Legislative Assembly of Alberta

The 27th Legislature
Third Session

Standing Committee
on
Health

Department of Health and Wellness
Consideration of Main Estimates

Monday, March 15, 2010
6:32 p.m.

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Standing Committee on Health

McFarland, Barry, Little Bow (PC), Chair
Pastoor, Bridget Brennan, Lethbridge-East (AL), Deputy Chair
Kang, Darshan S., Calgary-McCall (AL) *, Acting Deputy Chair, March 15, 2010

Forsyth, Heather, Calgary-Fish Creek (WA)
Groeneveld, George, Highwood (PC)
Horne, Fred, Edmonton-Rutherford (PC)
Lindsay, Fred, Stony Plain (PC)
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Olson, Verlyn, QC, Wetaskiwin-Camrose (PC)
Quest, Dave, Strathcona (PC)
Sherman, Dr. Raj, Edmonton-Meadowlark (PC)
Taft, Dr. Kevin, Edmonton-Riverview (AL)
Vandermeer, Tony, Edmonton-Beverly-Clareview (PC)

* substitution for Bridget Pastoor

Also in Attendance

Leskiw, Genia, Bonnyville-Cold Lake (PC)
Marz, Richard, Olds-Didsbury-Three Hills (PC)
Mason, Brian, Edmonton-Highlands-Norwood (ND)

Department of Health and Wellness Participant

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6:32 p.m. Monday, March 15, 2010

[Mr. McFarland in the chair]

Department of Health and Wellness
Consideration of Main Estimates

The Chair: Welcome, everyone, to the meeting. I'd like to note that the committee has under consideration the estimates of the Department of Health and Wellness for the fiscal year ending March 31, 2011.

I'd ask that we introduce ourselves for the record, please. Mr. Minister, if you would introduce your department staff attending with you. A reminder that only members or ministers may address the committee.

I'd like to note also that pursuant to Standing Order 56(2.1) to (2.4) Mr. Kang will be our deputy chair this evening as he is here as the official substitute for Ms Pastoor.

Mr. Zwozdesky: Shall I go ahead with my introductions?

The Chair: Please.

Mr. Zwozdesky: Thanks very much, Mr. Chair. Welcome to all who are here to join in this exciting estimates debate on Health and Wellness. I'd like to introduce to you my deputy minister, Jay Ramotar; my ADM for financial accountability, David Breakwell; my ADM for health policy and service standards, Susan Williams – if you would just wave your hands; thank you – the ADM for community and population health, Margaret King; my ADM for health workforce issues, Glenn Monteith; the ADM of corporate support, Martin Chamberlain; the acting ADM of health system performance and information management, Mark Brisson; and on my right, Charlene Wong, the executive director of financial planning.

The Chair: Thank you, Mr. Minister.

I'll start now with the introduction of our members, starting with Mrs. Forsyth, please.

Mrs. Forsyth: Hi, everybody. Heather Forsyth, Calgary-Fish Creek.

Mr. Quest: Good evening. Dave Quest, Strathcona.

Mr. Olson: Hi. Verlyn Olson, Wetaskiwin-Camrose.

Mrs. Leskiw: Genia Leskiw, Bonnyville-Cold Lake.

Mrs. Sawchuk: Karen Sawchuk, committee clerk.

The Chair: Barry McFarland, chair.

Mr. Kang: Darshan Kang, MLA, Calgary-McCall, vice-chair. Good evening, everyone.

Mr. Marz: Richard Marz, MLA, Olds-Didsbury-Three Hills.

Mr. Vandermeer: Tony Vandermeer, Edmonton-Beverly-Clareview.

Mr. Lindsay: Fred Lindsay, Stony Plain.

Mr. Horne: Fred Horne, Edmonton-Rutherford.

Dr. Taft: Kevin Taft, Edmonton-Riverview.

Mr. Mason: Brian Mason, Edmonton-Highlands-Norwood.

The Chair: Thank you, everyone. Now I'm just going to give a process review very briefly on speaking order and time.

Standing Order 59.01(4) prescribes the sequence as follows:

(a) the Minister, or the member of the Executive Council acting on the Minister's behalf, may make opening comments not to exceed 10 minutes.

We're firm on that.

(b) for the hour that follows, members of the Official Opposition and the Minister, or the member of the Executive Council acting on the Minister's behalf, may speak,

(c) for the next 20 minutes, the members of the third party [Wildrose], if any, and the Minister or the member of the Executive Council acting on the Minister's behalf, may speak, and [following that]

(d) any Member may speak.

With the concurrence of the committee the chair will recognize the members of the fourth party, the NDP, if any, following the members of the third party, and for the next 20 minutes the members of the fourth party and the minister or the members of the Executive Council acting on the minister's behalf may speak. Committee members, ministers, and other members who are not committee members may participate. Department officials and members' staff may be present but may not address the committee.

Members may speak more than once; however, speaking time is limited to 10 minutes at a time. A minister and member may combine their time for a total of 20 minutes. Members are asked to advise the chair at the beginning of their speech if they plan to combine this time with the minister's time. I'd appreciate that if I don't hear otherwise, I'm going to assume that's a yes.

Three hours have been scheduled to consider the estimates of the Department of Health and Wellness. If 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 we will adjourn. Otherwise, we will adjourn at 9:30 p.m. sharp.

Points of order will be dealt with as they arise, and the clock will continue to run.

The vote on the estimates is deferred until Committee of Supply on March 18, 2010.

I'm just going to ask Karen here if you want the amendment section read into the record.

Mrs. Sawchuk: Mr. Chair, I don't believe we had any amendments come through this evening. You can read it for the committee's information if you want.

The Chair: Okay. An amendment to the estimates cannot seek to increase the amount of the estimates being considered, change the destination of a grant, or change the destination or purpose of a subsidy. An amendment may be proposed to reduce an estimate, but the amendment cannot propose to reduce the estimate by its full amount. The vote on amendments is also deferred until Committee of Supply on March 18.

Written amendments must be reviewed by Parliamentary Counsel no later than 6 p.m. on the day they are to be moved, and 17 copies must be provided at the meeting. A written response by the office of the minister of health to questions deferred during the course of this meeting can be tabled in the Assembly by the minister or through the Clerk of the Legislative Assembly for the benefit of all

MLAs. A copy to the committee clerk would also be appreciated.

Minister, if you're ready now. I'm assuming that we don't have an objection to taking that break midway through here just for a reference break.

Seeing none, I'll ask the minister to proceed with his opening remarks.

Mr. Zwozdesky: Thank you very much, and good evening, everybody. It's a pleasure to be here tonight to talk briefly about our business plan, our priorities, and, of course, about the budget for 2010-11 itself. Our new business plan indicates the vision for Alberta Health and Wellness, which is to have healthy Albertans in a healthy Alberta. Our mission, simply stated, is to set policy and direction to lead, to achieve, and to sustain a responsive and an integrated and an accountable health system for all Albertans.

We fully support our Premier's vision of creating the best performing publicly funded health care system in Canada right here in Alberta, and we are totally committed to that objective. Therefore, our strategic priorities and our core business goals this year are aligned with my mandate letter from the Premier, which includes increasing access to quality health care, improving the efficiency and effectiveness of health care service delivery, and promoting strong and vibrant communities and reducing crime so that Albertans feel safe through our safe communities work.

Our seven business plan goals are: one, health system accountability; two, public assurance; three, a sustainable health system; four, healthy living and optimal well-being; five, appropriate access to services across the continuum of care; six, health workforce utilization and efficiency; and finally, seven, excellence through research, innovation, and technology.

In addition to the important ongoing core activities of the ministry, our six strategic priorities this year will be to build a strong foundation for public health; to strengthen community capacity; to increase options for community-based continuing care services; to use health professionals more effectively; to implement the Alberta pharmaceutical strategy to make drug coverage more accessible, affordable, efficient, and therapeutically effective for Albertans; and finally, to measure performance of the health system.

6:40

This work will be done within our $15 billion budget allocation for 2010-11. Our new budget is actually a reflection of what we've clearly heard from Albertans, and that is this: health remains one of their top priorities. Therefore, it goes without saying that it is also one of our government's top priorities. That's why we're taking very specific action to accomplish the vision enunciated earlier.

For example, for the first time we are providing Alberta Health Services, which is the delivery arm of health services in this province, with a predictable and stable five-year funding plan tied to performance measures. That, Mr. Chair and colleagues, will be the first of its kind in Alberta for sure, and I believe it's the first of its kind in all of Canada. Alberta Health Services, more specifically, will receive 6 per cent increases in each of the first three years, starting with April 2010 and, going through, then 4.5 per cent increases in years 4 and 5 of the five-year business plan. As far as I'm aware, this is the first one of its kind, as I've said, and it provides a very healthy road map for the future for Albertans.

In fact, the Alberta Health Services Board chair, Ken Hughes, recently was quoted in the media as saying: "We are really at a turning point in the history of health care in Alberta. It's truly a watershed moment." I totally agree. The predictable funding over five years will improve long-term and long-range planning to better meet the health needs of Albertans, and it will also help us have the best performing public health care system in Canada, as our Premier indicated. We will be in a position to emphasize the care in health care and to increase the wellness agenda.

I also want to quickly add that the days of health deficits are gone. In fact, we are eliminating and fully covering the $1.3 billion deficit that Alberta Health Services is carrying or is projected to carry by the end of March of this year. That accumulated deficit will have two provisions for eradication, the first of which is $542 million right now in the '09-10 fiscal year, followed by a $759 million provision in the '10-11 budget. With a clean financial slate Alberta Health Services will be able to use more of its resources for priority areas in our combined strategic plans. Base funding for Alberta Health Services, then, was increased by $812 million to reflect current operating costs. That brings the '09-10 adjusted base to $8.5 billion.

The annual operating budget for AHS will then be increased, assuming passage of this budget. In April of 2010 it'll be increased by 6 per cent, or $512 million. That will bring its base funding to a total of $9 billion for the delivery of health services across Alberta.

One very important point that I'd like to stress is that the additional funding for Alberta Health Services that I've just alluded to, particularly over the next five years, will also be tied to very specific performance measures. We must have and we must see and the public must experience improved results for the financial commitment that we are making. Albertans expect nothing less, and we're going to strive the hardest ever to deliver it.

These performance measures will provide Albertans with greater transparency, more accountability for how their health system is performing, and additional opportunities for input and engagement. The measures are currently under development, and we look forward to having them soon.

Now, as we look into the overall Health and Wellness budget itself, it includes $9 billion, as I've said, for Alberta Health Services' base operating costs and $5.3 billion for other health care costs, which are more on the Health and Wellness department side of the equation. Those range from physician compensation and education to prescription drugs, continuing care, and so on.

Aside from the $9 billion allocation for Alberta Health Services, which makes up over 60 per cent of our budget, our next largest spending allocation is for physician compensation and education. Let me quickly give you some breakout numbers for the bigger picture here. There is $3.3 billion allocated for physician compensation and education in 2010-11. This is a $253 million, or 8.2 per cent, increase, and it includes $184 million for physician compensation, $40 million for primary care networks, and $20 million for physician office computerization.

The $184 million, which I just alluded to, for physician compensation includes a $13 million increase, or 14 per cent, for medical residents' allowances that provides them remuneration while doing their residencies. Physician compensation also includes an $8 million, or 8 per cent, increase in academic alternate relationship plans to provide compensation for physicians who have multiple roles such as teaching and doing research as well as clinical work.

We had a groundbreaking trilateral agreement, as members here would probably know, back in 2003. I say "groundbreaking" because it did the following things. It marked the first time that health regions were included as partners in an agreement to compensate physicians, it expanded primary care services, and it supported information technology for physicians' offices.

In terms of other spending, Mr. Chair, we are allocating $930 million, which is an increase of $66 million, or 7.6 per cent, for prescription drugs, ambulance services, and other health benefits for Albertans such as prosthetics and orthotics. Included in that $930

million is $183 million for cancer therapy drugs and specialized, high-cost drugs, which is an increase of $23 million, or 14 per cent.

We will spend $488 million on other programs such as air ambulance, systems development, cancer research, prevention, continuing care initiatives, health services in correctional facilities, and allied services for insured nonmedical services provided by optometrists, dentists, oral surgeons, and podiatrists. The $488 million mentioned earlier also includes $25 million to provide health services in those facilities. That's an increase of $11 million, or 79 per cent, and it includes enhanced mental health and addictions services that will be provided by Alberta Health Services in correctional facilities.

We will spend $163 million on human tissue and blood services in 2010-11. That's a $9 million, or 5.8 per cent, increase to address the increasing cost and volume of blood and blood products needed in the health system.

We're allocating $166 million for community programs and healthy living initiatives to promote prevention, good health, and health protection. As I've said, increasing the wellness agenda is one of my priorities shared by all of government. We must emphasize prevention even more to keep Albertans healthy and out of the system in the first place.

There's also $96 million allocated in our budget for infrastructure support. That's in our budget. There's an additional $628 million this year in the Infrastructure budget for health facilities.

We're establishing $25 million in base funding for Alberta Health Services to use for diagnostic medical equipment, $60 million for external computer systems, $10 million for cancer corridor projects, and $1 million for facilities planning.

However, our ministry support services allocation shows a 2.2 per cent decrease from 2009-2010 due primarily to reduced costs for mailing services as a result of the elimination of Alberta health care premiums.

I want to emphasize, Mr. Chair, that there are no program cuts in our new budget. You can see in our income statements evidence to that effect. One of the issues, of course, is the academic health centres. It looks like it's being eliminated, but in fact it's not. Alberta Health Services will be receiving $9 billion, as I mentioned, and they'll be covering those costs for that particular program.

I won't get through all of this here in the next minute or two that I have left, but let me just close by saying that the $3.6 million that we're providing for the Health Quality Council in 2010-11 will support them in their priority activities such as implementation of the patient safety framework, a study of medication safety in supportive living, and a survey of primary care.

The Chair: Thank you, Mr. Minister. Unfortunately, you'll have to work some of the comments into some of your answers, I suspect.

At this point we invite Dr. Taft to begin.

Dr. Taft: Right. I assume, Mr. Minister, that we'll go back and forth through the 20 minutes?

Mr. Zwozdesky: Sure. As you wish. Best we can.

Dr. Taft: Yeah, best we can. That'll be great. Okay.

I appreciate your opening comments. You alluded to the $15 billion budget and the $9 billion of that that's going to Alberta Health Services several times through the budget documents. There's really just one line. It's, I think, about $9 billion. There's absolutely no detail on that, and I have a lot of trouble with that as a legislator. I hope other MLAs do as well.

