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| Alberta | 20e  | 1re  | Débat sur le budget | 28 mars 1983 | M. David John Russell | Ministre des Hôpitaux et de l'Assurance maladie | PC |

**Mr. Russell:** Mr. Speaker, I rise tonight to participate in the budget debate and share some various serious concerns and some proposed solutions with respect to the matter of funding Alberta's health care system. I want to congratulate my colleague the hon. Provincial Treasurer for bringing in what I think was an excellent budget, knowing the challenges he faced with respect to revenues. In my own case, I am more than keenly aware of the rising costs. Just before this Legislature assembled, we had to pass a special warrant for $150 million to put additional funding into our health care system. That's merely symptomatic of the challenge that faces all governments, probably in the world but certainly in North America, with respect to the problems of health care financing.

It's interesting to note that in the 20-year period between 1960 and 1980, Canada went from 5.6 per cent of its gross national product to 7.9 per cent of the product, with respect to contributions to health care. During the same period, the United States started out lower than us, at 5.3 per cent, but are now considerably higher, at 9.8 per cent, and still growing. So the cost of health care each year is consuming more and more of the gross national products of the expanding nations on the North American continent.

During the last decade, the per-capita costs of health care in Alberta went from $327 to $1,154. In Canada, the same figures went from $322 to $1,051. So again you can see, going back from the national figure to our scene here in Alberta, we are increasing at a more rapid rate than the national average. Our patient day cost in hospitals during this same period has gone from $66 to over $230. During that same decade, the median gross payments to our doctors went from $42,000 to $84,000 per year, exactly double. During that time, a single person's health care premium only increased from $69 to $114 per year.

That's a range of statistics that I want to throw out to set the tone and pace for the remarks I'm going to make, because I'm going to lay before you a fairly difficult and challenging problem, but not without its excitement too. I recall in 1971, the last year the Social Credit Party formed the government of this province, the then Provincial Treasurer brought in Alberta's first $1 billion budget - $ 1 billion the cost to government for all departments, and that was a breakthrough. In 1979, the first year I held the portfolio of Minister of Hospitals and Medical Care, I brought in the first department budget that broke through the $1 billion mark, and three years later, in 1982, brought in the first department budget that broke the $2 billion mark. So you can see the rate at which health care costs are expanding, and I think it's fairly self-evident that the revenues necessary to support a program of that nature haven't kept up.

If we go to this year's budget, you'll see that the Provincial Treasurer has brought in an overall operating increase for government of 4.7 per cent, whereas the Hospitals and Medical Care Department is 9 per cent. The Provincial Treasurer has decreased capital requirements by 10.4 per cent; the Hospitals and Medical Care Department has gone up 49 per cent over last year. Overall, the Provincial Treasurer is looking at a blended increase of 1.3 per cent, but in Hospitals and Medical Care we're looking at 14.6 per cent.

Now if it was a small department and the number of dollars we were talking about was relatively small, those figures wouldn't necessarily be important. But this year my department is asking for $2.2 billion out of a total of $9.4 billion of the provincial budget, nearly one-quarter, 23 per cent of the provincial budget, and growing at a rate much faster than the Provincial Treasurer's revenues or the rest of the provincial budget. So there's a challenge there, Mr. Speaker, and I haven't even told the whole story. Another $400 million-plus is also spent by way of public funds, via what we collect in premiums, contributions from the Canadian government, and our own Alberta Heritage Savings Trust Fund dollars. So we're talking about a lot of money.

I'd like to break my remarks down into two parts tonight, Mr. Speaker: first, talk about the capital part of the budget, because it's very significant and, secondly, the operating. In operating, I'll be talking about two sections, medical care and hospitalization.

First of all, in capital, we've instituted a program that I think is incredibly exciting. We've gone back, and we are rebuilding a hospital system that was rapidly becoming obsolete or too small because of the rapid growth and the economic surges that have happened in Alberta. At the same time, we're trying to dramatically expand the system to take care of a rapid increase in population. This year the budget request I'm putting in front of the Legislature for capital purchases has increased 55 per cent over last year's $236 million vote, to a gross figure of $366 million. In anybody's terms, I think that's a pretty significant boost for not only the hospital system but the Alberta economy for the coming 12 months.

