Legislative Assembly of Alberta

Title: **Thursday, May 10, 1990 8:00 p.m.**

Date: 90/05/10

[The Committee of Supply met at 8 p.m.]

head: Committee of Supply

[Mr. Jonson in the Chair]

MR. DEPUTY CHAIRMAN: I'd ask the Committee of Supply to please come to order.

head: Main Estimates 1990-91

Health

MR. DEPUTY CHAIRMAN: This evening we are considering the estimates of the Department of Health. By special arrangement it's been designated for this evening, and I would like to give priority, first of all, to the minister to make any remarks that she might wish to make, followed by Edmonton-Centre.

MRS. BETKOWSKI: Mr. Chairman, I thought that just to get this evening rolling, I would respond to the questions that were outstanding from April 25 . . .

REV. ROBERTS: They were all outstanding questions.

MRS. BETKOWSKI: Well, they were okay, but they were outstanding in terms of their timing. . . . and go through those before the other members get into their questions.

One of the questions related to The Rainbow Report. The hon. Member for Edmonton-Gold Bar asked about the cost of the video for the Premier's commission. I can indicate that the cost of production of the video was $93,317, which, of course, is not part of the Department of Health estimates. It's part of Executive Council estimates.

The second question is: what steps would we be taking to increase the portion of Alberta prescriptions that are generically dispensed? I thought I'd just run through the following steps that are under way to reduce the prescription price of drugs to Albertans. Firstly, a defined drug benefit list is being introduced later this year, which will help ensure that only therapeutically effective and medically required products are being dispensed. Secondly, we will take steps to develop an interchangeable drug list to provide guidance to pharmacists with respect to generic equivalents of drugs. Thirdly, an amendment to the pharmaceutical Act will be introduced to encourage the dispensing of generically equivalent products. Fourthly, in co-operation with Alberta Blue Cross and the Alberta Pharmaceutical Association, we are going to continue our efforts to educate prescribers, dispensers, and the public about the advantages of dispensing lower cost generic drugs. Fifthly, we will be making proposals to Alberta Blue Cross and the Pharmaceutical Association for the establishment of a drug utilization review process. Finally, we will establish a regular process for comparing prescription drug prices in Alberta versus those in other provinces.

The third question which is outstanding was with respect to the increase in the budget for a policy development division related to the Hyndman recommendations. The question was: were the two related? The answer is no. The increase in the policy development division is largely for legal fees with respect to third-party hospital claims.

Fourthly, the question with respect to the mental health advocate and whether or not he will be reporting to the Legislature: the response is yes, as outlined in the Mental Health Act.

Fifthly, with respect to the single point of entry – the amount of funding precisely and what model is going to be followed as to how the single point of entry will be managed and administered: we have outlined basically four objectives, which I will be going into later in my remarks, but the 1990-91 budget makes provision specifically for $3.1 million for the establishment of a single point of entry system.

The sixth question related to the evaluation that's been done on the health unit pilot projects with respect to senior citizens' wellness. The evaluation is currently under way with representatives from health units, the Alberta Council on Aging, the Senior Citizens Secretariat, and the Department of Health. The focus of the program is clearly to establish a client-based system with client input providing the continuum of care.

Mr. Chairman, before I sit down, I want to welcome the members of the Forum for Young Albertans who are here this evening. I understand they were in the House today, and I welcome them to the committee study tonight. Glad to see them here. Glad to see them all so interested in public life as they are.

I look forward to members' comments this evening.

MR. DEPUTY CHAIRMAN: Perhaps as chairman of the committee this evening I could just make a couple of comments to our guests. We're in the final day of budget estimates. This evening we're considering the expenditures for the Department of Health, which I think is a very high priority with everyone and our major area of expenditure as a government. This evening you'll have the opportunity to witness debate on those estimates and the purposes they're provided for. I hope you find the time that you have with us worth while.

The Member for Edmonton-Centre.

REV. ROBERTS: Thank you, Mr. Chairman. I'm glad to be able to have a second sort of kick at the cat here with this Department of Health. As I said in the first go-around, you know, it comprises about a third of the provincial expenditure but about one twentieth of the time we have in budget debate to discuss the matter. So placing the high value that the New Democratic caucus does on both education and health care, we thought these two departments were the ones of the highest priority to bring back for second review and scrutinizing even further the kinds of issues that need to be raised and looked at here tonight. Notwithstanding that fact, both the minister, as the chairman of the government's Edmonton caucus – I think there are four members in that – and I, as chairperson of the New Democrat Edmonton caucus, representing all 11 members there, are both here debating health issues tonight but also hoping that the Edmonton Oilers do well in the game and hope that we can be posted by the minister of career development on updates on the scores as they transpire. Is there anything to report on yet?

AN HON. MEMBER: One-nothing.

REV. ROBERTS: Is it 1-nothing? Oh well, there we go. Okay; we're off to a good start already tonight.

MR. WEISS: Two-nothing.

REV. ROBERTS: Two-nothing. Okay; thank you.

You know, I might even point out, Mr. Chairman, that we used to have two departments – it used to be Community and Occupational Health as well as Hospitals and Medical Care – and have two different times to go over a number of different questions, but with only one in terms of the Department of Health now, there is a lot to try to compact into one session, not to mention two.

I wanted to begin some of my comments, though, tonight by reiterating some of the comments I made the first time around in terms of what I still perceive to be the need for this minister and this government to take more action and to enter more of an implementation mode in terms of health policy. Now, the minister seems to have not taken this criticism well and is saying, "Well, we don't rush willy-nilly into things, and we don't want to rush in where angels might fear to tread." But on the other hand, it seems to me that after review upon review and report upon report – and the minister's mentioned about the great amount of money that's gone into the Hyndman report, the Watanabe report, not to mention the policy and planning division of the department itself, which is up, as we see, in vote 1.0.3. I'm sorry; I was trying to pay closer attention to what the minister said, something about legal fees, that that was needing to be paid for out of that vote. I'd like maybe a bit more clarification on what sort of legal fees. I thought hospitals had their own liability insurance and the rest. Oh, maybe the AMA tried to sue the minister. Maybe that's what it's about.

Nonetheless, a lot of money has gone into policy and planning and talking about health care. I say again that the time is now to get a timetable, to get an action plan, to get an implementation plan, and, in fact, that is the political agenda. I mean, the politics of the matter are that for good or for ill, at some point this government and this minister have to act. It's on so many matters and on so many issues that people talk to me about: "Well, we just don't know what's going to be coming down. We just don't know what the timetable is, what the implementation strategy is." The planning and all the process is there, but somehow there seems to be some political foot-dragging. It's not a matter of rushing in willy-nilly or not having done your homework; it's a matter of really making the political decisions. I'm going to continue to prompt this minister and this government to get in and make those decisions. I'm not going to agree with all of them; I am going to agree with others of them. Nonetheless, I think Albertans are going to be better served because, in fact, in terms of health care it's Albertan's lives and the quality of their lives that are at stake.

Whether it has to do with the Porters and their home care situation, or lack of it for someone under 65; baby Kaitlyn who was flown to Vancouver for heart surgery, and all that's happening there with her mother; people who are living with AIDS and need some long-term care; the children who had a high rate of whooping cough; the children who still need further mental health services; or native people in the inner city: these are all Albertans that have health needs which are going unmet. I think it's incumbent upon us all as legislators and this government and this minister to make those hard decisions and to get on with the implementation of strategies rather than just the study of them.

In fact, I remember an old preacher in New York, Bill Coffin, who once said – I think it was about the Philistines in the Old Testament. He said that before they'd go into battle, they used to take two cups of wine. They'd drink the first cup of wine to make sure they understood their battle plan, and they took the second cup of wine to make sure that when they went into battle, they didn't lack courage and they didn't lack daring. Maybe that's what I'm wanting to call for this minister and this government to have on these health issues: to take that second sip of wine and to get in with the courage and the daring and the political necessity that is going to prompt more action and more implementation.

I'd like, then, to get to some of the specific votes. I think last time I talked more in general policy terms about what was going on in the department, or trying to get a better understanding of policy terms. I'd like to talk this time about more of the programs and get some more clarification on them, although in the first one, just with respect to vote 1, I was obliged by the minister to finally get this very nice organizational chart and who's who in the department. I think it's a very good piece of work, and it's going to be very helpful to clarify what's going on and who's doing what and the various terms of reference.

But I again would like to ask the minister – I had read, I thought in the Hyndman report, and I thought I'd heard others talk about the fact, that the department in its organizational structure had not just a structure but had some terms of reference or had a game plan, had what hospitals are trying to develop in terms of a vision or a mission statement. Now, we tried to have this debate last year with respect to the Department of Health Bill, and I was trying to get more of a definition of what health is. But I'd like to – again, we're voting $22 million to the operational and administrative support of this department – have some gleaning with respect to what the mission statement is, what the understanding of health in its multifaceted approach is as this government understands it. We've had some comments from the minister, and that's helpful as far as it goes. But if there is a further statement, a more comprehensive one, what is it? We'd like to have it on the public record.

I know Don Junk does a good job there in policy development. Maybe if I get a bit more explanation about what this legal fee is, I'll know more about why it gets such a large jump in the Policy Development and Management Services, or perhaps some comment about . . . Again, we had the debate the other day about well, the Hyndman report has made its recommendations and report. What are the policy planning people in the department saying about it? In fact, there is a guy in evaluation. I'd like to know what he's doing, how he's evaluated these other reports. We're giving them lots of extra money. I'd like to see a better return on that investment in terms of how the department is evaluating both the Watanabe and the Hyndman reports. I guess it's coming. I know it's going to take some time to assess it all, but I'd like further clarification about what we can expect, what the timetable is for a response on that.

Then to move back quickly to vote 2, and we did touch on votes 2 and 3 – at least I did – more last time. But just to raise them again, vote 2, particularly for the young Albertans in the audience, is with respect to the Alberta health care insurance plan. That's really the $593 million that goes to pay doctors and assorted other professionals for health care services. I have a few points I continually like to ask the minister with respect to how that money is spent. Again agreeing that we're going to disagree, the first one has to do with the raising of health care premiums and what we know to be a flat tax for health care services, that this minister and this government do have a timetable for to raise to – I think she's even saying 50 percent

of the total that she wants to ding out of the pockets of Albertans. We can agree to disagree on that, but I would like to ask this minister whether or not she still continues to see this social program of health care being, as she continues to want to call it, an insurance program. The previous minister and I had this debate. I think I've mentioned before that he even agreed that it's not an insurance program. It doesn't work like life insurance or car insurance or home insurance where if you're a high-risk person, you pay more of a premium, and then if you aren't, you pay a lower premium.

MRS. BLACK: What is it?

REV. ROBERTS: Ours is a social program. It's like unemployment insurance. It's like pensions. It's a social program. People, if they have a certain health care need, have access to their service.

So maybe we're going to get to the real hidden agenda of the backbenchers here in this government. If they want to agree, let's get it on the record. Are you saying, therefore, that people in Alberta who have a higher risk for health needs, whether they have a predisposition to heart disease or cancer disease, whether they're poor and are going have more risk for injury and accidents and so on – are we saying that those higher risk people are in fact going to have to pay more for their health care premium?

Now, we have a bit of this in the Hyndman report. I'm amazed that the Alberta Hospital Association, the Alberta Medical Association, and others are saying: "Yeah. You know, if somebody smokes more or if somebody doesn't exercise as they should or, say, they eat a lot of red meat that ups their cholesterol level, if they drink too much, they're high risk people. Then we should make them pay more for their health care service." Is that where the hon. member for Fort Saskatchewan's going or . . . [interjections] I'm sorry. Where is he from? Clover Bar. Because it's quite a discussion out there, and certainly there is a punitive sense to this that might appeal to a lot of backbenchers and to some people. It's in discussion.

I'd like to hear from this minister. If she's still seeing it as an insurance plan, is she therefore saying that if you're in a typical insurance free market, if you're presenting a greater risk to the system, you should in fact pay more? If that's where we're going with this insurance system, then how is she going to penalize the poor, the indigent, and people who are already victims of a low health status? Because I think the moral and ethical dilemmas of that are enormous.

What we have here is a universal health care program. Anybody in this province who has a health care need should have it met regardless of their ability to pay and regardless of their own irresponsibility. I know that's hard to say, but that's what we're about. We want to educate; we want to encourage people to take better care of themselves. But there are going to be times when people do self-damaging things to themselves or limit their own health care status. But I don't want to see that punitive aspect of an insurance program take further root. If that's part of the hidden agenda here, we need to know about it, and we're going to have a debate about it.

I'd like to ask the minister, further, about what she's going to do if the Mulroney Conservatives, kissing cousins in Ottawa, continue to cut back on the reduction in federal transfer payments. It's in the other book here just how much we're cut back on, but it seemed to be the amount that would go right into vote 2. Yeah, Government of Canada Contributions: down 6.7 percent this year. We're told it's going to be down even further next year and the year after. I'm even told by some of my colleagues in Ottawa that the federal government is getting no political points out of health care, so what they really want to do is back off it entirely. It's up to the provinces. The provinces administer; the provinces set the policy. Let the provinces fund it, they say. So I'm wondering: with this continual erosion of federal funds, what is the game plan of the minister to either go to Ottawa and talk to Perrin Beatty and talk to Brian Mulroney and say this is unacceptable, as the Canadian Medical Association and others have done . . . Seeing the kind of underfunding we're getting after the Canada Health Act is in place, there is a responsibility for the federal government to keep the transfer payments at a high level and not to have that eroded. But it's hurting the health care insurance plan, and I want to know what the game plan is on that.

Part of the Tory philosophy is to starve an important social program – and we know that Tories like to starve it from, as I said before, the back side – and leave people to scramble into two tier, into privatizing, or into user fees to help to make up for that kind of irresponsibility at the federal level.

Again, a part of the real issue here – we didn't get into it before – is the whole cost of mediclinics and the fee for service that is, I feel, really driving a lot of primary health care that doctors in mediclinics throughout this province in particular are costing us. I'm sure the minister read the *Hansard* of last week where my community health centre proposals went forward. There is, I think, lots of room there, as I said last week, for that magic health care formula of increasing service and decreasing costs by virtue of establishing some community health centres. Whether it's in northern Alberta or in the city centres or directed to women's health care or to native health care or a number of different targeted areas, it's going to have the magic formula of increasing quality and decreasing costs.

Good luck, young Albertans, and come back again.

In fact, just for the record – I don't know if the student is still here. In the session I had, she wanted to know why the Order Paper is not printed on recycled paper. Maybe that's a good environmental health question. I forget if the student's still here – there she is – but I'd like to put it on the record. Why is the Order Paper and *Hansard* and the rest not printed on recycled paper, and recyclable? I think that is a very important question related to the environmental health of the province.

MR. KLEIN: It's coming.

REV. ROBERTS: It's coming. The Minister of the Environment says it's coming, like so many other things we . . .

MR. DEPUTY CHAIRMAN: Would the hon. member like to come back to order?

REV. ROBERTS: Then another thing, quickly, with respect to the Alberta health care insurance plan, and I've tried to raise it with the minister. I know she shares some concerns about outcome measurement. We've had some discussion on this with minor surgery. I'd like also to see it on the question of major surgery, as I raised in question period a while ago: how we can better get a sense of what the quality adjusted life year is going to be, how it's going to be increased by virtue of certain major surgical interventions. Maybe this could be more carefully understood on my part by knowing more about the monitoring committee and its terms of reference, but I'm hoping, and I see

that the minister – I'm paying my hundred dollars and going to this nice conference in Calgary – is going and addressing the same conference, Keeping Score of Health Care. I think we need to keep that kind of score, and I'd like to know if it's going to help to reduce some of the costs here.

With respect to some of the specialists, I'm still concerned if the minister has some initiatives for developing more geriatricians in the province – particularly I read about the need for certification in geriatric programs in southern Alberta – whether she's investigated some of the still thorny issues between the ophthalmologists and the optometrists with respect to basic eye care and vision examination and whether in fact optometrists can provide for some of those services at a lower cost than ophthalmologists, who are specialized in eye disease.

The question keeps coming up about midwives and midwifery. I'd like to know – and I guess it's over in professions and occupations: are we talking about nurse midwives here or midwives who are separately trained, such as at the McMaster program or other places where they do not have to first be a nurse to go on then to be a midwife, and that question having been understood, how is their fee going to be assessed with respect to the fee that obstetricians and GPs charge?