What's occurred under the Alberta Health and Wellness approach to Alberta Health Services is that it's almost like a separate government department has been created. The $9 billion that that one branch of your ministry gets is more than any government department gets. It's close to 25 per cent of the entire provincial government expenditures, and we have absolutely no detail. There's nothing there except one line that says $9 billion. So don't be surprised that I focus quite a few of my questions on that.

6:50

I'm just going to quote briefly from page 19 of the fiscal plan. It refers specifically to Health and Wellness.

> Health and Wellness operating expense is increasing 16.6% or $2.1 billion. This primarily reflects a $1.7 billion increase for Alberta Health Services.

Then it goes on to describe the five-year plan. It says here:

> Government is providing funds to deal with the [Alberta Health Services] . . . accumulated deficit, reset the 2010-11 AHS base operating grant to eliminate the annual deficit permanently, and provide a 6% increase for 2010-11 and the next two years.

That's a huge, huge amount of money, a massive increase. Everybody is wondering what the value will be from this. When the regional health authorities were disbanded and Alberta Health Services was created, we were told that efficiencies would improve and that this would save money, yet Alberta Health Services came back with a huge deficit. This budget asks us as a Legislature to not only wipe out that deficit but to build its value into the base funding for the department. So, Mr. Minister, I need you to tell me: where did the deficit come from? Where did that $1.3 billion come from?

Mr. Zwozdesky: It's a good question, Mr. Chair, and I'll beg your indulgence to try and explain it.

Dr. Taft: If you can, yeah, without burning up all the time.

Mr. Zwozdesky: I'll try and do it in less than two minutes.

Just to bring some clarity to this issue because I asked exactly the same question, hon. member, and I think all the colleagues here would know that. The accumulated deficit figures include the following: $343 million of accumulated deficits from the '08-09 year, and that was the final year of operation, as you would know, for the nine regional health authorities and the three provincial boards, the Alberta Cancer Board, AADAC, and the Alberta Mental Health Board. Then, effective April 1, 2009, those boards were amalgamated into one province-wide health authority along with the nine regions, and they were called Alberta Health Services. One billion dollars of projected deficit is also built into these numbers for '09-10. If you look at $343 million from the past and then $1 billion from April 1 going forward, that's the short version.

In order to provide some fuller context, Mr. Chair, a brief snapshot of the health system overall is needed with regard to fiscal positions. In '06-07 the health authorities recorded a combined accumulated surplus, actually, of $47 million. In 2007-08 the health authorities recorded a combined accumulated deficit of $97 million. In '08-09, the final year of operations for the nine regional health authorities and the three provincial boards I named earlier, the accumulated deficit rose to $343 million.

Now, the announcement to move to a single province-wide health services board to govern Alberta's health system was actually made on May 15, 2008. That was the announcement. The permanent board, however, wasn't announced until November 20, 2008. It became effective on December 1, 2008, and then the AHS board officially took over management of the health system on April 1, 2009.

We have the total combined deficit that I've already explained, but it's being covered, and that's a good thing. So $542 million of the deficit will be paid off during '09-10, the current year, and the balance, $759 million, will be paid off during the 2010-11 year.

I want to just comment quickly specific to the question about the $542 million of accumulated deficit that's being eliminated in '09-10, our current year: $343 million is from the former nine regions, plus $116 million is there to cover the approximate cost of the H1N1 epidemic, and another $83 million is there to cover capital deficit costs. It's important to note that of the $759 million that'll be covered in the '10-11 budget year $719 million is part of the $1 billion of projected deficit for '09-10 and another $40 million is there as one-time funding for pension adjustments as a result of the amalgamation of the three boards: the Cancer Board, AADAC, and the Alberta Mental Health Board. Then we have some additional costs with respect to the pension shortfall as we move people from one system to the other, and that's being covered as well.

Moving forward, we're providing the stable five-year funding plan, and that's probably one of the best, most positive things that we will be able to have done to help stabilize the overall health system.

I have some additional comments to explain the 6 per cent. Should I make them quickly, or would you like to proceed?

Dr. Taft: Okay.

Mr. Zwozdesky: It's basically 2 per cent for population, hon. member, 2.5 per cent for the aging factor, which is a good thing, and 1.5 per cent for new technologies, new procedures, new equipment, rising pharmaceutical costs, and so on. That's how the 6 per cent was arrived at.

Dr. Taft: Okay. I appreciate that. I'll read *Hansard* to fill in the detail.

Mr. Zwozdesky: There was a lot of information there.

Dr. Taft: That's okay. That's all right. Nonetheless, it amounts to a 16.6 per cent increase. Frankly, I have a concern that we were told as legislators that Alberta Health Services was going to contain and control costs, and it seems to just have lost control. I need to make it clear, Mr. Minister and to your staff, especially your deputy, that I'm not convinced that you or your deputy have the administrative systems or people in place, the administrative structures in place to actually keep Alberta Health Services in line.

I just want to briefly go back in time a little bit if you would indulge me. What you have in front of you, Mr. Minister, is an organization chart from the department of health from 1991-1992. Could you pass that to the deputy because I think it's really important that he sees this.

At that time, Mr. Minister, the minister had great capacity within the department. You can see, for example, on the right hand of that organization chart that there is a mental health division, there's an acute and long-term care division, and under that there are things like hospital services. The minister had people reporting directly to the deputy, people who would go out and work with, consult to, and sometimes police hospital administration, long-term care, and you can go across here. My point is that the minister and the deputy had an organization in place that formed a critical mass at the centre of the health care system that could hold service delivery to account.

In '94-95 the department was decimated. The staff was cut in half, and most of those functions were disbanded. They were pushed out into the regions, and within about three years the regions, in my view, became more powerful than either the deputy or the minister. They became more and more difficult to control. They had the brains, they had the money, they had the information to hold the deputy and the minister to ransom, as it were.

I think the current structure makes that even worse, even more extreme. I find myself wondering over and over: how will you, Mr. Minister, hold Alberta Health Services to account? Who has the information? Who are your experts? Maybe you have them. Maybe you have a branch somewhere in the organization chart – I've looked at your current organization chart, and I don't see it there – where there are experts in all of these different areas who are keeping tight tabs on the system. When I see one line in your budget that says $9 billion, I'm not convinced.

So I'm coming from that perspective, and I'm deeply worried that this 16.6 per cent, as one person put it to me, is like a sugar high. We're all going to feel great for a while, and then in about six months it's going to get gloomier and darker and grumpier, and you guys will be held hostage again.

I really wish I could have this discussion with the deputy because I know he's a tough, experienced civil servant. I'll start just by having you talk to me and talk to the members of this committee about: how do you as the minister hold Alberta Health Services to account? Do you have province-wide standards for long-term care, for infection control, for pharmaceuticals, for hospital administration, for budgeting, for nursing? Do you have any of that in the department reporting to the deputy so that he really knows what's going on?

7:00

Mr. Zwozdesky: Thank you.

How much time do we have, Mr. Chair, for this interchange, quickly?

The Chair: We've got eight minutes and five seconds.

Mr. Zwozdesky: Okay; good. I should be able to get some of these answers out quickly.

I'm quite sure I said in my opening comments, Mr. Chair, that the increases to Alberta Health Services don't come without some conditions. Those conditions include specific performance measures, specific targets. We didn't just arrive at the increase in the base budget in a haphazard fashion. It was very specifically determined that we wanted to see outcomes in terms of reductions in waiting times, in terms of reductions in waiting lists, in terms of increased access to specialists, and so on.

There are a number of things there. In fact, when Alberta Health Services came out with the dashboard indicators, which I know the Member for Edmonton-Riverview would know, and perhaps a couple of others here would, too – if you haven't had a chance to look at the dashboard indicators that we just announced, several weeks ago anyway, I would encourage you to take a look at that because in there we talk about things that the Health Quality Council also talks about, and that is: how do we help speed up access time to important surgeries? That's why we made the announcement just recently about increasing surgeries in this province by 2,230 additional surgeries before the end of March. That's why we said that we're going to ramp up the number of MRIs and the number of CAT scans, for example, by 3,500. That's just to take up the available budget in the '09-10 year, which ends on March 31.

Then, going forward, we'll have the beginning of the five-year plan. There will be yet more indications of how we're going to increase our chances, so to speak, of achieving those targets. Having these flow beds in Alberta Children's hospital in Calgary is an

important initiative that's already seeing tremendous results, having the medical assessment units that we just announced: 12 new beds at the Rockyview and up to 16 coming soon at the Royal Alex and then we're spreading that out elsewhere.

I could go on, but suffice it to say, hon. members, that there is a lot going on in the health services area, which is now possible because they don't have the $1.3 billion yoke chaining them down. That's why I indicated that performance measures are very critical. We have additional performance measures, Mr. Chair, that will be coming and will be part of the five-year plan that will be announced very shortly.

Now, the other question you asked was about holding them to account. I think your comment was something like: do you have structures in place to keep Alberta Health Services in line? You know, this is a fine line, hon. member. On the one hand we are responsible, and specifically I have the responsibility, for $15 billion worth of budget right away, starting April 1. We have to respect that, yes, I'm accountable, as is the Premier, as is the whole of government accountable for it. But, on the other hand, so do people not want politicians interfering in the medical decisions that have to be made. Those medical decisions are best left to the docs and the nurses and other professional health care providers. We have to maintain a degree of respect in the relationship that allows them that freedom to make unencumbered decisions.

With respect to some of the policy decisions such as the possibility that they wanted to look at to close down some acute-care beds, clearly now that you don't have $1.3 billion to worry about in terms of finding it somewhere, it was the wrong thing to do to try and close acute-care beds when we know there's a shortage of acute-care beds; similarly with long-term care beds. There are a number of things that we're doing to hold the whole system accountable to Albertans.

Finally, you asked about the regions having been more powerful at the time. You know, that was at a time of tremendous pare-downs that had to be made in order to get our overall provincial budget back into the black. So a lot had to be done, and it was felt at the time that moving to that decentralized system was good for the day. Today we're finding that with the huge increase in population, with the huge new dollars that have to be managed, one centralized system appears to be working better, but it will take a little bit of time to see the benefits of that, hon. member.

I could give you three examples right now. A centralized payroll system will yield results; a centralized buying capacity, bulk buying, or procurement by another name, would be another example; and there are others.

So we're working on that and so is Alberta Health Services, and they are just as accountable to Albertans as we are.

Dr. Taft: Well, when I see them going 16.6 per cent, an increase like that in their budget, a single line for $9 billion, I'm sorry, Mr. Minister, I am deeply skeptical. I'm deeply skeptical of your ability to hold them to account. Don't take this as a criticism of you. I'm trying to get the structure worked out here so that you can do your job.

If we actually look back to the years before the region was done – and I've run the numbers; I don't want to bore everybody with it – it's well established that through the period from the mid-80s to the early '90s, '92, '93, health spending in Alberta was essentially flat once you adjusted for inflation and population growth. The system contained costs, it delivered quality care, and it was accountable. There was tremendous public confidence, and there was high morale.

It feels like we're in the opposite situation now. Costs are once again jumping. I can tell you I have never had so many people approach me with their concerns, both inside and outside. Morale is low. Waiting lists are long. There's something very wrong with this system.

You talked about performance measures and, you know, your concern with interfering in medical decisions. Nobody's asking you to interfere in medical decisions, but we are asking you to build up the organization's muscles, to hold the system to account.

I would like to know, Mr. Minister, if you're prepared to table a complete and detailed organization chart of the Department of Health and Wellness. I'm curious to know: where is policy made? We're told over and over – the Member for Edmonton-Rutherford has been really clear that policy ought to be made in the department, but we really get the impression that policy is made in Alberta Health Services. The mental health policy, the policy you just mentioned on the supply of acute-care beds, long-term care policy, H1N1: all of these kinds of things seem to be being done in Alberta Health Services when I suspect they rightly belong in the department.

Two questions: would you table a detailed organization chart of Alberta Health and Wellness so that we can actually see if there's, I don't know, a mental health policy branch or things like that? Two, can you give us a clear explanation right now of where policy is really being made? It's mighty confusing to everybody.

Mr. Zwozdesky: Okay. Thank you.

Chair, time check, please? Two minutes?

The Chair: Just about. We're just about done on this first 10.

Mr. Zwozdesky: Okay. I'll try and be really, really quick here.

First of all, I don't think we should lose sight of the fact that Alberta Health Services is the delivery arm, and they report to me. [A bell sounded] I'll come back and answer this right away.

Are you cutting me off?

The Chair: You can continue. We're just letting you know what the time was.

Mr. Zwozdesky: Okay. I'll be less than a minute and a half, I'm sure.

Alberta Health Services does report to me as minister the same way the department reports to me as minister. There are two arms, as I've explained graphically and visually in the House, so there is that accountability. What I said right from day 1 is that we're going to tighten the relationship. We're not going to strangle it, but we're going to tighten it because we've got to get on the same page with this.

I know, hon. member, that you're sincere in your comments. I recognize that. I know that. We've had some chats, and I appreciate that, I really do, as I do other members as well. We will get there, but it won't happen as quickly overnight as everybody's expecting it to because it's a complicated Rubik's cube, this whole health portfolio, as you know. Nonetheless, they do report to me, and they are accountable in that way.

Now, you explained that the system once contained its costs and so on. I agree that the system did. What we have found over the last few years is that we didn't have quite as accurate a picture on what it really costs to run this new first-class health system, that has all kinds of new innovations, new techniques, new procedures, new equipment, new drugs that are coming on faster than you can keep track of, not to forget the fact that we have a huge population increase: more than half a million new people here than 10 years ago, never mind 25 years ago. But on that front let's just not lose

sight of things like MRIs and hip replacements and laser surgeries. What were these 25, 30, 35 years ago? I'll tell you what they were: they virtually didn't exist. Today they are an expectation in the system. It's a good thing, but we have to pay for it.

7:10

Finally, you asked two specific questions: will I table a detailed organizational chart of Alberta Health Services? Yes. I will undertake to do that. No problem whatsoever.

Secondly, with respect to policy, we make broad policy decisions under Alberta Health and Wellness. Those are government policy decisions. We also set the budget, we set strategic directions, we do legislation, and we do regulation.

Alberta Health Services has some policies of their own that they were developing, but some of them, hon. member, were done at a time when they were still looking for $1.3 billion worth of savings. I can't make that point strongly enough. Now that they don't have to find that $1.3 billion, I've asked them to review some of the policy-type decisions, Chair, that they were looking at doing such as the possibility of closing beds, for example, such as changes out at Alberta Hospital Edmonton.

In conclusion, we arrived at a consensus that said they could change some of those directions, and we did those things together. That was a policy decision that was made together, but some of them they had done in their own independent way, and that's how it had been set up at that time under different circumstances. Today is different.