There are four major parts to this capital program, and they're important. When I say parts, I mean thrusts. First of all, we want to continue the impetus of the overall directions of the program I mentioned to you earlier. We want to continue preparing for the four major urban hospitals which I previously made reference to and which will provide another 2,000 active-care beds for the citizens of Alberta. We want to start some very significant planning for some of the existing major metropolitan hospitals that are simply becoming obsolete and worn out and are going to need replacing in the next few years. Last but not least, we want to continue the very significant Heritage Savings Trust Fund projects.

I'd like to mention some highlights of what's involved in what I've just mentioned, Mr. Speaker, to give you an idea of what we're talking about. This means that work will continue on some 78 hospitals in a variety of communities throughout Alberta and involve approximately 95 different construction projects. To give you an idea of what's involved, $37 million is proposed for continuing work at Rockyview hospital in Calgary, $33 million for the new regional hospital in Grande Prairie, another $21 million for the Lethbridge regional hospital, and $33 million for the Medicine Hat regional hospital.

In addition to those major centres, there's another $175 million for a variety of new and renovated hospital projects in communities from one end of the province to the other. We also included a request for $15 million for improvements and additions to long-term care facilities. I am also kind of excited about two special projects, Mr. Speaker. Two of these new hospitals that are being continued will have special units attached to them for the medically dependent handicapped who are being moved from the site at Calgary. Those units will be located at Bow Island and Fort Macleod.

I mentioned the work continuing on the four urban hospitals that were previously announced, and I'm very sorry to say that there's going to be a slowdown. We had things geared up to start construction in April 1983 and, under current economic conditions, that's simply not going to be possible. I think anyone who is able to visualize the cash-flow requirements for those four hospitals once they are put into the construction stage can see the magnitude of the problem there in a program that's on a pay-as-you-go basis.

We've come up with a solution which I think will meet the requirements of our citizens very well. We've got $9 million in the budget this year to continue and finish the planning for all four hospitals. In addition to that, my colleague in Public Works, Supply and Services is purchasing the necessary sites, because the municipalities do not wish to provide them under the conditions we've outlined. So the sites will be purchased, the zoning and planning requirements that are necessary will have all been cleared up, the planning will be finished, and we'll be ready. We'll have those rolls of drawings on the shelf by this fall, and as soon as the window is open with some more capital funds, those hospitals will start to go. I can't give any more details on that at the present time. I've outlined some of the other work we are doing in the cities and on other projects, and I think we'll get by just fine with that new revised schedule.

In addition to that, there is significant planning money, and we're very anxious to keep planning and programming activities going during this particular period in the Alberta economy, Mr. Speaker. So for the Calgary General hospital board, there is $2 million to start planning their redevelopment program, $1.6 million for the Calgary Holy Cross, $1.6 million for the Edmonton General, and $1.8 million for the Edmonton Royal Alex. In addition, there is $600,000 for the board of the Cross Cancer hospital to commence their programming for the new upgrading and rebuilding plans they have under way, and $2.2 million for the Ponoka General hospital board for finishing programming work necessary for their new brain damage unit.

All in all, Mr. Speaker, I look at that and add on the $100 million we've got in the Heritage Savings Trust Fund, and there's not another capital program in health care facilities like this anywhere in Canada. Nobody in this Legislature needs to be at all defensive about what we are doing with respect to health care facilities. This is an incredible program, and it's going to be a wonderful boost for our local building economy.

Mr. Speaker, I would now like to switch to the problem of operating, because while it's exciting to build these projects, of course it's a bigger challenge to find the money to run them. Historically, the rule of thumb has been - and it's proved true - that the capital cost of the building is multiplied by 40 per cent each year, and that's your annual operating budget. Every time I talk about a $100 million hospital going up in some community, that means every year thereafter somebody has to find $40 million to run it. That gives you some idea of the challenge that's facing not only this government but hospital boards in the future.