Also, I had an incredible visit by one of my constituents who suffers from migraine headaches, and the pain that this woman is in . . . [interjections] Listen. I beg members not to laugh at this because this woman, far before I was an MLA – I think it went back to the Mary LeMessurier days – suffers from migraine headaches in a way that is just debilitating beyond imagination and gets very little care and comfort from any neurosurgeon or neurologist here in the province. There's certainly migraine headache clinics in some places, but again, I guess, if we're going to fund neurologists, can we see if there's a need for other people who suffer from migraine headaches to have access to the care that they need from certain neurologists?

Also some comments from the minister on the whole issue of whether we're going to continue to have unbridled fee for service medicine in this province; whether there is an increasing role for physicians to practise medicine who are on a salary. Further, whether some specialists, say, the dermatologists or the orthopeds, can have a certain capped amount of dollars each year to which they can bill up to an upper limit and no more. These are all measures to help to contain some of the costs for delivering quality services at a cost – and, in fact, we all have to live within budgets. We all here, as I understand, are on a salary. It's not unusual, and I think could help in the medical profession as well. I'd like to know if the minister is going more in that direction.

Some questions were already answered with respect to prescription drugs. I'd just like to remind the minister that it's my understanding that more and more generic drugs – in fact, generic drugs for people who are in hospital is the standard course of prescription. So I'm wondering: if people who are in hospital largely have access only to the best priced generic drug available, why when they get out of hospital can they bill Blue Cross or the public plans to have a high priced drug? That to the minister. I'm sure it'll be up for further debate in time as we get the deal that's being worked out with the Pharmaceutical Association and Blue Cross and the government.

I already talked about acute care last time. There were a couple of quick points. I was interested, after our discussion about acute care funding and the management information services which we're getting a handle on finally in the province, to read about how the Oregon Health Services Commission and the Legislature in the state of Oregon have made a very radical proposal to look at the sort of cost/benefit of 1,600 medical services and have found how some services have a very high cost/benefit and others have a very low cost/benefit. They're asking the Legislature in the state of Oregon to draw the line between what Medicaid is going to fund and what it isn't. I think it's an interesting issue. Maybe it's two or three years from our fuller discussion here, and I'm wondering if the minister has any sense that we are also moving in that direction, that we're looking at the cost/benefit of certain medical services. I know that when the previous minister tried to deinsure services, he did it on a kind of – some services had a low cost/benefit and on that basis were to be deinsured. We're going to get much more into this question as dollars continue to be an issue and we have more information about what the costs are of the services and what the benefits are. I think if the minister's thought about those things, I'd like to hear.

The Medical Education Service Component. Maybe this is the area where we can ask about the number of interns and the internship positions which are available in the province. I understood this to be sort of federally and provincially cost-shared. I don't like to think we need more doctors in the province necessarily. I'd like to know if there can be some internship positions which can be dedicated to the practice of rural medicine or, say, mental health, psychiatric care, or geriatric care; if we can provide two or three more internship positions dedicated to those areas, whether that's a possibility and some further funding can go toward that.

On the hospital side again, I know the minister's views about certain hospitals going around with private fund-raising firms to raise private dollars to supplement the public health dollars which are going to them already. We read in the paper today about the Misericordia hospital here in Edmonton claiming, at least, that they're sort of halfway toward their goal. I still think it begs a number of questions, not only the inequity between hospitals. I think the Misericordia hospital, for instance, could have a much more aggressive fund-raising campaign than, for instance, the Ponoka General hospital, who might have less of a base to draw from in terms of privately, charitably donated dollars. So it builds up a big inequity. I think the University hospital could do a lot more than the Royal Alex, for instance, on that score. It builds in all kinds of inequities. Furthermore, I guess the question I'd like to find out from the minister is: does she think it's okay for hospitals who are denied certain funds for programs from her department, for perhaps some very legitimate reasons, to then go and try to raise private dollars for those programs which have not received authorization from the department? I mean, if the Minister of Health wants to develop a comprehensive palliative care program in certain Edmonton hospitals and wants it located, say, at the General and some at the University, if the Misericordia wants to get in on that, should they be allowed to go out and raise private dollars so they can have that program too, when in fact in the common interest it maybe should and could be located at one or two centres? The same with adolescent mental health and a number of other programs. I think it raises some questions there.

I don't recall in the minister's answers so far what her decision is going to be with respect to emergency services in Calgary hospitals. This continues to be, I know, a plaguing problem, but the review, which I think has been somewhat impartial and neutral, has recommended the closure of the Peter Lougheed and Holy Cross hospitals' emergency departments. The boards have been changing their minds back and forth – I'm sure from

various representations from certain MLAs there in Calgary – but I'd like to know what the minister's answer is. Is she going to equivocate, as the boards try to do, or is she going to consolidate emergency health services at the Rockyview, Foothills, and General? What's going to be the answer, and when is it going to be out?

The same with respect to Edmonton. We did touch a bit on the Royal Alex, and I continue to bite my tongue and try to learn greater patience with respect to the redevelopment of the critical care wings at the Royal Alex. But there continues to be, I think, a very great need for some greater satellite service of the hospital in northeast Edmonton and where that is with respect to a health centre which is attached to the hospital, or say a place where there are some ambulance or some emergency services permanently stationed, so they can respond to a number of needs up in northeast Edmonton and get to the Royal Alex or wherever where there aren't red alerts happening all the time. I think this is a very great issue, as the population and the industry in that part of the city are very great. As we know, the closure of the General hospital's emergency has exacerbated the situation at the Royal Alex.

I'd like to ask the minister, too, if we can have an update with respect to how many acute care beds have been converted to long-term care beds, again an initiative that was announced in the throne speech a few years ago. I haven't heard much recently. All I've heard is that we're going to continue to ding the bed blockers. The poor folks who are stuck in acute care hospitals with nowhere to go are being charged an even greater per diem. In fact, I thought a more enlightened policy would be to look at the number of acute care beds and how many per thousand were needed and try to reduce that ratio and increase the ratio of long-term care beds per thousand. Where we're at with that kind of conversion – which though I argue is not an easy thing to do, nonetheless, with care, can be managed for the benefit of Albertans.

I think I got some pretty good answers with respect to long-term care in vote 4. The single point of entry: I guess we got the costs of it. Again, I'd like to know how many health unit jurisdictions are on the single point of entry and how many still need to get on yet. I guess we're still taking a voluntary approach. I think it's such a good idea. I'd like to have as many on as possible and as soon as possible. Also, with the assessment and placement, the AAPI tool – how widespread its use is now and whether in fact it has been recommended there can be some regional assessment and placement communities, not just the AAPI being used at certain long-term care facilities.

Again, in the long-term care, the auxiliary and nursing homes, we've had some great improvements on the rehab side and in some foot care, which has been improved. I still would like to know if there's some emphasis the minister is directing with respect to oral health for a number of elderly people in long-term care settings. The whole issue of bites and teeth and gums affects so much of the nutritional health of folks and I think needs to be strengthened. Mental health again in the long-term care facilities is a great area of improved need. With the mentally dysfunctioned elderly units at district 24 or what else is happening throughout the system: I'd like to get an update on that.

Not to mention the spiritual health of residents in long-term care facilities. I again would like to point out that, you know, for accreditation under whatever the national body is that accredits long-term facilities, they have to be able to provide for pastoral care and spiritual health of the residents. Yet I'm told there is not funding available for the hiring of and development of pastoral care workers in auxiliary hospitals and nursing homes. If we're going to say they need this service to be accredited, it's a valuable area for a number of elderly people and others who are facing issues of loneliness, issues of grief, issues of impending death. People with pastoral care skills can help walk residents through a lot of those issues and be with them, and yet long-term care facilities that try to provide for that service just don't get the money to do so. I think it's a shame, and it's not something we can overlook much longer.

Not to mention the staffing issues at long-term care facilities, whether it's registered nursing assistants or nursing aides. I'm told the ratio between staff and residents is very, very high. We talk about social workers with high caseloads. The caseloads in these centres are also very high and are leading to complaints of burnout, low morale, physical abuse of staff, and a whole range of other problems. I think if we're going to again look to the future, we know this sector of the health care field is going to do nothing but increase, and we don't want to do it with workers who are not prepared to meet that challenge. I'd like to hear from the minister what she's doing to increase support for AUPE and CUPE and other support staff in those facilities.

Moving to vote 5 on the community health side. With respect to home care funding, I think it's such a false brag to think that the government has increased it 44 percent in the last three or four years. Only an 8.2 percent increase this year is the truth of the matter, and even the funding totals each year have been a matter for some dispute. Last year the health units thought they had a certain amount, but when it came down to it, they really had only seven-twelfths of what they thought they were going to have, yet submitted to the minister and the department what their hopes and dreams would be for the targeted dollars. I think it turned out, as she could see, that what could be developed in terms of home care and the health units was three, four, and five times the amount that was even being allocated. I think if we . . .

[The hon. member's speaking time expired]

MR. DEPUTY CHAIRMAN: The Member for Taber-Warner, please.

MR. BOGLE: Thanks, Mr. Chairman. Sometimes I think it would do some if not all of us in this Assembly a lot of good if we spent some time looking at other parts of the world and the health care they are able to afford. It seems to me we take for granted so much of what we have. It seems to me that the health care system which has been developed in this country and fine-tuned in Alberta, which is recognized as being one of the best in the world, is something that indeed we should stop and reflect upon.

I note in our current budget that the health care expenditures – and that's the total envelope for community-based health: our mental health programs, the operation of our hospitals, the payments to our doctors – now represent over 26 percent of the total provincial budget. That's $3.8 billion out of a budget of $12,200,000. That's a 7 percent increase over last year – a 7 percent increase. At the same time, in our budget highlights document, which was handed out by the Provincial Treasurer the night the budget was presented, we see that in 1990 we expect our real economic growth to be about 3 percent. We also note in the document that over the last four years Alberta's program expenditures have grown at an average of only 1.8 percent. Yet

in this year alone we're talking about a 7 percent increase in health care. We're now at 26.1 percent of the total provincial budget.

It's interesting if you look back to 1971, the last budget brought in by the Social Credit adminstration. The budget Provincial Treasurer Anders Aalborg brought in was heralded as Alberta's first billion dollar budget, a breakthrough for Alberta. And what did health care represent? One hundred million dollars. Now, members of the Assembly, that's 10 percent.

AN HON. MEMBER: No; 1 percent.

MR. BOGLE: That's 10 percent, $100 million, hon. member . . .

MR. DEPUTY CHAIRMAN: Through the Chair, please.

MR. BOGLE: . . . out of a billion dollar budget. So while the pie has grown from $1 billion to $12 billion, the health care share of the pie has grown from 10 percent to 26 percent, and we as members must be cognizant of the fact that it can't continue to grow at the expense of other programs. We have to find ways, we have to continue to find ways to make the system efficient and effective in meeting the needs of the citizens of our province. We have to balance our wish list and our demands with what is practical and realistic and what can be done.

[Mr. Moore in the Chair]

As a rural member, I'm offended when I hear some suggest that the answer to our problems is to close down rural hospitals. We have approximately 130 hospitals across this province. Did you know that the largest 20 consume 80 percent of the hospital budget? Eighty percent. The other 110 share the remaining 20 percent. So anyone who suggests that we can solve the problem of the 20 large hospitals by closing down the other 110 – it may be in someone's mind a short-term solution, but it won't be long till they're back wanting more and a bigger share of that pie.

[Mr. Jonson in the Chair]

Several weeks ago during question period the hon. Member for Vegreville asked the minister questions about St. Joseph's hospital in his community. [interjection] The questions that were asked related not only to the deferred project for the auxiliary hospital, hon. member. I think it's important that we note Vegreville's not the only community with a waiting list. [interjection] Hon. member, you'll have your chance. You just sit down and be quiet for a minute. It's important that we recognize there are communities across the province with waiting lists, hospital boards with legitimate needs who have been working with the minister, with the department, and with MLAs very patiently through the process. While I'm in no way diminishing the request being put forward by the board at Vegreville, I am somewhat offended if anyone would suggest that other projects are of lesser importance or other projects should be put on a back burner so one would go ahead for another member. I had an opportunity to look at three other projects – at Manning in the northern part of the province, at Magrath . . .

REV. ROBERTS: Point of order, Mr. Chairman. It seems to me we're going to be talking about the capital vote budget for the department if not tomorrow then on Monday. I think the member's comments would be more appropriately placed at that time.

MRS. BETKOWSKI: Point of order. In fact those projects, which are the 35 which are slowed down, are a health consideration and are part of the decision-making process in health, and I think it's very appropriate that the hon. Member for Taber-Warner raise it here.

MR. DEPUTY CHAIRMAN: Perhaps, all hon. members, we could make succinct remarks and move on with the debate.

MR. BOGLE: It's ironic, Mr. Chairman, that the hon. Member for Edmonton-Centre spend an hour of this committee's time . . . [interjections]

MR. DEPUTY CHAIRMAN: Order. Hon. members, I think the advice of the Chair was relevant. Let's proceed with the debate as concisely . . . There are many members that wish to speak. There's been some disagreement over relevance, but let's proceed.

MR. BOGLE: Thank you, Mr. Chairman. I'll speak to the urgency of the issue. We have in communities such as Magrath, which currently has a 25-bed active treatment hospital, a request for a long-term care pod. That request was put on hold, along with the request from the Vegreville Auxiliary hospital. There are needs in Magrath, as there are in Vegreville and at Manning, where there currently is a 34-bed active care facility and a request for a new 30-bed auxiliary hospital, a request which was put on hold.

The one I'd like to spend more time on is my own, Mr. Chairman. I'm speaking of . . . [interjection] It's ironic. We have to sit and listen to you hour after hour. [interjection] Yes, they're relevant.

MR. DEPUTY CHAIRMAN: Order please. Hon. members, I think we're all aware that certain initial stages of hospital planning – very important ones, by the way – are within the minister's budget. The actual building of those capital projects, which comes under the Capital Fund, will come up a little later under the Minister of Public Works, Supply and Services. But again, I think we should proceed with the debate, be as concise as possible, and use the evening fruitfully.

MR. BOGLE: Well, Mr. Chairman, I shouldn't need all 30 minutes of my time. [interjection] All right, all 20 minutes. But if I'm interrupted continually, I guess I may.

Looking, then, at the application by the Milk River county's general hospital for a 21-bed long-term care addition, again a project which was worked on by the board for a longer period of time than referred to by the hon. Member for Vegreville in terms of his project . . .

MR. FOX: How long is the waiting list?

MR. BOGLE: Well, I'm coming to that, hon. member. I'm glad you ask, because the hon. Member for Vegreville pointed out a waiting list of 67. Keeping in mind that Vegreville has a population more than five times that of Milk River, I look at a waiting list in Milk River of 27. So if you want to talk numbers, hon. member, I think I can make a stronger case than you can

based on the population of the catchment area and the needs in the community.

In terms of the current statistics, we have 16 people who are either in the community in the senior citizens' lodge or the active treatment hospital in Milk River at this time. There are actually 12 in the lodge and four in the hospital. And there are another 11 residents of the community who are in nursing home beds elsewhere. Seven of them are in Lethbridge, two are in Raymond, one is in Coaldale, and one is in Taber. Now, those pioneers want to come home. They don't want to be in a nursing home in Lethbridge or Raymond or Taber or Coaldale; they'd like to come home. And there are a total of 27 people. Of course, that list changes from time to time, as would the hon. Member for Vegreville's list. But I wanted to share with the Assembly that while we're all concerned with ensuring that the projects within our own constituencies are given the highest priority and are dealt with in a fair and equitable way by the minister and her department, we must also be ever mindful of the global budget. We must be mindful of how far we've come and where we're going, and we should never lose sight of the fact that the budget which did represent 10 percent of the total provincial budget some 19 years ago has now grown to 26.1 percent today. Those are factors that should weigh on all our minds in this Assembly.

MR. DEPUTY CHAIRMAN: The Member for Calgary-McKnight.

MRS. GAGNON: Thank you, Mr. Chairman. I also am pleased that we have a second opportunity to speak about the Health department budget. I would like to begin by raising some of the concerns that relate to the education field as well. The first one I would speak about is the switch in the mandate for speech therapy from Education to Health. When this switch was made, the Minister of Health noted that the speech language service was very important in the early years so that hearing and speech problems could be detected and remedied. Unfortunately, it seems that many children are not getting this treatment earlier than they used to. As a matter of fact, some of them seem to be getting less service than they used to receive. The Edmonton Catholic school board, for instance, has reported that only 73 students in 13 schools had received direct treatment before Christmas compared with 384 students in 29 schools during the last school year. So I'd like to ask the minister two questions about this. Has the minister consulted with the Edmonton Catholic school board to find out how many children have had their number of sessions cut or have yet to receive treatment? Secondly, I wonder if the minister will consider some form of compensation or extra sessions for those children who have not been able to get treatment this school year and who have now been told that they won't be passing their grade level because the treatment was not available.

