8:17 a.m.

[Mr. White in the chair]

THE CHAIRMAN: Ladies and gentlemen, I'd like to call the meeting to order.

First, I'd like to introduce someone sitting up here with me that I'm sure you all know. Diane has been running the committee in the absence of Corinne in that she's off getting a new hip. So she's again a hippie. She has had one before and this is the second time, so it's a little touch and go. But the last we heard, she's doing just fine and will be back in four to seven weeks, depending on how her therapy works out.

We have a number of housekeeping items to be done, and that's the reason we called a little early. Hopefully the doughnuts did well this morning and got everybody up and at it. We have an agenda before you. Do we have a motion to approve? A hand went up. Is it agreed?

HON. MEMBERS: Agreed.

THE CHAIRMAN: It's carried.

Those of you who have been on this committee before have heard this little spiel before. You will know Standing Order 50. We do have to review it one more time, and for the record I'll read it in its entirety, which takes an awfully long time: "Public accounts, when tabled, stand referred to the Public Accounts Committee." That's the sum total of the Legislature's charge to us. The powers of the committee have traditionally been those and those only that refer to the current public accounts, those that have been filed in the Legislature along with the Auditor General's report on same. We do allow a little latitude insofar as the accounts for one year do refer to many years in the past, of course. So there is some latitude there.

Any further discussion or clarification on the powers of the committee or the lack thereof? There being none, we'll move on to item 3(c), which is the funding. Attached you'll find a copy of the budget for the 1999-2000 year passed by the Members' Services Committee in the January 26th meeting. We are all aware of the provisions in that budget. I suppose we should really have a motion to the effect to accept our own budget. Could I have a motion from someone?

MS BLAKEMAN: So moved.

THE CHAIRMAN: Is it agreed?

HON. MEMBERS: Agreed.

THE CHAIRMAN: Carried.

We also have been granted within that budget approval for three delegates to the Canadian convention of these committees, for matter of information. One of our members is off doing committee work at the moment -- I think he's almost on his way back now -- in looking to extend the parliamentary procedure of public accounts to some of the Third World countries. The vice-chairman of the committee, being originally of a Third World country himself, has a great deal to offer in that area. In fact, we're expecting a complete report upon his return, and he's agreed to do so.

We need a motion on our annual report to the Legislature as presented to you. I believe you have one in your package. Where is the one that I had? There it is. It's titled Report of the Standing Committee on Public Accounts, an auspicious title for sure. For those of you that have had the opportunity to review same, might we have a motion to the effect of acceptance? Is it agreed?

HON. MEMBERS: Agreed.

THE CHAIRMAN: Carried. Thank you.

Moving right along. The dates and times of the meetings and the schedule of attendees before us has been presented earlier in the week, actually for a couple of weeks. Do we have a general discussion? Are there any changes some would wish?

MS BLAKEMAN: I am aware that the Minister of Economic Development was scheduled earlier last year and had asked, given the budget being presented, I think, to be rescheduled. I notice now that her appearance is still quite far down the list. Can anything be done about that? It will be some time since she's appeared before this committee.

THE CHAIRMAN: I'm informed that they have all arranged their schedules to meet this schedule. I'll tell you what we can do. We'll take it under advisement this week and report next week if we can trade and move Economic Development up in place of another department. Is that reasonable?

MS BLAKEMAN: Well, yes. I'm assuming that there's this sort of rotation, and we're out of rotation with that particular minister now.

THE CHAIRMAN: Okay. We'll see what we can do, and we'll have a minireport for next week.

MS BLAKEMAN: Thank you.

THE CHAIRMAN: The scope of the questions. We needn't go into great depth. We understand what they are. They have been defined both by this chairman and former chairmen, and we're pretty well aware of them through testing the waters now and again.

The order and number of questions. Unless there's some further discussion, the chair had intended to continue with the tradition of a rotation of questions from the opposition members to the government members and back again and on one main question and a supplementary question to that. I see no hands flying in the air to object, so I gather we'll continue with that.

MR. SAPERS: If there are twice as many again, shouldn't we get twice as many questions to even it out.

THE CHAIRMAN: The chair is having difficulty hearing that objection.

Again, this is a public meeting. To my knowledge we have yet to have an in camera session here, and we'll continue with that, although if there is something that comes up, if the committee wishes to go in camera, then that in fact is the case.

Any further business on the organizational structure and budget and all that has to do with the schedule?

MRS. O'NEILL: Mr. Chairman, is there a date set for the '99 Canadian Council of Public Accounts meeting?

THE CHAIRMAN: Is there a date set? I believe it is August, the 22nd, 23rd, and 24th. It's three days there. Shiraz has that date, and he'll report that upon his return, I'm sure.

MS BLAKEMAN: I'm just wondering if you can outline the criteria for choosing the delegates that we send to that meeting.

THE CHAIRMAN: There have not been any set, as far as I know, by the committee. Traditionally it has been chairman, vice-chairman,

and a senior staff member. I don't think there has been any discussion on that before, although that doesn't mean there couldn't be a discussion. Perhaps we could lay that over as an item to be done when our vice-chairman has returned and apprised us of his latest findings on parts of other continents. So we will add that to the agenda for perhaps the last item next week when Mr. Shariff is to be back. We'll deal with that at, say, 9:45. Is that reasonable, a week hence? I see some nods. It's agreed? Terrific.

