditure side? I don't think we have a lot of leeway to play with here. I think that if we leave it too long, we're going to end up in a situation where we're going to be up towards that 87 per cent rather than at the level we are now and are going to have to be make some other choices about where that money is coming from, whether it means substantial increases in taxes or a reduction in other government-provided services.

Mr. Liepert: Well, first let me just correct one comment that the member made in talking about a 7.7 per cent increase in the department's budget. Actually, our department budget increase was 4.9 per cent, I think. We were within our budget able to give Alberta Health Services 7.7 per cent more for operating than we were able to give them last year.

A very good question that the member raises, and I think it's something that all of us need to give some thought to. I don't have any magic answers, but I would hope that as we're making changes to health care, we're making changes for Albertans of the future, not for Albertans today. I would like to have all members refer to the revised seniors' drug plan that we brought forward, taking effect in July 2010. In that plan 60 per cent of seniors, who are in the two lowest income categories, will actually pay less than they do today. If you think about the senior of tomorrow, when some of the younger members who are sitting around this table are seniors, who will probably have on average a much higher income than the average senior has today, that ratio will be flipped. Sixty per cent of seniors will be in a higher income category and will be paying a premium for a drug program because we as government, we as the taxpayers of Alberta, cannot continue to subsidize a seniors' drug program to the tune of 80 per cent of the cost when your drug costs are rising annually in double-digit numbers.

What we have put in place is a plan that will be more self-sustaining going forward when seniors on average will have a much higher level of income. I think we have to look at everything we do on that basis. It's not about necessarily changing it for the patient today, but it's changing it in a way that the taxpayer can afford to keep our publicly funded health care system in place for the patient of tomorrow.

Mr. Fawcett: I'm glad the minister went in that direction because that was part of my next question. I think the minister is entirely right. The feedback that I've gotten from some of the seniors since the recent announcement is: "Why premiums? It's like another tax." When I suggest and throw out this report, my suggestion is that we have a choice. It's either reducing spending in other areas or increasing taxes unless we make some changes in our health care system. It's quite simple.

I just wanted to ask the minister – and he provided some of the answer in his previous answer – about the whole concept around these changes to the pharmaceutical strategy for seniors, the idea of the government providing access to a publicly funded insurance plan or an insurance plan that doesn't discriminate based on medical history and all of that sort of thing while subsidizing the premiums and potential copayments. I like to think of them, if it's an insurance plan, as a deductible, no different than any other insurance plan that most of us subscribe to. Is this a type of model that we would likely see moving into the future in some of the reforms that we're looking at, specifically whether it be for situations such as chiropractors or that sort of thing?

Mr. Liepert: Well, I think it's important to differentiate between what is seen to be covered under the Canada Health Act and what is not necessarily seen to be covered under the Canada Health Act. You know, you will hear the comment: "Well, geez, we removed premiums for everyone else on the 1st of January. Now you're bringing back premiums for the seniors' drug plan." In reality the premiums that were assessed for the general population were, in essence, for Canada Health Act covered services. The drug plans, whether you're a senior or not, are not part of the Canada Health Act. In fact, only seniors and very low-income Albertans get subsidized on their drug costs. Everyone else under 65 is either enrolled in our Blue Cross plan, which we have adjusted premiums now to more reflect reality, or they're enrolled in an employer-based plan or they pay for it out of their own pocket.

Where you're going to see other things such as chiropractic and, frankly, anything else that isn't covered by the Canada Health Act that patients want to choose is by going to companies like Blue Cross or any company that offers an insurance plan and picking and choosing what you want to have covered, rather than having us the Department of Health and Wellness saying: you will use chiropractic because you get $200 a year subsidized; you, in essence, shouldn't be using all these other ones.

We need to give patients the ability to pick and choose those programs that aren't covered under the Canada Health Act.

9:15

Mr. Fawcett: Thank you. Again, I appreciate those answers.