I would like to go on to talk about the healthy school and ask the minister how her department works with the Department of Education to ensure that students in our schools are healthy. I would like to know if the Minister of Health has the opportunity to intervene and to co-operate in the high-needs inner school project. I'd like to raise two other health issues dealing with schools. One would be the HIV curriculum, which is now part of our health curriculum. I would like to know if it's going to be updated annually and if the minister provides the Department of Health with emerging knowledge about this disease so that the very latest in information is given to our students. I would like to know if there's an evaluation component which would assure Albertans that the curriculum is effective in the prevention of AIDS.

A second issue dealing with the schools would be in the area of nutrition. Many schools do have snack programs. These are usually run by volunteer groups. They are extremely important in many areas. In Edmonton alone we have 41,000 children who live below the poverty line. Many of these children come to school hungry. I wonder if the minister keeps herself informed about this situation of hunger in our schools. Not only is it impossible to learn if you are hungry, but it is also impossible to develop into a healthy citizen if you are hungry.

I'd like to speak just a little about the special-needs children in our schools. Our caucus totally supports integration to the greatest extent possible. However, I've heard some concerns from teachers who are expected to provide quasi-medical services in the schools and do not feel they have the training to do so. I would like to know if the school nurses help school boards and school staff to develop policies and practices which protect teachers who must give what are really health services in the schools.

I now would like to go on to asking a number of very specific questions related to the votes in the budget. Vote 5.6.5, Family Health Services, is up 2.9 percent. My question about that is: what is the mandate of this program, and could we have some details?

Vote 6, Mental Health Services. The total vote is up 6.1 percent. Last year it was 9.6. Program Support is up 5.8 percent. General Administration is up 13.7 percent. I'd like to know: what is the reason for an 81.3 percent increase for administration? Mental Health Review Panels is down 2.2 percent. What is the status of the review panels?

Community Mental Health Services, vote 6.2. The total vote is up 9.9 percent, and the Program Administration is up 61.7 percent. The question there: why a 62 percent increase? What new initiatives or programs are planned for this element to justify a 62 percent increase?

Vote 6.2.2, Suicide Prevention, is up 5.1 percent from last year. The tragic spate of suicides occurring in the province, particularly among young Albertans, indicates that the government's suicide prevention program is not reaching out as effectively as it should. With only a 5 percent increase, the department is going to be hard-pressed to address this frightening problem. Has the minister instructed this office to develop any new priorities or policies to help curb the growing rate of suicide?

Vote 6.2.4, Approved Homes Program, has been cut 20.3 percent. Why such a substantial cut in this program? The Approved Homes Program has grown from 76 homes and 220 beds in 1980 to 128 homes and 338 beds this year. This is an extremely successful program. Breakdowns are uncommon. Of 65 clients last year, seven were sent to hospital, and some of these were for medical reassessment. According to department staff, if it weren't for the program, one-third to one-half of the clients would be in a hospital bed at a cost of $768 a day for Foothills or $232 for long-term psychiatric care at Ponoka. Again, why such a substantial cut in this program?

The Premier's Council on the Status of Persons with Disabilities report recommended specific action for enhancing mental health services. Does Alberta Health intend to act on the council's recommendations? What is the department doing to ensure that its philosophy for mental health services in 1990 does reflect the need to provide quick response, life-skills

training, individualized support, regional autonomy, and case managers to lessen the confusion for the mentally ill in assessing services? What is the department doing to ensure the link between institutions and community support services is well developed so more ill people can safely make the transition from institution to the community?

Vote 6.3, Extended Community Care Programs, has been cut .4 percent. The program administration has been removed from this vote. Where has the administration responsibility for extended community care been moved and why?

Vote 6.3.1, Raymond Home, is up 3.5 percent; 6.3.2, Rosehaven Care Centre, is down 3.2 percent. Claresholm Care Centre is up 2 percent. Why was Rosehaven cut when the other two centres received at least a token increase?

The minister has promised that approximately $2 million of the mental health increase will be targeted toward enhancing the children's mental health program. Could we have the details, please? One of the fundamental problems with children's mental health is when parents who require help for their children are forced to struggle with a fragmented system where the services they need are spread among several government departments. Will the minister commit to develop a clear mandate and area of responsibility for delivering services to children with mental illness, with particular attention to determine which government department is responsible for children's mental health and how various services should be co-ordinated?

Will the minister consider expanding Alberta health care insurance to allow for coverage of psychiatric counseling to children? Will the minister commit to establishing a comprehensive treatment facility for preadolescents? There is no such identified centre in the province at this time. Is the minister looking to increase the number of psychiatrists and psychologists specializing in children's mental health?

Vote 7, Alcohol and Drug Abuse – Treatment, Prevention and Education. The total vote is up 5.8 percent. The greatest change is to vote 7.0.2, Provincial Prevention and Education Services, which has been cut by 22.2 percent. This program provides education and prevention programs, including a major program for adolescents, development of resource materials for internal and external professional groups, the Planning Ahead impaired driver's course and the IMPACT – Repeat Offender's program. Why the large cut? Does this reflect a change in the government's focus from AADAC to the new Family Life and Drug Abuse Foundation? Is AADAC moving away from a centre for education and prevention to one of purely treatment? Recently AADAC opened a new treatment centre for chemically addicted adolescents. While the program is run on an outpatient basis, will this centre not be in competition with the Kids of the Canadian West Foundation, and will AADAC be referring clients to Kids?

These, Mr. Chairman, are most of our concerns and questions. Other answers have been received to the questions which were raised earlier in the estimates.

Thank you for your attention.

MR. DEPUTY CHAIRMAN: Thank you.

The Member for Drayton Valley.

MR. THURBER: Thank you, Mr. Chairman. First of all, I would like to commend the minister and her staff again on trying to achieve a very difficult goal of streamlining the very complex program in the health department for the province of Alberta and for the people of Alberta. I believe they are doing an excellent job, and there's a long way to go. Different reports have come out and made some very viable suggestions that I think we have to look at over a long term and try and amalgamate with the flow of the health care needs.

I have some problems, Mr. Chairman, with the opposition members' statements from time to time, particularly the Liberals when they say we should get rid of the rural hospitals in Alberta.

MRS. GAGNON: We never said that.

MR. THURBER: Your leader has said that.

If I could continue, Mr. Chairman, I would like to outline some of the things that happen in rural Alberta, because I've been involved in it for a long, long time in both the hospital end and living in those areas. We have a very, very worthwhile program called the home care program, and this does take care of a lot of the needs of people in rural Alberta. It's probably one of the most valuable programs we can have in the health care field. It retains people in their own place of residence, among their friends and close to their own doctors and their own facilities. But there comes a point when home care can no longer look after these people, and the relatives and the friends and the whole system get tired. The people get tired, and they have to have further health care.

We in the rural areas have been great advocates of having more extended care facilities, not necessarily big ones or large ones but some in the communities, where the people can go into these institutions, auxiliary and nursing homes, and be close to their friends and their doctors and their relatives. What happens in a lot of cases is that the person ends up in an auxiliary home or an extended care home maybe a hundred miles from home. Now, I know what the city people would say if we took their elderly and their frail and took them a hundred miles out of the city to a home in the country. There would be the odd one who would recognize the value in this, but certainly a lot of the relatives and friends would be very angry about them being out in the boondocks. We feel the same way about our relatives and friends having to come to the city or be put on a waiting list where most people die before they get out of the home or the lodge that they happen to be in and get into a care facility. I think this is something we need to complete the circle. We also somehow have to establish this circle so that patients can flow into an extended care facility, and if they happen to get better where they can go back to their lodge, they can do so, yet there's still room for them to come back into the system at some point in time.

The other aspect that enters into it when you talk about our poor little rural hospitals – I had a relative in one of the major hospitals in Edmonton, and the average price for a bed in there on a daily basis is around $950; that's an average. If these people, once they have got through the worst of their acute care, could be moved back into the smaller hospitals in the local rural areas, the cost of care then goes down to around $200 per day and in some cases below that. I think this is a very valuable option that we have to keep open. These small hospitals can stabilize; move the patients to the larger hospitals for extensive care.

The other aspect that we have to look at in that regard is certainly an organized transfer system of some sort with the ambulances. Whether it be a ground transfer or a combination of ground and air transfer, it has to be organized, and there has to be a central system of some sort to advise on this and carry out the proper type of transfer. I don't think everybody needs

to be transferred by helicopter, and everybody doesn't need to be transferred by an extended care type of ambulance. There can be some vans put into place in that. But I think it needs to be organized on a provincewide basis. I think this is what the hon. minister and her staff are working on, to try to come up with a system that will respond to these needs.

I would just touch briefly on one recommendation in particular that comes out of The Rainbow Report, and that's the regionalization of the system in Alberta. I'm not so sure that we need the regional boards, and that's my own personal opinion, having served on boards from time to time. But I'm certain that there is an economic viability in regionalization of a lot of the services such as laundry and laboratory facilities and in some cases the dietary things. I think that's an area that needs a lot of discussion, and we have to do some work on that in the near future to make it a more viable system.

[Mr. Schumacher in the Chair]

Under the minister's care again the Mental Health Patient Advocate's office was established. I believe it was something that was needed. There's one thing that maybe should be looked at in that area. It could maybe be expanded, hon. minister, to include voluntary patients as well as involuntary. I think that if you check with the mental health advocate, he is getting inquiries from people not necessarily confined by responsible organizations but maybe voluntary patients as well. I believe we have to look at that and try and streamline the whole system.

I think you're doing an excellent job, and I'd just like to have my comments recorded so that we can proceed in that direction.

Thank you.

MRS. BETKOWSKI: Mr. Chairman, I'm going to just get in answers sort of as we go through this evening. I will not answer the questions from the Member for Edmonton-Centre, because I know he wants to get back in again and I may as well do it all at once.

With respect to the comments by the Member for Taber-Warner, in fact his comments were very much in order, because if you look at vote 3.1.3, of course, you will find a category entitled Provincial Programs and Capital Planning. That's exactly what the stage is that those 35 projects are involved in, so I think his comments were perfectly in order.

The hon. member did refer to the increase in the percentage of the provincial budget dedicated to health services and how that had grown substantially since 1971, when the first billion dollar budget was recorded. In fact, I would like to note that in the year '90-91 the proportion dedicated to health by the provincial government rose over that of '89-90. I think it's a significant statement in terms of the priority of this government with respect to health. In other words, some areas are having to do with less in order that we can maintain and enhance our health system.

The Member for Calgary-McKnight had several questions with respect to speech therapy, and that kind of detail I would have to supply in a letter. Perhaps her colleague might let her know that.

I did want to go into the issue of mental health services just a little more thoroughly. The whole objective of our mental health services program is to maintain and improve the mental health of Albertans through both inpatient treatment capability and rehabilitative services both in hospitals and in the community. Our leadership as a province with respect to our new Mental Health Act, our leadership as being the first province to statutorily establish a mental health advocate, is all part of the focus that this government places on mental health. The 1990-91 estimates within the estimates book reflect an increase of $2.7 million, or 5.9 percent, over the previous year's, and of that amount, $2 million is dedicated to children's mental health services. The remaining $700,000 is reflecting the cost of salary adjustment.

The hon. member asked: why does the Program Support budget, specifically the General Administration element, show such a sizable increase? I can say that while a 13.7 percent increase does appear rather large, the dollar value of that increase is $190,000, and of that amount, $93,000 is the administrative cost for implementing and evaluating the children's mental health program. The remaining dollars reflect the realignment of three positions due to some reorganization within the mental health division.

The hon. Member for Calgary-McKnight also asked about the Program Administration element increasing by 61.7 percent, and I can tell her that the entire cost relates to the children's mental health program. The $150,000 increase includes $80,000 to hire consultants, these psychologists that she mentioned in her remarks, to assist in the development of the various components of children's mental health enhancement, which include native service education and training, suicide prevention, and other programs. In addition, with respect to children's mental health I can say that the vast amount of the $2 million – in other words, $1.7 million – is related to child and family therapy and will see the hiring of 27 new positions for that purpose. So I think in fact that if you look at the allocation, it's not enough, but it's a start in the furthering of our children's mental health initiatives, and I believe it's appropriately placed in trying to increase the capacity in our mental health clinics to deal with children's special needs.

The third question the hon. member asked was with respect to the budgets for the community care centres and why they were declining as it shows in the book. I can say that the decrease reflects activities at Rosehaven Care Centre. In 1988-89 a decision was made to close 83 beds in that facility. The closures were realized during '89-90, and therefore the budget reductions are reflected in '90-91.

The other question that the hon. Member for Calgary-McKnight had was with respect to the AADAC budget, wondering why there was an apparent de-emphasis on provincial prevention and education services. I can tell the hon. member that there is no such decline in the services of prevention and education; rather, what has happened is that the new course fees for impaired driver programs are a revenue offset in this program. So the cost has gone down but the service continues.

Finally, with respect to the Member for Drayton Valley – this isn't a point that was made solely by him, but I think it's one that needs to be put on the record; that's the whole issue of health being an urban/rural debate or issue. I want to go on record as saying that it is not an urban/rural issue. It has nothing to do with urban/rural. It has everything to do with providing services to Albertans no matter where they live, a reasonable access to health services. It is not defined by a simple urban/rural debate. The health services in Spirit River or in Drayton Valley or in Breton or in Vegreville are as important to people within those communities as they are to anyone living in Edmonton or Calgary.

So I will look forward to the continuing saga.

MR. CHAIRMAN: The hon. Member for Edmonton-Avonmore.

MS M. LAING: Thank you. I welcome this opportunity to enter this debate. I would just like to raise a couple of concerns in regard to the issues raised by the Member for Taber-Warner and the Member for Drayton Valley. It seems to me that their focus is on hospitals and high technology, and what we need to do is refocus our health care concern on poverty. I would just read from The Rainbow Report, page 16.

> The health care system is picking up the deficiencies in Canada's distribution of income, housing and its social system in general . . . Incomes should be raised at least to the equivalent of the poverty line.

I think that's very instructive when we talk about using health care dollars wisely.

We know that poverty is a major cause of ill health. Malnutrition and stress make people vulnerable to disease. Poverty also makes people vulnerable to mental illness, to despair and suicide, and it is a major health care issue for children. Malnourished, pregnant mothers give birth to babies of low birth weight. These children are at risk when they are born, and they require costly care if they are to survive. In addition, they may suffer developmental damage and delays; sometimes they're irreversible. I would suggest, then, that if we're going to really address the issue of health care, the Minister of Health and the Minister of Family and Social Services get together and address the issue of poverty.

Now, back to the estimates as they are. I'm going to jump around because I made notes not in the order in which the votes occurred but in the order in which the ideas occurred to me. The first one I would like to address is the issue of mental health, vote 6. I think it's really important when we address mental health issues that, one, we recognize that one in eight Canadians – and I would suggest that's at least the ratio for Albertans – suffers from some sort of mental illness or disorder. I think it's really important that we separate mental health care needs from psychiatric care. Psychiatric care is care that is for the most part responsive to clinically diagnosed disease or disorders and often requires institutionalization. Again, The Rainbow Report says that 82 percent of the budget for health care is spent on institutions, yet mental health care is best given prior to the need for institutionalization. It is an area of health where early intervention can truly mean savings in dollars.

Most people do not suffer from a clinically diagnosable disease. They are our ordinary, common, garden-variety neurotics, which probably most of us are some days, especially when we have long sittings into the night. People who suffer from life's stresses – and here I think of things like death, loss of job, divorce, illness in the family: those kinds of things – sometimes need help dealing with that stress. Sometimes they just lack coping skills, the strategies to get on with everyday living, and sometimes that is manifest in phobias and anxieties. Those kinds of things are really amenable to treatment by someone less costly than a psychiatrist in a hospital. In fact, these people do not benefit from being hospitalized. So I would ask the minister if she is willing to commit to funding for counseling by psychologists and social workers.

I think it's important that we also see mental health care in terms of a holistic model of health care, that the physical and mental well-being of a person in fact are part of a whole, and we cannot separate them out. The mentally ill person . . . who's listening to the hockey game? [interjection] Sorry.

I think that we have to recognize that the physically ill have mental health care needs so that a person going in for surgery – and this is proven through research – will deal with that better, be healed more quickly from the surgery itself if they've had a chance to have someone talk to them about what's happening to them, to deal with their fears, their anxieties. That has shown a significant reduction in the number of days that need to be spent in a hospital. In the same way, people that have mental illness problems may also have physical illness that arises out of their mental health problems.