All other business being concluded, I should like to welcome the Hon. Halvar Jonson, who is, as we all know, the minister of the toughest department to manage at this point. I'd like to open the floor for you to give an overview just as soon as we have completed an introduction of our permanent guests, the members of the Auditor General's team.

Would you like to introduce them?

8:27

MR. SHANDRO: Yes. I'm Nick Shandro, Assistant Auditor General with responsibility for the Health portfolio in our office. On my right I have Trevor Shaw, who is an audit principal, and he works and has responsibility in the Health portfolio. Brian Corbishley, on Trevor's right, is in charge of systems auditing. He's an AAG, and he resides in our Calgary office. Merwan Saher, who is also an Assistant Auditor General, is responsible for the production of the report as well as many other things in our office.

THE CHAIRMAN: Mr. Minister, if you'd like to introduce your members and give some overview.

MR. JONSON: Thank you, Mr. Chairman. Good morning to all members of the Public Accounts Committee. I would like to introduce the staff from Alberta Health that are with me this morning. On my right is Don Ford, Deputy Minister of Health, and on my left is Aslam Bhatti, who is the assistant deputy minister in charge of finance.

Also, Mr. Chairman, I probably should resist but I can't, and that is that I hope all goes well with the medical services provided to your family, and yes, there are hip operations being done in the province of Alberta. I just hope that everything works out there. I think everyone in Alberta wants to have a good health care system available to them, and that's certainly our goal here in Alberta Health.

I'd like to just proceed, Mr. Chairman, with a few introductory remarks. I look forward to the questions of the Public Accounts Committee, and with the capable staff with me today, I hope we can address them whether they are general or specific.

Mr. Chairman, ensuring access, quality, and stability in Alberta's publicly funded health system was the key focus of the business plan for 1997-98, which is under discussion this morning. Because of our government's fiscal responsibility in this particular year, we were able to follow through on government's reinvestment announcements and program actions announced in November 1996 as part of the Action on Health initiatives. Our efforts to reduce administration and duplication in Alberta's health system allowed us to reinvest funds saved back into the system to address additional pressure points that arose during the 1996-97 year. What I'm referring to there is that we followed through and completed a reorganization of Alberta Health, of the department, which I think led to a better configuration in terms of delivering services but also savings in money. We also, working with regional health authorities, brought attention to our goal, which is to keep administration costs to a minimum.

I think, Mr. Chairman, it may be useful to begin by looking back at the key directions that served as the starting point for the 1997-98 business plan. In that business plan, we set our sights on ensuring that all Albertans have access to quality services when they need them, streamlining and simplifying the system with reduced duplication and people working together in a co-ordinated system, getting the best value for public dollars through reduced administration and effective and efficient management, and providing more services in communities and in clients' homes. We realize that today there are still expectations, demands, if you will, for additional home care service, but if you look at the figures and you look at the actual service, which is most important out there, we have expanded home care capacity in this province.

Another initiative was the added priority given to measuring results and reporting regularly to Albertans. We were providing more emphasis on education, prevention of illness and injury, and promotion of healthy lifestyles, and we were continually working at improving the health system through education, appropriate leading-edge treatments, research, information, and technology. Mr. Chairman, I think that during the 1997-98 year, which we are discussing today, we made progress on meeting those goals.

Mr. Chairman, 1997-98 saw Ministry of Health expenditures increase over 1996-97 by approximately $384 million, albeit a significant part of that dealt with the Y2K or millennium bug issue. It increased $384 million to $4.2 billion, an increase of 10 percent. Of this increase, approximately $300 million was provided to health authorities to address pressures of an increasing aging population; to address increased volumes of key lifesaving procedures such as organ transplants, cardiac surgery, renal dialysis, and neurosurgery; to address the need for additional frontline workers; to enhance services such as long-term care, home care, and emergency services; and also to assist seven regional health authorities on a onetime basis to eliminate inherited accumulated deficits at the time of regionalization.

Further increases allowed health authorities to address local health system pressure points and enhance priority services in their geographic areas. They recognized the increased demands being placed on the health system and were allocated funds to help ensure that the system can meet the needs of Albertans.

In addition, as I was saying, Mr. Chairman, a onetime allocation of $170 million was provided to health authorities and Alberta's health system to ensure that key medical equipment and health computer systems are year 2000 compliant. Ensuring that essential medical equipment is year 2000 compliant is a unique and high-cost issue. Therefore this funding was allocated to support health authorities in securing the safety of medical equipment and computers through testing, repair, or replacement. This additional funding freed resources that the health authorities would have otherwise required to address ongoing equipment replacement costs and allowed these resources to be redirected to address short-term operating cost pressures and pressure points at the local level.