Dr. Taft: Okay. So in your two-armed creature that we've talked about a few times, where, I guess, you're the head – we're not certain who's the body – one arm is Alberta Health and Wellness and the other arm is Alberta Health Services.

Mr. Zwozdesky: One is the department and one is . . .

Dr. Taft: One is the department and one is the board. You said a few moments ago that the board reports to you as the minister.

Mr. Zwozdesky: They're accountable to me, yes.

Dr. Taft: They're accountable to you as the minister. We can look at the memorandum of understanding in a minute here. When they report to you as the minister, what capacity do you have to sit down with them and say, you know: my evidence is that you're spending too much on diagnostic services and not enough on pharmaceuticals and too much on orthopaedic surgeries, and you've got problems with infection control in your rural hospitals, so, Mr. Hughes and Dr. Duckett, the leash is getting shorter. What capacity do you have if they're reporting to you and not to the department to do that kind of thing?

Mr. Zwozdesky: Well, I have a lot of capacity to do some of that kind of thing, and that's why we're working so diligently on a new way of doing this business. It's called the five-year funding plan. I think when you're talking about accountability, obviously there's the financial side, but there is also the policy side: the minipolicy side, the maxipolicy side, and so on. In terms of capacity, I have a great deal of capacity. The board reports to me, the CEO reports to the board, but we're not all so independent that we don't talk to each other. In fact, we talk rather frequently, especially of late, because we're trying so hard to get some consistent messaging out there, some consistent purpose, and we're trying to get everybody focused on the same page.

You know how many people are involved, almost 90,000 all totalled. It's a bit of a challenge and a bit of a chore, so I'm not expecting miracles overnight, but I am expecting a greater sense of accountability and a clearer directional focus aimed and centred around the performance measures, some of which are here already, some of which are still coming as part of the five-year plan.

The final comment I'll make is that in the business plan and in the budget document before us, hon. members, are targets. There are specific targets there, so we'll be very accountable back, and a lot of that is tied directly to Alberta Health Services.

Dr. Taft: Okay. You're not convincing me.

Mr. Zwozdesky: That's because I'm trying to be quick.

Dr. Taft: No. I think it's more than that.

Mr. Zwozdesky: Well, tell me what you'd like to hear.

Dr. Taft: No, no. I don't want to tell you what I'd like to hear.

Mr. Zwozdesky: No. I'm serious: tell me what you'd like to hear.

Dr. Taft: What I would have liked you to have said is: "You know what? I have a hospital operations branch with 20 of the best health administrators in Canada, who are poring through how all the hospitals are run. I have a long-term care policy branch, who's independent from Alberta Health Services, who's feeding me information, who's out on the site saying: these are the issues in long-term care." On and on; we could go across the whole range. What I want you to convince me of is that you have the expertise and the administrative capacity independent of Alberta Health Services to hold that $9 billion monstrosity to account.

Mr. Zwozdesky: Can I just briefly add, Chair, something I didn't mention earlier? We do have within the department of Alberta Health and Wellness a compliance assurance branch, which I'll try and outline in the organizational chart that I'll give you. I'll give you not only Alberta Health Services, hon. member, but I'll also give all members here the organizational chart for Alberta Health and Wellness, and I'll break it out a little bit more.

Dr. Taft: Actually, we have Alberta Health Services. We have lots of that. They posted at one point a 250-page organization chart. I think it's down to 50 pages or something. It's not Alberta Health Services I want the org chart for. We've got that. It's Alberta Health and Wellness. I want to see that creative tension between those.

Mr. Zwozdesky: Okay. We'll get it for you. Nobody has brought it with them.

Dr. Taft: Linked to this is the issue that's near and dear – well, I don't want to speak for anybody else – to my heart. I know the Member for Edmonton-Rutherford and others have commented on it. Who is making policy? Do you have as the Minister of Health and Wellness in Alberta Health and Wellness the capacity to develop a policy on activity-based funding? Huge shift. Huge shift. Is that being driven by Stephen Duckett in Alberta Health Services, or do you have some independent, arm's-length people working on activity-based funding? Who's developing provincial policy on long-term care? Who's developing provincial policy on pharmaceuticals and emergency medical services and ambulance and on and on? Where is that policy being developed?

Mr. Horne said two or three weeks ago at St. Paul's church that the role of Alberta Health and Wellness is to construct policy, I think was the word used, and the role of Alberta Health Services is to implement it. But that's not coming across. It feels like the same people who are developing the policy are then operationalizing it. Could you make some specific references? Mental health: does Alberta Health and Wellness have a mental health branch that's worked out provincial policy, and if they did, why the mess-up with Alberta Hospital?

Mr. Zwozdesky: Well, let me just comment on some of these in general. When you look back at the org chart that you circulated earlier, hon. Member for Edmonton-Riverview, there are a number of functions there that we just picked off immediately. This is not a thorough examination by any stretch yet. But, for example, there still is a research and planning branch. There still is a community mental health services branch. There still is a communicable disease control and epidemiology branch. There's an emergency health services branch. There's a hospital services branch. There's a long-term care planning branch. There's a home care and community long-term care planning branch. There is an environmental health services branch. There's a health promotion branch. Do we still have the family health services branch? That's renamed. Okay. We still have a research policy and planning branch. The list goes on. They might have slightly different names today, but the functions are correct and still there. When the organizational chart comes back to all members here, Mr. Chairman, we will have a much more thorough look at it.

With respect to mental health and addictions, yes, we set that policy. With respect to infectious disease control and prevention methods, yes, we still set that. We're working with Alberta Health Services right now to help develop further strategies regarding addictions and mental health issues. The strategic directions, by the way, for all of those are top priorities for us going forward. We recognize the difficulties there, and we're working very hard with Alberta Health Services to make sure we get it right.

Dr. Taft: Okay. Well, I look forward to that organization chart.

I worry, then, if all that capacity is there, when we're voting on this massive budget, the examples of the last 12 months on policy confusions, beds opening and closing – you said that your department, Health and Wellness, I guess, has developed the mental health policy for the province. Then why all the confusion around what's happening to Alberta Hospital? You know, it looks like it's breaking down.

7:20

Mr. Zwozdesky: You know, hon. member, I was out there for a visit. I was honouring a commitment to go and see a patient out there, and while I was there, I also honoured a commitment to meet with the folks from UNA and the folks from AUPE. We had a wonderful visit. We had a tour. We talked to some patients and talked to a lot of the head administrators. I was joined by the hon. Member for Edmonton-Meadowlark and the hon. Member for Edmonton-Rutherford and the member in whose constituency it is, the Member for Edmonton-Manning. That was just last week.

I want to just clear up something. If there was confusion, there shouldn't be any confusion now because the implementation team delivered its report, and it was pretty clear what the future direction would be. That was that the forensic unit stays there, the adult psychiatry unit stays there, and the rehab psychiatry unit stays there. The only group that is scheduled for moving is the geriatric psychiatry group, and that's 106 patients.

One of the things that I learned during the tour, which I did not know, is that people in the past haven't been scheduled for Alberta Hospital Edmonton residency on a permanent basis, Mr. Chair. They're there for anywhere from two days to two weeks to two months, for less, for a little bit more, whatever. But on average the stays at Alberta Hospital Edmonton are in the small-number-of-weeks period. I didn't realize that quite so emphatically as I did last week. I hadn't realized it before.

So we're scheduling to move 106 geriatric patients who can be moved to the Villa Caritas site.

Dr. Taft: Okay. Well, I hope that under this budget and under this deputy and the other fine staff of Alberta Health and Wellness the policy confusion around all kinds of issues ends. My advice, for what that's worth, is that more of that policy function should be brought into Alberta Health and Wellness and taken out of the hands of the delivery people because those two functions need to have a little bit of creative tension. If they're all together in one organization, you're going to be held to ransom, and we'll be back here in a lot less than five years with huge demands for more money because the performance indicators weren't met, and we don't really know why, but they're telling us that, well, if they just had another 16 per cent, they'd get it.

Activity-based funding, Mr. Minister. I assume some of this budget is going to go into activity-based funding, is going to be allocated that way. A couple of questions to start off with. You don't need to name names, but what are the positions in Alberta Health and Wellness that are in charge of developing the policy on activity-based funding, or is it, as you said in the House yesterday, all Alberta Health Services? It's a huge policy shift. So that was question 1: who in the department is holding Alberta Health Services to account in developing the policy?

Related to that, question 2 on activity-based funding: what are the implications for health care delivery outside of Calgary and Edmonton as activity-based funding takes hold? One of the real concerns is that it will actually draw activity out of all the rest of the province – Grande Prairie, Red Deer, Lethbridge, and so on – and concentrate it in so-called centres of excellence in Calgary and Edmonton, further weakening the delivery of health care in areas outside of Edmonton and Calgary.

Mr. Zwozdesky: Yeah. I'm just looking at a sheet here that tells me that Alberta Health Services does have a director in charge of this activity-based funding. You know that? Okay.

Dr. Taft: Yes. I may have the same piece of paper.

Mr. Zwozdesky: Yeah. That's the same one. He reports to a senior vice-president and so on.

Dr. Taft: That's right. That's Alberta Health Services. I'm looking for Alberta Health and Wellness. This is the group where, I noted today in question period, five of the six positions are vacant.

Mr. Zwozdesky: Yeah. I looked that up right after QP, and I see where it says: vacant, vacant, and so on.

Dr. Taft: But I'm not interested in Alberta Health Services.

Mr. Zwozdesky: No. I know.

Dr. Taft: I want to know in your department.

Mr. Zwozdesky: You know, there were some positions in Alberta Health and Wellness that looked at this, but I don't know if it was an exclusive domain, that they were only doing activity-based funding, because we have some groups such as the folks who are here today who looked at a number of funding-type models. They certainly looked at activity-based funding, and as I think I indicated in the House today, we're proceeding with some activity-based funding in one area specifically. That will be long-term care. Let's have a look at how volume and pricing and so on works out. They've also looked at population-based funding models and global funding and block funding and so on. There are probably about half a dozen or so of them that have been looked at, and we do have people in our department who work specifically on that. Health systems and information is the specific area.

Dr. Taft: Okay. Well, the more detail you give, the better that would be.

Mr. Zwozdesky: Sure.

Dr. Taft: You didn't answer my second question, which was around any evidence that activity-based funding will actually concentrate the delivery of services in centres of excellence in the two big cities and correspondingly drain resources out of the rest of the province.

Mr. Zwozdesky: I don't think there will be any drain of resources. I want to say, hon. members, Mr. Chair, and others, that there is some proof in the pudding that this type of a funding model does work elsewhere. My recollection is that Ontario may well have been the first province to use activity-based funding as part of their wait time strategy, and it was successful in the selected hospitals who used it, and it was successful in specific areas such as cataract surgery, joint replacement, and cardiac bypass.

In 2008 four Vancouver hospitals, I believe, enrolled in the emergency department improvement initiative, and through that initiative hospitals received additional payments for treating patients within specified time frames without compromising quality of care or safety. In fact, the Vancouver Coastal health authority affirms that the overall health care delivery there has since improved because of their activity-based funding approach. Other than that, Mr. Chair, there are a number of other locations where this funding has been used and seems to have been used quite successfully: United Kingdom, Australia, Sweden, and the United States.

Dr. Taft: Well, it's been pretty controversial in some of those jurisdictions. It's long established and long known that having specialized surgical centres, for example, in the public system – specialized cataract surgery, specialized hip and knee surgery, and so on – works really well, but again you made a brief comment that there won't be any draining of services or concentrating of services in centres of excellence under activity-based funding.

The Chair: Last 20.

Dr. Taft: But you, backed up with your department and its mighty staff, are going to have to take some special initiatives to prevent that from happening. It's also curious to me that examples you gave on activity-based funding didn't mention long-term care.

Mr. Zwozdesky: Just very, very quickly, that's why we're just picking one area to start. I need some convincing as well that it's going to work in Alberta because just because it works somewhere else doesn't necessarily mean it works here. I share your concern there.

Dr. Taft: Okay. The list you gave a moment ago mentioned cataracts and orthopaedics and bypasses. It didn't mention long-term care, so I don't know if it's being used somewhere else in long-term care.

Back to that $9 billion big, blank cheque. There used to be under the regions a clear rationale, complicated but clear and accountable, called a funding formula, the regional funding formula for handing out money. There was an assessment given to the number of people, the age structure, income levels, health conditions, ethnic backgrounds. All of that was worked up into a substantial, complicated formula, and funding was then allocated – at least, it was always the story we were told – to the regions according to that formula. People from Calgary sometimes grumbled that they got less per capita than Edmonton, but the minister was able to stand up – and I saw him do this – in the House and say: "You know, there's a reason for that. There's a funding formula. Calgary has higher incomes, better health indicators, and so on." There was a coherent explanation.

7:30

That funding formula is gone, as far as I know. I'm wondering how in this budget money is allocated. How is it decided that the budget for the Foothills will be X, the budget for the University hospital will be Y, the Alex will get this, or the QE II will get that? What's the rationale other than raw, internal politics?

Mr. Zwozdesky: I want to comment on your point about the blank cheque. It's not a blank cheque. I know you don't mean it quite that way, but I can't let that go. I have to just clarify a couple of things here. Alberta Health Services is getting over $9 billion, and I'll just enunciate some of the areas, Mr. Chair, where that funding is going so that people don't think it's all blank. It will provide acute care, long-term care, continuing care. It provides public and community health initiatives. It provides mental health services. It provides cancer treatment. It provides home care services. It provides funding for transplants, for cardiac surgery, and renal dialysis. It provides addiction prevention and treatment programs. It provides ground and emergency ambulance. I could go on for quite a bit of time.

Dr. Taft: Okay. We got the menu.

Mr. Zwozdesky: So it's not a blank cheque.

It is tied to performance measures, hon. member, but you haven't seen all of them yet. They still do use a funding formula. I don't have those details, but perhaps I could undertake to provide you with more information in that regard. We do provide funding to that one board, so there's no need for any specific allocations on a regional basis. I want to find out how AHS makes those allocation decisions because that's what your question really is. My understanding is that it's based on the health needs in the area.

Dr. Taft: In my constituency there's the University hospital.

Mr. Zwozdesky: Yes.

Dr. Taft: You can perhaps follow up and just explain to me what the budget is for the University hospital and the Mazankowski. Actually, there are a lot of major health facilities in my constituency. How is that determined in comparison to the Foothills hospital and related facilities in Calgary? I think that's really fundamental to try to understand. Of course, that plays out all the way down to the little hospital in Tofield or the nursing station in Red Earth Creek or wherever it is.

Mr. Zwozdesky: I think I have the gist of your question.

Dr. Taft: Okay. Good. We're communicating.

Just back to activity-based funding. Would you also undertake, then, to provide that proof, provide the evidence that it has worked well? You know, I would assume there are some internal discussion papers in your department that support this policy.