So I think we need to see this as holistic medicine, and it's also a prevention model in that early intervention in the area of mental area care prevents the more serious deterioration that may lead to the more costly institutionalization. I think again that we need to see that early intervention may, in fact, reduce the suicide rate and suicide risk. Suicide does not occur in isolation. It is in relation to life's stresses, inability to cope, and possibly some personality factors.

I'm concerned when the minister talks about the money that has gone to children's mental health. In looking at the budget one might conclude, although not necessarily, that some of the money that is going to children's mental health has come from money that had gone to institutions. I think children's mental health is a very serious concern, but it must not be developed at the expense of the chronically ill. So I would ask for assurance from the minister in regard to this.

Again, I hear that the minister has committed to new positions in the area of working with children's mental health. I think that we also need to look at community-based agencies that deal with children's mental health issues and the whole issue of violence in the family. At the present time we treat children who themselves are victims of sexual violence in the family. However, children that observe violence against one of their parents or their siblings are also damaged by that violence, and they need help. In addition, children who have experienced violence outside of the family need support. If, in fact, a child has been sexually abused, say by someone known to the family, they for the most part cannot get treatment from our child sexual abuse treatment programs, but both the child and the family are deeply traumatized by that. Again, the long-term implications of untreated violence in childhood is certainly a major concern that we're facing now.

I appreciate that the minister talks about taking on the treatment of families. I guess the concern I have is that mental health services take on the treating of families in which there is violence. My understanding is that in some Alberta mental health clinics a person is not eligible for treatment unless there is a clinical diagnosis available. Well, for the most part batterers are not clinically ill; they are an extreme of the norm. There is no profile and there is no clinical designation for them, so I'm not sure how they're going to be worked into the system. I'm also very deeply concerned about people dealing with violence in the family who do not know what a serious and sensitive issue this is. I think we've all heard or known of counselors who did not understand the ramifications of intervention and who have in fact caused harm inasmuch as they have not understood how lethal some of these situations are. So I would say that we must be very cautious in dealing with the treatment accorded families in which there is violence. It's not only a mental health issue. In fact, in some cases it is not a mental health issue in that nobody in the family is mentally ill; the batterers are acting out a learned pattern of behaviour to get their own way.

The next issue that I would like to raise is the need, again, for a women's health centre. I think women's health centres are extremely important because they are founded on women's needs and experiences as they themselves define them. We know that for too long a male-dominated medical profession has dictated to women and defined their experiences in terms of what a man would experience in the same situation, and they have been totally wrong. I think it's important to recognize that the life patterns of women are different from men. Their life stressors are different. They live in a different social context in that more of them are poor, more of them do not have economic autonomy and independence. They experience violence and powerlessness in a way that men do not. For many years battered women were treated by physicians for the depression which they experienced, and the physicians saw that as an individual deficit in the woman when in fact it was her social context, her home environment that would have made the best of us depressed. Again, we need to, I think, really pay attention to what women need and want. I think we also have to look at women's responsibility for caring for others as a kind of stressor that needs to be addressed in a health care setting, especially women that are in the paid labour force and work at home or women who are caring for adult children that are handicapped or for aging parents. We need to address their health care needs.

We need health centres that deal with the specific kinds of violence that women experience. It's only 15 years ago that we established rape crisis centres. It's only 10 to 15 years ago that we established shelters for battered women. It's only in the last decade that we have started to understand the psychological impact of these experiences. It is only now that we are starting to understand the impact of violence in childhood on the adult person and the long-term dysfunctional behaviour that may result from that. I talk about suicides, phobias, alcohol and drug abuse, sexual acting out: all of these issues that are specifically related to women because they deal with the violence of childhood differently, for the most part, than do men, who themselves may become aggressors. Women turn their aggression against themselves.

We need a health care centre that deals with women's reproductive health care needs. I'm thinking here particularly around family counseling. I think the issue of abortion needs to be addressed in this context. I have some sympathies for the minister's position about abortion being performed in hospitals, but I think that in a health care setting where women's health care is treated in a holistic fashion, we could deal with this issue as part of women's reproductive health care needs.

Much around women's reproductive health, or life actually, has been defined in terms of illness. I still occasionally see change of life in ads, which I find totally offensive. Women want to be able to care for themselves, and for that they need education as to how to care for themselves and how to prevent suffering from things that are preventable. Too often the medical model has not held women to be capable of doing that and has not held women as totally able to take on their own health care, even though they are charged with caring for other people's health. Women want to understand their bodies. They want to be involved in their own health care, as they are in other people's health care, and I think a women's health centre model can best meet the needs of women in terms of this kind of health care.

I would now like to move on to the family life and drug abuse foundation. I have grave concerns, for a number of reasons, about how this money has been set apart. It seems to me that AADAC has a bureaucratic structure that could well have administered these funds and in fact could have well defined the initiatives and the criteria for research, inasmuch as they are already involved and they must know where the needs are. I would also suggest that AADAC is capable of developing innovative programs. So I'm concerned that this has been set apart.

I have another very serious concern about this family life and drug abuse foundation. It is that, in fact, it focuses only really on one kind of concern that families have, and that is drug abuse. Families have many other concerns that impact on their well-being, including, as I said earlier, poverty, unemployment, often just the struggle to keep their heads above water. We need to look into our society as to the causes of drug abuse, particularly with young people. We hear from them that they have a lack of hope for the future, often because there are not jobs with a future. The jobs available are only low paying, do not give them a sense of future. In these days of restraint we see access to educational opportunities being reduced. Again, how do young people deal with the destroying of their aspirations, the thwarting of their aspirations?

They have broader concerns, concerns about the environment and the degradation that is going on. I'm not only talking about what happens here in Alberta; I'm talking about a worldwide problem: the oil spills, the kinds of things that impact on us each day in the news. We see the dead birds and the dead fish on the beaches, and we say, "Where is this going?" We hear of what is happening to our environment and the impact of our failure to recognize that we have a finite earth with finite resources. We know that children fear the threat of nuclear annihilation; that has been demonstrated through the research. We've heard of children as young as eight or nine being suicidal because they fear they have no future. Approximately a third of young people believe that the world will end through a nuclear holocaust or an environmental disaster in their lifetime. So we have to address those issues.

Another issue that we have to address is abuse in the family. A significant number of children who are involved with drug and alcohol abuse are children that have experienced or witnessed abuse in their own families. It's a way to deaden the pain, to check out, to not be there, to not witness it. So we have to say, "How do we address those issues?" I would suggest a family life and drug abuse foundation is too narrowly focused. We need to look at a much broader understanding of this very serious problem. We also live in a society of quick fixes in which I think to a certain extent we see the TV programs where everything that can go wrong can be solved in half an hour or an hour at the most, and everybody lives happily ever after.

I think a further concern is that some of this money that has been put here could have been better spent in FCSS for early intervention with families that are experiencing distress, that see in their young people the early indicators that maybe something is going wrong: drug or alcohol abuse, suicide, depression, acting out – these kinds of behaviours; even in terms of children with learning disabilities, programs to intervene and ensure that those are diagnosed and that those kids get the kind of early intervention so that their sense of self is not destroyed by their failure in school. So I have grave concerns about this foundation in terms of wrong bureaucracy and misplaced priorities.

The next vote I would like to look at is vote 7: Kids of the Canadian West, funded by AADAC. I have grave concerns about this program. I have raised it before. I have grave concerns because of the treatment modality that is used. As far

as I can tell, it teaches an external locus of control. It teaches through fear of punishment, and it does not teach children how to cope with life's stress. But further, I have concerns about violations of human rights legislation and the Child Welfare Act. I have raised this concern with the chairman of AADAC, and he has assured me that monitoring will be done to ensure that no human rights are violated and that the Child Welfare Act will not be violated. But he has not indicated when this monitoring will be done, by whom, and how. I would ask for the specifics of this process of monitoring.

I also know that AADAC has an assessment protocol to determine appropriate placement and treatment modalities for young people who are involved in drug and alcohol abuse. I have no sense and have been given no sense of the assessment procedures and protocols in place in this program. Is it simply a referral by parents that are extremely distressed with their child's behaviour? So again I would ask for assessments procedures and protocols and who will do them.

The last issue I'd like to address is the health units, vote 5. I've heard of staffing concerns in the rural areas. People in health units are front line to do prevention and early intervention, with mothers and their children particularly, in the areas of nutrition, parenting skills, and violence that may be occurring in the family, or even neglect. I think that often people that are neglectful or abuse their children physically lack an understanding of child development and lack good parenting skills. They may in their own past have experienced abuse as children and they act out of that experience. So I think we could have a nonthreatening intervention at this level if, in fact, these health units are properly staffed. Of course, they would also be places that we could get out information as to interspousal violence.

An excellent resource for reproductive health counseling and care, but we see that there is but a small increase in the allocation in relation to the increased responsibilities.

I would close by saying that I would reiterate Calgary-McKnight's points in regard to speech therapy. I have heard again concerns raised about this process working, and I'm wondering why in fact we had this change in mandate. So with that I would close.

Thank you.

MR. CHAIRMAN: The hon. Member for Clover Bar. The hon. Member for Stony Plain.

MR. WOLOSHYN: Thank you, Mr. Chairman, and I appreciate the Member for Clover Bar yielding to me. There are just a few comments that I would like to make, and I would hope that they're on topic.

We've talked about the votes and the moneys, and there have been a couple of areas that have been of some degree of concern to me. Recently I forwarded a copy of a letter to the minister with respect to a particular patient who was going to have troubles with respect to being admitted to the cancer clinic and not being permitted to smoke. Although I am personally a nonsmoker – and I suppose to a degree an antismoker – I find it very, very distasteful when people who are terminally ill and are forced into an institution are forced or at least claim to be forced by that institution not only not to have the privilege, I suppose, of smoking there but of having to leave the premises and, in fact, the property. I can't necessarily verify this other than by the correspondence which I passed on to the minister and left with her. I do hope that matter is pursued and that there is some degree of compassion shown to these people. The Minister of Education, I'm sure, would agree with me totally on that one.

MR. DINNING: Yes.

MR. WOLOSHYN: The other area that I have some degree of concern again arises from a constituent problem. There's a lady of the tender age of 89. She has families that provide nursing care for her, look after her medication and so on, and because she doesn't require the nursing care, the housekeeping or home care aspect is denied to her. I think it's rather strange that in order for her to qualify for some very badly needed assistance, she has to in fact force the system into spending more money than really is warranted.

In the area of extended care, if you will, or that particular field, I was quite impressed with the people at the Aberhart hospital who are offering auxiliary care to patients, mostly elderly but some not elderly. However, I was extremely distressed in the last few months to find that the renovations that were being carried on there – and that was very good; the renovations are badly needed. However, when you do any kind of construction, especially the removal of it, there is a certain amount of dust that's being raised. Two patients I know, of personally have been adversely affected. Although with respect to the Aberhart it's somewhat too late to do anything about it, I would sincerely like to see the Minister of Health have some special attention paid to patients with their particular needs in any kind of facility that's going to be undergoing some degree of renovation. As a matter of fact, two of the patients there were suffering from respiratory problems, and as a result were put into some degree of distress.

As we merrily go along we get into the area of acute care and auxiliary care. I find it rather distressing, not strictly from the economic point of view but simply from the different levels of care that are provided, to find so many acute care beds being occupied by auxiliary care patients. Now, if you look at the elderly, all too frequently an elderly person will stay in an acute care facility for well over a year waiting to find accommodation in an auxiliary hospital. What happens during the course of that year, because of the different levels of care that are given and the needs being so greatly different, the patient actually regresses while in the more expensive facility. I think something has to be done, and I would just suggest to the minister that there be some direction given to the acute care hospitals to have a look at having small auxiliary care units, especially if they're going to accommodate the elderly, so that the nurses in these units can best address the needs of these people. I think from a psychological point of view the elderly that are assigned to acute care hospitals suffer rather severely.

While on the topic of the elderly, I would wonder how much interaction, how much communication is being carried on with the Youville centre at the General hospital. I haven't heard too much from there, and I was wondering if the minister could enlighten us on the directions taken or what progress is being made in the field of geriatric care out of the Youville centre. .

Lately, in the last couple of years, there have been two rather severe incidents involving our native communities. One was a tuberculosis outbreak in northern Alberta a couple of years back. The other was the recent outbreak of whooping cough in central Alberta. Although I won't dwell on the specifics of it, I think one of the areas that is severely lacking in Alberta is a clarification of responsibility for the provision of health care to native peoples, treaty Indians more specifically. I would suggest

very strongly that the provincial government, through the Minister of Health, should clarify the responsibilities and the roles of both the federal department of health and welfare and what the province can do. I think it's rather scary and distressing to think that up in northern Alberta some of our health unit people were denied access to assist the tuberculosis patients because of some political reason or other, and I would suggest that the whooping cough outbreak in Hobbema happened simply because there wasn't any kind of communication between the local community and the health units in the area until it was far too late. So perhaps there can be some method, either through the schools or through the local health units on the reserves. But we should have some way of monitoring the immunization levels for our native people. I think that would be a benefit to all concerned.

The hon. Member for Calgary-McKnight alluded to the recent transfer of speech pathology from the Education domain into the domain of the Health department. The question I would have is: what monitoring system, if any, is in place to see that, first of all, the needs that are required are being addressed? We hear all sorts of numbers being tossed around, and quite frankly I don't how many people are going without service, how many people who require the service have never been found. That's something I don't know. But it appears to have been rather a shock to the systems, and I take that the larger systems. I don't believe the health units were the least bit prepared to provide the service, and in the same token, the school systems were perhaps not very well prepared to give up the service.

While on the topic of health units and schools I would like to know if there is a formal arrangement between Education and Health, or an informal understanding, as to the relationship between the health units and the schools that goes beyond the actual nurse functions in terms of immunization and screenings that are currently happening, into the field of the nurses' involvement in the classroom. I'm suggesting perhaps some position paper as was put out by this minister when she was Minister of Education with respect to the relationship with social services. I would like to see a very close co-operation between the health units and their delivery of speech pathology service to the schools, and also a very close co-operation between the schools and the health units in the delivery of some curriculum types of topics such as AIDS prevention and the whole area of human sexuality. If there isn't some sort of master agreement, I would like to see one developed. I am painfully aware of one school system in particular that does not seem to want to have the presence or the participation of health unit personnel in the delivery of theme 5 of health education in the school, and I think that is too bad.

The other one. I notice in vote 5.6.4 a rather substantial amount of money that's being addressed to the speech and audiology area. I wonder if the minister can give us a breakdown – I don't know if this is even possible – of how much of that budget, how many dollars could be directly attributed to the schools. In other words, I'm trying to find out how much of that particular budget would be a school-based budget. The other question in this area. My understanding is that there is a shortage of speech pathologists. I know there is a significant difference in pay scales between what they were receiving as school employees and what they would receive if they transferred over to the health units. To put it simply: do we have a sufficient number of speech pathologists available to meet the needs of the community and the schools?

The other general area that I would like to touch on for a moment is the area of health monitoring, if you will, in a community by the local health units. Now, they have responsibilities all the way from checking up on restaurants down to making sure that local, small landfill sites are being properly run, and I would wonder if there is sufficient attention being paid to the training, to the expectations, and to the regulations governing what we, in fact, expect of them, because I feel there is an awful lot of difference between what Environment expects and what the local health units and the local authorities can, in fact, deliver. That's one area that I think should be looked at a little further.

Going back for a moment to the relationship between the province and the federal government, I would like to know a little bit more about what the arrangements are for provincial funding to the Cold Lake hospital and to the federally operated hospitals and nursing stations: some details on how that is arrived at and, quite frankly, why our provincial dollar is going into that particular federal category.

The last general note I would have to make – it's an observation, and I hope the minister takes it to heart – is what appears to be a growing need but perhaps a reluctance, for whatever reasons, by various bodies to get more actively involved, and that's what I'd refer to as health care co-ordination. The health care givers should all have the same objectives in mind whether they be on the home care level, acute care, auxiliary care, nursing homes, or whatever. It seems to me that too often empires are seemingly carved out in these areas and perhaps to the detriment of getting the most efficient return on our dollars. With that I would like to close.

Thank you very much for your indulgence, Madam Minister, and yours, Mr. Minister of Education, for agreeing with me.

MR. CHAIRMAN: The hon. Member for Bow Valley.

MR. MUSGROVE: Thank you, Mr. Chairman. I would like to centre most of my remarks on the co-operation between the minister and the senior citizens council.

