Alberta's Health Care:

What People Want.

ALBERTA'S
NDP
OPPOSITION

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Dear Friends:

I want to extend my sincere gratitude to all Albertans who came to our health care hearings. The response was overwhelming. Rachel Notley and I heard exciting ideas about how to improve the system, and many suggestions for protecting and preserving what we already have.

Health care is an issue that transcends political positioning, and one close to the hearts of Albertans and most Canadians.

Our caucus receives countless letters, phone calls, and emails from Albertans struggling to navigate the health care system. These health care hearings were borne of our desire to document these concerns, and to share these stories.

We held hearings in seven communities: Fort McMurray, Grande Prairie, Edmonton, Red Deer, Calgary, Lethbridge and Medicine Hat. We identified problems through the input of hearing participants, and have formulated our recommendations based on that input.

These recommendations have been compiled into a comprehensive report which we will deliver back to these communities in the spring of 2010. This report outlines NDP proposals for health care reform, and our caucus will use it during Legislative debate.

We have learned a great deal from the citizens of Alberta. In every corner of this province, people have grave concerns about the state of health care and the direction taken by the Conservative government.

Alberta's NDP is the trusted defender of public health care, and committed to guarding its ideals. Since the early days of Tommy Douglas and Medicare, the NDP has fought to protect our system and move it forward while maintaining the public delivery model Canadians value.

Thank you for your interest and engagement in this process. We look forward to meeting again as we tour Alberta with our findings.

Sincerely,

Brian Mason, Leader, NDP Opposition
MLA Edmonton Highlands-Norwood

Executive Summary

The following sections represent key issues identified at the hearings. They offer brief explanations, a sampling of participant feedback, and recommendations.

1.0 Secrecy and Misleading Language

The government uses deliberately misleading language. Participants at our hearings identified a gap between what the government says about health care and what it is doing. The government has a track record of suppressing documents about their plans for health reform. In 2009 the NDP released two such documents; one pertaining to mental health and another to long-term care. Albertans want the government to tell them about planned changes to the health care system.

Recommendations:

- Government must publicly release all planning documents relative to health care reform.
- Government must end the use of deliberately misleading language.

2.0 Seniors Health Care

Albertans are worried they won't be able to afford or access the health care services they need when they get older. This fear is based on the government's move to reduce public services such as long-term care (LTC), and increase private sector delivery, which is more costly and does not meet the needs of many seniors. Health services for seniors have not kept pace with their growing population. A shortage of appropriate care creates inefficiency.

Recommendations:

- Abandon the plan to have three times more designated assisted living (DAL) beds than long-term care beds.
- Create more regional LTC spaces in seniors' communities, or within reasonable traveling distance from where seniors live.

- Budget the creation of sufficient numbers of LTC beds to meet 2020 population and health projections.
- Implement mandatory minimum staffing ratios of registered nurses, licensed practical nurses, and health care aides at LTC and DAL facilities.

3.0 Managing the Healthcare System

The government's health reform aims to find a way to privatize health care within a publicly funded service rather than focusing on changes that will improve health outcomes.

Recommendations:

- Free-up acute care beds by building more LTC beds and mental health beds (see Sec. 3.1 & Sec. 3.5).
- Abandon plans to award hospital funding based on the number of procedures performed.
- Create new community health centres, staffed by salaried health professionals, which offer a spectrum of publicly delivered services.
- Create a university-based assessment centre to determine the merits of all pharmaceuticals and medical equipment. The centre should be arms length and publicly funded. (See Sec. 4.0).
- Build new acute-care beds to maintain today's ratio of Albertans per bed.
- Eliminate contracting of medical services such as joint replacement surgery, eye surgery and diagnostic lab services to private companies.

4.0 Drugs

Some Albertans can't afford the drugs they've been prescribed. Many are forced to choose between filling a prescription or the fridge. Access to life-saving drugs should not be determined by income level. We recognize that our recommendation of universal pharmacare represents substantial investment. It can be supported

through the cost-saving associated with improvements in the overall health of Albertans, and increased efficiencies in the health care system.

Recommendations:

- Cap seniors drug costs at $25 per month.
- Expand seniors' pharmacare to all Albertans (universal drug coverage).
- Create a university-based assessment centre to determine the merits of all pharmaceuticals and medical equipment. The centre should be arms length and publicly funded. (See Sec. 3.0)

5.0 Mental health

Participants at our hearings expressed concern over the lack of services to diagnose, treat and support the mentally ill. In addition to a reduced quality of life for the mentally ill, this lack of support increases the burden on social services agencies, the police and the courts. We heard about a lack of government funded and administered community-based mental health programs.

Recommendations:

- Redevelop Alberta Hospital Edmonton and the Centennial Centre to meet the needs of residents.
- Expand the number of mental health care beds in the community.
- Dedicate resources to improve the quality and quantity of mental health services in rural areas.
- Ensure 24-hour-access across the province to toll-free suicide prevention hotlines.

6.0 Rural Health Care

Albertans who live outside the major centres face particular obstacles to accessing health care services. Rural Albertans told us that instead of improvements, they see access to health care getting worse.

Recommendations:

- Enhance incentives to attract healthcare professionals to rural locations.
- Assess services in rural hospitals to ensure they meet the needs of those in the community and surrounding area.
- Improve communication between residents and community health councils, and formalize consultation between the councils and Alberta Health Services.
- Maintain rural hospitals.
- Elect representatives to community health councils.
- Follow through on capital upgrade commitments made in rural communities.

7.0 Staff Shortages

The government's strategy to reduce health care costs has dramatically reduced the number of health care professionals working in the system. The result is service delays, increased costs, and the loss of trained health professionals to other jurisdictions. The ongoing shortage of doctors is also of great concern to Albertans.