Other expenditures of note included the following. Physicians received additional funding totaling $29 million in 1997-98 to recognize the increased utilization of physician services. Drug costs under the Alberta Blue Cross nongroup plan increased by approximately $17 million over 1996-97 actuals due primarily to increased utilization and emergence of new high-cost drugs. Mr. Chairman, this whole area of pharmaceuticals is certainly a positive development in the health care system. We're hearing, not every day but certainly on a regular basis, about new breakthroughs in these products in terms of being effective in health care. They are a rapidly increasing area of costs which exceed any projections which are related to cost of living or other general indicators of what should be spent in a particular system.

Additional expenditures of approximately $18 million were incurred in developing health information systems as part of the

information management strategy to provide better information on which to make health decisions. Seven million dollars in new funding was announced for interhospital ground ambulance transfers for emergency patients. As a bit of background for this item, this funding covers transfers when a medical decision is made that the patient requires care that isn't available in the first eligible facility and ground ambulance is medically required for transport. Previously, individual Albertans were responsible for these costs.

Increased utilization of chiropractic and optometric services resulted in additional expenditures of $4 million in 1997-98. In addition, Alberta's share of costs for blood and blood products was approximately $4 million over that budgeted. I would also like to add that in the year ahead and the year we're currently in, the whole blood provision system in this country is being reorganized and re-established and is endeavouring to meet some of the issues that have come up with respect to that. I anticipate that there will be continued significant demands on our treasury with respect to that particular item.

8:37

Mr. Chairman, there was another reinvestment of $2.3 million in emerging areas of genetics such as gene therapy and cancer-related genetic testing, and this reconfirmed, I think, our commitment to continue to support leading-edge activities for the benefit of all Albertans.

All told, Mr. Chairman, during 1997-98 Alberta Health received supplementary estimates totaling $236 million in addition to the $148 million approved at the beginning of the year to address the issues and pressures mentioned above. This resulted in a total operating budget of $4.222 billion. Actual expenses were $4.219 billion; consequently, $3 million of the authorized budget was not used. I anticipate the question as to why we didn't use it, but I think -- I haven't figured out the percentage -- that $3 million out of $4.2 billion is a fairly small percentage, and I always think it's better to be on the positive side than on the negative.

Mr. Chairman, the quality publicly funded health system, which is accessible to all Albertans, is one of the government's highest priorities. The additional funding allocated to health authorities in 1997-98 was made to ensure that such a health system remains in place.

Mr. Chairman, before I conclude, I'd like to note a number of important and innovative developments that were under way in the 1997-98 year. Each of these is helping us work towards the goal that I outlined earlier. The long-term care review began with a focus on how to provide continuing care to an aging Alberta population. We worked with and continue to work with health authorities and other stakeholders to improve accountability and the quality of health services by developing an accountability framework for the health system. We want to further refine this in the year ahead. We want to be more specific about accountability, about performance measures for the health care system.

New health promotion programs were introduced targeted at young families, such as the You're Amazing initiative, and this was implemented.

We proceeded with the next steps on the Alberta Wellnet, which is the provincewide health information network. Important groundwork was done on legislation to protect the privacy of individuals' health information and also ensure that it can be shared appropriately to improve patient care.

Work was under way to review primary health care in the province, and several pilot projects have proceeded this year. In fact, I should mention, Mr. Chairman, that yesterday as I accompanied the federal Minister of Health on his tour and rollout on the federal budget, we visited the Northeast health care centre here in Edmonton. As part of that project there is a very significant pilot project with respect to developing an overall, forward-looking model of primary care. That, I should also acknowledge, is in part funded by the health initiatives fund of the federal government.

We have, Mr. Chairman, expanded the programs in communities and the provision of services in people's homes, as I mentioned earlier, and there continues to be an emphasis on research in this province thanks to the heritage medical foundation and other sources available to the health system.

Certainly, Mr. Chairman, I would like to candidly acknowledge that there's clearly more work to do in a number of areas. We have a number of issues, and there are certainly numerous challenges ahead. I look forward to hearing views and getting some good advice over the next three days at the health summit in Calgary. As a department we are committed to our continuing search for better ways to deliver health services and improve the health of all Albertans. We'll be looking for the best ways to improve health in the province and to give Albertans what they expect, a first-rate health system of which we can be confident and proud.

Thank you, Mr. Chairman, for allowing me to make these introductory remarks. I look forward to your questions -- or at least my department people look forward to your questions if I can't answer them -- on the public accounts of Alberta Health for 1997-98.

THE CHAIRMAN: The first questions. Mr. Sapers, followed by Mr. Stevens.

MR. SAPERS: Thank you, Mr. Chairman. Good morning, Mr. Minister, Don, Aslam. Nice to see you. I'll direct my questions to the minister, but feel free to jump in.

The Auditor General recommended in his '97-98 report that the Department of Health provide some guidance for establishing appropriate and equitable building and equipment guidelines and a base for each RHA. I think there was some comment that the department should work with the regional health authorities to improve their planning systems and their ability to try to predict needs for funding capital assets in the future. The RHAs, I understand, estimate that about $90 million per year is required on average to fund capital equipment requirements. What systems are now in place as a result of that commentary in the Auditor General's report to provide for interregional equity by considering the existing financial condition of each regional health authority?