However, first I would have to say a few words about what happens in Bow Valley. As the minister has heard, the new hospital that was designated for Bassano and then put on hold is, of course, a disappointment to the people in Bassano. However, they have told me that they are business men and women and that they can recognize that the province shouldn't be spending money that we haven't got, albeit they are really disappointed. [some applause] I can see our people across the way are suggesting that they shouldn't build a hospital in Bassano. Anyway, Bassano now has a 30-bed active treatment hospital of about 1940 vintage, and to renovate it would cost more than a new building. The new hospital is supposed to reduce the amount of active treatment beds considerably, but it's supposed to have some 25 or 30 extended care beds. The hospital board tells me that when that new extended care facility is built, it will be full. The Blackfoot Reserve is part of the Bassano hospital district, and the Blackfoot tell me that some of their extended care patients are in hospitals all over Alberta and they would be happy to move them back to Bassano.

I got a letter the other day from the administrator of the Brooks hospital asking me about their diabetic education program, and although it hasn't been refused, they were telling me that they hadn't been notified of the approval either. Also, there's been a deal made over the ultrasound in the Brooks hospital, and they were asking where that was at.

A prime example of what our city MLAs are talking about as far as rural hospitals. Empress is a small village right on the Saskatchewan border. It's 100 miles from Medicine Hat, where the first regional hospital is, and it's got a fairly new state-of-the-art hospital. They have a problem keeping a doctor there. But for the people that live out in that area that is so far from any medical services, that's very important. If there was a major accident in that area, Empress could at least stabilize people till they could get them to a regional hospital. Although I understand our city people don't recognize the need for that, to those people that live out in that area that's *very* important.

As far as the seniors council in connection with the Health department, why, we do co-operate with them on a lot of different things. For instance, the Department of Health in some major advertisements advertised the seniors council toll-free line this spring. As a result, we have had the telephones over there ringing off the wall. I believe there were up to 1,500 toll-free line calls already this month, and that's for benefits for seniors. Certainly that is doing something for the seniors of Alberta, and I really appreciate the minister advertising that line for us.

We also put on quite a few studies and seminars on gerontology, and we offer grants to other organizations that put on studies on gerontology. One of the members mentioned Youville. We have been quite involved with some of the things that happen at Youville. Last fall we presented them with a moderate grant for the studies on gerontology. But I was at Youville earlier this year with a concern the administrator had over their dental unit that they'd put in Youville, and being that Youville is a rehabilitation centre and not an extended care centre, they put in a dental unit to serve seniors while they were there. Now, the administrator was not charging any more for dental work than was paid for out of medicare and discovered that they were going to have to close it down because the charges from medicare weren't covering the dentist charges and the capital cost of the facilities. She said they had started charging $10 a visit for people using the dental unit in Youville. Although the patients were not strongly opposed to paying $10, the staff of the hospital were. They said that we don't charge people for any health care in Youville, and so they were objecting to it.

We were speaking of home care. Certainly that is something that the seniors council gets very involved in. There's a lot of concern about the aging population. Alberta presently is a fairly young province. I think 8.7 percent of the people that live in Alberta are over 65, as compared to the percentage of population in Canada that is over 65 is somewhere between 12 and 13 percent. But this varies a lot from different centres in Alberta. There are places where probably less than 2 percent of the population is over 65 and other centres where the percentage of senior citizens is somewhere in the neighbourhood of 20 percent. So we have to be concerned that the money for home care is not distributed equally to health units but has to take into consideration the percentage of senior citizens that live within that health unit and the cost that is being paid out to those health units for the benefit of seniors.

It's suggested that we're approaching the time when there are more people over 65 years old in Alberta than there are people that are under 18 years old, and this is going to be a concern over health costs. The experts on this tell me that's a myth. They said that the cost of education and services to people under 18 years old is higher than it is to the people that are over 65, particularly as seniors nowadays are living healthier. Over 85 percent of people over 65 live in their own homes, and over 50 percent over 85 live in their own homes. So you can see that they're not a drain on the tax dollars, as some people are concerned about.

But we do need to do certain things. One that we are promoting more of is adult day care. Now, we have people living in institutions nowadays because they need certain medication that can't be given by anyone else but a doctor or in a hospital. But there's no reason why a person can't go to a hospital in the morning and receive his medication and go home to his or her family at night. [interjection] Yeah. One of *my* colleagues said, "For a shot of rye." I guess that's probably all right, as long as it's not too many.

Another thing is our seniors' lodges. Now they're under the jurisdiction of Municipal Affairs, and that's rightfully so, but there should be a co-operative effort to offer a different level of health care in our lodges than is presently being offered. Some of the lodge boards will not agree with that, but I believe that at the time I spent on a lodge board, the average population was about 76 years old. Now in most of the lodges in Alberta the average age is about 86. So to have a shift nurse come in at some point in time during the day to administer medication I think would be a benefit to those lodges, and it would be a different level of care.

Another thing we need to look at is that historically when people entered a nursing home, it was considered that they would stay there until they went into the auxiliary hospital, that they were at the beginning of the end of their life. Nowadays people can go into a nursing home, be rehabilitated, and return to their own surroundings. I believe that is something that we should be considering more.

We have to think about the mental health of our seniors, and that has a lot to do with their health. I think we have to have a look at retirement, and I think the way retirement has taken place in the past has to be changed. The average working person in the past was encouraged to be as productive as possible till the day he became 65 years old, and then he was told to be nonproductive, and that was pretty hard to accept, psychologically, by the person. I think we should be working out a retirement package where a person would start to share work at probably the age of 55 or 60 and then carry on as a part-time worker as long as he wanted. If he wanted to work until he was age 70 and share part of his workday with someone else, that should be acceptable.

When we consider mental health, this happens: quite a few of our seniors retire and become concerned about their health. That's a myth that we have to get rid of: when you get old, you're unhealthy. I am told that for over 50 percent of the people in Alberta that enter our health care system into the hospitals, it's because they have taken too many prescription or nonprescription drugs. Now, I find this not only a serious problem to their health but also a financial problem to the province because of the fact that the prescription drugs, in particular, are covered 80 percent by the province, and then we have to go to the expense of the cure of it, a financial drain. And this is because of mental health problems over retirement.

Now, I was in Ottawa recently to a seminar on gerontology. It was called Aging into the 21st Century. We all talk about income for senior citizens. The words that we heard at that seminar from the experts were that a sustainable income is not enough for retired people. You have to keep them active and involved in the community and keep their minds working so that they're not concerned about their health and not concerned

about being retired. And I actually believe that. I believe that whatever a person wants to do after age 65 – if he wants to work longer; if he wants to become involved in some kind of recreation – we certainly should keep them active, and that is the job of the community. Then they begin to feel that they're still part of the community, that they're not singled out as someone that's different from the rest of the family, and that is a very important function of the community.

Mr. Chairman, we do put out a lot of publications over at the seniors council, and I think most of the members have received our new program for seniors, which tells you of all the benefits for seniors, including health units and telephone numbers for all the needs of seniors, both provincially and federally. We did put out a publication about Women on Aging, and we have put out an On Aging series, which leads people to understand what aging is all about. So if some of the members haven't got those, why, just phone over to our office and we'll be happy to provide them for you.

With those comments, Mr. Chairman, I again would like to thank the minister for the co-operation we've had.

Thank you very much.

MR. CHAIRMAN: The hon. Member for West Yellowhead.

MR. DOYLE: Thank you, Mr. Chairman. I'll be very brief. I enjoyed listening to many of the people who spoke before me that know much more about health care than I do. I'm probably one of the members in the House that very seldom ever uses my health care card, but I think the health care card is the most beneficial card that anybody in the province of Alberta can carry with them. No matter where you go, you can run up the costs no matter what and not have to worry about being locked in like you might be if you were, say, under the American health care system. We do have a good health care system in Alberta, and I compliment the minister. I'm very pleased that we have a minister that actually had her roots in the great riding of West Yellowhead for many years.

On vote 3.1.8, Air Ambulance, Mr. Chairman, I would like the minister to comment on Air Ambulance and how broadly it's used in Alberta, especially in rural Alberta.

Also, vote 3.6.1, operating support for rural community hospital beds. In the riding of West Yellowhead, of course, we had some cuts at St. John's hospital of 83.8 percent and at the Hinton hospital of 55.6 percent. The needs in West Yellowhead are just as great as the needs in the rural ridings anyplace else in Alberta. We need hospitals there as much as the people in the cities need their hospitals.

I would like to also add that the auxiliary hospitals in the riding of West Yellowhead certainly could use more beds. People from Jasper are now in the Canmore hospital, in the Edson hospital, some in Edmonton. Some of the people from Edson cannot be housed in the Edson auxiliary hospital because it is full with people from Jasper, Hinton, and other areas. The auxiliary beds are definitely needed in the Edson and Hinton communities, and before long we will need some beds in the Grande Cache community, although it is a rather more youthful community.

[Mr. Jonson in the Chair]

The minister, I appreciated, said some time ago that consultation is the best process in health care. I believe that also, but I do have a concern in regard to St. John's hospital and the consultation that took place on that matter. I would hope that the minister would take the wishes of the Sisters of Service, who served in that hospital for some 60 years and give good health care. In the years that I was on council in the town of Edson I heard nothing about any transfer wanting to take place or that should take place to any other type of service. The Sisters of Service simply asked that it be transferred to the Catholic Hospitals Foundation. Many citizens of that community along with the Sisters of Service are very displeased at the way the transfer took place. I believe the minister is such a fine person that she could go through a consultation process and address the concerns of these people who have expressed their sorrow with the way it was handled.

Also, Mr. Chairman, I'm very pleased that in the town of Grande Cache we have the great services of Grande Prairie Regional College, which gives courses in Grande Cache, and also the QEII hospital, which the minister opened, I believe, in 1987. They also give courses in Grande Cache. But the minister must know that in order to have these people travel from Grande Prairie to Grande Cache, they must have a safe highway to drive on. I just wish the minister of transportation were here so he would be able to understand that we have some very professional people driving back and forth between Grande Prairie and Grande Cache on Highway 40. The minister should perhaps ask the minister of transportation if he would provide a better highway for those very qualified people to travel back and forth for those very good instructions they give in the community of Grande Cache.

Mr. Chairman, the AADAC budget, 7.0.2, Provincial Prevention and Education Services. Many people on the FCSS boards are concerned about cuts in the past in AADAC services. I believe the ratio in family violence and those types of things – about 10 percent of those people come from the dreaded disease of drug addiction, and about 90 percent of family problems actually come from alcohol-related situations. I would hope that the minister would consider in the future at least, or if she has any spare money anywhere, which I know is hard to find these days, putting more money into the AADAC programs.

Mr. Chairman, I would like to wait for the response from the minister, especially on the air ambulance services, because we have many rural airports in Alberta that were built at a great expense to the taxpayers of Alberta, and I would like to know if those airports are being used as frequently as necessary for air ambulance services. Again I would like to press the minister to seriously consider more funding for auxiliary hospitals, especially in the rural areas.

On that, Mr. Chairman, I would like to wish the minister a very good year ahead, and I wait for her response.

MRS. BETKOWSKI: Mr. Chairman, I think this is a good opportunity for me to get in and cover some of the points that have been raised by the various speakers. Certainly the number of speakers is an indication of how highly we regard our health system, and I thank all of them for participating in these estimates tonight.

First, with respect to the Member for Edmonton-Avonmore, the whole issue of mental health and the opportunity for psychiatric versus a softer model of care. I very much appreciated her remarks and certainly agree with her that the balance is one that we have to seek in mental health. With the new Provincial Mental Health Advisory Council that will be established and the regional plans which will look at the complement of the designated hospitals, with community support

around those hospitals, I'm hopeful that we can start looking at the whole issue of regional planning for mental health services. Certainly if you look at the issue of schizophrenia, as an example, it's a perfect example of where you can have patients going into the institution to have drug treatment and therapy, perhaps, but once established, there's no reason why they have to stay in those institutions. I think the use of the community to monitor, perhaps to support in a way similar to the way we handle social assistance or probation, could be the kind of model that we might envisage, where you'll have the community as a monitoring and support group to what has been established by the institution. I think that would really serve mental health well, and I'm hopeful that with some of the nominees we're looking at, we can get that kind of understanding and expertise built into our mental health infrastructure in the province.

I can assure the hon. member that children's mental health dollars are new dollars; the $2 million are new dollars. Again, the whole complement between institution and community is there, but those are certainly new dollars.

The women's health centre is one that I'm quite familiar with. Certainly the work that's been done by the Edmonton YWCA has been extensive in consultation. My department is assessing that proposal very carefully. There's some concern about duplication within some of the components of that women's health centre, and I'm sure the hon. member would agree with me that we don't wish to duplicate service; we want to complement and do the best job we can. That is the purpose of the review, a very thorough one. I've met with the YWCA people to tell them that, and they certainly support that review because they're not interested in a centre that would be any kind of duplication of another. So we're looking at it very, very carefully.

The issue of reproductive clinics. The issue of woman as victim is one that I'm of the view we need to support through education – teaching women to be better consumers of health, to be able to use the system better – and in turn educate the system better with respect to women's issues. I think there's very much a symbiotic kind of relationship that can be set up. I just want to thank the hon. member for her comments.

Stony Plain made a number of comments. The first was with respect to some correspondence he had forwarded to me from an individual who wanted to be able to smoke while in hospital. I'm not going to make a judgment with respect to it. Certainly the issue of establishing policies like smoking policies is the responsibility of individual health boards. That is a policy that the Cross Cancer Institute has. I regret that the individual feels uncertain in terms of the stress that she feels, and needs to smoke. However, I think we have to support the institutions to build those kinds of policies that apply for them.

The hon. Member for Stony Plain also indicated that there was an issue with respect to housekeeping assistance. If he could get me the specifics on the issue, I would be happy to look into it for him.

Youville centre. Youville centre is a real jewel, I would say, in the delivery of health care, particularly the issue of specialty geriatric services. It really is a northern Alberta service, and the Youville centre is able to offer an array of. programs which Albertans from all over this province write to me about, and I'm sure to the hon. member, because of how unique they are and how fortunate we are to have that kind of service in Alberta. The support for Youville continues, and continues within this budget. We are also looking, as he may know, at the issue of a geriatric assessment and centre of excellence in Calgary to serve southern Alberta. That is one that is in the planning stage right now.

The hon. member suggests that we need to set up small auxiliary units within acute care facilities. I'm not convinced I agree with him. I think certainly we have to look at the needs of the long-term care patient, and that's why we have so many initiatives with respect to long-term care under way in the province. Since he and the Member for Bow Valley mentioned the whole issue of single point of entry and long-term care generally, I, think it would be useful for me to run through and to let the hon. member know what in fact we are doing with respect to getting people out of acute care beds and into perhaps more appropriate auxiliary care, but perhaps community care too.

I mentioned earlier on single point of entry that our '90-91 budget contained $3.1 million for single point of entry, which is $1.6 million in vote 4 and $1.5 million in vote 5. The objectives of single point of entry are four. The first is to ensure the assessment and case co-ordination of services for clients seeking entry into the long-term care system. The second is to create a regional single point of entry co-ordination and planning mechanism. The third is to create a regional facility placement mechanism. The fourth is to develop an information system to support a single point of entry. There is a bias to the community on single point of entry. I admit the bias; I support the bias. In other words, when an individual is moving into single point of entry for an assessment for long-term care, the bias is towards finding the least intrusive model of care in the community before institutional care is ever considered. The system is working well. It is at this point voluntary; I'm prepared to take steps to make it mandatory. I think we need a year to look at it because this is a year when we can see a whole bunch of facilities coming into single point of entry. I think we need to support the communities as they move into single point of entry rather than the top-down, heavy-handed approach that so often, I believe, inhibits our health ability rather than supports it.

Whooping cough. The hon. member made the statement that he thought there wasn't enough communication between the reserves and the local health units, who are certainly giving vaccine. We have to be very careful, and I don't think we can have it both ways. For example, in the ambulance Act draft that was tabled in the spring of last year, the issue of interfering with federal jurisdiction with respect to natives was one that came out as part of the criticism of that draft. As a result, there will be amendments proposed to work through that. But I don't think we can be heavy-handed in moving in on the issue. I certainly am concerned about the level of vaccination on some of the reserves. I wrote to the federal minister of health and implored him to come to grips with it and to start to look at how we can improve the rate of immunization, and in fact offered the services of the province. The province is supporting, even with the antibiotic treatment, when the period of time in which to apply the vaccine cannot be done.

So while I agree with him that we need to up the rates of vaccination on those reserves, I think we have to be very careful to respect the jurisdictional question, particularly on something as important as native health. If we look at the issue of native health with respect to setting some health status targets, I'm of the view that if we were to do that with respect to lots of the general indicators like teen pregnancy, like low birth weights, we would start to be able to target our resources into some of the high need areas, one of which is clearly natives, in our province.