Recommendations:

- End the hiring freeze on health care professionals.
- Establish a Health Care Professional Planning Secretariat to ensure student graduations keep up with projected demands for nursing staff.
- Abandon move to decrease ratio of RNs in relation to LPNs and HCAs.
- Publish current listings of: the number of health care staff working in the province; the number of positions available; the number and type of health care staff in each facility; and staff-to-patient ratios.

8.0 Women's Health

Women face particular health issues that need to be taken more seriously by government, including access to midwifery and abortion services.

Recommendations:

- Develop and fund midwifery education programs at Alberta's post-secondary institutions.
- Ensure consistent access to abortion services throughout the province.
- Ensure funding for abortions and abortion-related services including pre-abortion ultra-sounds, and counseling.

9.0 Aboriginal health

Aboriginal people, both on and off reserve, face distinct barriers in accessing health care.

Recommendations:

- Include elders and councils in health policy development specific to Aboriginal communities.
- Establish programs to improve nutrition for Aboriginal people.
- Restore funding cut from Aboriginal suicide prevention program.
- Create incentives to attract Aboriginal students to health care professions.

10. Continuum of Care

The most cost-effective way to manage the health care system is to help Albertans stay healthy and thereby reduce demand on the system. Hearing participants often felt medical conditions may have been less acute if patients had received better care and education earlier on. They also complained that the cost of treatments such as chiropractic and physiotherapy rendered these services unaffordable. Increasing access to such treatment options through public funding would reduce long-term costs to the health care system.

Recommendation:

- Publicly funded and delivered healthcare must be expanded to include preventative, rehabilitative, and chronic disease management care outside of the hospital setting.

Introduction

There was clear consensus among hearing participants that Albertans expect the following four things from their health care system:

1. **High quality care: best practices, education and training**
2. **Accessibility: ensuring beds and services in urban and rural areas**
3. **Affordability: publicly funded and publicly delivered**
4. **Timeliness: immediate care when it's needed**

The recommendations in this report are based on these expectations, and two recurring themes from our hearings: the lack of long-term care beds and increasing wait times.

The NDP believes that creating more long-term care beds is the key to unlocking solutions that will improve health care delivery. This report draws links between the shortage of long-term care beds and many of the problems Albertans encounter trying to obtain health services.

The repercussions of this bed shortage ripple through the entire health care system, and ultimately result in increased wait-times.

For the last 20 years Alberta's health care system has been the subject of much experimentation. We see higher levels of funding when the economy is strong. When it is weak, we see cutbacks, hiring freezes, layoffs, cancelled surgeries, and bed closures.

Much of the experimentation we've seen has proven costly and fruitless, and has often led to policy reversals. The most obvious case in point is the creation, consolidation and elimination of health regions.

Albertans from all walks of life experience obstacles which prevent them from receiving the health services they need when they need them. Major improvements in Albertans' health are most likely to come through innovations in delivery and policy that focus on the continuum of care.

The best solutions will come from maintaining and strengthening the public health system, and honouring the principle of equity upon which it is based.

1.0 Secrecy and Misleading Language

The Alberta government is using misleading language to disguise its true intentions. Albertans don't believe what government is saying about its plans for health reform. The five phrases Albertans find most misleading are:

"Choice" – code for privatization

A senior requiring long-term care that is inaccessible has no choice.

The government uses this term frequently when talking about seniors, suggesting they can choose the type of accommodation and level of care they desire. Choice is a term associated with consumerism. The notion of shopping for health care comes from private industry. In Alberta, a shortage of long-term care undermines any meaningful choice seniors can make.

"Aging in place" – code for Designated Assisted Living facilities

Designated Assisted Living is not a substitute for Long-Term Care.

The government's continuing *"Aging in the Right Place"* strategy aims to give seniors "more opportunities to age on their own terms, and in the right place." The term is meant to sound empowering, but refers to facilities that charge out-of-pocket for the full range of elder care. This is unaffordable for many seniors. (See Appendix C)

"Community-based" – code for private delivery

Community-based care shifts the cost of care from government to individuals.

The concept of community-based care has been subverted by government in an attempt to cut costs. Government uses this term to describe service outside of hospital, and often privately delivered. Examples include designated assisted living facilities and the Copeman clinic in Calgary.

"Publicly funded" – code for privately delivered

Private delivery means you pay twice.

The government repeatedly stresses its support for "publicly funded" health care. By specifying "publicly funded," the government is creating a market for the private, profit-based delivery of health services. Private delivery means reduced accountability. It also means taxpayer dollars are used to pay shareholder dividends.

"Scope of practice" – code for cutting health care staff

Reducing the ratio of highly-trained to lesser-trained staff increases health care costs and puts patients at risk.

The government uses this term to suggest highly-trained health professionals are performing duties for which they are over-trained, and that money can be saved by transferring these tasks to lower-paid staff. Alberta Health Services CEO Stephen Duckett uses this language to rationalize plans to "hire less than 40% of nursing graduates (and) layoff RNs." University of Alberta research shows patient death rates and health care costs are lower – and patient outcomes better – with greater proportions of RNs to non-RNs health care staff.

Recommendations:

Government must publicly release all planning documents relative to health care reform.

Government must end the use of deliberately misleading language.

2.0 Seniors Health Care

Feelings of anger and frustration regarding the government's treatment of senior citizens were expressed at all of our hearings. Participants shared tragic stories of elderly loved ones unable to receive appropriate care.

Complaints included extreme wait times for long-term care beds, seniors being left unattended in hospitals and care facilities, families having to assume the role of care givers, placement of seniors in facilities where complex medical needs cannot be met, and a general deterioration of publicly funded services.

Attempts to cut operating costs by reducing staff levels, and by replacing highly trained workers with lesser trained workers, make it harder for seniors to obtain quality care in a consistent and timely way.