The last question that I have does surround mental health. Again, I think this is one of those issues where sometimes we don't necessarily see the forest through the trees. I have heard some comments from my constituents at a meeting that I had that the government has chronically underfunded mental health, and I think the minister, maybe, even admitted as much in saying that we might have been able to avoid at least a certain portion of some of the issues that we have today. The big question that I have is: how do we define mental health? To me it seems like a very broad, broad issue, and if we don't have some specific parameters around it, we can throw as much money at it as possible, but I'm not sure that it's necessarily going to get any better. I'm just wondering: how do we define mental health? How do we work collaboratively with the other departments that you've mentioned to make sure that the funding that we are providing now is targeted and we know that we're getting results for that money?

Mr. Liepert: I think you raise a good question. To me it's one of the reasons why merging all of the 12 entities into one health delivery system was so important. We had silos before: we treated mental health separately from general health delivery; we treated cancer separately. Quite honestly, I believe that whether you have cancer, whether you have mental illness, or whether you have the flu, it's health and it should be treated equitably across the board.

I do want to make sure I don't leave the impression that I said we underfunded mental health in the past because I don't know if that's right or not. What I did say and I would repeat is that I think it was easy to kind of ignore the whole area of mental health.

Your question around definition I think is a good one because, you know, if you really take a look at treating mental health as part of the health system, you're dealing with: are they mental health issues or aren't they? Where does fetal alcohol syndrome fit in? That gets treated as a mental health symptom, but really it may be an addiction or just bad preventative health. So it is hard to kind of define in a narrow way what is mental health and what isn't. That's why I think it's important to have it integrated within the entire health system so that you can deal with it as a true health issue.

Mr. Fawcett: I guess my last comment is a point that I was trying to make, and I think the minister can understand me, being a former Education minister. I think what happens is that we've seen the proliferation of special-needs students, and mental health can be very much the same type of concept. I mean, I think possibly we all might have some mental health issues on a day-to-day basis, so just to understand the concept of mental health might allow us to improve the delivery of it and whether we're using our resources effectively.

Mr. Liepert: Yeah. I think that's why it's important for all medical professionals to have a better understanding of the issues around mental health and addictions and all of these related issues so that it can be treated as a health issue.

The Chair: Thank you, gentlemen.

Dr. Swann, followed by Dr. Sherman.

Dr. Swann: Thank you very much. Well, the question of effective spending has been the one we've raised repeatedly. The fact that we're spending as a province in government services 23 per cent more than the average provincial administration does raise questions about where we're spending it and what we're getting for it. So we continue to ask for a value-for-money audit, no less in the health system than in other aspects of our government services.

Again, I guess I would be challenging the minister to look at how little we're spending in prevention, why we have been so delayed in getting early intervention in home care. I'd like to know more about the trend in home-care spending in the last five years. Clearly, tremendous savings and improved health benefits have been shown from home-care services. What is the trend there?

A third question. What are we doing to keep family physicians in family medicine, both getting trained in family medicine and staying in family medicine? We're losing them as fast as they're being trained. Clearly, the work conditions are not what are attracting people to stay there.

My final question. Why was no Alberta professional with a health background chosen for the Alberta Health Services Board?

Mr. Liepert: Okay. I've heard this member refer on several occasions to effective spending in health care, that we're spending 23 per cent more than other provinces are spending. So I say to this member: isn't that evidence enough that we shouldn't continue doing what we've been doing and expect to get different results? Let's put a different model in place, and let's give it an opportunity to work.

You know, we can do countless and endless studies and reviews and undertakings. I'm going to actually go through *Hansard* and the leader's comments in the next couple of days and highlight how many times tonight he has asked for a review, an audit, a this, a that. Where is the money going to come from for all of that? Are we going to take it out of health care delivery? I think we have to make some common-sense decisions. Let the audit look at the things they can look at. We don't need to go into endless studies and undertakings to figure out that the system hasn't been delivering effective health care. Talk to any Albertan, and they'll tell you that. They'll tell you that when they get into the system, it is outstanding. It's getting into the system that is the problem.