There are significant differences, Mr. Minister, in the capacity, the location, the age of building and other fixed assets in each RHA, but there doesn't seem to be any mechanism to level out the playing field when the RHAs are competing for capital dollars. I'm wondering if you can tell me what your department has done to address that issue.

MR. JONSON: First of all, Mr. Chairman, in the whole area of capital funding -- and that would include both actual infrastructure and equipment -- we recognize there is a major need within the health care system in this particular area, and quite frankly we have given our priority in terms of directing funding to what we judge to be a greater need, and that is the actual delivery of service over the last two to three years.

The second thing I'd just like to mention is that I referred in my opening remarks a couple of times to the whole Y2K issue. We may want to explore that further or not, but this has taken away very significantly from the capacity of government to do some of the things we want to do and we know need to be done in the whole area of normal capital renewal, particularly in health since we're talking about that. What I'm saying is that first of all, because of the more emergent need to deal with the Y2K problem, we have not made the

progress in the actual delivery of funding for capital renewal that we wanted to or would like to have.

Now, with respect to your question, yes, we do inventory or review with our regional health authorities their capital needs. We want to develop a long-term capital plan. We have in place and are working to refine the set of criteria that we apply to the approval of projects, and perhaps I could ask Mr. Bhatti to comment further on the specifics.

MR. BHATTI: Yes. When the regional health authorities came into effect and when we pooled the resources and gave them out on the population-based formula, it was made quite clear in conjunction with the health authorities that they would fund equipment requirements from their allocation. The reason for doing it that way rather than having a separate capital funding account is that various authorities obtain their equipment requirements in different ways. Some lease it, some buy it, and to provide the greatest amount of flexibility, it's best to do it that way. The Laing committee during the summer had also recommended along with the Auditor General that steps be taken to ensure that the capital infrastructure is maintained, and we are following up with that recommendation, specifically relating to having health authorities set aside money on an annual basis, the annual amortization amount. It would be similar to a business setting aside a sinking fund for capital replacement, so in the future we have the ability to replace equipment as required. As technology changes and as health system delivery changes, equipment requirements are going to vary. So it's best for the health authorities to determine what resources they want to put in, and it's best for us to provide all health authorities, on an equitable way, funding for total health services.

8:47

MR. JONSON: Could I mention one other thing. I was just thinking that perhaps there's one other part of your question that we should respond to, and that is that, yes, we have done an overall facilities review across regional health authorities; in other words, in terms of their needs on the construction side.

MR. SAPERS: I won't pose it as a question because I don't want it to be my supplementary, but I'm hoping that review will become public.

My supplementary question is about the sinking fund that Mr. Bhatti just mentioned. I take it from your answer, then, that some guidance has been provided by the department to the RHAs to set aside reserve targets. Could you tell me what those reserve targets are, and what kind of monitoring is going to be in place to ensure that they're adequate? We constantly are hearing that it's just simply not enough, that the money set aside for particularly capital equipment replacement barely keeps pace with replacing existing technology but doesn't allow for taking advantage of new technology.

MR. JONSON: Well, I think I'd just like to comment before Aslam gives the specific answer. You're really talking about two things. I think it's really important that we work to maintain our current capital equipment base, and I'll ask Aslam to comment on that. The other thing, of course, is that when it comes to additional new equipment keeping pace, as you say, I agree there is that need. But as in many areas of health care there is no end to the amount of money that could be spent to try to become ideal in terms of having equipment available. For instance -- I'm not trying to be facetious here, but I suppose some people would say that ideally we should have an MRI operating in every acute care hospital in the province over a hundred beds and people should not have to travel more than 50 miles for an MRI. That, quite frankly, is just not reasonable or practical in terms of the operating costs, the capital costs involved. So there have to be some choices made now and in the future with respect to balancing the resources that are available relative to other needs in the health care system and in government versus having all the leading-edge equipment available to us.

MR. BHATTI: What I understood from the Auditor General's staff, and we fully concur, is that equipment is like any other resource. Be it a human resource or capital infrastructure, it is a resource that is required to deliver a service. We have to ensure and maintain that resource just like we would maintain any other resource. Over the last year and a half we've been working with the regional health authorities, with a group of their CFOs, to come out with a policy to determine how we would develop this concept of the sinking fund and what percentage of their annual amortization needs to be set aside on a phase-in basis. So maybe over a two- or three-year period of time we can come to an annual replacement amount that could be set aside. It'll take some time, but I think the health authorities are cognizant now that capital infrastructure, be it equipment or construction and so forth, is costed in business.

THE CHAIRMAN: Might we have a comment from the Auditor General's office?

MR. SHANDRO: Our report emphasizes working with the health authorities, and I think Aslam earlier indicated that there's more than one way of delivering a service. One way is by owning the equipment. Another way might be on a fee-for-service basis. Therefore, those decisions are made at the health authorities and are part of their operating responsibilities. It's very difficult to just strictly set arbitrary reserve requirements when the operating decisions that health authorities make may be different, and they can easily switch between capital requirements and operating requirements depending on how they configure their service delivery needs. Therefore, I think we need to focus also on the health authorities' responsibilities.