2.1 Not enough beds for seniors

The shortage of long-term care beds creates a domino effect, which reduces the availability of other beds in the health care system, and creates a chain of delays through the entire continuum of care.

Working backward – from a senior requiring LTC to an emergency patient requiring immediate paramedic and ambulance service – the chain of delay progresses as follows:

- LTC spaces are unavailable and new beds are not being created.
- A senior requiring LTC must wait until a bed opens up.
- Until then, the waiting senior occupies a bed elsewhere – often an acute care bed in a hospital.
- Fewer available acute care beds slows emergency and surgical intake.
- Wait times for emergency admittance and surgical procedures increases.
- Ambulances back-up at hospitals.
- Response times for emergency responders increases.

The shortage of LTC beds is a direct result of the government's strategy to offload the cost of care onto patients and their families. They are doing this by shifting toward private delivery of service at designated assisted living facilities.

Dr. E. Sandra Corbett of the Alberta Medical Association told us the lack of LTC beds has turned some local hospitals into make-shift LTC centres, where acute care beds are blocked for periods which can extend beyond one year.

Dr. Corbett submitted a letter describing this chain of delay to the Ministry of Health and Wellness in April 2009. She concluded hospitals are not designed to house LTC patients, and delays caused by bed blockages lead to back-ups in emergency rooms. Similar problems exist in Fort McMurray, where at any given time up to 25 seniors occupy acute care beds in the local hospital.

Fort McMurray resident Jean Jensen explained why she can't afford to wait much longer for access to long-term care: "In 1995 we received approval for 31 beds on the fourth floor of our hospital – one respite bed and 30 long-term care beds – and that was supposed to be a temporary arrangement," she said. "The third floor of the hospital now has 20-25 seniors occupying acute care beds who have been assessed as requiring long-term care. After a recent meeting with Alberta Health Services (AHS) Chief Executive Officer (CEO) Dr. Stephen Duckett… we were told it could take up to 10 years to get something," Jensen added. "I am 80 and I and don't have ten years to wait."

In Lethbridge the family of Alzheimer's patient Max Grandfield described frustration caused by the lack of LTC beds: While waiting for a LTC bed, Grandfield first occupied a bed in a designated assisted living (DAL) facility. He later occupied an acute care bed in the Chinook hospital. In both settings, Grandfield's medical needs were not met. His presence in these facilities meant space was unavailable for a patient better suited to DAL care, and intake was delayed for emergency or surgical patients at the Chinook hospital.

Recommendations:

Abandon the plan to have three times more designated assisted living (DAL) beds than long-term care beds.

Create more regional long-term care spaces in seniors' communities, or within reasonable traveling distance from where seniors live.

2.2 Deterioration of public services

Fewer services are being offered in LTC and DAL facilities. At the same time, service fees are rising, and a trend to shift the burden of care away from facilities leaves families struggling to cope.

Edmonton resident Carol Wodak said reduced staffing levels at her mother's LTC facility resulted in poor care. Rather than being toileted regularly, Wodak's mother was often left strapped in a wheelchair wearing diapers. Family members attended the LTC facility to feed Wodak's mother, because staff didn't have enough time to provide proper one-on-one assistance.

Medicine Hat health worker Lydia Wozniak said reduced services are partly the result of cost-saving measures that see fewer staff tending to patients with complicated needs. Issues like increased body weight and low staff-to-patient ratios mean seniors cannot be safely lifted from their beds or wheelchair for proper toileting and bathing.

Recommendation:
Implement mandatory minimum staffing ratios of registered nurses, licensed practical nurses, and health care aides at long-term care and designated assisted living facilities.

2.3 Inappropriate placements

Government's shift away from publicly funded LTC toward privately funded DAL facilities leads to inappropriate placements. This taxes Alberta's emergency response system and hospital infrastructure.

In addition to providing reduced care, fees for service at DAL facilities are also much greater than LTC facilities.

Groups like Public Interest Alberta attended our hearings and highlighted the problem by referencing the 1,500 Alberta seniors who have been assessed as needing LTC. Such groups are concerned that the government's effort to move away from LTC is forcing a growing number of these seniors to make do with home-care and community supports that are insufficient.

Recommendation:
Budget for the creation of sufficient numbers of long-term care beds to meet 2020 population and health projections.

3.0 Managing the Health Care System

Broadly speaking, the goal of a health care system is to ensure patients receive services in an efficient manner, in a way that puts them in contact with the right specialists, medications, and treatments with the least possible delay.

The goal of managing that system should be, first and foremost, patient outcomes – which are directly linked to accessing services. These in turn are directly linked to the capacity of the system to accommodate incoming patients, i.e. the availability of beds, doctors, nurses, and other health care workers.

Linking patient outcomes to private funding represents a dangerous precedent that would see the health care system run as a private business enterprise as opposed to a public service.

That is the model the Progressive Conservative government favours.

At the May 2009 Tri-Profession Conference of nurses, doctors, and pharmacists in Banff, former health minister Ron Liepert said, "I believe that down the road, the public cannot be the sole payer of the health care system."

At our hearings we heard resounding opposition to the notion that private funding is necessary to maintain the health care system. Many challenges the system faces today are linked to the quantity and availability of acute care beds, mental health beds and long-term care beds.

3.1 Wait Times

We heard complaints about wait times in hospitals and for specialists at all of our hearings.

A recent Health Quality Council of Alberta report showed that wait times at emergency rooms increased between 2007 and 2009. The median wait for patients who were treated and then discharged was 3.6 hours, up from 3.4 hours in 2007.