Speech pathology. I didn't like the statement, actually, that the hon. member made. I'm just trying to find it, because I wrote it down. It was that health units weren't prepared to take over speech pathology, and schools weren't prepared to give it up. Well, tough. The issue was that we did not have a component of speech therapy across this province. Some school boards were delivering it and doing a very fine job, but some weren't. Some felt it wasn't something that school boards should have to do. As a result, we had to decide, between the Minister of Education and myself, having switched portfolios, which way it would go. While it's fine to say that the school system should be the one to deliver it, that's fine for school-age kids, but what about adults who have speech pathology needs and preschool kids who have speech pathology needs?

As a result, we now have it situated in health units as a responsibility. In other words, they have to build a program, not unlike special education, that serves the needs of their health unit jurisdiction. We have a shortage of speech therapists; there's no question of that. But, interestingly, we're getting lots more into the province than we had even predicted to have by this point. I'm confident that by September, having had this past year as a transition year, the level of speech pathology out into the community will be virtually up to the minimum standard we set in the policy on speech pathology, and then we can go from there. But I think it was the correct decision to finally identify a group that would be responsible for the delivery rather than the patchwork that we had across the province.

I also want to mention, because the hon. Minister of Education asked me to mention, the special education review which is under way, which includes the Department of Health, the Family and Social Services department, and the Department of Education. It is really looking at the special ed and health issues in our education system – What is special ed? What is health? – all of those delineations. The ASTA had some done very fine work in a collaborative effort, and now the three departments are getting together to deal with it.

With respect to health units in schools, because the hon. member's very familiar with the education system, I'm sure he knows that a teacher invites people into his or her classroom, and that includes the resources of community health and community health nurses.

Member for Bow Valley, I wanted to talk about long-term care and give members a sense of how far we've come on the Mirosh initiatives. The total amount of funding that's been provided over the past two years, including this budget, for '89-90 and '90-91 is $24.2 million. We are getting into the many components of the long-term care report initiatives between votes 4 and 5, including, hon. Member for Bow Valley, the seniors' wellness clinics, the adult care, the recreation program upgrades. All of these initiatives which were identified so effectively in the Mirosh report are now becoming a reality, albeit perhaps a little slower than we had hoped they would. But I believe we've been able to target the resources in the area that they're needed most, and clearly home care has been one of the targets. Single point of entry has been a clear target, and nursing home expansion, to break down the delineation between nursing home and auxiliary care to allow heavier care in the nursing homes, has been a focus over the last two years of those efforts. But I think the fact that we've put in the $24.2 million over the past two years is a very clear indication of the support that this province has given to enhancing our long-term care system.

Now there's only one remaining, and that's West Yellowhead. I agree with the hon. member that the need for auxiliary beds in the West Yellowhead area is a need that's been identified and supported by the province. There are some projects up in the area of West Yellowhead which are some of the 35 projects which are this year proceeding only to the next point in planning and are being held for the remainder of the year. The question as to which of those projects proceed on the next year's fiscal basis, because clearly we can't do them all next year – the question of sequence is one that we have to look at as a province, and I'll be bringing forward recommendations to my colleagues and then to this Legislature in regard to the prioritizing of those projects which are approved. But I want to assure the hon. member and the people of West Yellowhead that this is not a break of a promise that was committed; it is simply a delay. The question is not if; the question is when.

With respect to the St. John's hospital, I'm glad to have on the record that the hon. Member for West Yellowhead does not support the decision of the province to give the new hospital, the new capital project, to a municipal board. I'm glad to finally have his point of view on it, and I'm sure his former councillors in the town of Edson will be interested in that point of view, as well as members of his community.

With respect to vote 7.0.2, I had already responded to that question in terms of the decrease when I answered the Member for Calgary-McKnight, and that will be in my earlier remarks.

Thank you.

MR. DEPUTY CHAIRMAN: The Member for Edmonton-Centre.

REV. ROBERTS: Thank you, Mr. Chairman. I wanted to pick up on a few other points that I've been wanting to get on the record, particularly in the last couple of votes, 5 and 6. I must say, though, just in defence of my colleague from West Yellowhead – he might have time to speak to the issue himself. I'd like to clarify the matter that the member is talking about, the consultation process that many felt was an inadequate and a faulty one with respect to the St. John's hospital, Edson. The outcome might not be in dispute, but how that outcome was arrived at is in dispute, and I think the member himself might want to speak to that.

Anyway, with respect to vote 5, getting back to the community health section, particularly home care, a lot has been said already. Actually, I really appreciated that discourse by the Member for Bow Valley on – I thought it was the Senior Citizens Secretariat. Nonetheless, I think he said some very positive things, and I wanted to congratulate him on that and particularly the work of the secretariat with respect to their pushing for greater home care funding. As I finished saying earlier, I don't know how we'd get a grasp on just what dollar total is necessary here to meet the needs. Certainly the amounts that were requested were very high, as the health units and the home care nurses saw what they could do if they had the money. The 44 percent over the last four years, I think, again is just beginning to scratch the surface of what can be done. So we're moving in the right direction. I guess it's just a matter of how far, how fast, and who does it.

I would like to ask the minister a question which has been posed to me, and I think it's an important one, with respect to how the home care dollar is itself allocated and what the mechanism is for establishing who gets what dollars. I know the Member for Bow Valley already said that it should depend on

the number of seniors in each of the different health units. But I'm wondering if there's been any consideration given to using a similar funding mechanism as we now have even in the acute care hospital sector with the acute care funding project, the sort of case mix index arrangement – whether such a funding mechanism might not also be applied to certain health unit programs, particularly home care.

It's clear to me that you don't just talk about home care in the generic way. Some recipients of home care have very heavy needs and are particularly sick, in the community and in their places of residence. For some there just need to be more nursing hours per day or per week than for others. I'm told, for instance, that in the Vegreville area a number of those who receive home care – actually, if they did not receive home care, they would go right into an auxiliary hospital level of care. In fact their case mix is very high.

So I'm wondering, in defence of those who are dealing not just with high caseloads but a high case mix index in the home care sector, whether some consideration might be given to how the home care dollar is allocated according to that kind of index. Now, again it would be a very difficult thing, perhaps, to try to assess, but I think we might get, as we're discovering in the acute care sector, more fairness in how the dollar is allocated, where we know it's going to go to meet those heavier care cases in the home. Otherwise, I'd like to know what sort of rationale is given when you have – I forget the dollar figures – say $100 million dollars of requests that came in and there was only $20 million to go out. What rationale was used? I'm sure somebody had to sit down with a pen and make some judgments, and I just want to know what rationale was being used and how the home care dollar is currently allocated, upon what basis.

I'd also like to ask the minister if she has some concern, as I do, about the development of private sector home and homemaking care. We have, for instance, the whole increasing phenomenon of UpJohn and Para-Med and others who are private, for-profit deliverers of home and homemaking care. I have heard some reports that, of course, they want to expand their services and expand their empire, so to speak, as they can realize, as many do, that home care is an area where there are going to be a lot of needs and it's going to be increasing over time. My concern is if they do develop more services and more elderly people want to have access to their services but have to pay first, whether or not we're going to be developing almost a two-tier system in home care: if you're a rich senior with something of a disposable income, you can buy more homemaking and home care services from UpJohn and Para-Med and some others, but if you're like many other seniors in the province who don't have a high disposable income, you just can't buy or finance that kind of care.

Now, some lines have to be drawn. I'm not sure how much the public purse and the health care sector should finance in terms of homemaking care. My bias, though, is toward wanting to develop it as much as possible, but some line has to be drawn at some point in terms of what's going to be provided from the public purse and what some people who can benefit from homemaking might have to pay out of their pocket. But I don't want to be pressuring that situation, with groups like UpJohn and Para-Med trying to corner the market and develop their services and make a two-tier system in the home care side.

I'd also like to ask, perhaps along the same kind of lines, how the funding allocation for the various health units, the 27 health units throughout the province, is arrived at. It's a real mystery to me. I don't know whether they have some historical basis to this or certain programs which seem to be of higher priority than others. I'm persuaded by some arguments that it might well be done on a per capita basis, in terms of certain dollars going to a health unit because of their sheer population size or the various caseloads they'd have for immunization or for home care or dental health for kids or whatever they're doing. But I am continually amazed by the desperate underfunding of the Calgary Health Services program, and I think that . . . You know, we've had a number of Calgary MLAs here and a former minister from Calgary, and I'd like to hear what they have to say about the people at Calgary Health Services, who have great difficulty in meeting a lot of the needs for their citizenry and they claim that on a per capita . . .

MRS. MIROSH: Just stick to Edmonton, Reverend.

REV. ROBERTS: Well, my goodness, here we go. Let's get a little debate going here.

On a per capita basis the Calgary health service, in comparison to Edmonton or even High Level or some of the others, receives far fewer dollars and yet has a great population, a growing population, a lot of kids, a lot of elderly. They need programs – in fact, they're having to cut back on certain programs – which I think are very essential and need to be further developed in the city of Calgary. Now, whether it's the bias of the Member for Calgary-Glenmore or my own lack of information, I would just like to know – it's never been explained to me by this minister or the previous one or anybody else around here – just how the health unit dollar is allocated and upon what basis.

Now, if you're telling them, you know, Gerry Bonham's left, maybe some think that's a good thing, but if you're going to tell them, "No, you can't just run up a deficit and expect to be bailed out at the end of each fiscal year," maybe that's an approach to take. But they're desperate and they need to have some further explanation. In their defence I, too, would like to have that kind of explanation, not just in the Calgary situation, though that's foremost on my mind, but how it works throughout the system.

With respect to the immunization, we did touch on that just a bit earlier. The Member for Stony Plain talked about whooping cough and the rest. I am quite encouraged by some recent developments from public health. I still maintain that the document we presented in the Assembly on April 2 entitled New Democrat Official Opposition proposals for Action on Immunization and detailed at least seven key recommendations, which I think would go a long way to ensure that similar outbreaks of whooping cough or in fact . . . As I might have mentioned, the minister's just been in Chicago. There's a great outbreak of measles. Then you fly up and stop in Minneapolis and you read in the paper there that there's an outbreak of measles. So maybe it's coming northward here. Who knows? I think the point is: we need to ensure that there are high rates of immunization, and that can only be done by a collaborative effort, understanding the difficulties and sensitivities of federal jurisdiction over native reserves and the school system. There are a lot of different players no doubt, but at least someone has to be there to be the catalyst and to get a comprehensive campaign going.

Now, wouldn't you know that I just went home the other night and got this nice letter from Dr. Waters. As a proud parent of a child under two years old I must congratulate the department and the minister and Dr. Waters for this very handy and very readable campaign in terms of the immunization race and how

the health unit can help in that, and an accompanying letter. Again, you know, good work. I might want to say it should have been done this time last year. Let's hope it's an annual thing that's going to be continuing to happen each and every year. As our recommendations say, there needs to be an annual mailout or campaign, and certainly as we know, this government likes to have all public education campaigns on TV and all the rest. So aim it at immunization levels, and I think it will certainly ensure a much healthier future for our children, which is something that we New Democrats particularly are concerned about achieving, and we can't do it with low immunization levels.

I also want to pick up with the minister comments I read that she made at the Health Unit Association annual meeting about an environmental health strategic plan. Now, this is news to me. When we nearly every day have time for Ministerial Statements and I know the minister has access to news conferences and the rest, this is news to me that there is in fact an environmental health strategic plan. I don't know if I can quote him correctly in that such things as the Al-Pac project would not proceed if there were not – I guess the adjective is going to be the operative word – "adequate" or "necessary" environmental safeguards. But certainly we know that the whole pulp mill development in the north – dioxins and furans and the rest in the water and in our province – has a very negative health impact. So I want to see more about what's in this strategic plan and more of the minister's own reservations about the proceeding of the Al-Pac project despite all the other politics that are going on around that issue.

Members have also made the comment about the need for early intervention programs, but I'd particularly like to raise the issue, as I understand it, that the early intervention programs, particularly for developmentally delayed children, is an area that can also deserve a lot more attention and work. In fact, we met with some people in my colleague's constituency in Vegreville – one mother who has been well served by some early intervention assistance with a developmentally delayed child she had – but saw that a lot more could go on and that there were other parents who could benefit similarly from the program. I mean, the Glenrose rehab services can't do it all. I think that if we could equip and try to emphasize with the health units how they could develop more staff and more ability for parents to refer to how to deal with kids who are – what? – two and three years old to get that early assessment and get some early intervention going, it would be a boon to people in Vegreville and throughout the province where it's an issue.

Together with this it's been said that – well, the Head Start, I guess, in the school system or the Nobody's Perfect program, which is another great health unit program aimed at, I believe, immigrant parents, or it's a parenting program. My goodness, Nobody's Perfect is such a wonderful title, and I'm glad it's a program that is gaining national stature, but still it's hard to get some funding for those who want to develop it in the health units.

I also wanted to ask the minister if she has some understanding or clarification about the provincial policy on the early postpartum discharge program. Now again it was my understanding that in the city of Calgary this was a program that was up and running and doing very well indeed. The health unit, together with the various hospitals, was able to go in and see, with some new moms and their newborns, how they could safely get home a day or two even earlier than was normal, thus saving, according to the Watanabe report, hundreds of thousands of dollars in inpatient stays if you can get the discharge early postpartum.

The information I had or the concern that was raised with me is that that was going well in Calgary and then all of a sudden a pilot of the same program was begun at the Royal Alexandra hospital and with the health unit here, when in fact it really didn't need to be piloted. We know it's got some good work and some good information around it. What are we learning more about that we haven't learned already? And if, as I'm persuaded, it's a good program – it's something that is, again, a way to increase health unit work to help decrease some of the inpatient hospital costs; it's the way to go – is not the Calgary experience enough? What more are we learning now? And when is it going to be a provincewide program so that all the health units will be able to do some early postpartum discharge planning with the new moms and babies throughout the province's hospitals so that we can have an average length of stay of not even a day after birth for moms in the province, where that's appropriate?

Similarly, if I could just get some update on the – I can't remember the exact name of it, but I thought it was kind of like an early intervention program for elderly who were going into emergency rooms and units in hospitals who might well, with some home care or with some health unit intervention, not face admission but in fact get home again and be cared for outside of hospital. Can you tell me the name of that? Anyway, it's a good program that was started here with district 24, I believe. What's the name of it? Can't remember?

MR. FOX: Seniors' day program?

REV. ROBERTS: No. Anyway, I thought district 24 was doing it and it was beginning to get some funding to look at how they could keep elderly who are in hospital emergency rooms from being actually admitted and instead of that go home with the appropriate care.

I'm sure, again, the issue of the extended health benefits . . .

MRS. MIROSH: The quick response team.

REV: ROBERTS: The quick response team. Thank you. How well is the quick response team program going? It would be good, because I think it's a good program and needs some support there.

On the extended health benefits side, I guess questions have been raised already – having now met with the Diabetes Association and knowing full well all the implications of lack of blood glucose monitoring for diabetics in the province – about how this issue is going to be resolved. I think the minister has at her desk a number of very good options. Again, as someone who knows well the difficulty of diabetics to have to finance each week and each month and each year the blood glucose strips and the monitoring machine and all the rest – I mean, it should be part and parcel of basic health care in this province. I just want to know, again, how much longer we have to wait to have this become a reality. My preference would be that it could be funded under the extended health benefits, but if the minister has other solutions, I'd like to hear them as soon as possible.

We touched a bit, too, on the native health issue, and I think it's a very important one that needs a lot of care with respect to it being under federal jurisdiction in some respect. But I'd like to raise with the minister and members of the Assembly in committee here just how we're meeting the needs of natives in

the urban context. These are native people who are off the reserve, who have come to the city, who live down in the Boyle Street area and Edmonton-Centre and throughout the cities of Edmonton and Calgary and other cities and towns throughout the province. I was very pleased to read about I thought some very useful and creative work being developed by the Edmonton board of health and the Indian health care association of Alberta, together working at how they could develop a program that could get some native community health workers themselves to link up the medical system with the native community in an urban context. We know the issues are widespread here. The health status of native people, particularly in our cities, is extremely low, and I think it's an area if we're really concerned about health care and setting health targets and meeting the needs of Albertans, a consideration for $175,000 for this native urban health project didn't sound to me like a lot of money. I'm just not sure if over three years and with the six native community health workers, this has been reviewed by the department and if the proposal is wanting and needs to be improved. Certainly I think it's a very creative and very important initiative that needs to be examined and looked at. Heavens, out of a $3 billion budget we must be able to find $715,000 over three years.