One of the problems health authorities have is they're more adept at dealing with people issues than with equipment issues because equipment doesn't squeak when it's running out of money, whereas people, when they feel they need an increase, do talk about the increase. So to put some balance between what you need to invest in aging equipment as opposed to what you need to invest in frontline workers, that issue has to be dealt with in terms of where is the best investment in terms of helping the people do their job.

I previously talked about the increasing paper side as opposed to bedside that is happening in hospitals because of the complexity of new medications and drugs and the like. Certainly some issues have to be addressed, and I'm hopeful that the Wellnet initiative itself will prove successful in moving us ahead technologically and the equipment that needs to support it. So it's a complex issue not totally saddled at the Department of Health.

THE CHAIRMAN: All right. Moving right along, Mr. Stevens followed by Ms Olsen and Mr. Ducharme.

MR. STEVENS: Thank you, Mr. Chairman. I'd like to start by saying good morning to the minister, his staff, and to the representatives of the Auditor General's department. It's always, of course, interesting to read and study the financial statements of the Ministry of Health, so my questions today will deal with the financial statements.

The first question I have is in relation to the statement of revenues and expenses found on page 64 of the annual report, and in particular it relates to the line dealing with internal government transfers under

the general heading revenues. The internal government revenue transfers reflect an increase of $130 million over the budget amount. Mr. Minister, I'd appreciate it if you could provide an explanation for that significant change.

MR. JONSON: Mr. Chairman, the item here is related once again to the Y2K money, the money that was allocated to the health system for purposes of dealing with this computer and equipment problem, and specifically the source of the funding was the lottery fund. There was a transfer from that particular entity to capital expenditure. So it was a need that was recognized, the source within the overall provincial budget identified, and available to make that transfer was the lottery fund.

THE CHAIRMAN: Supplementary?

MR. STEVENS: Yes. Turning to page 84, which is schedule 7 of the financial statement, under program 1, department support services, I note there is an overexpenditure of some $2.4 million. Mr. Minister, if you could please provide an explanation as to why those costs exceed that budget.

MR. JONSON: Very specifically this $2.4 million is to deal with Alberta Health's deemed responsibility with respect to the sterilization claims that are coming in, relative to what's being handled through Justice with respect to the whole Michener Centre sterilization issue that has been an issue for government. I can ask Aslam to explain how our responsibility here is deemed to be $2.4 million, but that's what the draw is or the reason for it. Aslam?

8:57

MR. BHATTI: Yeah. There are three departments involved in this issue: as the minister indicated, one is Justice, who are handling the issue on behalf the government, and Family and Social Services and the Department of Health. Between Family and Social Services and the Department of Health, Health has a responsibility for about 11 percent of the costs associated with that issue. In that year actually the cost was around $7 million, and 2.4 of it is what we have to find from other sources within the ministry to supplement it.

THE CHAIRMAN: Ms Olsen, followed by Mr. Ducharme and Ms Blakeman.

MS OLSEN: Thank you, and welcome to the minister and his staff and the AG's staff again. I want to refer to the Auditor General's report in relation to performance measurements. We'll be looking specifically at pages 135 and 138. The Auditor General "recommended that the Department of Health and health authorities implement a plan to improve performance measurement and reporting." Specifically, they stated that new links need to be adopted. My question to the minister is: what steps were taken by Alberta Health in '97-98 to develop performance measures that provide a more definitive link between the cost of service and the quality of service provided?

MR. JONSON: This is ongoing work, but we have made a major effort in Alberta Health over the past couple of years to develop an overall accountability framework. We're now working from that overall accountability framework on more specific measures, and we want to work towards making them realistic in terms of the goals that are being set but also as specific as possible. It's an ongoing effort of this department. That, I know, is a very general answer, Mr. Chairman, but we have accepted that particular concern that's being raised and in fact made quite a bit of effort to develop it as quickly as possible. I will make one kind of defensive remark, and that is that I think we're probably as advanced in this area as any other province in Canada in terms of developing our performance measures.

MS OLSEN: I have to note that in throne speeches since I've been elected that accountability framework has been mentioned, so I'd be interested to see when it's done. However, following on the outcome measurements, can the minister indicate what steps were taken by Alberta Health to assist RHAs in developing performance measures that are related to the care of people within the health care system; for example, nursing care hours per patient, the ratio of professional to support staff, the number of people waiting for surgery, the length of stay in emergency, those kinds of things? That's what Albertans are concerned about, and I'm wondering -- it was a recommendation. What's been done in that regard?

MR. JONSON: I'll just make one or two comments and then ask Aslam to give more details on it. I'd just like to make one interesting comment about this, and that is that you did mention specifically, at least as I understood it, that we need to develop performance measures with respect to what's an adequate stay in a hospital.

MS OLSEN: I probably have 10 or twelve examples that I'm sure you would like to see as indicators.