Patients who were admitted to hospital after being treated in an ER had a median wait time of 14.4 hours, an increase from 11.1 hours in 2007.[1]

Wait lists have increased as a result of recent cuts made by Alberta Health Services. In 2009, for example, AHS reduced the number of cataract surgeries it purchased by 2,000. The number of surgeries fell from 10,340 in 2008 to 8,500 in 2009.[2]

Wait times in emergency rooms put people's health in jeopardy. The average wait time in November 2008 at the University of Alberta hospital was 8.1 hours before treatment, and 14.5 hours before they were admitted.[3] At other Edmonton hospitals the combined wait for treatment and admission was almost 30 hours. Dr. Matthew Cooke, who was instrumental in solving the ER crisis in the U.K., told Alberta's ER doctors in 2009 that the U.K. was successful in reducing its ER wait times to four hours by building 5,000 new long-term care beds.

Recommendation:
Free-up acute care beds by building more long-term care beds and mental health beds (See Sec. 3.5).

3.2 Funding Models

Alberta Health Services CEO Stephen Duckett suggests activity-based funding is a model that should be employed in Alberta. Rather than providing each hospital with a block of operating funds – the funding model currently used in Alberta – activity-based funding uses the number of procedures a hospital performs to determine its budget.

Providing incentives to reduce wait lists is a sound principle, but funding arrangements must not reward quantity over quality. Any incentive funding should be awarded for improvements in patient health.

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[1] *Urban and Regional Emergency Department Patients Experience Report 2009*, Health Quality Council of Alberta, 2010.

[2] Michele Lang, "Waits soar for cataract surgery; Superboard cost-cutting takes blame," Calgary Herald, May 18, 2009; Alberta Health Services

[3] Jodie Sinnema, "Wait can average 27 hours for unlucky ER patients," Edmonton Journal, March 14, 2009; Alberta Health Services

The British Medical Association said activity-based funding "fragments care since the provision of care is seen as a series of episodes that attract payment rather than as a long-term commitment to the provision of care for an individual."[4]

Recommendation:

Abandon plans to award hospital funding based on the number of procedures performed.

3.3 Community Health Centres

Medicine Hat participant Dennis Perrier suggested we can improve the quality and efficiency of primary health care with more publicly funded community health centres. This model has been successful in Pincher Creek, Saskatoon, and Sault Ste. Marie. Community health centres employ salaried health care professionals who work as part of collaborative teams that may include general practitioners, RNs, LPNs, psychologists, specialist doctors, dieticians, social workers, and physiotherapists. The Pincher Creek centre offers: acute care, continuing care, 24-hour emergency services, intensive care, obstetrics, surgery and palliative care. Freed from the concerns of running businesses, they are able to concentrate on providing appropriate, quality care to their patients. Mr. Perrier suggested that this is a model that has proven very effective and should be introduced elsewhere in the province.

The Boyle McCauley Health Centre in Edmonton's city centre is another example of a facility where urban access to services decreases demand on hospitals.

Recommendation:

Create new community health centres staffed by salaried doctors which offer a spectrum of services that are publicly delivered.

3.4 Ineffective Spending

As mentioned later in Sec. 4.0 of this report, there is concern that some medications are being brought into the system that do not offer the best benefit to Albertans.

[4] British Medical Association, "BMA evidence to the Health Select Committee inquiry into Commissioning, October 2009." http://www.bma.org.uk/healthcare_policy/responses_consultations/healthcomevi.jsp

There is concern that pharmaceutical corporations have too much influence in our current system. This also applies to companies that sell medical equipment.

Recommendation:
Create a university-based assessment centre to determine the merits of all pharmaceuticals and medical equipment. The centre should be arms length and publicly funded.

3.5 Hospital Beds

The most recent data from the Canadian Institute for Health Information shows that in 2000 Alberta had 10,661 hospital beds. At that time, Alberta's population was just over 2.8 million people. The ratio in 2000 was 270 Albertans per general hospital bed. By 2006, the numbers of beds had decreased to 9,487[5] while the population had increased to nearly 3.3 million. This resulted in a net decrease of 1,174 general hospital beds and a new ratio of 347 Albertans per bed. While the number of Albertans grew, the provincial government closed hospital beds.

According to Alberta Health Services' annual report and Alberta Health and Wellness reports, the number of acute care hospital beds has been cut from 13,300 in 1989 to 6,800 in June 2009. This represents a reduction of nearly 50% of our acute care hospital beds.

Recommendations:
Free-up acute care beds by building more long-term care beds and mental health beds (See Sec. 3.1).

Build new acute-care beds to maintain today's ratio of Albertans per bed.

3.6 Privatization within the Public System

Last year, a government panel studied the integration of laboratory services in Alberta. The panel was led by Jennifer Rice, former medical director of American-owned private lab company DynaLIFEDX. Last spring, the government announced

[5] Canadian Institute for Health Information: *Number of Hospitals and Number of Hospital Beds, by Province, Territory and Canada, 1999-2000 to 2005-2006*

all cervical testing in the province would be done through two labs under contract to Alberta Health Services. One of those labs is DynaLIFEDx.

The government claimed these changes would save money, enhance quality, and eliminate "costly duplication of service."

Red Deer resident Floyd Van Slyke's concerns about privatization were echoed by participants at several hearings: "With privatization, I am always afraid that the comfort of the shareholders might supersede the needs of the patient," he said.

Health care workers have expressed skepticism, saying greater distance between patients, doctors, and labs increases wait times for test results and the chance of errors.

Elizabeth Ballerman of the Health Sciences Association of Alberta identified the potential for an oligopoly of private service in a public healthcare system. With only two labs conducting these tests costs could inflate dramatically in future.

Details of the costs and efficiency of these services are not available because they are provided by a private corporation.

Recommendation:

Eliminate contracting of medical services such as joint replacement surgery, eye surgery and diagnostic lab services to private companies.

4.0 Drugs

As a percentage of the overall healthcare budget pharmaceutical costs have almost doubled over the last 35 years[6]. Hearing participants expressed concerns over drugs costs and confusion over copayment components of insurance plans.