Mr. Zwozdesky: Well, we'll find out some more information for you, hon. member. I talked earlier in my comments about this being a payment model based on volume and the type of services that are provided to each person on an activity basis. I can tell you this, though, just so that other members don't feel that this is a doom and gloom situation, because it truly isn't. The objectives of this new activity-based funding are to increase the efficiencies, obviously, but also to align the resources with the care needs that exist and, ultimately, to help reduce wait times.

We're providing more resources to providers who have clients, obviously, with higher care needs relative to other providers, so that has already been taken into account. We feel that this is meritorious of implementation, as I said, in the one area, so that we will have more information on that. We'll be watching it very closely as well just to see how it unfolds.

Dr. Taft: All right. Just before we leave activity-based funding, you've talked a number of times about benchmarks and performance indicators and so on. Are you planning to use the increased number of surgeries, in this case it would be the hip and knee and cataract surgeries you announced the extra funding for two or three weeks ago, performed by what are almost entirely for-profit surgical centres in this increase, as the benchmark for activity-based funding allocations in this budget? Have you taken that extra money from this spring, ramped it up, and then that becomes the benchmark for this budget?

Mr. Zwozdesky: You know, the honest answer is that we don't have the complete performance measure package, that whole suite, finished yet in tandem with the five-year funding plan. That is coming, and I think I alluded to that earlier. I will get you more specific information on that in general because I know where you're coming from.

Dr. Taft: I appreciate your honesty, but those are the reasons why I have a little trouble with a $9 billion budget or a $15 billion budget. It's just, like: trust us, and we'll figure it out as we go. I know you and the deputy have only been there a short time. I sure hope we don't have this conversation next year.

I want to talk for a minute about nursing levels and registered nurses, the policy there. There's a lot of talk coming out of Alberta Health Services about shifting the allocation of RN versus LPN resources. There's talk that RNs do – I forget; 20 per cent of their work could be done by somebody else. When we're looking at this budget, is there a shift unfolding in this budget that will see the ratio between LPNs and RNs change so that there are more LPNs per hour of RN coverage? Who is making that policy, again an immense policy with huge province-wide implications. Is that policy which Dr. Duckett has spoken so much about actually initiated from the department, or is it from Alberta Health Services?

Mr. Zwozdesky: I want to answer the question, first of all, by saying that we're pledged and committed to delivering on the increase in the number of graduating RNs per year. I think if that comes to pass – and it looks like it will – whatever the most beneficial ratio is will be at least maintained if not improved upon. Perhaps it's there now. I'm not sure, but perhaps it is.

In terms of LPNs we have a number of people who are coming to this province from foreign locations who are occupying LPN positions, and some of them are upgrading themselves to RN positions, so to speak. Now, how the ratios will be affected, I guess, remains to be seen, but I don't see any change, certainly no change to the detriment of what the existing ratio right now is. What is changing is the scope of practice of some nurses. We've spoken with them. What is it that nurses can do? What will doctors agree to have them do? What will LPNs do? What will the RNs agree to having LPNs do? What will nursing aides do? I mean, there are so many in the suite, as you know: nurse practitioners and so on, psychiatric nurses and so on.

A comment here from one of my staff members. We have about 8,000 LPNs right now. Is that the number? We have about 32,000 RNs. That's an increase, is it? Yeah. The scope of practice for LPNs allows for them to be used in direct care more than, perhaps, they were in the past, and RNs are being used more to manage the care. Now, I'll get you some more on that as well, hon. member. These are just a couple of notes that have been slipped to me by staff.

Dr. Taft: Okay. We have 10 minutes or so left?

The Chair: Nine.

Dr. Taft: I need to take a couple of minutes to return to an issue that I've raised since I was first elected as an MLA and have had a lot of push-back on but that I think is fundamental to the effective management of this budget, and that is addressing issues of conflict of interest. I would hope the deputy, who has come from a transportation background and so on – I'm sure he's extremely alert to these kinds of things. I'll describe very briefly what I mean.

7:40

There's quite a long history in this province of senior physicians – ophthalmologists and physicians doing cataract surgery, orthopaedic surgeons, radiologists, and anaesthetists would be four examples – with the same individual occupying a decision-making place in the public system, the decision-making over how contracts are allocated, also owning, being a shareholder in a clinic that's receiving that contract.

The extreme case – and I was just rereading this correspondence before I came in here. We have a copy of a letter on Calgary regional health authority letterhead – this is several years ago – from Peter Huang, who is a shareholder in Enterprise Universal, which owns the Holy Cross, to Peter Huang, to himself, and he's allocating himself a significant number of cataract surgeries. It's a conflict of interest. It would not be unlike an assistant deputy minister in Transportation, you know, giving a contract to a company in which his wife or he has an interest. This is occurring in cataract surgery. It's occurring in orthopaedic surgery. I've had physicians raise it with me. The same concern is occurring in radiology, and there are certainly yellow flags that it's occurring in anaesthetics.

The Legislature passed an act in the last couple of years, the agencies and committees governance act. Somebody help me with that. Anyway, it's clear in that act, and it's just a fundamental principle of good public management that those conflicts of interest should not be tolerated. They are, and they have been for a long time. The doctors will come, some of them, the ones with a vested interest, and say: "Well, this happens all the time. You don't worry about it, Mr. Minister." You should worry about it. You should

have vigorous, tough, conflict-of-interest policies that bring those to an end because they're corrupting, distorting the system. Frankly, if you want to move into more private delivery of services, it really distorts the marketplace.

Ophthalmologists have approached me saying, "It's really, really unfair that my competitor controls who gets those contracts," and they're right. So I would urge you to take a tough look at that and don't buy into the line that's been sold so effectively for so many years. Bring that to an end and have the public decision-makers making those decisions without any vested interest. It can be done. Otherwise, we're bringing forces into this system, Mr. Minister, so that there's a vested interest in driving up costs and distorting how service is delivered. So under this budget I'd really, really ask you to take a tough line on that.

Mr. Zwozdesky: Can I get a copy of that letter?

Dr. Taft: Oh, I've got boxes of stuff on this.

Mr. Zwozdesky: I'm just wondering: are there two Peter Huangs?

Dr. Taft: No, no. It's the same person. I mean, he took me to court on it, and he ultimately withdrew the case. That's just one of several examples.

Mr. Zwozdesky: But you don't have a copy handy.

Dr. Taft: I don't have it here.

Mr. Zwozdesky: Okay. Fair enough.

Dr. Taft: We can certainly get you lots of interest on that. I don't know if you have any comments you want to make on that issue.

Mr. Zwozdesky: I don't know the issue at all, so I'll have a look at what you're saying, and I'll read *Hansard* through again just to make sure I've got it right.

Dr. Taft: Okay. The last five minutes or so?

The Chair: We are down to four minutes, sir.

Dr. Taft: Four minutes. We could go on at great length. I would like just to briefly discuss the memorandum of understanding on governance between the Minister of Health and Wellness and the Alberta Health Services Board. Again, under this MOU there's going to be $9 billion spent. Are there any plans, Mr. Minister, to revisit the terms of this MOU? This is the agreement between the minister and the Alberta Health Services Board, and it lays out various terms. It's dated May 29, 2008, and I believe somewhere in here it's got a three-year time frame. Are there plans afoot to begin opening the MOU up?

Mr. Zwozdesky: I think what I recall is that there is a discussion going on right now that might see the mandate, roles, and responsibilities, or whatever that document is called, being reviewed. That's under that act you referenced, the Alberta Public Agencies Governance Act. So that document is under development. I think the MOU that was there in – did you say May of . . .

Dr. Taft: May of 2008.

Mr. Zwozdesky: Yeah. I think that was more of a transitional document during the changeover from nine to one. I believe that's the answer.

Dr. Taft: Okay. That would be great to see. I mean, I'm glad we could get this. It's interesting to read it because it's very clear in here: "The Minister is responsible to the government and the people of Alberta." I might argue to the Legislature, but anyway it's clear who you're responsible to. The deputy minister is responsible to the minister; that's laid out here. The CEO of Alberta Health Services is responsible to the board; that's laid out here. But the reporting lines of the Alberta Health Services Board are, frankly, as far as I can read this, only kind of inferred. It talks about: the primary mandate of the board is to provide governance and direction and so on.

I would urge you that if we're going to hold those people to account for 25 per cent of Alberta's provincial government budget, you've got to tighten the leash and you gotta spell that out in the memorandum of understanding. This version, as I've read it, isn't clear enough. So if you're renegotiating it, that would be great. Your poor old deputy minister here, kind of says here that he can be friends with them and he can collaborate and he can give them feedback and receive reports, but if he wants to take action, it ain't there.

Mr. Zwozdesky: That may be one reason why it's under discussion, review, and development right now. The transition is virtually complete.

Dr. Taft: Okay. I look forward to all those piles of information that you promise, Mr. Minister. I'm sure we're down to the last seconds here.

The Chair: Thirty seconds.

Dr. Taft: I appreciate your efforts, and we could continue.

Mr. Zwozdesky: In the 15 seconds left I just wanted to make a point that Alberta Health Services has recently issued a request for proposals for outsourcing some surgery, such as the cataract example that you mentioned, and that's part of their procurement process. Interested parties must respond and within their responses, be it known, they will be evaluated, and the decisions and so on will be communicated in an open and fair manner.

The Chair: Thank you very much, Minister. On that note, we are adjourned for five minutes – no more, no less – and we'll be right back at it with Mrs. Forsyth, please.

[The committee adjourned from 7:49 p.m. to 7:54 p.m.]

The Chair: For the next 20 minutes, then, the members of the third party. Mrs. Forsyth.

Mrs. Forsyth: Thank you, Chair, and thank you, Minister. I appreciate your time. I've been madly writing notes. I want to follow up on something that Dr. Taft did. It's on page 149 under ministry. Right underneath it starts with:

> The ministry's focus and role is strategic in developing policy, setting standards and regulations, ensuring accountability, and pursuing innovations on behalf of Albertans. Alberta Health Services provides health services delivery in response to direction . . . from the ministry.

I guess what's confusing for me – and it has been discussed this evening – is in regard to: what is the role of Alberta Health Services, and what is your role? In speaking to Dr. Taft, you made it very clear what your role was. I guess my first question is: if your role is to set directions to Alberta Health Services, then I need to ask who made the decisions in regard to the Alberta Hospital closures. Are you saying, then, that that was your decision?

Mr. Zwozdesky: Alberta Hospital Edmonton?

Mrs. Forsyth: Closure.

I want to ask you about the gag order that is rippling through the province in regard to not allowing doctors to speak, and the latest incident was the Tom Baker centre. Was that your direction? You stood in the Legislature a week ago and indicated that, one, you weren't aware of it and, two, you were going to check into it.

I guess I'm trying to find out at whose direction are those orders. I know Fred intervened on the Alberta Hospital decision. At least that's what the papers indicated. Who's making those directions? Is it Alberta Health Services, or is it you?

Mr. Zwozdesky: The issue of the rumoured closures of Alberta Hospital Edmonton, prior to me taking over and prior to the implementation team report, would have been true in terms of rumours. But, as you know, the implementation team went out there and did their work and decided that the forensic unit would stay, which was always the case, and the acute psychiatry program would also now stay – that's a new decision – and the rehab service would also stay. Those were, to my knowledge at least, reasonably new decisions after the I team went out and did its work. It's only the geriatric psychiatry program that is scheduled.

Mrs. Forsyth: No. You mentioned that. Who made the decisions in regard to – I met with the doctors from Alberta Hospital. They were clearly told that those beds were closing. There has been a shift in policy to the geriatric patients, but we met with the whole staff, and they were clearly told that those beds in Alberta Hospital were closing.

Mr. Zwozdesky: Which ones? The geriatric ones?

Mrs. Forsyth: No. The forensic unit can't close.

Mr. Zwozdesky: No. It never was scheduled to close.

Mrs. Forsyth: I mean, those are court ordered, for one thing. But there are lots of mental patients that, as you said, some of them go in there for two days, a week, two months, because there's nowhere else for them to go. They were told that all of the beds, excluding the forensic unit, were all going to be closed, and the patients that were currently in Alberta Hospital would be put into the community. Their beef on that was the fact that there was no community support set up. Where were these people going to go? I'm trying to find out who overturned that decision. I mean, it was the right decision, obviously, but who made that decision in the first place to close those? Was it the ministry – it clearly says in your mandate that it's under your direction – or was it Alberta Health Services that made that decision?

Mr. Zwozdesky: I'll have to find out, Chair, if there's any paperwork on that. I haven't seen any. I don't know that a decision to close them was ever made. I think it's more the case – now, this is just my view of the world, if you will; this is all before my time – that there were discussions about what could be, so to speak, closed; in other words, which patients could be moved and which ones couldn't. But in the end the only ones that are scheduled to be moved are those that are in the geriatric program, so that should be welcome news for the people who are in the forensic units or the adult psychiatry units or in the rehab psychiatry units. I'll try and find out more for you, hon. member.

Mrs. Forsyth: What about the gag order, then?

Mr. Zwozdesky: You know, I've heard this term before, and I don't know of any gag order. I don't like the term – and I'm sure you don't either – but it's out there. I realize some people are using it. I think that there is an understanding through the code of conduct between Alberta Health Services and the doctors that the doctors should be and should feel free to be commenting on anything of a medical nature, whereas things of a policy nature should be left to the Alberta Health Services people to comment on and/or the minister and/or Alberta Health and Wellness. Now, that's my understanding of where that situation sits right now, but I have heard the issue raised under the term "code of conduct," so I'd like to have a look at that and just see how those contracts read.

8:00

Mrs. Forsyth: Have you heard the words "no talk"? They're using "gag," "not talking," all of these things. We have talked, actually, to doctors in the Calgary region who have been told that they can't come out publicly and criticize anything that's happening in regard to the decisions and, again, the confusion coming from Dr. Duckett or you on the direction of the closures, et cetera, that are occurring across the region. My question. You sounded very strong in the Legislature and somewhat taken aback about this gag order or no-talk order, whatever you want to call it. Would you be willing to send a memo out to the staff saying that that's not part and parcel of your beliefs?

Mr. Zwozdesky: It's on an agenda that I have to discuss with Alberta Health Services. I don't have enough background on it right now. This just came to my attention for the first time a few days ago, and I have already taken some action to find out more about it. As soon as I have a chance to review the details and just see exactly what different people mean by the terms that you're using, I'll be in a better position to answer that question more openly, more honestly, and much more effectively.