Not only is our hospital system expensive and challenging, but so is our health care system. There are two aspects to the health care system in Alberta, Mr. Speaker, and actually they're common across Canada. If you stop and think about those, you'll see the nature of the challenge that faces us as legislators. Our health care system is universal, and it's on demand. You just think about those two things for a moment: universal and on demand. That means that tomorrow morning everybody in this room could show up at a doctor's office and ask for, and probably receive, every test he felt was necessary to diagnose his health. If he didn't like what the first doctor told him, he could go to a second, a third, and a fourth.

We've had some people go to as many as eight in one day for the kind of procedures I mentioned. The only thing that would be asked of the individual, by way of responsibility, is perhaps some extra billing. All the rest would be churned out by that computer over on Great Road that does nothing but print cheques 365 days of the year. That's the nature of the problem, Mr. Speaker.

Last year our health care system costs increased 30 per cent over the previous year. When you're talking about a program in the neighbourhood of $600 million and looking at costs increasing 30 per cent a year, you know that obviously something has to be done. You can't just keep reaching into the public purse, on a non-responsible basis, to fund a program of that nature.

I think even more disturbing than the 30 per cent increase in costs was the 17 per cent increase in utilization. We had a 4.5 per cent increase in population, so I can explain that much. But I cannot explain the other 12.5 per cent increase in utilization. I guess it just means that we're all seeing doctors more and, if that is another developing trend, of course that adds to the problem.

For the coming fiscal year, we expect the federal cash contribution to go from this year's $77 million to $83 million. The addition of $6 million under the established programs financing Act isn't really a very significant increase. Although it's a lot of money, the amount of increase isn't very large when you look at the kinds of projections we're afraid are coming. The general revenue contribution we're asking for is going to be $353 million. Earlier, during the Budget Address by my colleague, we mentioned that health care premiums are going to be raised. Something that my colleague didn't mention and which is optional is the Blue Cross plan, which covers a variety of optional health care services. Those premiums also will be significantly increased on July I of this year. One year later, we propose to turn the administration of that plan back from the Department of Hospitals and Medical Care to the Alberta Blue Cross plan, and hope to effect some additional savings that way.

I want to refer hon. members to the graph on page 77 of the Treasurer's Budget Address. Those of you who have it in front of you, it is a bar graph showing the health care premiums as a percentage of health care costs for any given year. If you draw a line through the graph at the level which we propose for the '83-84 fiscal year, you'll see that in the last 13 years there were 10 years when that share was higher and only three years when that share was lower. So the increases that we're asking citizens to contribute are very realistic when, in the life of the medicare plan, you look back to 1970. I want to make that point because I think it is important.

I mentioned the increase in premiums under the Blue Cross plan. Mr. Speaker, it's our belief that Alberta Blue Cross will start to devise a number of optional programs on a wider basis, giving citizens a wider choice of optional health care insurance that they may or may not wish to take out. We also expect that other insurance groups may enter that optional health care insurance field.

The last thing I want to talk about is the cost of running hospitals, because this is the year of decision and change. We've been talking about it, that it has been coming, and the year is here. About three years ago, we completed a very comprehensive report by a commission of private citizens on hospital utilization. We have the results of that. We've seen the questions that are still unanswered. We know where we think we can effect improvements in the use of our hospital buildings, and also ask for the co-operation of the medical profession in using those hospital facilities in a more efficient way. As a government department, we've also been doing a considerable amount of work with respect to trying to improve the operating practice of different hospitals and, in turn, get a better basis for our department to establish the annual budgets of each hospital. By annual budgets, I mean the grant which we turn over, on a global basis, to the various hospital boards.

We've come up with what we believe is a very exciting model. We call it the Medicus model - that's the name of the consultant involved in the last stages of doing this - and propose to put three hospitals of different sizes on this new budgeting technique for the coming fiscal year. The three hospitals are the Foothills Provincial hospital in Calgary, the Medicine Hat general, and the Drumheller General hospital. We've also used the principles of that Medicus plan in carrying out what we called reassessments or responses to budget appeals put forward by a variety of hospital boards during the past 12 months. .