4.1 Drug Coverage

In extreme cases drug costs for some patients can exceed $5,000 per month. Albertans want assurances that will be able to get the drugs they need without having to declare bankruptcy.

The province's latest pharmaceutical plan for seniors is not universal, creates financial barriers that prevent seniors from getting prescription drugs, and shifts long-term costs from government to seniors.

Representatives from the Friends of Medicare said optional and income-tested drug coverage has the potential to create a market for further private insurance.

Participants recognized that a universal drug coverage program could not be implemented immediately. They suggested phasing in a pharmacare plan over several years, starting with immediate changes to seniors' drug coverage.

Universal pharmacare requires significant investment, but hearing participants agreed it could be supported through cost savings achieved in other areas of the health care system.

Recommendations:

Cap seniors drug costs at $25 per month.

Expand seniors' pharmacare to all Albertans (universal drug coverage).

4.2 The Need for Proper Prescription

Participants identified waste in the prescription of unnecessary drugs.

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[6] Canadian Institute for Health Information, "National Health Expenditure Trends: 1997-2009," Novemebr 19, 2009.

Wendy Armstrong of the Consumer's Association of Canada described initiatives taken by the Institute for Clinical Evaluative Sciences, the Manitoba Health Policy Centre and the Canadian Health Services Research Foundation.

These bodies vet medications and equipment before they are used in mainstream healthcare settings. Government and taxpayers can ensure unnecessary pharmaceuticals and equipment are not being wasted in the public system.

Recommendation:
Create a university-based assessment centre to determine the merits of all pharmaceuticals and medical equipment. The centre should be arms length and publicly funded.

5.0 Mental health

A government's treatment of the mentally ill is often used as a benchmark for measuring commitment to other social initiatives. When mental health is underfunded, other social services are likely to be as well. This prevents breaking a cycle that plagues not only mental health patients, but also families, social agencies, police and the courts.

Consider the following facts about mental health in Alberta[7,8]

- Approximately 20% of Albertans will experience mental illness in their lifetime.
- Mental illness is the top reason for doctor's visits.
- 39% of all billing from general practitioners is for mental health treatment.
- Untreated or inappropriately treated mental illness costs Alberta $5 billion/year.
- Albertans miss 50,000 work days per year because of mental illness.
- 40% of disability claims are mental-health related.
- 30% of calls to Telehealth are about mental health issues.

Mental health issues were highlighted at our Edmonton hearing, where the closure of beds at Alberta Hospital Edmonton (AHE) had recently generated much controversy. Mental health experts told us that community programs are not in place to serve the needs of patients displaced by closures at AHE.

Participants at all of our hearings expressed concern over the erosion of government services available to diagnose, treat and support the mentally ill, especially in rural settings.

[7] Provincial Mental Health Bed Review, "Beyond Beds…To Balanced Care and Mental Health," McDermott Consulting, January 29, 2007.

[8] Canadian Mental Health Association

5.1 Alberta Hospital Edmonton / Centennial Centre for Mental Health & Brain Injury

According to *Beyond Beds...to Balanced Mental Health Care* – a government report that was released by the NDP in 2009, Alberta has four times fewer mental health care beds than the national average.

It also showed how Alberta's Progressive Conservative government has ignored repeated recommendations to improve the mental health system by adding more beds and services throughout the province.

At our hearings, mental health professionals and concerned citizens told us closing beds at Alberta Hospital Edmonton will reduce the capacity for the mental health system to treat patients, and will eliminate an important treatment option for hundreds of vulnerable Albertans.

The government maintains that displaced patients will be cared for through community supports, but mental health workers told us current community programs are not capable of providing the level of care necessary.

Recommendation:
Redevelop Alberta Hospital Edmonton and the Centennial Centre to meet the needs of residents.

5.2 Lack of rural mental health services

We heard several stories of hardship resulting from the scarcity of mental health services in rural areas.

In the town of McLennan (187 km NE of Grande Prairie), Jean Moore, a former member of the Regional Mental Health Advisory Committee, said no health care staff are trained to treat mental health issues. Aboriginal communities also lack mental health resources.

Recommendations:
Expand the number of mental health care beds in the community.

Dedicate resources to improve the quality and quantity of mental health services in rural areas.

Ensure 24-hour access across the province to toll-free suicide prevention hotlines.

6.0 Rural Health Care

Many rural Albertans feel the Progressive Conservative government has ignored access to health care in their communities. The health care system has become overly centralized, and accountability to rural communities has suffered.

Participants listed a shortage of trained professionals, failure to maintain, upgrade or build rural hospitals, poor ambulance service and limited seniors' care as the greatest challenges facing rural areas.

6.1 Shortage of Healthcare Professionals

There is a shortage of family doctors, specialists, nurses, paramedics, and technologists in many rural communities.

Rural doctors who spoke at our hearings said they are routinely forced to work on-call. Nurse Roxanne Dreger spoke of the inability to fill paramedic positions, and limits to ambulance services. High Prairie councilor Wilf Willier told us that a shortage of anesthesiologists contributed to the inability of local hospitals to provide obstetric care. In Southern Alberta, we heard that expectant mothers in Brooks are forced to travel to Lethbridge or Medicine Hat to receive care after 20 weeks.

With a shortage of trained staff comes a shortage of services. Participants were frustrated by a lack of Alberta Health Services representation in rural areas, and felt like no one was listening to their concerns or answering their questions.

Recommendations:

Enhance incentives to attract healthcare professionals to rural locations.

Assess services in rural hospitals to ensure they meet the needs of those in the community and surrounding area.

Improve communication between residents and community health councils, and formalize consultation between the councils and Alberta Health Services.

Elect representatives to community health councils.