I'm not quite sure what we're looking at in terms of a trend in home care. We have had some challenges in the last number of years in finding the appropriate personnel. Even if we would have increased the funding, we didn't have the people. Our home-care providers tell us that the funding that was provided in the budget will now in this economic environment allow the opportunity to train some people in home care, and they think we've got an opportunity to provide some services that probably for workforce issues weren't there in the last couple of years.

The member made a comment relative to family physicians, that we're losing them faster than we're training them. Well, the statistics don't prove that out. That again is a comment that is not correct, and it is not helping the situation. You can politicize health care all you want if you like – go ahead – but it's not fact. We are not losing them faster than we're training them. Every year we have more physicians practising in this province than we had the year previous.

Again, I'm going to go through all of your comments, and I'm going to highlight every one of these fearmongering comments that you've laced through all of your questions, and I'm going to send them across to you and say: prove it.

Finally, relative to the board, well, a number of the members that were put on the board have some health care experience. I can tell you that if we had put a doc on the board, the nurses wouldn't have been happy. If we had put a nurse and a doc, then the physiotherapists and the pharmacists wouldn't have been happy. But I will say this and I've said this to the Alberta Medical Association across the table: quite frankly, it's about time we started running health care like a $7 billion business and not having it run by health care professionals. I'm not going to sit here and have a board of health care professionals running a $7 billion business.

The Chair: Nothing further, Dr. Swann?

Dr. Sherman.

Dr. Sherman: Thank you to the hon. Member for Calgary-Mountain View.

Okay. Minister, quick ones. There's a staffing issue, efficiency of the system. The real solution is that we've got too many patients. As you so eloquently said in the House, our kids are all fat.

Now, there are two types of wellness. One is primary care, which is doctors and nurses and family doctors, prevention, and regular physical exams. The other is just eating right, moving more, better habits, which isn't doctors and nurses and not necessarily health care. Can you comment on how we can best deliver that type of wellness, which, actually, may not be your ministry and may not be a government program at all. What are your suggestions and thoughts on that?

9:25

Mr. Liepert: Well, I think you raise a good point. We as government, we as the Department of Health and Wellness can run all the ads and send out all the brochures to Albertans that we like and say how good it is to be healthy and all of those sorts of things, and I'm not sure people pay a lot of attention. I believe strongly that we need a movement in this province, and it needs to be a movement that's not led by, with all due respect, bureaucrats. I've had a number of people come to me, prominent people in this province, wanting to do something to lead a health care initiative. We're going to figure this out in the next short period of time with the Member for Edmonton-Meadowlark's help. I think we've got a great opportunity to put in place an initiative that is not a government initiative; it is an initiative by Albertans for Albertans.

Dr. Sherman: Thank you. Secondly, years ago they made a decision nationally – I don't know if it was government or if it was the College of Family Physicians – where they took out the general rotating internship. The quality of doctoral training is different in

that you either became a family doctor or you went through medical school and then did a general rotating year, which means you all were in a common stream. They took out that year, so kids are being asked in first year to decide to be brain surgeons or family docs. The spirit of collaboration amongst the physicians at that childhood and infancy end of medicine is not there the way it used to be. Can you comment on whether it's the bureaucracy or the government that plays a role or if we can further that agenda to bring that year back? Many of the educators feel that removing that year was a bad decision to make.

Mr. Liepert: I can't off the top tell you the history of that. I could maybe get an assessment – that would be an assessment from our department combined with the Medical Association – and respond.

Dr. Sherman: Thank you. One of the other issues in hospitals is that we actually have an exit block. It's not an access problem. The reason we have an access problem is because of the output, exit block. Dr. Duckett did one really good thing. We were only discharging four and a half days a week upstairs. The discharges dropped off after Friday afternoon, on Saturdays, and on Sundays because a different doctor was on call. Discharge planning wasn't done when people were admitted.