Mrs. Forsyth: Okay. I want to move on. One of the things that you talked about was the $8 million that Alberta Health Services was going to use to increase surgeries. You talked about that to Dr. Taft. What percentage of the increase are you going to be putting into home care when these patients leave the hospital, after they're released, for someone to take care of them at home? As far as hip surgeries go, I see a lot of those in seniors' homes with no home care behind them and other seniors, actually, taking care of them, which is quite frightening to me. I'd like to know the percentage of home care increase that you're going to be providing when you're putting all these people through the system in a very short time.

Mr. Zwozdesky: Home care is built into that $9 billion piece. I don't recall the exact amount of money there, but my recollection – and I hope I'm right – is that home care funding is actually increasing this coming year.

Mrs. Forsyth: No. I'm talking about the budget that you're trying

to burn right now until the end of March to put all of these people that you've talked about through surgeries, the $8 million.

Mr. Zwozdesky: Oh, I see. Okay.

Mrs. Forsyth: What percentage are you increasing in home care to take care of these patients as they're released? Right now home care cannot take care of the patients that they have.

Mr. Zwozdesky: I'm reasonably certain that there was something worked out in that regard. I don't have a percentage figure for you right here. I can't do the math. Maybe somebody else could do that math for me. Is it available to us? I don't know if we have that information here today, hon. member, but we'll undertake to give you a written answer to that.

I guess what you should know, though, is that it wasn't just decided to increase the number of surgeries and so on without looking at the continuum of care that's needed thereafter. I know that for sure. In fact, my staff are telling me that there's an additional $5 million.

Mrs. Forsyth: Is that this year or next year?

Mr. Zwozdesky: That's this current year.

Mrs. Forsyth: When was that $5 million put in place? If you're talking about 2009-2010, a $5 million increase, that isn't keeping up with the population and the philosophy of the Premier in regard to leaving more people in their homes. That was on the budget prior – look, you don't need to give me an answer tonight. I'd just like to know what it is.

Mr. Zwozdesky: I know we'll get it, but the short answer is $5 million more.

Mrs. Forsyth: That was the increase from last year.

Mr. Zwozdesky: In the current year, '09-10, for this period right now, to the end of March.

Mrs. Forsyth: You're playing catch-up. That's what I'm trying to say.

Mr. Zwozdesky: Well, no. It's forward catching. We're doing an additional 2,230 surgeries.

Mrs. Forsyth: Is the $5 million in addition to what's already in last year's budget to the end of March? Is there an additional $5 million to take care of all of the patients that you're pumping through the system in a very short period of time that are going to have to end up going home? Is there additional home care with that $8 million that you're providing for additional surgeries? What increase is going to home care?

Mr. Zwozdesky: I've got your question now. We'll get you a written answer for that.

Mrs. Forsyth: Okay. Thank you.

I want to get to goal 5 of the government of Alberta's strategic business plan, and it's the promotion of "efficiency, increasing patient access and optimizing health services for Albertans." How does the government propose to increase efficiency and optimize health services in this province?

Mr. Zwozdesky: How do we plan to increase efficiency and optimize health services? Well, I think most of that is going to come out of the five-year funding plan, where for the first time ever there is the ability to make a five-year plan. As you know, we've always got plans, hon. member. You know that full well. We have a three-year plan. We have a five-year, a 10-year, a 15-year, a 20-year plan, and so on.

But this is the first time that we've actually had the stable, predictable funding attached to it, and that's why it's so critical to not look at any one of these pieces in isolation because the performance measures are a part of that. The targets are a part of that. Certainly, these goals and objectives are all a part of that. But that's all just coming down the pipe here. It's not all finalized yet, but it's coming out very soon.

Mrs. Forsyth: So we know we have this five-year business plan. We know we're going to have a 6 per cent increase every year. I think that when you were talking to Dr. Taft, you alluded to 500,000 patients entering the system. What I need to know is: even though you've increased it by 6 per cent, how are you going to make the system more efficient, more manageable? I would suggest that one of the biggest criticisms is the lack of family doctors. How many family doctors are you going to increase this year, year 1, year 2, year 3, year 4, and year 5? It increases efficiency, it increases patient access, and it optimizes health services if people aren't running around looking for a family doctor. I mean, that's one that comes to me quickly as one of the things that I have to do. I would like to know: for years 1, 2, 3, 4, and 5 how many family doctors are you going to increase on that yearly basis?

Mr. Zwozdesky: I don't have the specific details just in front of me. I probably have it here somewhere. I just can't spot it fast enough to satisfy the committee's time. What I can tell you is that between 2004 and 2008, which is the last set of stats that I looked at, the number of, for example, internationally recruited doctors increased by 36 per cent, so that's a pretty positive thing. In fact, I think it was a leading figure. I know that we're leading overall in the recruitment of doctors compared with other provinces by a figure that, I think, is 22.5 per cent. To put that sort of differently, we're doing better at recruiting and filling some of the positions that you're talking about than we were before.

Yes, there are some specific policies and specific dollars allocated toward increasing that even more. I was reminded just recently that at one hospital, for example, in Calgary, as many as 20 to 25 per cent of people coming into emergency on a given day reported that they did not have a family doctor to go to. As part of that equation, too, we also have to take a look at what kind of relationships some of those patients are or perhaps are not establishing with medical centres, where some of them might like to go, and how many of them were or were not aware of the Health Link line for that kind of help.

I mean, it's a related point to having more family docs, but those are some of the measures that we're looking at right now to increase the efficiency and effectiveness of our five-year funding plan.

Mrs. Forsyth: Okay. So get me the information on the family doctors, your increases in years 1, 2, 3, 4, and 5.

Again, you talk about what your role is, what Alberta Health Services' is. I'd really like to understand. They know the money is there years 1, 2, 3, 4, and 5. How are they going to address what I said to you earlier: the efficiencies, increasing patient access, and optimizing health services for Albertans? So you've got your arm and their arm, and somewhere the two arms should come together so that you have a plan to deal with years 1, 2, 3, 4, and 5.

Mr. Zwozdesky: And that's exactly the point of the five-year funding plan, too, in part.

Mrs. Forsyth: If I may, I'd like to go on. I want to talk to you just briefly – Dr. Taft asked you a question when you were talking about the deficits, and you alluded to the three provincial boards that had deficits: the Alberta Cancer Board, AADAC, and the Alberta Mental Health Board. I sat on the Mental Health Board, and I know that Fred also was involved with the Mental Health Board. I could be wrong, but it seems to me that when I was on that board, we didn't have a deficit at that particular time.

8:10

Mr. Zwozdesky: I just want to clarify. I did not say that those three boards had a deficit. What I said was that the previous regime, which was nine regional health authorities, and the three boards together – I mean, some of them were running in the black, as you know, and some weren't. I was just making a global comment about the older regime.

Mrs. Forsyth: So it wasn't the three provincial boards that had the deficits.

Mr. Zwozdesky: No.

Mrs. Forsyth: It was the nine regional health authorities.

Mr. Zwozdesky: Yeah. To be clear, nine regional health authorities and the three provincial boards – and then I explained who the three boards were – together, lumped all together, had accumulated $.34 billion worth of deficit.

Mrs. Forsyth: I just want to clear up on behalf of the Alberta Mental Health Board, that had very dedicated professionals on it, and AADAC, that I've done a lot of work on in the past: those two particular boards, to my knowledge, did not have deficits. They were very fiscally responsible from what I understand.

Mr. Zwozdesky: You're probably right, hon. member. I looked after AADAC when I was first appointed as the associate minister, and I don't recall them functioning with a deficit either. But I have information going forward as opposed to looking backward. I'll review your question in *Hansard* and just see if there's something I can augment with.

Mrs. Forsyth: Okay. I want to talk about sustainability of the publicly funded health care system. While Health and Wellness acknowledges that the escalation of costs – and this is in your book, again, under Significant Opportunities and Challenges, sustainability of the public health care system – jeopardizes "the continued viability and affordability of the system," how do you propose to deal with this issue?

Mr. Zwozdesky: I don't know if I've got the question quite right, but I want to make a comment that's related to it, at least, and that is in terms of the sustainability of the health system. You know, I indicated that as a government we took some very bold steps, which weren't all that easy to take. One of them was to eradicate a $1.3 billion deficit. The other was to make the system whole by looking at what adjustment it was necessary to make to the base. To put that in different words, we asked the question: how much does it cost to run this first-class health system? The answer came back: just under $8 billion on an annual basis. I'm talking about the Health Services arm. So we made it whole and raised it to $8.5 billion because that's what it takes. Then we said: what's it going to take to run it in the future? That's where the 6 per cent comes in for the first year.

Now, the reason I stopped to point that out is because I think that now with one provincial board there are some advantages, clearly. One of them is more consistency in information gathering and more consistency in data and statistical inputting so that we have the whole province, so to speak, talking in a more similar language than was done before. I don't ever want to be critical of the previous nine health authorities because they each did a good job under different circumstances, to whatever degree. What we found, however, was that the information wasn't coming in on a consistent basis in a consistent language and so on that was easily translatable at the provincial level to make those rapid decisions that needed to be made when you were making policy moves or budget moves or strategic direction moves at the provincial level.

So they came back and said: $8.5 billion. We added the 6 per cent. That's why I say that that's a comfortable number, that the government has said looks like a good plan going forward. We said: what will you need next year? They said: another 6 per cent and another 6 per cent and then 4.5 per cent in the two out-years. So that's how that was arrived at. It was done exactly with your question in mind. Will that ensure sustainability, and secondly, will it ensure that we don't have any more deficits? Well, barring any more epidemics or other disasters or other unforeseen circumstances, the answer is: yes, there will be no more deficits; yes, the system will be sustainable.

The Chair: Thank you, Mr. Minister.

We have to move on now to Mr. Brian Mason.

Mr. Mason: Thank you very much, Mr. Chairman. Mr. Minister, I'd like to start by asking about your commitment to establishing more transparency and really clear performance measures. There are a number of health indicators that used to be available on your department's website that are no longer available. The Alberta health care insurance plan used to have a registry of data on home care, but that's no longer available. Health and Wellness used to report on physician billing but no longer does. There used to be a government website that had data that tracked waiting lists, but the website is no longer available. There used to be an audit that the government would publish dealing with the demographics for people in long-term care facilities, but this information is no longer available.

Today in the House a written question asking for the number of Albertans on wait-lists for long-term care and the age range of those individuals was denied because the government said it didn't have that information. I wonder if we can have your assurance that the collection, analysis, and public dissemination of this information will be restored immediately.

Mr. Zwozdesky: Your first point about my commitment to more transparency: absolutely. We're doing a lot to have a more accountable framework in place, a more open and transparent process in place, and I commit to that absolutely. We have to just remember, though, as we're asking the question and answering it that everything is not quite as easily arrived at as one would like.

Mr. Mason: They were available before, and now they're not.

Mr. Zwozdesky: I've got an example here for you. I'll review that point. I'm dealing with another hon. member around the table here who wanted information about which doctors were consulted with

respect to the increased surgeries that we're doing between now and the end of March. I don't see that as a problem to release whatsoever. However, I have to respect doctor confidentiality here, too, so until I get sign-off from those who will give it, I can't release that information. I'm pledged to try and do the best I can to release as much of it as I can, but I don't do it in a silo. I have to do it respecting confidentiality and privacy laws.

With respect to clear performance measures the short answer is yes, we are doing everything possible to make sure that the performance measures are not only clear and concise but that the general public understands them and buys into them. That's part of what the Member for Edmonton-Rutherford is doing with the blueprint for action, for example, engaging the public on a more regular basis with respect to the four recommendations that we've accepted on behalf of government coming out of the Minister's Advisory Committee on Health.

Regarding your point about home care stats or data, whatever, not being available right now, I'm told that the statistical supplements, which are produced by Alberta Health and Wellness, are available.

With regard to the wait-list registry, I've mentioned this point myself, hon. member. One of the problems that we had was that we couldn't get the information coming in to us from all nine regions in that consistent fashion that we desired. As a result, everybody was speaking just a little bit different language, and as a result, the Alberta wait-list registry, I believe it was called, had to be taken down. We're working on resurrecting it because we now have the information coming in a little more consistently, or perhaps we're asking for it more consistently, whatever the case. But the point is that it had to be taken down because it wasn't consistent. As soon as it's ready, it will be back up and running.

Wait-list information, in fact, is produced by Alberta Health Services, as you probably know. As that data is getting improved, so, too, will the use of the information and the availability of it for the public. We're also going to be including performance measures in a very public way in that discussion. That will all come forward.

Regarding the question that was asked in the House today, I was busily preparing for my estimates, so I drafted the response to it, but I'll get my executive assistant to just provide me with a copy of those notes if possible, and I'll get it to you before the end of this meeting.

8:20

Mr. Mason: Okay. I think, Mr. Minister, this was not about privacy, you know, because it doesn't deal with individuals. It's data about the performance of the system that's really important to people, like wait times. It's been some time now. How long has it been, Kevin, since we got rid of the nine regions?

Dr. Taft: A year.

Mr. Mason: It's been a year. Surely to goodness the problem of nine different entities reporting in different ways was solved some time ago, so we should be getting this back up. I'm going to leave that because I have to move very quickly because I only get 20 minutes. There are five very specific types of information that was provided and in one degree or another has been curtailed or eliminated altogether.

I want to ask what the compensation is in this proposed budget for the board, not the administration but the board of Alberta health.

Mr. Zwozdesky: Alberta Health Services?

Mr. Mason: Health Services. That's right.

Mr. Zwozdesky: My recollection is that the chair gets paid about $60,000.

Mr. Mason: The total compensation, including what it takes to run the board, so board secretaries and stuff.

Mr. Zwozdesky: I was just going to comment on the stipends.

Mr. Mason: Yeah. I know the individual costs.

Mr. Zwozdesky: You're talking about expenses: hotels, meals, and so on.

Mr. Mason: Yeah. The total compensation package of that.

Mr. Zwozdesky: Well, the first part of the answer, just to answer some of it at least – my recollection is that the chair gets approximately $60,000 a year as a stipend, and board members are around $40,000 a year.

Mr. Mason: Does that include per-meeting costs?

Mr. Zwozdesky: No.

Mr. Mason: They get paid per meeting, too, don't they?

Mr. Zwozdesky: Well, we'll get the exact number for you.

Mr. Mason: Okay. I'm just going to go on the assumption here, since we don't have a specific answer, that it's a lot when you add it all up. I'm just taking a wild guess. My question. I'm going to take what Dr. Taft has said and just take it a bit further. Why do we need a board to run Alberta Health Services?

Mr. Zwozdesky: You know, I answered that earlier, but I'll just answer it again. The delivery of the actual services and the prioriz-ing of who gets the service, when they get it, and where they get it is best left up to the people with the medical experience.

Mr. Mason: That's not the board. I know who's on that board, and it's not any medical people.