6.2 Closing or downgrading rural hospitals

Closure of rural hospitals increases the time it takes for residents to access emergency care.

Citizens from around Beaverlodge expressed concern that the loss of their hospital would lead to the loss of doctors practicing in their community.

Many rural Albertans fear community hospitals are in danger of being closed. These concerns stem from the government's failure to upgrade or replace rural hospitals as promised.

The closure of Beaverlodge hospital threatens to overextend the regional hospital in Grande Prairie and increase the time it takes rural residents to get emergency hospital care.

Residents from the eastern part of the Peace Country told us how the downgrading of the Grimshaw hospital eliminated access to 24 hour care in the communities between Fairview and Peace River.

High Prairie residents have been waiting years for a new hospital. Nearly two years after a ribbon-cutting ceremony, no ground has been broken. Their facility is in need of repair and operating at capacity.

Recommendations:

Maintain rural hospitals.

Follow through on capital upgrade commitments made in rural communities.

7.0 Staff Shortages

Patients and medical staff told repeated stories about extreme shortages of health staff: the results of hiring freezes, cutbacks, and forced retirements that left current staff feeling overworked and undervalued.

Participants also felt that every Albertan should have access to a family physician. The current shortage of doctors is severe.

In March, 2009, there were 1,483 job postings for nursing positions on the government jobs website. Healthcare workers were being offered financial incentives to remain in their positions beyond their planned retirement date. In the spring the government claimed a shortage of nurses no longer existed. They froze hiring and began encouraging nurses to take early retirement.

A survey conducted by the University of Alberta's Faculty of Nursing showed that in 2008, 90 per cent of students wanted to work in Alberta. In 2009, 80 per cent of the nursing students said they were willing to leave the province to find jobs.

United Nurses of Alberta representative Keith Wiley said the nursing shortage remains, despite government claims otherwise.

Nursing students suggested faculty members work with government to coordinate intake numbers with the province's long-term need for nursing staff.

Recommendations:

End the hiring freeze on health care professionals.

Establish a Health Care Professional Planning Secretariat to ensure student graduations keep up with projected demands for nursing staff.

Abandon the move to decrease the ratio of RNs in relation to LPNs and HCAs.

Publish current updated listings of: the number of health care staff working in the province; the number of positions available; the number and type of health care staff in each facility; and staff-to-patient ratios.

8.0 Women's Health

Participants highlighted some public health issues that impact women. The most common subjects were abortion and midwifery services.

8.1 Midwifery Services

Midwifery services recently became covered by Alberta Health Services, but birthing options remain extremely limited in Alberta. Simple insurance coverage fails to address the lack of midwives in the province and the lack of midwifery training programs.

Limits on the number of babies midwives may deliver in a year also present a challenge. Last year, more than 1,000 women had their midwife deliveries covered publicly. The midwives in the province reached that limit. In 2010 the cap will increase by nearly 50%, but there are still too few midwives in relation to the number of women requesting their services.

Currently, aspiring midwives must complete their schooling from institutions out of province. Many are studying through a program in Utah via distance education, but still require hands-on training from local midwives. Students who relocate for their schooling may not return to Alberta upon completion.

Recommendation:
Develop and fund midwifery education programs at Alberta's post-secondary institutions.

8.2 Choice

There are currently three abortion clinics in Alberta: Women's Health Options in Edmonton, the Kensington Clinic in Calgary, and Calgary's Peter Lougheed Centre. We heard from women disturbed by the difficulty obtaining abortions in Alberta. Most women who live outside of Calgary and Edmonton must travel long distances to obtain the service. This is costly and creates several additional complications. Medical students are not required to learn abortion procedures in all medical programs.

Recommendations:
Ensure consistent access to abortion services throughout the province.

Ensure funding for abortions and abortion-related services including pre-abortion ultra-sounds, and counseling.

9.0 Aboriginal health

Alberta's First Nations and Aboriginal populations don't have adequate access to doctors, dentists, nurses, mental health professional, pharmacists, and other valuable health services.

Statistically, Aboriginal persons are at higher risk of developing health problems associated with homelessness, poverty, malnutrition and substance abuse. Two of the most significant factors contributing to these circumstances are the inability of governments to provide a wider array of health services in rural settings, and barriers preventing Aboriginal peoples from accessing preventative health resources within the community.

Members of the Athabasca Tribal Council told us members of their community must travel to Fort McMurray to access most health services. Residents of the Fort McKay First Nation cannot access many health services unless they have use of a vehicle – which many do not.

We also heard concerns about a lack of local grocers in remote Aboriginal communities. Of four communities in the Fort McKay area, only Fort Chipewyan has a grocery store. A lack of healthy dietary choices can exacerbate underlying health conditions. Where remote populations have access to local grocers, costs are often prohibitive.

Recent cuts to funding for Aboriginal suicide prevention programs were also criticized because Aboriginal populations have a disproportionately higher risk of suicide.

Recommendations:

Include elders and councils in health policy development specific to Aboriginal communities.

Establish programs to improve nutrition for Aboriginal people.

Restore funding cut from Aboriginal suicide prevention program.

Create incentives to attract Aboriginal students to health care professions.

10.0 Continuum of Care

Within the broader context of the social determinants of health, Albertans are concerned about the fractured way our system cares for people when they become unhealthy.

Many hearing participants were frustrated by health ailments they felt could have been prevented, or limited, if they had been able to receive service sooner. They said access to preventative, rehabilitative, and chronic disease care was limited or unaffordable. They said their health and the health of loved ones deteriorated as a result.

We were told about the need for nutritional support for high-risk groups; the need for chiropractic intervention or physiotherapy; and the need for adequate dental care. People also said that if chronic disease management for conditions like diabetes was funded by the province, fewer Albertans would end up in hospital.