While all this has been going on, we've been working very hard with the different boards in trying to establish what we think are nationally accepted standards with respect to staff/patient ratios, when they're related to the kinds of programs the different hospitals are delivering.

So instead of building on the size of the hospital or what its budget was last year, we'll now look at a programming basis, the number of people necessary to deliver those programs throughout the year, and base our global support on that.

The last thing I want to mention in this overview of hospital operating costs is to remind people that for the last several years we've been saying that the day is ending when hospital budgets could be completely funded all the time, with autonomous boards, by global government funds or grants. We've had debates in this House about where additional discretionary funds may come from. We discussed lotteries. We discussed at some length a return to the system that used to be in place; that is, the local requisitioning on the property tax. We discussed the principle and the idea that a user pay some fair share of hospital costs.

Our caucus has considered this very weighty problem at some length during the past months, and effective October 1, 1983, a system of hospital user fees is going to be introduced into Alberta. It's a very fair system. As I describe it, I think you'll see the merits of it and the protections that have been built into the system to prevent anyone not receiving hospital care because they may not be able to afford a user fee.

The five principles of the plan are as follows. First of all, it's discretionary. We are merely going to make it permissive for boards, on an individual basis and at their own discretion, to set any number of a range of hospital user fees if in the judgment of the board they decide they need that additional money beyond the global grants we give them. It will be self-administering. We do not propose to set up a central bureaucracy to oversee this plan. The responsibility will fall on the hospital boards to charge the user fee, and on the user of the facilities to keep track of the fees he has paid throughout the year.

The third principle is that the range of fees all have a maximum, so there's not the possibility of it working a hardship on anybody. The fourth principle is that there's a very large class of exemptions - different kinds of Albertans we either don't want to have to pay user fees for the use of the hospitals or whom we believe may not be able to pay them. So those groups of citizens have all been exempted.

The last principle is that in any calendar year there is an annual limit that a family would be asked to contribute in the way of hospital user fees. That last principle is put there to safeguard against the possibility of anyone family that may have a tough year with respect to the health of the family being financially hurt in a major way by a large range of hospital user fees.

Mr. Speaker, the net result of this plan that I'm announcing today is that no family will ever pay more than one day's average hospital costs in any given year in Alberta. For those who are able to afford it, I think that's an extremely fair proposition to ask people to support.

To give hon. members an idea of the kinds of fees we're talking about, in the couple of minutes left I'll very quickly go over the schedule of user charges that will be permissive by way of regulation effective October I, 1983: admission charge, $10 maximum; emergency and outpatient charge, $10 maximum; and the per diem charge, $20 a day maximum or 10 per cent of the hospital's average per diem costs, whichever is less. The preferred rates which are added to the per diem charge for semiprivate and private rooms are $8 and $16 a day. At this time, we don't propose to make any changes in the charges for auxiliary hospitals or nursing homes.

The exemptions are fairly lengthy but, very quickly, we've tied them. All groups of citizens, including senior citizens, are tied to the income exemptions as now pertain to the health care insurance plan. So the unique part of that exemption is that senior citizens who can afford to pay will be asked to pay in some cases. This is a new thrust in our health care approach to senior citizens, but it's one they have asked us to do.

Social allowance recipients obviously won't be asked to pay, nor will newborns or children up to and including the age of six. Another large group of citizens who suffer from chronic illnesses or special diseases, special treatments which require a lot of hospital care, will be exempt from any of these charges. That includes people like cancer patients, those on renal dialysis, et cetera. The last group is another group that will be defined in detail in the regulations, children who have a single or multiple handicap and require some long-term hospitalization.

I mentioned that the maximum yearly charge will be set by regulation and, for a family, will be the average cost of one day's stay in the hospital.

So there it is, Mr. Speaker, an outline of some of the fiscal and financial considerations we as members will have to be concerned with as we deal with the health care plans of our citizens. I'm excited about them. I don't think there's another health minister in Canada that could stand up and reel off the list of benefits that I've just described. We have an incredible capital program on a pay-as-you-go basis. We've got the richest and broadest medicare plan in Canada, and all that is being delivered to citizens who enjoy the lowest taxation situation by far in our country.

Thank you very much.