MR. JONSON: Well, I just want to comment -- and I'll have Aslam update us on the overall approach -- I would just like to mention that one of the things we find as we work on this, which I think may be of interest to the committee, is that there's been some challenge or some question of the merits of having patients out of hospital beds as quickly as possible. There's been the comment that for a certain procedure people are being released from hospital in three days where it used to be five. As we develop our performance measures and do our overall assessment, we find that actually the quicker you can get out of hospital on a reasonable basis the better in terms of overall recovery and getting back to, quote, normal. So what we're wrestling with here as we work to establish our performance measures is that with better treatments, better technology, better home care and so forth, some of the targets can't always be as hard and fast and specific as we might have thought a few years ago because the whole area of health care is changing.

MR. BHATTI: You raise two issues basically. One is the input side in terms of how much nursing care should be provided for a specific type of case and so forth, and the other is the issue of wait lists: how long people should wait for a certain type of procedure. On the first one there is quite a debate across the country in terms of whether governments or authorities should specify whether you need so many nursing care hours for a certain individual in long-term care or through delivery of a birth. It is felt that it's best left to the medical practitioners to determine that because each case situation is different, and to specify that you need, like we used to do in Alberta 10 years ago, 2.4 nursing hours for a certain type of patient -- well, technology has changed considerably; the case situation has changed. So the feel I get from across the country is it's best to leave it with a care provider at the bedside to decide whether it's nursing, LPN, physician, or some other form. The key issue is that it be funded adequately for the resource, but let them determine the resource.

In terms of wait lists there's a lot of talk about that. The federal government along with the provinces just started an initiative in

determining how wait lists should be determined or figuring out what's the best way to measure a wait list, because wait lists are dependent upon individuals asking for their own physicians for a certain service, and if the physicians happen to be on holiday, they go on a wait list and it appears the person's waiting for a long time when in fact alternate physicians and providers are available to deal with the situation. But we human beings like to have a personal physician or provider that we want to continue to go to. So it's a tough one to answer in terms of wait lists.

THE CHAIRMAN: Thank you.

MR. DUCHARME: Good morning, everyone. My questions relate to the 1997-98 Health annual report on page 73 under note 11, contingencies, and under other. "The Ministry is liable under equity agreements . . . between the Department and Voluntary Hospital Owners," and the department claims the payout upon termination to be $13.9 million at March 31, 1998. The owners claim $21.8 million is due at March 31, 1998. This is an approximate difference of $8 million. Why such a large difference?

MR. JONSON: I'll ask Aslam to give the specifics, but just on this general area, we have been endeavouring to resolve this issue for some time. I'm sure the voluntary hospital sector looks at it the same way, that they've been endeavouring to resolve it for some time. But I think it is quite accurate to say at this point in time that the ball is in their court. We feel we've had a lot of discussion on this whole area, and we've left it with the voluntary sector to tell us exactly what is the number they think is needed here for what purposes. So we're still in negotiations. I guess that's the point I'm making, but over to Aslam for specifics.

9:07

MR. BHATTI: If I can make a clarification to your question: you're absolutely correct on the $13.9 million as our liability to the voluntaries in terms of equity agreements. The number of 21.8 actually doesn't refer to the same item, although it's a paragraph that just follows that in the book. The 21.8 is legal actions filed against the ministry, and they largely relate to blood issues, hep C and so forth.

Coming back to the other question, the number is slightly different than 13.9 in terms of what the voluntaries claim it to be. That should be the number where it says the $14 million that we've indicated here. It relates to whether interest earned on the money we've provided them for operations should be counted as part of equity or not. Those discussions are happening, and we hope within the next two to three months to resolve this issue.

MR. DUCHARME: That handles my question. Thank you.

THE CHAIRMAN: Ms Blakeman, followed by Mr. Johnson and Mr. Sapers.

MS BLAKEMAN: Thank you, Mr. Chairman, and welcome to everyone who's joined us this sunshiny morning. My questions relate to the Auditor General's report, page 124, and specifically to recommendation 26, in which the Auditor General is recommending "that the Department of Health and the health authorities implement a joint strategy for . . . the timeliness of [their] business plans." The question inquiring minds would like to know: what explanation was provided by management to the Auditor General's office during '97-98 for the failure of the 13 health authorities to finalize and approve their business plans until August '98, five months into the fiscal year?

MR. JONSON: Well, I'd like to give a general comment to that. First of all, we certainly are endeavouring to respond to what is certainly a constructive recommendation from the Auditor General's department. In this particular budget year, as I recall, I guess you could say government caused part of the problem, and that is that we did a positive thing which, however, created this particular problem. That is, we infused significant dollars into the health care system late in the calendar year. You see, ideally it would be nice for the regional health authorities to be able to have their funding known for the next fiscal year, I would say probably about October, November, so they could develop their overall business plan. However, I don't think anyone would say we shouldn't have, since we were able to put in that additional money in this particular year that we did in the fall. And now again this year -- and we'll blame this on the federal government this time -- here we are as a government, as Alberta Health, having to keep everything in abeyance in terms of finalizing our budget relative to knowing specifically what the federal government is going to do with respect to health funding.

I know this year we're going to have a similar problem because we're just now being able to make decisions and to develop our provincial business plan around the dollars that are now available. Then that has got to be announced and passed on to the regional health authorities, and then they're going to have to race to adjust for that. So this is some of the background to what's happened here, but certainly the overall recommendation of the Auditor General's department, of course, makes sense.