Mr. Zwozdesky: Let me just finish my point. I'll start over. The best position here is to remember that decisions regarding medical procedures – where they are done, when they are done, who does them, and so on – are best left to the people with that particular expertise. Those are, clearly, the people who are the doctors. The people who design the funding that goes here and goes there and so on meet with those folks. They decide how some of this gets done, and that's without any political interference whatsoever.

That's what I was talking about earlier, hon. member, and that's why you have these two arms. You have one arm that looks after the delivery of the service without any political interference. They decide those things I've just mentioned. On the other side of it we decide the policy, the budget, the legislation that is needed, the regulations that are needed, the strategic decisions, and so on.

I don't know how many more times I can try to clarify how that works, but that's why you have to have the arm's length. In order to have that be effective, you have to have that board in place because there's still a lot of information to be collected and some directions that have to be set at that level.

Mr. Mason: I'm sorry, Mr. Minister, but I'm not buying it. You know, I would suggest to you that the reason that they put a board in

place and that the composition of that board is such as it is, with executives and CEOs and so on, was because the previous minister was pursuing a business model, which he said in the House, you know, a number of times, for health care and that these people were going to be trying to operate health care as a business. I'd like to ask you as the new minister if you think that that model is the right model for our health care system.

Mr. Zwozdesky: Well, it's the model I've got. It's the model I'm working with. It'll remain to be seen whether it's as good as we're hoping it will be.

Mr. Mason: So you're still hoping that it'll work out?

Mr. Zwozdesky: Let's remember two fundamental things, okay? The first fundamental thing is that the amalgamation of all nine plus three boards under one province-wide board was done at a time when there were projections for a $1.3 billion deficit to be addressed. So they had to bring in a blend of people who had experience in running operations of a massive nature. I mean, we're talking $8 billion, $9 billion here. You want people, certainly, who have medical expertise, and there is somebody there with that. You want people with accounting expertise. There are people with that. You want people with business savvy. All of them have some of that, I'm sure. Some have more than others in terms of experience. You want people who have experience in engineering and chemistry and the whole gamut. That's what you needed at that time.

Now, there are three or four vacancies on that board right now, and we'll be filling those fairly soon. I think the application deadline is March 26 or thereabouts. There are some positions available now. We've got about a year and a half, two years almost of experience with the board, such as it is, and I think we know now where you're looking to see what other, additional expertise you have to have in there. There are some people with legal expertise and so on that are needed.

Mr. Mason: Again, I need to move on. But my advice would be, you know, axe the board and replace it with the deputy minister, and let's get on with things.

I want to ask about Dr. Duckett's model for health care that he has been pursuing. Now, he's written a number of papers in Australia, and he's got a very strong model that he has written about and defended. He was actually never in a position to fully implement that model in Australia. Only Alberta has given him the opportunity to do that. It involves, basically, stripping nurses out of the system and replacing them with other people, not just LPNs but in many cases just nursing aides. For example, instead of having registered nurses active on the unit, there would be one, and he or she would supervise.

Already we have in our system where medications, for example, are done at a central location and sent out. But they're not administered by a nurse; they're often administered just by a health care aide who is just following the instructions. So there's no direct observation of the impact of medications on a patient whose condition might be changing, for example, or might be having a different reaction, might need more, might need less of the medication, might need something else.

This whole approach reduces the number of trained medical professionals and the skill levels in the system as a way of saving money. I want to know, Mr. Minister, from you if you endorse that model and are going to continue to support Alberta Health Services, its board, and its chief executive in the pursuit of that approach.

Mr. Zwozdesky: You know, Mr. Chairman, I don't know of anyone who is pursuing a direction where the changing needs of a patient or the changing conditions of a patient would be ignored. That is contrary to what we're trying to do. I'm very surprised to hear you say that. If you have specific examples and can back up what you're saying, I would be very interested to see it.

Mr. Mason: We will provide it to you. Certainly, in our meetings with professionals and with professional associations they've told us that the way medications are administered in larger hospitals is that the doctor prescribes the medications, the medications that have been prescribed are assembled and packaged by pharmacists at a separate location and then sent to the ward where the patient is, and these medications are then administered not by registered nurses, sometimes by LPNs, but very often just by a health care aide. Now, that may not be correct, but that is what some people who certainly should know have told us.

The model that Dr. Duckett has been pursuing is based on finding cost savings primarily at the expense of eliminating large numbers of registered nurses from the health care system. The basic question I'm trying to get at here is whether or not you agree with that approach.

8:30

Mr. Zwozdesky: Well, I've not heard of that approach.

Mr. Mason: I'll send you some of Dr. Duckett's writings on this.

Mr. Zwozdesky: Yeah. Well, I don't know. I just can't imagine that there would be anything going on that would deliberately compromise patient quality or patient care or patient safety. It sounds to me like you're alluding to something in that vein, which I very much disagree with.

Mr. Mason: All right. Well, we'll send it. When the objective is to cut costs and reduce costs from the system, then that's what people will do if that's what they're incented to do.

How's my time, Mr. Chairman?

The Chair: Four minutes and two seconds.

Mr. Mason: Holy smokes. Okay.

On activity-based funding there's been some research, and it's a little mixed. There are some apparent benefits in some places, as you mentioned, from activity-based funding, but there are all sorts of games that are then played, and the tendency is for a concentration of services because as people specialize, they get better at it. I think Dr. Taft alluded to that.

Some of the research we've done says that health care researchers call practices by hospitals to tweak their practices to maximize earnings under that system "gaming." There are three that are mentioned here. One is to favour simple cases over more time-consuming and complex cases, a practice known as cream skimming or risk selection. Another form of gaming is upcoding: fraudulently placing patients in more lucrative payment categories.

In August of 2007 a news release from Canadian Doctors for Medicare warned that an overdependence on activity-based payments would also erode hospitals' commitment to providing a full range of services to all patients and reduce efficiency through higher administrative costs. There are a number of other things that can be done, too. You set a system where certain things are rewarded and other things are not, so the people are pursuing more funding under that model, and they can do that by playing some of these games. I

just wondered if you had had a chance to review some of the research that indicates the real limitations in this.

Dr. Michael Rachlis is a health policy analyst, and he teaches at the University of Toronto. He said that:

> In the late 1980s Ontario applied activity-based funding for a small portion of overall hospital funding. Administrators pressured staff to discharge postpartum mothers and their newborns first because they were designated for the lowest payment. Hospitals cut their length of stay by 40 per cent. As unprepared mothers went home early to inadequate community services, the readmission rate for newborns surged by 60 per cent.

There are a lot of pitfalls, Mr. Minister, and I would really suggest you make sure that it's studied from all angles before you give your okay.

Mr. Zwozdesky: Do I have 30 seconds?

The Chair: You've got one minute.

Mr. Zwozdesky: Okay. You know, a valid point that you raise on the readmission possibilities, and I've raised this as well myself. I said that we have to be extremely careful when we do any kind of rejigging of the system, be it on the financial side or the policy side or wherever, to make sure that we're not putting anyone at risk, to make sure that we're not rushing people through the system, and to make sure that we're not accomplishing one thing on one side of the equation while inheriting a bevy of problems on the other. That would include not wanting problems of increased readmissions because of early discharge or because of other complications or whatever. That's not the kind of system that is being attempted to be set up.

With respect to the comment about favouring simple cases over complicated ones, I mentioned in my opening comments – I think it was in there – or in answer to a question that we are taking steps to ensure that that is not going to occur so that this is going to be a fair funding model that doesn't rush people through and isn't focused totally on the bottom line.

Having said that, let's also remember that you have to look at the system for some efficiencies somewhere. I'm all in favour of looking at efficiencies as long as it doesn't compromise patient care, patient quality, and patient safety. I'm willing to listen.

Mr. Mason: Me, too.

Mr. Zwozdesky: I know you are.

The Chair: Thank you, Mr. Minister. The time is now up.

We will move to Mr. Fred Horne.

Mr. Horne: Thank you, Mr. Chair. Good evening, Minister. I'd like to talk about a couple of areas over the next few minutes that you've commented on quite extensively since your appointment. They both have to do with what I think are some of the opportunities open to us by moving to a single governance model for our health system, and that is specifically making some policy decisions that we want to apply across the province and ensuring that the benefits accrue to all Albertans regardless of where they live.

The first area I'd just like to spend a little time talking about is your recent announcement of a six-week plan to reduce waiting times. You came out very early on this after the budget and the announcement of the five-year funding plan for Alberta Health Services and suggested that it should be an early priority for us to target some of these additional funds toward reducing waiting lists for high-demand procedures, specifically areas like heart surgery, orthopaedics, neurosurgery, cataract surgery, and others. I just wondered if you'd spend a little bit of time commenting, first of all, on why that decision, why that early priority. Secondly, I believe you've hinted that we should expect a second push on some of these procedures later this spring. If you could tell us a little bit more about that. Are there any early results you can report on for the push that's currently under way?

Mr. Zwozdesky: A good question. Thank you. You know, if we're going to arrive at the best performing publicly funded health care system in Canada, you've got to pick a few starting points, and you have to pick a few areas, in my view, where not only are you going to be able to accomplish something toward that objective, but you're also genuinely providing increased and improved services for Albertans.

I don't know if there's anything more frustrating to a lot of people in this province than having to sit and wait in a long lineup. I don't care if that's at the emergency department or if that's waiting for an acute-care bed to open up upstairs or if that's waiting to see a specialist or if it's waiting for an important surgery: cataract, hip, cancer, whatever it might be. That having been said, we looked at that whole issue very, very seriously, sat down, and said: "What can we do to unclog, to debottleneck the system? What can we do right now while we have a little bit of room financially and while we still have the benefit of this year ahead of us for another couple of weeks till the end of March?"

That was one of the strategies that we came up with, looking at increasing the number of surgeries. It was done in tandem by Alberta Health Services with health facilities across the province, where applicable, and with the docs and the staff and others who are all part of that continuum. In the end it was determined that 2,230 surgeries, as defined in the accompanying document, could be done, could be done safely, could be done effectively, could be done efficiently with the $8 million provided. So that's one of the things we're doing.

There's more to it than that. That's why we're looking at these additional things to help reduce wait times, such as the medical assessment units, which I've talked about quite a lot. I won't spend a whole bunch of time on it. Basically, when people come into the emergency department – and while I don't profess to be an expert, at least I have visited nine of them in the last eight or nine weeks, and I have a first-hand familiarity with it to the degree that I was able to get it.

All of them told me, whether it was the triage nurses or the docs or others involved in the system, that you have a bottleneck right here, right now, and I saw it. It's partly in the lounge waiting area. It's partly in the next step, where you go to the major side if you're really in serious trouble or you go to the minor side if it can keep and hold for an hour or two or whatever. Then you have the next problem, which is waiting in sometimes uncomfortable circumstances for the next step, and that is going upstairs or whatever. So they came up with this interim step that provides a bed right there that is still supervised called a medical assessment unit, where people can be looked after, and while they're being moved to that bed, it frees up the space all the way back to the lounge area where the people first come in. That's another important activity.

8:40

With respect to the Children's hospital in Calgary, I think I said that there's an example there of the flow beds that were recently announced, flow beds at the Alberta Children's hospital. They were introduced in September of 2009. It's a transitional triage area

where emergency department doctors and nurses can quickly assess children and determine the need for further treatment. So that's another initiative to help debottleneck the system while always focusing on patient care.

There will be more of these coming, but I'm just talking about the short-term right now, to the end of March, on the first couple of examples. But we have to continue that forward, and that's why in the press release we made a very specific point of saying that this is just the beginning. Now, we've got April, May, June – that's another part of the plan – and then we've got the rest of the year, and then we've got the whole five years to work with. So there's a lot of positive stuff that we'll be doing to help address the issues that you're referencing, hon. member.

Mr. Horne: Okay, thank you, Minister. Just a little further to that, then. We've seen you take advantage of early opportunities to reduce waiting times for some selected surgery where the capacity existed. How is this, coupled with the five-year funding plan, going to translate into reducing waiting times in the long term? I guess there are two parts to this. There's how we use the funding and how we use policy decisions to target specific surgeries that are very high demand. But there's also the part you mentioned earlier, and that's knowing what the waiting times actually are. I think you said in an earlier answer that it was your intention to try to reinstate the waiting list registry and to make it accurate.

Mr. Zwozdesky: Could I jump in just on that point? I saw that wait-list registry. I had referred people to it, and other people who were here at the time when it was introduced probably did the same. It worked extremely well. I'm just profoundly disappointed that it's not up and running yet. There are some logistical complications with it, but we're solving those. One of my personal priorities, if I can put it that way, as minister is to try and get that service up and running.

There are qualified, capable, caring, professional doctors throughout this province who can provide some of the services that people are waiting for in the major centres, and they can be provided in some of the smaller centres. Hips and knees and other ortho type services, for example, are available in some of our surrounding areas. I've just forgotten which ones specifically, but I remember Wetaskiwin, Ponoka, Camrose, Pincher Creek, and the list would go on, you know. But how would people know that? How would people know that? Their instinct is not to sort of phone the mayor of Camrose and say: can I come out there for a hip operation? I mean, that's not their instinct. Their instinct is to go to their doctor and to have the operation done right where they are. But there are very good premises elsewhere where that can be provided. So that's a priority.

In terms of the other part of your question, you know the dashboard indicators program that I talked about. You know about the Health Quality Council reports that were there. I have to tell you that when I travelled to these I think it's nine hospitals so far that we've been to – the hon. Member for Edmonton-Meadowlark and I in particular went to see these places, and of course he's recognized at every one of them because he is an emergency doc from the Royal Alex as well as being an MLA, which is very helpful to me. They all told us: if you want to unclog the system, we'd be happy to sit down and talk with you one on one in a longer discussion to see how that can be done.

The medical assessment units is one of those ideas. The flow-through beds is another. I suspect there will be other ideas. I would never pretend to say that I or the executive team have all the brightest ideas. But when you talk and meet with doctors, which we've met with – oh, I guess in terms of appearing before some and others in private meetings, it's probably over 200 so far – we're getting some great ideas on how we can come closer to establishing, for example, national standards. I'll be raising that at the federal-provincial-territorial ministers' meeting in September, which I think is in Newfoundland. We want to get down to: what is an acceptable wait time in an emergency area?

Now, I know that there are some percentiles that we have to work with here. We're doing extremely well in a lot of them, but we're not doing very well in a few of them. Still, the overall picture is pretty good, but it can be a heck of a lot better. We want to get it down to a reasonable wait time. I've outlined some strategies, how we're going to get there.

The final comment I'll make is this. The five-year funding plan: I'm holding out a lot of hope for that because tied to it is a lot of increased funding and tied to it, again, are performance measures that we want to see results. Perhaps more importantly, we want Albertans to experience those results.