The other exit block we have is long-term care. There are three types of long-term care patients. One is someone who gets acutely ill. They lose five pounds of muscle mass, they get wobbly, then they fall down a couple of times, and then they can't go home, which is really subacute care. Can you comment on whether the Health Services Board will be increasing subacute care?

Mr. Liepert: When I talk to operators of long-term care, they tell me that long-term care today is what used to be acute care many years ago. I mean, it's everything from tube feeding to bed lifts to all of those sorts of things. It's changed dramatically. I think probably your reference to subacute care is not that much different than long-term care today.

I guess just a quick comment on the discharge. If there was one good thing I read in the *Edmonton Journal* on the weekend, it was a story about you and that little comment in there, and I thought that was worth reading.

Dr. Sherman: Thank you. The other issue. A number of my friends who run these long-term care facilities only have one palliative care bed. We have a lot of sick people in long-term care. They've made the decision not to get any extra treatment. Their orders are written, advance directives are done, but the problem is that a lot of these patients have to come to acute-care hospitals in the last stages of their life. Can you comment on community hospices and more resourcing for palliative care beds inside the long-term care facilities because a lot of these people are actually ending up in acute-care beds where, one, they shouldn't be and they don't want to be.

Mr. Liepert: I think those kinds of details are the kinds of things that we need to work through in our continuing care strategy. We need to work it through with all of the providers of long-term care because they're not all private, they're not all government. But that is something that I'd certainly take away. I don't know that there's much that I could comment on other than if that is in fact correct, it's another one of those blockages in the system.

Dr. Sherman: Now, to the other hon. member, the reason why when I use the word "abandoned," I get a bit emotional: my own father nine years ago was dying in the waiting room at the Vancouver General. We felt we had abandoned him because we were all across the country. We actually moved him here. He shouldn't be alive today. A 10 per cent rejection factor is incompatible with life, to live nine years, that long. We as a family made a commitment to look after dad. We kept him in our homes, and we used choice programs and subacute care. But you're right. Maybe it was an inappropriate use of a word, and I'll take that back.

There are a lot of seniors that don't have their family members here. Sometimes the family members don't get along so well with one another. Then they show up with us, and they want different things done. One wants everything done; the other one wants nothing done. That ends up being a battle.

I will say that the good thing is, for everyone here, that I had Paula Simons working with me on Sunday, on the busiest day of the week. Dr. Duckett showed up, I guess, in the emergency department, oh, three weeks ago, a month ago and told everybody to discharge seven days a week. At the northeast department we had 16 people in the waiting room. We just sort of went on the computer screen to look at the U of A and the Alex, and there were two patients waiting in the waiting rooms because they actually were discharging people on the weekends. A simple measure like that. There were no ambulances waiting for lineups. The day before at the U of A had to be one of the busiest days of the year with very sick patients showing up. Many of them actually need to go into hospital. We treat them and release them, but many of them get readmitted. So that's actually a good thing, that suddenly a switch got flipped.

Today is a busy day at the Alex. I was just there. In the last three or four weeks the EDs have been great. I'm reassured and my colleagues will be reassured that these ED wait times of four hours and eight hours . . . [A timer sounded]

The Chair: Actually, Dr. Sherman, that's what that sound means: we're out of time.

Minister, on behalf of our committee I'd like to thank you for your answers to our questions. Thank you to the members for the excellent questions and to our staff for putting everything together this evening.

Mr. Liepert: I'd just like to commit that we will go through *Hansard* and for those questions that I wasn't able to answer in detail, we'll provide them to the committee going forward.

The Chair: Excellent. Thank you.

Members, we'll meet again on Wednesday evening to consider the estimates of Children and Youth Services. See you then. Thank you.

[The committee adjourned at 9:32 p.m.]

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