If I could ask a few questions about the whole AIDS issue and the AIDS strategy. I am still concerned that there's a drop in the budget here. I thought I heard the minister say, "Well, it's because we know what we're doing in education and prevention, and we don't need these extra administrative costs." The word I get from the field and the community is that there's still a lot that needs to be done and a lot of clarification about what programs are proceeding. For instance, the needle exchange program I think I raised before: where is that at? Are we going to get the federal funds? Is it just going to be in Calgary, is it going to be in Edmonton, or is it going to be provincewide? In fact, the provincial AIDS advisory council hasn't met for some months: the need to network and collaborate especially between groups that have a lot of vested interest, whether they're the AIDS Network here or AIDS Calgary or a new development in Lethbridge, bringing them in in terms of co-ordinating with what the health units are doing and what the schools are doing.

A lot of work still needs to be done to oversee and ensure that the very best of prevention and education with respect to the transmission of HIV is going on. Even universal precautions in hospitals – I'm told that most hospitals don't have the funding to teach nurses and those who deal with blood and bodily fluids how they can and should take universal precautions against infection, whether it's AIDS or hepatitis. So I would just like to know more about the rationale for some cutbacks here in administration. I mean, even police officers, I'm told, still need a lot of education with respect to how AIDS is transmitted and what to do in terms of violent crime and so on. We had the debate here about public health measures to apprehend those who were willfully and dangerously and maliciously spreading the disease. We had that whole debate, and then that person was arrested by the Calgary police and criminally charged.

I know we've come a long way, but I think more needs to be done in the education/prevention side here, even on the human rights side. I am told that HIV infection now does qualify as a physical disability and that someone who is tested positive for the HI virus cannot be fired from their job or evicted from their place of residence or whatever. I guess it's not appropriate to ask this minister, but I think a lot more still needs to be done to educate the public as well about AIDS and HIV transmission and the need for a lot more care and understanding of that issue, even with the embalming issue. I guess again that this is another minister, but even in the funeral industry embalmers are now licensed and regulated for dealing with those who have died of infectious diseases such as AIDS. There should be no reason in the world why the loved ones of persons who have died with AIDS cannot have that person embalmed, yet in this province it's still not allowed. So more needs to be done there.

On the care and accommodation side I think this is a growing part of the issue, especially those people living with AIDS who are in need of long-term care. I'm still very impressed by the interagency committee here in Edmonton, and I know similar groups in Calgary and throughout the province who are trying to get their act together in terms of how to deal with the long-term care needs and accommodation of people who are living with AIDS. Yet, again, I'm told that the funding is both inadequate and slow. It wasn't until the end of the fiscal year that they were assured of what funding would be forthcoming. Maybe the minister could clarify when she said, as she did last time, that she was the minister of the homosexual and the heterosexual, how persons with AIDS, being a part of that community, are not being discriminated against when it comes to their needs for long-term care as they continue to live with AIDS. I think we've had the reports and the rest in the province, and I think we need to get on now and appropriately fund by way of the interagency committee the growing needs of care and accommodation for people living with AIDS.

Then I'd just like to ask the minister as well – I keep hearing about the need for a national AIDS strategy and that in fact Perrin Beatty I thought had recently announced that sometime in June he would be presenting the national AIDS strategy. But I'm also wondering if there isn't a place for an interprovincial AIDS strategy, that as different provinces are developing different programs, both on the prevention side and the treatment side, whether this minister has contemplated, with either her ADM of public health or the AIDS director or whoever, a first ministers' conference on AIDS to bring together the provincial expertise that is developing so that we can at the provincial level not just wait for a national AIDS strategy in terms of research and certain things, but bring provincial people together and say, "This is what we're doing in Alberta; this is what we're doing in Ontario, Quebec, Manitoba," and share more effectively what the programs are that are developing, share together and ensure that throughout all of the provinces of Canada we're helping each other in what can only be described as one of the greatest challenges to the health care system today.

Moving on a bit more to vote 6 and the whole mental health field, I had a few comments again which I don't think others have touched on. I would just like to raise them. I mean, we've heard the minister say that she supports a shift in focus and a shift in emphasis, and I think even perhaps a shift in dollars to go from the institutional health care side to community-based health care. But you have to wonder when we look at the mental health budget here – exclusive of the new money for the children's mental health services; that's a need that's long overdue, and it's now being met partially by that new money. But where does that leave the rest of the system? As I figure it, there's almost no increase at all for community-based agencies delivering mental health services, like the CMHA and others who are out there in the community delivering those services. Yet the hospital sector – and I don't know if the minister has a separate line for what has gone into the institutional mental health side, but I'm assuming it's at least the 3 percent that all

hospitals have gotten. So if the hospitals like Alberta Hospital Edmonton and Ponoka and other psychiatrically designated hospitals are getting a 3 percent increase for the institutional care, what's happening to the community-based agencies who continue to have to struggle to deliver services to adults with mental health needs? Does this not betray in some sense the minister's own stated commitment to make this shift from institutional to community-based care, when after all the talk and the rhetoric what the real dollar amount is is that the institution is getting more and the community-based services are getting, well, nothing more? They're not getting any less but not much more. Even they have salary costs and the rest, which I'm sure inflation is going to eat up.

I did have a constituent who called from the House Next Door, a good program over there by Robertson-Wesley United Church, who said that he was going to leave the program. He'd worked there four or five years, had gotten no wage increase, and the program was getting more and more difficult and challenging. He was burning out, and he was going to look for work elsewhere. Was it the church's fault, or was it the government's fault, or why was there not any new funding coming into that program for those with mental health needs at the House Next Door? So I said, "Well, just hang on, and don't leave the job quite yet; let's see if we get some answers from the minister in terms of some real commitment to the reallocation of the mental health dollar."

[The member's speaking time expired]

MR. DEPUTY CHAIRMAN: The hon. Member for Edmonton-Kingsway, not there; West Yellowhead, not there.

The hon. Member for Vegreville.

MR. McEACHERN: Edmonton-Kingsway too. Is it hard to see?

MR. DEPUTY CHAIRMAN: I have excellent eyesight. You're not in your place, hon. member.

The Member for Vegreville.

MR. FOX: Thank you, Mr. Chairman. I'm pleased to have the opportunity to raise a few concerns with the hon. Minister of Health during this special occasion, a chance to review her budget estimates for a second time. I think it ought to be noted: the special designation of this evening's discussion by the Official Opposition is a clear indication of the important emphasis that we place on health care for Albertans. Certainly there are a lot of health care needs in the Vegreville constituency that I would like to discuss with the minister.

The Member for Taber-Warner broached the topic of hospital construction – auxiliary hospital and nursing home construction projects – in the province, and I think, you know, I'll have some comments relating to the specific construction projects that are needed in my constituency when that budget is being discussed under the Capital Fund estimates. But I would like to get some answers from the minister about just how the department makes decisions about which projects go ahead when and which ones are on hold for a period of time, because I think we can all admit that we are in a time of pending crisis with a rapidly aging population in the province of Alberta. With the government having placed an emphasis over the last several years on building acute care facilities here and there without having placed much of an emphasis on building long-term care facilities, we're in a desperate situation in some areas of the province where there are a large number of seniors, pioneers in our communities, who are needing nursing home or auxiliary hospital care and can't get it because these facilities in many communities, and I'm sure several in the Taber-Warner constituency as well, are full.

Just to outline briefly for members, the Vegreville constituency has the highest percentage of seniors in the province; that is, people over the age of 65. I think if statistics were checked we'd see that we also have by far the highest percentage of people over the age of 75. These are pioneers whose rugged, determined spirit helped build Alberta's northeast, and I think we need to think very seriously about the kinds of things that we do to care for them in their later years.

There are some other facilities in the Vegreville constituency that I'd like to remind members of. There was a brand new hospital opened in Tofield in 1987. It's a multipurpose facility with active care beds, nursing home beds, and auxiliary hospital beds. The auxiliary hospital side is filled and has a waiting list of 50. The Vegreville hospital is filled and has a waiting list of 67. The town of Vegreville has a percentage of population of people over 65 of close to 23 percent. So the need is very great. The board recognized this need sometime ago, and began planning for a 40-bed addition in 1977. That's 13 years ago. It was apparently approved in 1987, and then there was some discussion, apparently at the request of the Department of Public Works, Supply and Services.

Instead of going ahead with building the 40-bed addition to accommodate the seniors waiting, the department recommended that the board look at building an entire new facility: a 130-bed facility to replace the existing one and provide the additional space. The board went through some of that planning process and then was told at a later date that there likely wouldn't be enough money in the budget to build a whole new facility, so they had to go back to look at building the 40-bed addition to add 40 beds to the existing 90-bed facility at the Vegreville Auxiliary hospital and nursing home. So the planning went on and on and on. Certainly, the expectation was there that this project would go ahead this year. Now, I know a number of communities expect these things to go ahead, but I think we need to try and demonstrate that the need is here and that the need is great.

[Mr. Schumacher in the Chair]

It's interesting that when people in the community asked the hon. Premier when he was campaigning during the 1989 election what kind of priority would be placed on the project in Vegreville, he assured them, in fact flatly stated at the meeting held in Vegreville, that it will go ahead this year. He also said that the only way taxes will go is down. But I think commitments made are commitments that should be kept. If the Premier wasn't prepared to make a commitment, then he shouldn't have given the board and the people he spoke to that kind of hope at the time. I had the opportunity recently to tour the facility with our health critic, my hon. colleague for Edmonton-Centre, and in so doing we learned through our discussion with the board that looking at building this addition and, indeed, working towards replacing the entire facility would save the minister's budget a considerable amount of money over time.

The Member for Taber-Warner quite rightly referred to the fact that long-term care patients unable to find space in nursing homes or auxiliary hospitals are often accommodated in acute care settings at considerable extra expense to the minister's

budget. In Vegreville at last count there were 18 long-term care patients who were taking up space in the acute care hospital, the St. Joseph's hospital there, at a cost of $395 a day. When you cost that out over a calendar year, it's $2,595,000 to keep the patients in that setting. If they were in an auxiliary hospital situation where the costs are about $110 a day, the cost per annum would be around $722,000 to look after those patients. And the quality of care would be better, because in the nursing home/auxiliary care kind of setting long-term care priorities for patients are quite different than they are for active care patients. We're able to provide recreational therapy and physiotherapy and interaction with other patients or other residents in a similar situation. It makes for a much more wholesome and healthy kind of environment, I think, for our seniors. So in terms of saving the minister's budget money, I think the department has to reassess its decision to delay this project.

The other concern that was obvious to both my colleague the Member for Edmonton-Centre and me on our visit to that facility was that it's woefully out of date. The 90-bed facility that's there is inadequate in every sense of the word. There are only two bathrooms in part of the hospital there for patients. The bathrooms in each room are so small that people in wheelchairs do not have access to the bathrooms. In fact, it would take two staff members to lift a patient from their wheelchair onto the toilet; there's not room for two staff people in there. So we have an unacceptably high rate of workers' compensation claims coming from that facility, because the staff, quite literally, are working themselves far too hard to try and provide the kind of care that they know the patients need and they know they want to provide for the patients. The facility just doesn't help them. There aren't any facilities there for recreational therapy, pathetic facilities there for physiotherapy for the patients. The mechanical systems are very poor. There is not adequate wheelchair access. I submit that operating this facility costs a lot more than it needs to cost because it was built poorly in the beginning and it's poorly designed and it no longer meets the needs.

I know that the Minister of Health is very aware of this. We've had a chance to discuss it on a number of occasions, and I have no doubt of her commitment and no doubt of her ability to properly assess the needs of Albertans in various communities. I'm raising these concerns so I have an opportunity, I guess, to convince her colleagues, some of whom I think may make decisions based on things other than demonstrated need for some of these facilities.

I think there were some efforts made by a previous minister, and I believe followed up by the current minister, to fund facilities like auxiliary hospitals, nursing homes on a flexible kind of basis so that patients could be assessed as to the level of care that they require, the kind of demand on staff, the kind of direct medical attention required so that we wouldn't fund each facility equally based on just the number of beds they have. Some consideration would be given to the actual caseload and requirements of the patients that live in that facility. I think my suggestion would be that more work be done in that area to work towards the kind of sensitive funding that I think is required as we deal with a progressively aging population.

I have put a motion for a return on the Order Paper, and I hope the minister has a chance to respond positively to it. I do have a list that describes all of the projects that are either proceeding to construction, proceeding to tender, on hold, or going ahead with some dollars today. I've got that list, and if the Member for Taber-Warner wants me to share it with him, I'd be happy to. But what I'm hoping to get from the minister is an indication of the number of people on the waiting list for all of the facilities described therein that are either additions to or replacement of existing long-term care facilities.

The 67 people I described as being on the waiting list for the Vegreville auxiliary hospital and nursing home at this time are people whose needs have already been assessed. These are patients who need auxiliary care. We estimate that within three to five years that list will be 100 in the Vegreville area. The need is very great. I want to emphasize that again for the minister and her colleagues, and I hope that the government will be able to demonstrate to me and to Albertans when they sit down and assess the dozens of requests that come from communities who have needs across the province, that they are assessed in a fair and balanced way that takes into consideration not only the . . . [interjection] I know the Member for Athabasca-Lac La Biche thinks that decisions should be made on politics, not need. I've heard his input on that sort of thing before, and I think that's a shame, because I think that's not the way this minister wants to operate.

I think we need to be able to assess the legitimate needs of the people in a community with some projections included in there as well, so that we can prepare in advance for what's happening in different communities rather than being in a situation where there are a number of long-term care facilities filled to overflowing, with waiting lists in different areas around the province. This could have been anticipated. It could have been dealt with a long time ago, but it wasn't, and there's a considerable amount of catch-up that has to be done at this point.

While talking about that facility, I would like to ask the minister specifically how she handles requests that come from Legions and groups representing veterans in the country or departments of veterans' affairs for hospitals to designate space for veterans. The Royal Canadian Legion in Vegreville sent a letter to the Hon. Gerald Merrithew, Minister of Veterans Affairs in Ottawa, with copies to me and the MP for the Vegreville constituency, basically pointing out that the average age of First World War veterans in the area is about 87, Second World War veterans average age 67. There are a number of veterans living in the Vegreville area. The Department of Veterans Affairs is charged with the responsibility of providing care for these seniors or advocating on behalf of the veterans, and they're urging the Department of Veterans Affairs to negotiate space in the proposed expansion to the Vegreville auxiliary hospital and nursing home to make sure that the people who went overseas and fought for our freedoms can be assured that in their later years they will be able to receive the care they need in the communities they've spent their lives in. I'm just wondering if the minister is aware of requests like this. Are there precedents for this kind of request? What kind of assessment does she do in that regard?

I think when we're talking about long-term care for seniors, we have to talk about a continuum of care that doesn't involve just the nursing home and auxiliary hospital situation. The Vegreville auxiliary hospital and nursing home has made application to the department for some consideration in a pilot project that involves day programs for seniors, a kind of outreach in the community day programs for seniors. I'd like the minister to respond to that situation, and tell us how the project's coming, which communities are going to be accepted in terms of a pilot project. Has it been done in other com-

munities: day programs for seniors operating in sort of an outreach capacity from auxiliary hospitals and nursing homes?

Certainly the area that we all hear a lot of talk about and need to understand more about, I submit, is the area of home care. It's long been recognized by everyone involved in the field that an ounce of prevention is worth a pound of cure. In terms of providing care for seniors that means going out and trying to provide some home care for them so that they can remain in their own homes longer, not only provide better care for them in a more familiar and comfortable setting but save the government money, save the taxpayers money, because we don't have to be spending $395 a day to keep them in an auxiliary hospital situation.

Now, in the Vegreville health unit district my understanding is that there are approximately 500 clients on home care, and they have from time to time had to turn people away who require home care assistance and cut people off services they have been providing, because they operate continually in a deficit situation. The need again is very great in the Vegreville area because we have the highest percentage of seniors of any constituency in the province. I have raised this concern with the minister in conversation, and I believe I have an undertaking from her to look into the specifics of the home care problems in the Vegreville health unit district because I think a number of other health unit areas in the province are not experiencing the same kind of problems with regard to levels of home care funding and the kind of demands that are being made on the funds that are available.

How does this relate to planning for auxiliary hospitals and nursing homes? Well, the estimate from the people we spoke to out in the Vegreville health unit area about home care was that there are approximately a hundred home care clients right now that they're providing care for who will in the very near future require auxiliary care. Now, these are people who are not going to go from a home care situation in their home to a lodge, live there for a while, and then move into a nursing home, live there for a while, and then move into an auxiliary hospital. These are high-needs clients who are able to remain in their homes with some assistance in terms of meal preparation, medical care from time to time, housekeeping, that sort of thing, but their needs are such and they've been assessed to show that they're going to go right from home care to requiring full-blown auxiliary hospital care. There's a tremendous need right now for expansion of the Vegreville auxiliary hospital and nursing home, and there's a tremendous potential need in the future.