Mr. Horne: Thank you. I have one other question, Minister. I'm not sure how short of time we are, but another policy area that you've talked about extensively – and it's actually an innovation here in Alberta – is the establishment of our primary care networks. As I'm sure everyone around the table knows, these are multidisciplinary teams that are dedicated to providing primary care in a given community. They all include physicians. They can include and do include nurses, pharmacists, mental health professionals, and others working together to deliver a variety of programs. They're very flexible, Minister. There has been a lot of innovation developed since these were first established in 2003.

An important policy question going forward is: how are we going to leverage this to provide even more care to Albertans in their own communities? I wonder if you could comment a bit about what policy direction you'll be giving in that area, how much coverage we have now in the province with PCNs, and how you see that growing.

Mr. Zwozdesky: I'm grateful for that question, Mr. Chair, because I am very passionate about PCNs. The ones that I've seen so far convince me that that is a good model to go forward with. Just for the clarity of the question, we're talking about a team-based approach where a patient comes into a particular facility and is met perhaps in the usual fashion but has at his or her disposal immediately access to a physician, perhaps a dietitian, perhaps a physiotherapist, perhaps some other clinician, perhaps an optometrist, perhaps a nutritionist, et cetera. The teams are a little bit different depending on where you go.

Now, that's what's called primary care networks. We have 32 at the moment that are up and active throughout the province of Alberta, and I believe we have 11 that are under way. We'll probably be announcing another one within days. We have also a budget to back it up. I think somewhere in your document is about, if my memory serves, $170 million or $171 million for the primary care initiative, and that's by and large primary care networks. They work extremely well.

You know what, hon. member? In some cases the patients themselves have actually told me that they were so pleased with what was going on there that they'd found out they didn't actually need to see a doctor. They didn't need to engage the higher paid person at the site because they got the information they needed from their nutritionist or something akin to that, depending on what it was. So you'll see a very strong commitment in this budget to continuing with the primary care network initiative.

Mr. Horne: Thank you, Mr. Chair. Those are my questions.

The Chair: Thank you, Mr. Horne.

We'll now go back to Dr. Taft, please.

Dr. Taft: Thanks very much, Mr. Chairman. Several more questions. I'm sure everybody here regrets we couldn't go till midnight.

I'm going to start just by letting you know, Mr. Minister, that when it comes time to vote on this budget, I cannot support this budget. I just feel as a legislator that it's too murky. A single line with $9 billion on it just leaves me deeply concerned. The answers that you've provided, while they're well intentioned and so on, make it feel very much like it's a work in progress. I just can't live with that, trying to be a responsible MLA. So when the time comes to vote on this, for what it's worth – I expect you'll manage to get it through anyway – I won't be supporting it.

A handful of specific questions under this budget. I am still getting concerns from family members of people who are in . . . [interjections]

Mr. Zwozdesky: By the way, you can speak. I listen. I'm a conductor, and I listen to all the instruments at once, so you go ahead.

Dr. Taft: Okay. I'm getting concerns from family members of acute patients in Alberta Hospital that they are still under pressure to provide basic personal supplies: toothbrushes, soap, deodorant, things like that. In some cases staff are having to step in out of pocket because, as you know, some of these patients do not have family members. So I would ask you this straight out: is there money in this $9 billion to provide basic personal items like toothbrushes and soap and such for people who are in Alberta Hospital Edmonton and, for that matter, other equivalent facilities?

8:50

Mr. Zwozdesky: I'm sure that within a $9 billion budget for Alberta Health Services, there is room for those basics where they are provided for.

Dr. Taft: Okay. I will pass that back to the people who have brought it to my attention as recently as the last few days, and I'll hold you to account on that.

Mr. Zwozdesky: You bet.

Dr. Taft: My second question is around cancer care delivery. For me one of the most disturbing decisions in the last year was the disbanding of the Alberta Cancer Board. It was, in my experience, very credible, had tremendous public support. As an MLA I virtually never had concerns with it, and if I did, they were quickly addressed.

I am hearing from people in the cancer care delivery system that with the disbandment of the Cancer Board we are seeing, in fact, a fragmenting of services, so what was once a coherent cancer delivery system is getting broken into silos. Mr. Minister, an example would be that pharmacy under cancer delivery is pulled out from control by cancer delivery specialists, and it's in a different part of Alberta Health Services. Radiology has gone in another silo. Even things like security systems are being run from somewhere in rural Alberta, and on it goes. I'm getting very serious concerns that what was a coherent cancer delivery system is now becoming a group of silos administered as fragments. I would ask you, Mr. Minister: is there any consideration in this budget to restore the Alberta Cancer Board so that this province has a coherent cancer delivery system?

Mr. Zwozdesky: I have to say that I, too, was a fan of the Alberta Cancer Board, particularly the one here. I had personal dealings there when my father was there, with the Cross Cancer, I should say. They were very glowing of how the system was managed, and I thought they were doing a pretty good job. However, it was felt important to bring it all under one roof, so the three boards that I alluded to plus the nine regional health authorities were amalgamated for the reasons of the day.

Now, to my knowledge there is some discussion about how to improve and streamline some of the to and fro-ing, if you will, some discussions with improvements that are necessary to be made. In fact, I had some discussion with some cancer docs just last week in that regard. There is money in this budget to fix a lot of things, and if there are some shortcomings in that regard, hon. member, I'll read your comments again more carefully in *Hansard* and get back to you. I hear what you're saying about the siloing. I'm not aware that that's going on, but I will review that.

Dr. Taft: I'm hearing this not only in cancer delivery but in other areas as well, that the coherence of particular delivery sites has been shattered and that you have all these streams reporting up and out to somewhere else rather than working locally, but it's most vivid in cancer care. Frankly, this is not an issue of spending more. This may well be an issue of spending less, of being more efficient. When you have radiology and pharmacy and surgery and everything else working together under a coherent system, it's going to have better outcomes and cost you less. If you came forward with the notion to restore the Alberta Cancer Board, I would be the first one to give you big hugs and kisses.

Mr. Zwozdesky: That could be a very scary thing.

Dr. Taft: That might have the wrong effect.

Related to this are questions around the capital plan. This is one of the reasons I just feel I cannot support this budget, unless I'm misunderstanding, and I may be. I may be because it's a bit confusing to read. Some of this budget is for capital projects. [interjection] None of the $15 billion is for capital projects?

Mr. Zwozdesky: Well, there are two kinds, hon. member. There is approximately 90-some million dollars, as I recall, in this budget, which is our piece of the action.

Dr. Taft: Okay. So the rest of it is all under Infrastructure?

Mr. Zwozdesky: Yeah. There's sort of $2.5 billion overall. This coming year I think you'll see roughly $628 million for health facilities and a couple of related things in the Infrastructure budget.

Dr. Taft: Terrific. My question is around how that list of capital projects is determined. Of course, there's been debate on this in the Legislature in the last couple of weeks regarding the Tom Baker cancer centre, the QE II in Grande Prairie, et cetera. How will you determine what's on the capital projects list?

Mr. Zwozdesky: There is a lot to this answer. I'll just give you a couple of points. One of the central components is called the community needs assessment, and in all of the cases that I'm aware of, those community assessments have been done. As part of that community assessment you're looking at what kinds of services are required where and when. You're looking at population growth. You're looking at specific issues. Some of them might be aboriginal related, for example. There are a number of factors that are part of

that. Then you've got other factors in there, such as age of the population and so on.

Dr. Taft: I understand that part of it. I'm sure that by the time it gets to the preliminary list, all of that background work is long done.

Mr. Zwozdesky: Exactly.

Dr. Taft: To get from the preliminary list to the final list, so there's a shovel in the ground: do you decide that? Does the Premier decide that? Does the Minister of Infrastructure decide it?

Mr. Zwozdesky: It's a little bit of all three, but it's essentially my lead as minister for health.

Dr. Taft: Okay. If you come forward and recommend something, odds are it'll get accepted.

Mr. Zwozdesky: Yeah. Anything that is health facility related has its genesis and its conclusion in this ministry, but we do it in tandem with the people you've referenced and the ministries you've alluded to.

Dr. Taft: Okay. There are two specific facilities. I don't know if you can comment on them now or come back to me. One is the east Calgary health centre, and the other is the one up by the Cromdale Hotel. Is it the urgent care centre?

Let's just talk briefly about the east Calgary health centre. Do you have a sense – or could you follow up and tell us – when that would be fully operational?

Mr. Zwozdesky: Yeah. I'll get you an update on that, hon. member.

The other one that you're talking about might be the new East Edmonton health centre, which just opened a few weeks ago.

Dr. Taft: That's just the one.

Mr. Zwozdesky: That's approximately 112th Avenue and 82nd Street, thereabouts.

Dr. Taft: That's the one, yeah. My understanding is that it's not doing what it was originally intended to do. Is there a chance of that original vision now under this budget being fulfilled?

Mr. Zwozdesky: Well, you know, hon. member, according to my notes it's an urgent care centre and a family medicine centre, which is still being developed in part. It's a centre that houses many different providers working together on mental health, dental, home care, AADAC. It's the first initiative of its kind. It's also got children's services located on-site, and two-thirds of the new facility is now occupied, so there's still a little ways to go.

Dr. Taft: Okay. So you have the money in here to fulfill that initial vision? Is that what you're telling me?

Mr. Zwozdesky: Well, I can't make any announcements here tonight, obviously. I'm just saying that I am aware of that one. I am aware of the Calgary east centre as well and the South Calgary campus and the Tom Baker and Grande Prairie, and the list goes on from there. But we haven't made the final decisions yet is all I'm trying to tell you.

Dr. Taft: Okay. Some of it's capital money. Some of it's operating. My question might have confused the two for you.

Mr. Zwozdesky: Exactly. That's a valid point. In 20 seconds or less, you know, you have to be really careful in these decisions to fund a capital project by making sure that you've got the operating dollars and the maintenance dollars to make good on it. That's part of the equation here.

Dr. Taft: Right. Okay. Two other quick points, if I may, because I'm sure others want to speak. You mentioned, I think, even in your opening comments – and certainly this has come up a number of times – that Alberta Health Services saved money when it consolidated functions like purchasing, I think, human resources, et cetera. Now, we've raised this issue. We've asked for specifics from Alberta Health Services. The most we got was a mention on I think it was IT and human resources and on purchasing. Dr. Duckett said they'd save money on standardizing how they purchase egg products.

9:00

Will you be able to provide a detailed list or have you even received from Alberta Health Services a detailed list of where all these several hundred millions of dollars in claimed savings came from? Where are they? I'm sure it's not just from buying eggs more efficiently. I've put it to Dr. Duckett; I've put it to others: give us the list. It could be wonderful news. If it's real, it's wonderful news. If they've saved hundreds of millions of dollars through efficiency, let's trumpet it. But if they're not trumpeting it, then I start to say: gee, did it really happen? Well, have you seen the list?

Mr. Zwozdesky: I have not seen the list. I don't know if there is a list. What I know is what they've told me and what I've passed on to you and to others, and that is that by having one central provincial-wide board, there are some efficiencies that they are predicting are several hundreds of millions of dollars. I've explained what they were: central payroll system being one, one CEO instead of 12, bulk buying or common procurement being another. The list goes on, I assume anyway.

Dr. Taft: Well, maybe it's just my oppositional nature. Show me the proof.

Mr. Zwozdesky: Yeah. That's fair enough.

Dr. Taft: I would ask you to put that challenge to Alberta Health Services. Hundreds of millions of dollars is a lot of money.

Mr. Zwozdesky: You bet.

Dr. Taft: Let's see it. Itemize it.

Last question. When you revise the memorandum of understanding between yourself and Alberta Health Services and Alberta Health and Wellness, in the interest of public accountability and disclosure will you share that as this one has been shared?

Mr. Zwozdesky: I can't see why not. As I say, that's just a discussion that's going on right now, and it's under development. But under the guise of openness and transparency I can't see why that wouldn't be available to you.

Dr. Taft: Okay. I appreciate that.

Thank you, Mr. Chairman.

The Chair: Thank you, Dr. Taft.

We'll move to Mr. Dave Quest now, please.

Mr. Quest: Thank you, Mr. Chair. A few questions; a couple of line items that kind of caught my eye, Minister. There are a lot of things that we do very well in our health care system. One of them is that our wait times for CAT scans and ultrasound in this province are amongst the shortest in the country. Looking on page 235, line item 10.0.4 under infrastructure support, diagnostic medical equipment: a very significant, huge reduction in our commitment to that equipment. I'm just wondering what our plan is, then, with that kind of reduction, how we're going to ensure that we keep the wait times as short as they've been for those diagnoses.

Mr. Zwozdesky: Yeah. Good questions. The forecast for 2009-10 of $83 million is a one-time coverage of some outstandings that they had. That's what the $83 million will do. Going forward, we've made a provisional allowance because we know that some additional or new or replacement or whatever diagnostic medical equipment will be needed. In fact, I'm hearing some of that, hon. member, as I tour the province right now. We've made a provision for about $25 million. But the $83 million was a one-time bailout, if you like.

Mr. Quest: Okay. Another line item. Now, this one is going the other way. Health services provided in correctional facilities: not quite double from last year. I'm obviously wondering what's happening there. That's page 235 also. It's line 7.0.7.

Mr. Zwozdesky: Yeah. My recollection of that one, hon. member, is that the health services in correctional services are being transferred to us from Solicitor General, and we in turn are giving it over to Alberta Health Services. I think that's correct. That's my recollection of it anyway. That's why you see – where are those numbers? – line 7.07. That's what we're doing in regard to health services in correctional facilities. If you want more on that, hon. member, I can undertake to provide it, but if you're comfortable with that, then . . .

Mr. Quest: Well, as long as there's a corresponding decrease in Sol Gen, I guess it makes sense.

Mr. Zwozdesky: Oh, yeah, there would be. There would be a $25 million hole in their budget.

Mr. Quest: Great. Okay.

Just switching to pharma 2, then, if I can, we know what was going on with the cost of prescription drugs and what continues to go on with those. Of course, we have now capped or reduced the rebate amounts to pharmacies, which is good. But I know a number of us, especially some of my rural colleagues, have been hearing a great deal from their pharmacists about what that's going to do to their viability. I'm just kind of wondering what you're going to do to ensure that our pharmacies do actually remain profitable and sustainable without these rebates.

Mr. Zwozdesky: That's a very good question. A couple of things. First of all, Mr. Chair, the rebates are expected to be reduced. What we reduced was the cost of new generic drugs from 75 per cent of the brand name to 45 per cent for new ones, those that are not yet on stream as of whatever the date of the announcement was.