Some people do not follow medical advice because the prescribed treatment is too expensive. This causes patients to re-enter the health care system repeatedly, which increases costs.

In order to keep the population healthy in an efficient way, the continuum of healthcare must be accessible universally and affordable. This includes preventative care, rehabilitative care, chronic disease management and palliative care. Because these are fee-for-service treatments, they are not available in an equitable way. This ultimately increases costs and inefficiencies in our health care system.

Recommendation:
Publicly funded and delivered healthcare must be expanded to include preventative, rehabilitative, and chronic disease management care outside of the hospital setting.

Conclusion

When the Progressive Conservative government set out to turn the health care system on its head after the last election, they deliberately avoided public consultation and used misleading messages to keep their plans for reform secret.

Having been shut out of the process, Albertans felt confused and frustrated. They began to feel resentment, and many no longer trust the Progressive Conservative government with health care.

Alberta's NDP Opposition sensed this, and went on the road to listen to the concerns of ordinary people at public hearings. Albertans recognize the NDP as the most reliable defender of public health care, which is why so many attended.

Albertans want a health care system that provides high quality service when they need it, funded through public investment, and delivered in public settings. They want to be kept apprised about changes that affect services and costs.

We must ensure people are no longer forced to wait for treatments or beds; that seniors are no longer forced to live in facilities that can't meet their needs; that Aboriginal people and rural Albertans no longer need to travel hours for mental health or emergency care; that women no longer have to go without prenatal care; and that no one is denied life-saving drugs because they don't make enough money.

Furthermore, we must demand that our government answer when it is questioned, and set an example of accountability, transparency, and equity.

Alberta's NDP Opposition believes that we can achieve these goals, no matter how Herculean they may seem. The first step must always be to talk with Albertans.

Amidst the frustration, two overarching concerns were expressed at all of our hearings – the solutions to which we believe hold a key to improving our health care system: the shortage of long-term care beds and increasing wait times.

These are two of the greatest challenges facing our health care system today.

Appendices

Appendix A: Schedule of Hearings

Calgary September 29, 2009 Memorial Park Library 2:00 – 5:00 pm	**Edmonton** October 6, 2009 Stanley A. Milner Library 3:00 – 5:30 pm	**Fort McMurray** November 9, 2009 Sawridge Inn Conference Centre 1:00 – 3:00 pm	**Grande Prairie** October 14, 2009 Holiday Inn Hotel and Suites 1:00 – 4:00 pm
Lethbridge October 21, 2009 Lethbridge Lodge 3:00 – 5:00 pm	**Medicine Hat** October 22, 2009 Holiday Inn Express 11:00 am – 1:00 pm	**Red Deer** October 13, 2009 Red Deer Lodge 3:00 – 5:00 pm	

Appendix B: Hearing Participants

<table>
<tr><td>Calgary</td><td>Arthur Clemments: Community Member
Diane Lantz: United Nurses of Alberta, Local 1 President
Edie Gonzalez: Community Member
Faye Herrick: Schizophrenia Society of Alberta, Director of Calgary Chapter
Dr. H. Swanson: Community Member
Mel Teghtmeyer: Friends of Medicare, Chapter Director
Merle Terleshy: Community Member
Oscar Fech: Community Member
Pat Brownlee: Coalition of Seniors Advocates, President
Rebecca Aizenman: Community Member
Stan Nykiel: Coalition of Seniors Advocates
Ted Woynillowicz: Friends of Medicare, Chapter Director</td></tr>
<tr><td>Edmonton</td><td>Carol Wodak: Seniors’ Advocate
David Eggen: Friends of Medicare: Executive Director
Elizabeth Ballerman: Health Sciences Association of Alberta, President
Garry Pool: Alberta Council on Aging, President
Jennifer Herman: Community Member, Nursing Student
Lesley Levasseur: Community Member, Nursing Student
Lisa Storgaard: Seniors United Now
Murray Billett: Police Commissioner
Noel Sommerville: Public Interest Alberta, Seniors’ Task Force
Sue Huff: Edmonton Public School Board, Trustee
Wendy Armstrong: Consumers’ Association of Canada (Alberta) and Pharmawatch
Mary Jane Buchanan: Seniors’ Community Health Council
Keith Wiley: UNA, Communications</td></tr>
<tr><td>Fort McMurray</td><td>Angélina Gionet: L'Association canadienne-française de l'Alberta, Agente’ / Coordinator
E. Sandra Corbett: Alberta Medical Association, President of Psychiatry Section
Elaine Read: Wood Buffalo Safe Healthy Community Network, Coordinator
Jean Jensen: Community Member
Pat Mercury: Athabasca Tribal Council, Health Officer
Randy Hale: The Salvation Army, Captain
Roland LeFort: CEP Local 777, President
Stephanie Dargis: Fort McMurray Family Crisis Society, Outreach Coordinator
Steve Coutereille:Mikisew Cree, Councillor</td></tr>
<tr><td>Grande Prairie</td><td>Adony Melathopoulos: Peace Health Coalition, Secretary
Catharine Sheppard: Odyssey House Women’s Shelter, Executive Director
Dr. David Miller: Beaverlodge Hospital, Chief of Staff
Elaine Lunam: Beaverlodge Hospital Auxiliary, Treasurer
Jean Moore: Smoky River Health Coalition
Marie Bateman: Beaverlodge Hospital Auxiliary, President
Marie Pearson: Community Member, Retired Nurse
Roxanne Dreger: United Nurses of Alberta, Local Representative
Wilf Willier: Town of High Prairie, Councilor</td></tr>
<tr><td>Lethbridge</td><td>Bev Muendel-Atherstone: Psychologist
Florence Granfield: Community Member
Geraldine Buchannan: Community Member
James Moore: Friends of Medicare</td></tr>
</table>