So I hope the minister will have a chance to reassess the decisions made about those projects, come back and respond to the motion for a return that I've placed on the Order Paper so that we can find out just what is the real need for projects everywhere in the province. It's not up to MLAs to decide that. I mean, certainly we're not in a position. We all have priorities we want to advocate for in our own constituencies, but Albertans have to be assured that there is in place a fair kind of assessment of the needs of the people in our communities and that those needs are going to be responded to in the best possible way by the government of the day. I can tell you that the people in Vegreville are not convinced that that's the case. Recognizing that we have a very high need there, it's not being addressed. The concerns are great and growing.

Another thing that I wanted to raise with the minister, and I thank my colleague the hon. Member for Edmonton-Centre for raising it briefly, is the need for an early intervention program, again in the Vegreville health unit area. There was an ad hoc committee formed that made a proposal to the minister's office to get some assistance so that the Vegreville health unit could have someone who was working as an early intervention co-ordinator along with some aides who would go out and work directly with the families and individuals who could benefit from early intervention. I'd like to know what happened to that application and how the minister plans to address the need. I understand that there are early intervention programs operating in some areas of the province, and while I recognize we can't have exactly the same services for everybody everywhere in Alberta, I think we should have as an objective providing a good, basic, minimum kind of service for people regardless of where they live. If a family living in Vegreville has a child who has been assessed as developmentally delayed and this child is under the age of two and a half or three years old, there's nothing available for them. They have no opportunity; whereas, if they lived in another community that had an early intervention program operating, their needs would be met. I'd like the minister to tell us where these early intervention programs are operating and what the department's plans are for making sure that people in the province have reasonable access, our children have reasonable access, to early intervention programs.

I might point out for members that there have been studies that show that there are substantial gains in IQ and other cognitive measures for children who have the benefit of early intervention programs. Statistics in our area indicate that there may be up to 20 families who need that service. We have moved towards providing integrated education for the children in the area. I think that recognizing that education is a continuum, child development is a continuum that doesn't just begin when they enter school; it has to start much sooner. If the growth and development potential of children is to be maximized prior to school entry, I think there is need for early intervention programs in Vegreville certainly and in other communities in the province.

The benefits of the early intervention program would be enjoyed not only by the children affected and the families who try so very hard to provide care for these kids; the benefits would be enjoyed as well by the province's budget in the long term. I think it fair to say that there would be less need for financial involvement in the care of these individuals as they grow older if they're able to benefit from the early intervention program.

I understand that the Brassard report, the Premier's council report, and the northeastern Alberta Private Agencies Social Services report have all supported the view that individuals with disabilities should have the right to become and to be recognized as responsible, capable, and productive citizens within our society. I think that being agreed to, we have to recognize that an early intervention program should become, then, the first and perhaps the most important step towards achieving this goal, giving parents and families the support required to raise special needs children. So I'm hoping the minister will have a chance to respond to that concern. I might just point out a motto that the One Hundred Ten workshop in Vegreville provided to me in a letter that they wrote in support of this project: "Intervention now can prevent segregation later." Given our objectives in terms of education and overall care for people, I think that's something we need to deal with as well.

The last thing I would like to leave the minister with is just a request to determine what strategy she has to make sure that communities in rural Alberta that have hospitals have doctors. It's a problem in a number of areas in the province. People who

are trained as doctors and who practise as doctors tend to want to locate in larger communities, in major cities, and we've got a very difficult time attracting medical professionals to rural communities. There is a concern, for example, in the town of Two Hills, a beautiful 100- or 110-bed hospital there. The one doctor that's been there over the last several years, who's done yeoman service, is just worn out from trying to meet everybody's needs all the time. They haven't been able to attract ongoing support for him, and he's leaving. There was some talk about the hospital having to close because there was not a doctor there. The needs of the communities exist, and I'd like the minister to be able to tell us what kind of strategy she and her department have to try and attract or provide incentives for doctors who are willing to locate in hospitals in rural areas outside major centres in the province of Alberta.

Thank you.

MRS. BETKOWSKI: Mr. Chairman, I think it's time I got in and worked on some of these issues, because I don't think I'll get another chance.

I would like to work my way through, if I can, the remarks by the hon. Member for Edmonton-Centre, with the couple of occasions he's had to speak to the issues in health this evening. First of all, he spoke about the mission statement in the Department of Health. In fact, we do have a mission statement that we've developed within the Department of Health, and right now we're in an exercise of ensuring that that mission statement is consistent with the vision envisaged by the Premier's commission in The Rainbow Report. While the hon. member may think that's a simple exercise, in fact the bringing together of that vision and checking our consistency with it and noticing areas that are not the same is a very important exercise – and determining if we're wrong, in the sense that the vision that's been expressed might be inconsistent with some other views. So that work is going on. But we do certainly have a mission statement, and it was one of the primary aims of the new Department of Health when it was created by the Premier in September of 1988. Interestingly, the mission statement is much more than just the combined mission statements of the two former departments because in fact Health as an entity is more than Community and Occupational Health and Hospitals and Medical Care. I mean, the bringing together has created a whole new synthesis.

With respect to health care premiums the hon. member is right: we're not going to agree on this one. But I happen to believe that our movement from the existing about 40 percent of the health care costs for those covered by premiums to 50 percent and then gearing our premiums to that percentage of cost is an appropriate move. It's appropriate for the reasons that I've expressed in the House, but I will repeat here again that it creates an awareness on the part of an individual when they pay that premium or when they see that premium going up, an awareness of the realities of our health care system. Utilization increases, albeit imperfectly measured, are very much a part of health systems, and I think rather than policing or punishing those who might use the health system, because we never want to be put in a position of doing that, we have to increase awareness. So it really is a public education measure, and it's one that I believe is appropriate.

The hon. member is right about one other thing, and that is the whole issue of whether or not the health care insurance plan is in fact an insurance plan. It's really an insurance plan in the manner that it's a premium-paying plan, and those premiums are dedicated to a special fund. He's right; it is not an insurance plan in the sense that you get penalized for having this disease or that disease, nor would that be consistent with the Canada Health Act. So if I have misled him in any way with respect to my sense of what is an insurance plan and what isn't, then I apologize and hope the record sets itself straight. It's on the record.

He asked the question of what if the federal government continues to cut back, as they certainly have in this year, and the forecasted plan is that they will do so in the coming years. I was interested today because I was speaking, Mr. Chairman, at a conference in Ottawa on the resource management in health, which was sponsored by the *Financial Post.* I was interested to hear the deputy minister of health say that this reduction measure, which is affecting Alberta in a very real way with respect to established programs financing this year, would only be for a certain number of years, and then everything would get back to normal. I'm skeptical. And the question comes to Albertans: what do we do if the federal government continues to decrease its support for something as important as health when in fact they've legislated their involvement in health? Well, what do we do? It's our constitutional responsibility, Mr. Chairman, under the Constitution, that Alberta and all the provinces have the jurisdiction over health. So what will we do? We will continue to support our health care system because we deem it to be the second priority to education in our government. So that commitment stands, and if others don't recognize their commitment and don't live up to their commitment, then we will have no choice but to dedicate provincial resources to that very, very important sector.

The hon. member asked about mediclinics, about the role of the permanent monitoring committee, and about his proposal for community health care centres. I believe there is certainly a role for community support services, and I think as we look at the whole issue of primary care within health, we need to look at different models for delivery of primary care. My concern, however, and the reason why the matter is being referred to the permanent monitoring committee, is the reality that people go to clinics in a community sense and then re-enter the health system within 48 hours in about 80 percent of the cases. At least, that was the original statistic we had on the matter. So I am not opposed to community clinics; in fact, I'm very much supportive of them. But what we have to do is ensure that we are delivering a service there that is unique, that is not being duplicated in the acute care system, and that it is sustaining and exists unto itself and is not something that's going to be used or abused in the overall context of health as we manage it.

Midwifery. As the hon. member knows, the issue of midwifery appeared once before before the Health Disciplines Board and was deemed to not be a licensed profession within the province. The matter will be before the Health Disciplines Board again, I understand this month, and like everyone else in this House and in Alberta I will be following with interest the resolution of the issue. I look forward to hearing the recommendations from the Health Facilities Review Committee because of course they have to do the licensing, or at least the approval of the profession within Alberta, before a legislative framework can follow.

The hon. member talked about salaried physicians, and he also talked about setting an upper limit in terms of income for some professions on the fee-for-service basis. I don't agree with his latter point in terms of an upper limit, but the whole issue of models for payment for health professionals is one that we are looking at carefully. In fact, we have examples throughout the

province of different models; for example, for oncologists who are at the Alberta Cancer Board, who are on basically a salary component, and physicians at places like the Boyle McCauley Health Centre, who are on a salary. So the examples exist in the province. The question becomes: how can we get that introduced into the system? It's certainly one that we are working on with the AMA and others.

The issue of rural health is one that several members, including Edmonton-Centre and Vegreville, mentioned. The issue of supply of physicians is one where we've seen an increase clearly beyond the rate of population growth in our province, yet the question of the distribution of those physicians is the problem that we face. We don't have enough physicians in the areas that we need them, in terms of specialty, in particular areas of the province. It's a problem that's been addressed by a couple of groups, including the AMA and others. I have a committee that will be reporting to me, hopefully by next month, made up of the two deans of medicine from the University of Alberta and the University of Calgary, of the AMA, the college, and the Rural Health Association of Alberta. I'm hopeful they will come forward with quite a comprehensive framework for finding ways to get physicians trained in the uniqueness of smaller health care centres and the issue of just generally having those physicians out there in that marvelous infrastructure of health facilities that we have throughout this province.

Actually, one of the issues – and I think it's important to just raise it here – that was discussed at this health conference that I was at in Ottawa, was the issue of universality of our health system, clearly one of the principles in the Canada Health Act and a principle which I wholeheartedly support. But the reality is that we have limits in terms of our resources to dedicate to our universal health system, and the question becomes: where should those limits be applied? It's a very important debate. It was one that was ensuing when I had to leave Ottawa to come back here and do my estimates. But the question becomes: where do you place the limit? Do you limit services provided? Do you place limits on the basis of income? Do you place limits on new, young graduates going into our health system? These are very real questions and very important debates and ones that I hope we will be able to pursue further.

The Royal Alexandra hospital. I can't say any facility has a special spot in my heart, but this one really does, and it's because my father was a practitioner at the Royal Alexandra hospital. So I kind of have a soft spot in my heart for it. Nonetheless, it's treated like every other facility in the province. I was born there too; that's another reason why it's really special. But the issue of the capital plan at the Royal Alex: it is not one of the 35 projects. The Royal Alex, with a very specific need in critical care and the expansion of their emergency, is one of the busiest in North America, I would note, and that capital plan is proceeding to the point of tender in this fiscal year. So it's one of the nine projects, for the delineation of hon. member. It's not one of the 35, because of the health need.

The whole issue of a potential for an urgent care centre – call it what you will – as a satellite to the Royal Alexandra in northeast Edmonton is one that I have asked the board to come back to me with proposals on. They're looking at it very carefully. This would be more than a medicentre. It would hopefully have the potential of being the ambulance centre and basically being a wing of the hospital, though not connected to it. I think it's a marvelous opportunity, and frankly the discussion in the Calgary advisory committee on ambulance – the Kohut report, chaired by Mr. Cornish – contemplated these kinds of satellite centres from a hospital.

I think the issue of pastoral care is one that we might look at in a more thoughtful way than perhaps the estimates provide us with the opportunity. My question is whether or not health dollars, which are scarce, should be specifically dedicated to pastoral care within institutions. I don't know the answer. I've met with the Alberta pastoral association, the Catholic Hospitals Foundation, and others, and many view, as I do and as the hon. member does, the whole issue of the spiritual person, particularly when faced with the difficulties of acute care or even long-term care, as a very real issue in health. The question is: how do we encourage it? Is it the place where we should put our limited resources? Where is the balance? I don't, frankly, have all the answers, and I would be grateful to the hon. member if we might have a little more thoughtful discussion on it at some point.

The question of hospital fund-raising privately. We are working, obviously, with health facilities all around the province, particularly hospitals, to determine and establish role statements, which would be done in a co-operative way to determine the kinds of programs that would be delivered at that facility. I think that kind of role statement complements the issue raised by the hon. member. He was concerned that because a facility might be turned down for a particular program because it might exist in another place, it would be very useful to have a role statement say: This is our role; we will dedicate our private funding to this thing which is consistent with the regional role. I think, in fact, it's a very complementary role. I'm not one who thinks we shouldn't be doing the fund-raising. Certainly I believe that individuals want to have a chance, by choice, to dedicate specific funds to a specific facility, and I don't think we should take that right away from them.

Health units. Ah, the Calgary board of health is underfunded. There is an historic difference between, certainly, the Edmonton and Calgary health units, but that difference has been steadily lessened over the last five years. It was started when the hon. Member for Calgary-Shaw was the Minister of Community and Occupational Health, and that trend has continued with the hon. Member for Edmonton-Glenora to bring more equitable funding between the two health units. The historic reason for that was that the Edmonton board of health was delivering a broader program. They were funding programs like the Boyle McCauley Health Centre. That kind of thing does not exist in Calgary. So we are looking at the whole issue of equity in funding amongst health units, and believe me, it's a big issue. But I would be pleased to give the hon. member a sense of the gap and how it has narrowed substantially over the last several years.

The environmental health strategic plan, which the hon. member mentioned and which I mentioned in my remarks to the health units in Banff, is one that will – because there are environmental health issues being addressed in several departments, including Agriculture, Health, Environment, Economic Development and Trade, we have decided to pull together a sense of where are the environmental health issues, are we duplicating, and can we get better value out of the resources that we have? All of those departments will be part of that strategic plan.

The question with respect to Al-Pac. I'm surprised the hon. member would ask me that question, because it's our Premier's statement, which has been repeated in this House on numerous occasions by not only our Premier but our Minister of the Environment, that the project will not proceed unless it can be done in an environmentally effective and safe way. That's not

a new position; that's one that's been espoused by this government and certainly was part of a campaign which took place about a year ago.

Early intervention programs. It's partly why I am as strong an advocate for health being the responsible body with respect to speech pathology. Early intervention is something that we need to do with respect to some kids who are developmentally delayed, and it's one that we have paid close attention to. We could always dedicate more; I fully acknowledge that. But the work that's being done in early intervention around the province is something that I think we should all be proud of, and we should continue to work towards ensuring that we complement the work done between school boards and the health units.

MR. CHAIRMAN: I hesitate to interrupt the hon. minister, but pursuant to Standing Order 58(1) and Standing Order 59(2), the Chair is required to put a single question to the committee. The question for the committee is: does the committee agree that each one of the resolutions not yet voted upon relating to the main estimates of the government and the Legislative Assembly for 1990-91, including the supplementary estimates of expenditures and disbursements covered by special warrants for the fiscal year ended March 31, 1990, be approved? All those in favour, please say aye.

SOME HON. MEMBERS: Aye.

MR. CHAIRMAN: Opposed, please say no.

SOME HON. MEMBERS: No.

MR. CHAIRMAN: In my opinion, the ayes have it.
Deputy Government House Leader.

MR. GOGO: Mr. Chairman, I move the committee rise and report.

[Motion carried]

[Mr. Speaker in the Chair]

MR. SPEAKER: Order please.
The Member for Drumheller.

MR. SCHUMACHER: Mr. Speaker, the Committee of Supply has had under consideration certain resolutions and reports as follows: each one of the resolutions not yet voted upon relating to the main estimates of the government and the Legislative Assembly for 1990-91, including the supplementary estimates of expenditures and disbursements covered by the special warrants for the fiscal year ended March 31, 1990. Mr. Speaker, I wish to file a list of those resolutions voted upon by the Committee of Supply pursuant to Standing Order 58.

MR. SPEAKER: All those in favour of the report, please say aye.

SOME HON. MEMBERS: Aye.

MR. SPEAKER: Opposed, please say no.

SOME HON. MEMBERS: No.

MR. SPEAKER: Carried.
Deputy Government House Leader.

MR. GOGO: Mr. Speaker, it's the intention of the government tomorrow to call as government business the Alberta Heritage Savings Trust Fund capital projects division.

[At 11:47 p.m. the House adjourned to Friday at 10 a.m.]