Aslam, do you want to talk to that?

MR. BHATTI: Yes. Timing is the issue here. Now with our budget coming in on March 11, we'll have to give time to the regional health authorities to develop their business plans to submit to us. Likely about April 15 or 30 is when we'll receive them, and over the next month we'll discuss it with them and then approve it in June. So that's the time line. Ideally, as the minister said, if we could announce in October, we could have the whole plan process approved by the end of February, and then it could start the year off, you know, as well.

But you must remember, though, that there is a group of regional health authorities with Alberta Health staff that continuously meets on defining the requirements of what goes into a business plan and discussion on performance measures specifically as well. They're aware from a financial point of view to a certain degree as to how the discussions are going, so it's not a complete, complete surprise to them when it happens late in the year.

MS BLAKEMAN: I still find it an irony that the government expects business plans when they are unable or unwilling to provide the money to people. Which leads into my second question, which is: why did six of the regional health authorities not have capital spending plans included as part of the business plans that were put in late?

MR. JONSON: Well, I think I'd have to just get the specifics there, but I guess I'd have to ask -- I can't ask that, Mr. Chairman, so I won't. But if you're referring to capital in terms of infrastructure, I assume the reason is -- and quite frankly I don't know specifically the answer to your question -- that they weren't planning to do anything with respect to capital infrastructure and probably didn't have the resources to do so.

MS BLAKEMAN: If there's further information, I'd be happy to have the minister supply it through the chair in writing.

MR. JONSON: Certainly.

THE CHAIRMAN: If you have further information on the capital issues, if you'd supply it through the chair, we'll supply it to all members.

MR. JONSON: Oh, certainly. But if I could just ask, Mr. Chairman, for clarification . . .

THE CHAIRMAN: Certainly.

MR. JONSON: In terms of the capital program, if the member is asking about why some regional health authorities didn't have a, quote, capital plan, if that is meant in terms of new buildings or major renovations . . .

MR. BHATTI: Equipment.

MR. JONSON: . . . or equipment. But we should recognize that, believe it or not, in some regional health authorities they do have adequate space. You know, the actual capital isn't necessarily part of their plans. Certainly equipment is for all of them.

THE CHAIRMAN: If you feel strongly that further supplementation of the answer is necessary, if you'd file it through the secretary, we'll deliver it out.

Mr. Johnson, followed by Mr. Sapers and Mr. Melchin.

MR. JOHNSON: Thank you, Mr. Chairman. Good morning, Mr. Minister and others. My question refers to page 72, note 10 of the annual report, section 1. What are some of the larger service contract commitments the ministry has that would be included in the amount of $125 million as stated on page 72?

MR. JONSON: Well, Mr. Chairman, it is a significant amount of money. I think probably the largest single set of contracts is with our air ambulance over the next five years. That's about $54 million. We have the whole area of information technology and management services contracts dealing with those improvements internal to government as well as the overall Wellnet initiative. That's about $40 million over three years. Yes, we do contract with collection agencies relative to collection of health care premiums. That's $16 million. We are committing some $6 million over three years for the telehealth initiative. We have something called the Canadian Institute for Health Information, which Don will explain, where we're contracting for $2 million, and there is a series of other contracts which are in the neighbourhood of $7 million for a total of $125 million.

MR. FORD: The Canadian Institute of Health Information is a creature of the federal/provincial/territorial deputies, and its purpose is to provide a consolidation of information at a national level with consistency in reportability. Over the course of the year they produce various reports which compare the financial activities, the service activities, and other issues such as staff resource activities, physician numbers, import, export, et cetera, on a national basis and consolidate the provincial/territorial information on behalf of all provinces to allow that to occur. So our contract with them is our contribution towards that activity along with all other provinces and territories and the federal government.

9:17

MR. JOHNSON: Could you also be a little more specific on the item just above that, specific program commitments, on what might be included in that figure of close to $98 million?

MR. JONSON: Mr. Chairman, there's a bit of history here. Some of these things relate back quite a ways. I mention that because the most significant amount of money that's involved here is -- some years ago the government made a decision to subsidize the interest that nondistrict nursing homes were paying on money that they borrowed to upgrade or renovate their facilities. That was referred to as the nondistrict nursing home capital upgrade agreements matter. It represents about $59 million. This is going down, but we're still paying out that commitment that was made some years ago. There's also a capital debt retirement program between the department and owners of private and voluntary nursing homes. That's $17 million.

Then we get into another area where we have committed $9.6 million for the purchase of vaccines and serum. Health research: as I mentioned in my opening remarks, in a couple of ways part of the money is routed through the Heritage Foundation for Medical Research. We are committing $7.5 million, and there is an assortment of other specific program commitments of $4.7 million.

They're ongoing commitments, as I've said. Particularly, the first one, which is the major one, goes back a number of years, and we're still of course honoring that commitment.

MR. JOHNSON: Thank you.

THE CHAIRMAN: Mr. Sapers, please, followed by Mr. Melchin and Ms Olsen.