The second thing that we recently announced was a reduction from 75 per cent to 56 per cent of brand name drug prices for existing generics, those that were there, obviously, prior to the announcement. Now, in addition to that, however, we also said we would help pharmacies by bringing in an additional $3, $2, $1 formula for prescription drugs that are under $75. It'll be $3 more per prescription in the $10.90 category, $2 more per prescription in that category in the second year, and $1 in the third year. The question is: is that enough, and what would the fourth year look like? That's the deal that we're looking at bringing in here.

Secondly, to recognize that there are going to be some difficulties in remote-and-rural areas – and that should all be hyphenated – there is a one-time provision at this stage of $5 million for that factor.

Now, there is also a big discussion going on about what's called expanded services. We are going to be bringing in a system that pays pharmacists for something that they've been doing for a long time but not getting paid for. Let me give you some examples. Patient consultation is something that consumes professional time and ought to be compensated for.

Medicinal reviews is another area. Pharmacists do these routinely. There are some patients who take two, three, four, five different prescription drugs all in the same day. Pharmacists have to be very vigilant to make sure that what a patient is being prescribed from one doctor jives with what they're getting from another doctor's prescription, and so on. So medicinal reviews are something that we're also going to be compensating pharmacists for, which we haven't been to date.

Thirdly, we're also compensating pharmacists for immunizations. Not every pharmacist yet is doing immunizations, but those that are are part of a bit of a pilot project, if you will, in this area.

So there are some additional compensation factors still coming in. But when the smoke clears and all is said and done, a couple of things will happen, obviously. One, patients, Albertans, will be paying a lot less for their drugs. Secondly, pharmacists will be compensated for a lot of areas that they're not currently being compensated in. That's the background.

Now to your question. I am acutely aware that some folks from the Value Drug Mart chain, which includes Value Drug Mart and Apple Drugs and Rxellence drug marts, were not at the table when these negotiations were held over the last year or so other than for two meetings. Then they had some confidentiality issues and so on. When I found that out in January, I immediately phoned them. I said: look, as part of getting on the same page and part of relationship building, let's sit down and chat.

9:10

Well, we've had three chats so far, and we're going to have a few more so that we can get to know what their issues are because they were not able to express them beyond the second meeting by their own choosing, of course, for the reasons that I've mentioned, which I have accepted are their own personal reasons. I'd hope that we will be able to have that discussion with them and come up with something that ensures the viability of pharmacies throughout the province. But we'll respect the nature of the previous agreements that have already been struck.

Mr. Quest: Okay. We've got some onside and some not onside.

Just to recap, the $3, $2, $1: by year 4 that subsidy, if you like, is gone. The $5 million for the transition: is that over the four years, or is that $5 million now?

Mr. Zwozdesky: It's $5 million over a period of the first three months: April, May, June. Well, we'll be spreading it out. In other words, it goes out as quickly as we can.

Mr. Quest: The first three months. So this is just short. Okay.

Getting back to these rural ones to give them and, I guess, all of us some assurance that this transition is actually going to work, some, of course, do their consultation, if you like, in the store. But

I know some will hop in their vehicle after hours and drive to a lodge and do some there and so on. There's time on the road and that kind of thing. Are these compensation formulas for consultation close to finalized now, or do they just happen through the transition? How will that work? Just some assurance for these pharmacists.

Mr. Zwozdesky: Thank you. Good question. In fact, we are close to finalizing something based on the pilots that have been done out there. There are a number of pharmacies and a number of pharmacists who are part of the pilot, and we've got some good information there. But I want to make it really clear, Mr. Chair and others, that there isn't a one size that will fit all on the pharmaceutical strategy. It's just impossible.

Those of us who grew up in rural Alberta know that full well. It's just an apples and oranges situation on some of these issues because you have to understand things like time and distance and the number of potential customers that you might have, how many prescriptions per week are being filled, and how in a rural setting everybody knows each other on a much more intimate basis. There's a little more chattering that goes on, and there's a lot more information that's discussed. In many cases, Mr. Chair, as you would know full well from your background, the local pharmacist might be the closest and the only, you know, medically related link for people in that community. This is going to take a little bit of doing to still sort out. That's why we've had some very good, solid, and, I hope they will agree, positive meetings toward accomplishing what you're asking about.

Mr. Quest: All right. Well, I guess from that, then, we can anticipate continued commitment to make sure that we have rural pharmacists in the rural areas that we need them in.

Thank you, Mr. Chair. That's all the questions I have.

The Chair: Thank you, Mr. Quest.

Our next set of questions is back to Mr. Brian Mason.

Mr. Mason: Thank you very much, Mr. Chairman. Mr. Minister, as you are aware, our caucus held recently a number of hearings around the province on health care. One of the things that we heard very clearly was a dissatisfaction with the government's direction on long-term care. Now, you've indicated, I think, in the House on several occasions that there's a big announcement coming with respect to long-term care. I don't expect you're going to make it tonight, but I do want to indicate that one of the serious problems that we heard was the lack of available beds for long-term care backing up the system since many patients who need long-term care but can't get it then occupy acute-care beds. That, in fact, is probably one of the predominant reasons for the increasing waiting time in emergency rooms. It's not that they can't take people in at the front end, but once they're stabilized and they need to go to an acute-care bed, those beds are blocked. That means that they can't bring people in the front end anymore because all the beds in the emergency room are blocked.

When we raise this in the Assembly, well, the Premier tries to turn it into an issue of the opposition wanting to institutionalize seniors who don't really belong in an institutional setting: "We want to keep people at home. We want to keep couples together; they've been married for 50 years. The opposition wants to split them up." And so on. You know, the actual case is much different from that. People who go into long-term care are assessed by medical people as requiring that level of care. It's not the opposition; it's the panels of medical professionals who do the assessment because they require medical care. That's why long-term care is part of the medical system and not part of the department of seniors.

I wonder if you can tell us if, in fact, the government gets this and is going to do something to attempt to restore some of the long-term care beds that have been lost and increase the number so that we don't have seniors either being cared for in an assisted-living facility, where they don't get the care they need and have to pay for everything they get, or occupying acute-care beds or being cared for at home, inadequately in some cases, by family members who don't have the training and the support. That's the situation facing hundreds, if not thousands, of seniors right now in our province, and I'd like to hear from you a commitment to solve that problem.

Mr. Zwozdesky: A couple of points in that regard. We did make a commitment to continue maintaining the 14,500 long-term care beds that are already out there. We also made a commitment to increase the number. I'm a strong, strong supporter of that. I know you are as well, and so is everybody here, I'm sure, not only because it is the right thing to do for seniors, mostly, who require them but also because it helps us with that Rubik's cube that I keep talking about.

You nailed it in part when you said that there are some people who are in acute-care beds that ought to be in long-term care beds. We're all saying the same thing here. It's just that we can't seem to get the accommodations built fast enough, but we will take some steps toward that, I hope, as part of the forthcoming announcement at the end of March and going forward as well.

I also know that back in September of 2009 Alberta Health Services had announced a three-year plan to increase community-living spaces, some of which would be long-term care, by 775 spaces. I believe we're on track with that. I don't know if there is anybody who can tell me we aren't. My recollection of the discussions I've had with Alberta Health Services is that we are there. We're working from many different positions to try and increase the number and the different types of community-care beds that are within that larger umbrella of continuing care strategies.

Mr. Mason: Again, this was under the previous minister, to be fair. The strategy, as we could discern it, because there was always a certain amount of interpretation that was required, was that the increased needs of seniors who need medical care of some sort, nursing care and so on, would be met through an assisted-living model. As we understand that, you pay a basic accommodation fee, and then anything else you need in terms of services comes, essentially, off a menu – it's like à la carte – and you have to pay for it. You know, if you need assistance to get to your meals, you have to pay so much a month for that. If you need assistance with your medications or a bath once a week and so on: all of these are on a cost-plus basis, and it adds up very quickly to a great deal of money. Can you tell me if that is still the government's strategy for meeting the needs of seniors who need medical assistance in their housing situation?

9:20

Mr. Zwozdesky: You know, hon. member, I looked at this very issue this morning. I was chatting with some colleagues, and I had some statistics provided by my department working together with Seniors. I'd be more than happy to sit down and go through some of those with you because I was quite surprised on the surface to read that Alberta's long-term care rates – and I think it was long-term care, unless it was some other category – are actually among the lowest anywhere, if not the lowest, in some categories across the whole of Canada until you ask the question you just asked, and that's the array of additional charges that might be there.

I don't have an answer to that right at this moment, but I'm going to get that. You and I can chat about that some more because I share

your concern in that regard. Having the lowest overall charges for long-term care on a rental basis is one thing, but what's the suite of services that you get or don't get to go along with it? Every province handles this a little differently, I found out, so it's difficult to make comparisons. It's a question of: what can Albertans afford, what should they be affording, and how can we improve the services for them?

Mr. Mason: Well, the definition is very important. It's critical. As I understand the term "long-term care," as it's used, it is accommodation for seniors within the health system, essentially a hospital-type setting, either a nursing home or an auxiliary hospital. In those facilities you pay a basic fee, and your drugs are covered because, essentially, you're in the hospital. Your drugs are paid for if you're in hospital, not when you're out. Other assistance, nursing care, is provided, and that's covered by the health care system, not by the individual. That's what we're talking about. We're not talking about a private model or a model in which you purchase an array of services one at a time.

I would suggest that you talk to a wonderful person from Hinton, Lynda Johnson. I don't know if you've met her.

Mr. Zwozdesky: I haven't met her. What's her number? I'll call her.

Mr. Mason: I'll get it for you.

I'll just tell you a little bit about her story. When her husband's mother was in a long-term care facility in Hinton – it's now a Good Samaritan; it's been converted from long-term care to assisted living – she was so concerned about the lack of care that she did what hundreds and hundreds of children are doing for their aging parents; that is, they provide the care for them as volunteers in the facility.

When her mother-in-law died, she undertook a tour of all the long-term care facilities in the province. I think there are about 150. She has travelled and been to each one, and she's become a real advocate of this question. What has concerned her is that there has been a real move to convert long-term care – they did this to the Hinton facility. They converted it from long-term care, where people got their drugs covered, they had nurses on site, and they got the care they needed, to assisted living, and the care that people needed was no longer available or no longer affordable. The conversion of long-term care facilities, Mr. Minister, is a very, very great concern.

How much time, Mr. Chairman?

The Chair: You've got about six minutes.

Mr. Mason: About six minutes. Okay.

I guess I want to go back – and I'd appreciate these in writing, actually, if you can accommodate me, Mr. Minister – over some questions I asked where I wasn't clear on whether I got the answer right. The first question is: who is allowed to administer drugs in hospital settings, in hospital wards? What is the minimum educational requirement for persons who administer medication in hospital wards?

A second one – I'd appreciate if this could also be in writing – is the total compensation, the all-in compensation of the Alberta Health Services Board, including the support services for the board.

I would appreciate knowing four items: the health indicators that I indicated aren't available; the Alberta health care insurance used to have a registry of data on home care; Health and Wellness used to report on physician billing and the Health wait-list registry, which you've talked about; and the demographics for people in long-term care facilities. There was an audit that the government used to publish, and that's no longer available. These were brought to our attention by a leading health care researcher in Alberta who used this in their research and has watched these sources of data about how our health care system is doing just sort of disappear. If you could provide responses on that, I would very much like it.

The final question, not in writing, has to do with a written question that was voted on today in the House.

Mr. Zwozdesky: Which one was it? What number?

Mr. Mason: I don't know the number. It was a Liberal question. I think it was Dr. Taft's.

Mr. Zwozdesky: Was it rejected?

Mr. Mason: Yeah, it was rejected. It was asking for the number of Albertans on wait-lists for long-term care and the age range of those individuals. The government says it does not have the information. Is that right?

Dr. Taft: I think it was amended.

Mr. Zwozdesky: I think so, too.

Dr. Taft: I wasn't there for the debate, but I think it was amended.

Mr. Mason: Well, that's what I understood.

Mr. Zwozdesky: How many Albertans were on wait-lists for long-term care placement?

Mr. Mason: Yeah. The number of Albertans on wait-lists for long-term care and the age range of those individuals. My notes say that it was denied because the government says it doesn't have the information.

Mr. Zwozdesky: No. In fact, if I could just clarify that, I believe you're talking about Written Question 10. I said we would accept it. Well, I said it through the other House leader who was on duty. We simply had to amend it to say, "As of December 31, 2009, how many Albertans were on wait-lists for long-term care placement both in hospital facilities and in the community?" That's the amendment. The rationale for that was because the specific information requested regarding the age range of individuals waiting for long-term care placement is not available from Alberta Health Services.

The latest wait-list figures released by Alberta Health Services are from the third quarter of the '09-10 fiscal year. As of December 31, 2009, there were 742 individuals waiting in acute care and 999 individuals waiting in the community for long-term care placement. So we answered it the best we could.

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

When is your big announcement about long-term care? You've alluded to it a few times. I thought it was going to be this week.

Mr. Zwozdesky: No, no. I've always said it would be on or about March 31, and I'm hoping that we can honour the March 31 commitment within a day or so of that. That'll be the overall plan for health-related facilities, including renovations, new projects perhaps, others that were deferred and can be undeferred or some that will maybe remain deferred. I mean, all of those decisions are just being discussed right now.

Mr. Mason: So this is a capital announcement?

Mr. Zwozdesky: Yes.

Mr. Mason: It's a capital spending announcement.

Mr. Zwozdesky: Correct.

Mr. Mason: Okay. That's good. I think that'll be welcome.

What about the policy around long-term care? Are you going to be announcing any changes with regard to the policy or the strategy for how you're going to deliver these services to people?

Mr. Zwozdesky: Yeah. You know, a good question. That's a part of the discussion I had with some colleagues this morning, hon. member, not to necessarily go out there and change anything but just to provide some clarity to the whole issue because you've got so many different types and styles of beds that are out there that people are sometimes talking about, in one way meaning something different and so on. You've got acute care, which we all understand, you have subacute, you have assisted living, you have supportive living, you have long-term care, et cetera, et cetera. I think one of the things you can expect going forward is at least a greater amount of clarity surrounding that. In fact, I've sort of asked for a chart to be developed talking about some of the suites of services.

The Chair: Thank you, Minister. I really do apologize for the interruption.

I must advise the committee that the time allotted for this item of business has been concluded. I apologize to the government members who patiently waited, not being able to ask their questions.

I'd like to remind the committee members that we're scheduled to meet Wednesday, March 17, to consider the estimates of the Department of Children and Youth Services. Another reminder: it'll be St. Patrick's Day.

Pursuant to Standing Order 59.01(2)(a) this meeting is adjourned. Thank you very much.

[The committee adjourned at 9:30 p.m.]

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