	Liz Glover: Community Member Mark Sandilands: University of Lethbridge, Professor Emeritus Michael Cormican: Friends of Medicare Shannon Phillips: Womanspace Resource Centre
Medicine Hat	Agnus Wiley: Community Member Dennis Perrier: Friends of Medicare Lydia Wozniuk: Staff at a Long-term Care Facility, United Steelworkers Local 1-207 Paul Nederveen: Community Member Ray White: United Steelworkers
Red Deer	Chuck Rhoads: Native Friendship Centre, Rocky Mountain House Coordinator Dean Cunningham: Centennial Hospital Ponoka, Registered Psychiatric Nurse Denny Hougan: Council of Canadians Floyd Van Slyke: Community Member Janet Schultz: Communtiy Member Ken Collier: Friends of Medicare, Board Chair Sam Denhaan: Central Alberta Council on Aging, President Stephen Merridew: Community Member

Appendix C: Example: Schedule of Fees (Designated Assisted Living)

The [redacted] service charges 2007 2009

The [redacted] is an assisted living facility in Edmonton. It receives block funding from Capital Health to provide home care to eligible residents; it offers individual service options to residents who do not qualify for home care, and enhanced services to those who need more care than basic home care provides. The new price list for these services represents a 25 – 50% increase in prices since 2007. While "the market" is alleged to offer competition, it is striking that the charges for these services are fairly standard across the industry.

Keep in mind that the Continuing Care Strategy proposes to distinguish between "basic" and "enhanced" services in long term care facilities, and to allow operators to charge for the "enhanced" services.

Individual Services offered by The [redacted] Community but usually not available from Home Care	2007	2009
Medication Assistance Program	$150 per Month	$200 per Month
Night checks	$100 per Month	$150 per Month
In House Escort Service, each way	$3 per Escort	$8 per Escort
Continuing In House Escort Service:		
Meal escort once per day	$155 per Month	$200 per Month
Meal escort twice per	$225 per month	$300 per month
Off Site Appointment Escort	$ 20 per hour	$35 per hour
Tray service	$ 5 per delivery	$8 per delivery
Continuing Tray Service:		
1 tray per day	$105 per month	$125 per month
2 trays per day	$200 per Month	$225 per Month
3 trays per day	$295 per month	$325 per month
Cueing for meals	$ 50 per Month	$75 per Month
Morning Light Housekeeping	$125 per Month	$150 per Month
Weekly personal Laundry Service - One Load	$ 25 per Month	$ 65 per Month
ironing	$ 3 per garment	
Bed Linens & Towels Supply & Launder -	$ 50 per month	$ 75 per month
Companionship	$Per Agency Rate	$Per Agency Rate
Enhanced Living Options to supplement Home Care services		
Support Stockings	$100 per Month	$125 per Month
Oxygen Management	$150 per Month	$175 per Month
Incontinence Management	$155 per Month	$175 per Month
Weekly Bath/Shower Assists	$60 per Month	$100 per Month
ANCILLARY SERVICES RATES		
Parking	$50 per month	$50 per month
Resident Breakfast Package	$110 per month	$125 per month
Resident Lunch	$7 each	$8 each
Resident Lunch Package	$165 per month	$185 per month
Resident Dinner	$10 each	$12 each
Guest Lunch	$8 each	$10 each
Guest Dinner	$12 each	$14 each
Brunch/Theme Dinner	$14.00 each	$20 each
Guest Room - Jennies/Queen - Randolph's/Twin (2)	$59 per night	$99 per night
Housekeeping (additional)	$16 per hour	$20 per hour
Personal Care Aide (15 ' min. minimum)	$20 per hour	$25 per hour
Licensed Practical Nurse (15 min. minimum)	$32 per hour	$35 per hour
Registered Nurse (15 min. minimum)	$42 per hour	$45 per hour
Handy Man Service (20 min. minimum)	$21 per hour	$25 per hour
Resident Breakfast Package (Preparation)	$175 per month	$200 per month

Assisted Living Service Package

The Assisted Living Service Package attends to personal care needs. According to the assessed individual needs of the resident, these services can be provided outside of a secured living environment. Cost will be determined based on individual assessment.

Services may include the following:

A Regular health monitoring and assessment
A Liaison with physician
A Blood pressure monitoring as ordered by physician
A Weight taken monthly or as ordered by physician (where physically possible) A Assistance with Activities of Daily Living (dressing, grooming, hygiene) A Meal service in Main Dining Room, with escort or cuing as needed
Enhanced activity programming and support
Night checks as required
Enhanced, intermittent staffing support for care/service delivery
Medication Administration Program
A Incontinence management (products to be supplied by the resident) A Optional personal laundry care
A Weekly light housekeeping services (washroom as needed)
Fresh towel exchange service daily

The Assisted Living Service Package does not provide for intense personal care and support of a resident. For example: Personal Care Attendants would not regularly be scheduled to spend long periods solely attending to the needs of a single resident on a long-term, ongoing basis. The [redacted] Community would, however, work in co-operation with Home Care and other appropriate resources to co-ordinate short-term intense personal care support in exceptional circumstances.

Examples of such situations may include:

A Medical or post surgical recovery
Residents who are urgently waitlisted for higher level care centres > Short Term support for significant behaviour management issues
High resource services such as Palliative Care support.

Enhanced Living Options Packages

If only one or two individual enhanced living options services are needed to provide for specific resident needs or desires, these services may be contracted separately, no matter where the resident lives within the facility. However, as the need for service increases, (for example, if several options are needed), or for those residents requiring Safe Living Unit or Assisted Living care support, our Director of Care will recommend a further assessment and a care conference to determine how services can be provided or what arrangement can be made. This conference may include [redacted] staff, a Home Care representative, physician, and other health care professionals, as well as the resident/responsible party. We are here to serve our residents and will do our best to provide you with quality care at all times.