MR. SAPERS: Thanks. I'm looking at page 127 of the Auditor General's report and specifically recommendation 27, which reads:

It is recommended that the Department of Health:

- improve the quality and timeliness of the information used in the population-based funding formula;
- improve the consistency and predictability of the formula;
- analyze reasons for utilization and cost differences between regions;
- review the continuing application of the no-loss provision, and
- develop better methods of forecasting funding requirements.

It's curious to me that at this date we're still looking at that kind of recommendation from the Auditor General. I appreciate the complexity of moving to a population-based formula, but I'm wondering if you could provide an explanation on behalf of the RHAs, with combined expenses well in excess of $300 million, for failing to provide management system information that would provide for the specifics of the allocation to the service pools under the population-based formula.

The first year of the funding formula was last year. I think that was the first full year, '97-98. I understand that $42 million in reported expenses were not allocated to one of the service pools because they were uncoded. What's the explanation for that?

MR. JONSON: I'd like to make just a general comment, Mr. Chairman. I'll be presumptuous enough to indicate that overall the move to a population-based funding formula for health is essential, and I think Alberta is certainly leading or at the front of the line in terms of moving in this, which I think has to be the direction for funding health care in the future. I guess it's a bit like the old adage. Someone said years ago that democracy is a very slow and cumbersome form of government and has many weaknesses except for all others. Therefore, I think the funding formula approach that we're taking is a very good step.

We certainly agree with the Auditor General in terms of the issues in the areas of a gap or problems that have been identified, but we're working to update our information to get our communication and our tracking systems in place to the best degree possible. I'd just ask you to consider this particular type of challenge that we have, and

that is that it is indicated, for instance, with respect to recognizing population growth that we should be projecting ahead so that, let's say, in this upcoming budget year we should be projecting ahead accurately to accommodate the population growth that we, quote, anticipate in the province of Alberta in the coming year.

Now, I don't know any way that we can be perfectly accurate in doing so. We have to use projections. We have to make our best estimate, and we are trying to do that kind of forward funding. For instance, the issue comes up: you're not identifying the people that will be in the system. Well, they aren't here yet. So there is a real challenge here in terms of some of this accounting and projecting, but we do need to work to improve it.

I'd ask Aslam to give a little more insight into the specifics.

MR. BHATTI: Mr. Sapers, you alluded to the formula having various pools as to how the funding is determined. There are pools, and the main ones are obviously inpatient services, long-term care, home care, ambulatory care, and promotion and prevention. We in Alberta are probably the furthest ahead in being able to identify the inpatient side, the long-term care side, the home care side, and doing the formula for the coming year, we have very good ambulatory care data, which none of the other provinces have. There isn't a province that we know of in Canada that can turn around and give the specific type of information by those pools that I mentioned to you that we can and that we can utilize to allocate funds.

You are correct. There is one area that we haven't coded, which is the promotion and prevention side, but when you take a look at the residual amount, when you have determined the other pool sizes, it's less than 2 percent of the budget. It isn't an area that the health authorities and I guess to some extent that we have paid sufficient attention to. Considering the bulk of the money, 98 percent of the money, goes into the other pools, and that's where we have concentrated our efforts.

MR. SAPERS: Yeah, thanks. I appreciate that and, Mr. Minister, your earlier comments, but my question wasn't about predicting the future. It was about a system that has failed to capture over $40 million worth of transactions. So the challenge of looking into a crystal ball I accept, but that's not what I was referring to.

The fact is that even with the larger pools -- and I notice that Mr. Bhatti is anxious to get into this. Where the larger pools are I don't think we can take tremendous comfort just in the fact that we're ahead of other provinces. Damnation by faint praise perhaps. I'm not sure. In 1997-98 there were 4,300 acute care transactions, 2,800 home care treatments, representing combined totals of over $35 million in the larger pools that weren't coded properly or reported properly because the department wasn't able to track down the patients' registration numbers. What steps have been taken to ensure that acute care and home care treatments are properly allocated within a pool?

Mr. Minister, I also want you to reflect on your earlier response about getting people out of hospitals sooner to get into home care. While you're answering the question, if you want to add another degree of complexity, think about the interregional complications.

9:27

MR. JONSON: Well, Mr. Chairman, that does beg just a brief response. I'm not going to back away at all from my first statement about our wanting to move people out of acute care into long-term care or hopefully in the vast majority of cases back to their normal state of living in their homes. If the implication is that somehow we should be standardizing people in terms of how long they stay in hospital so that we can better catch up with our information system, I just cannot accept that. Yes, the flexibility within the health care system does give us real challenges with respect to tracking patients and the services that they're receiving, so I'd ask Aslam to go further on that.

MR. BHATTI: I'm not sure if it's fair to say that the department didn't track the registrations of people. When you enter into the health system -- for instance, if you go to the Sturgeon hospital, it is that hospital that asks you for your health care card. If you don't have your card with you, that creates a difficulty. They will provide the service. Their first order of business is to provide you with service, whether you have a card or not. Then they follow up with finding out what the number is. Well, if you've moved and have failed to inform the health registry, then that creates a difficulty. So those are the types of things.

Now, that's not to say that we can't improve. We in fact have a pilot project right now. We're working with the northwestern region whereby we're allowing them to enroll patients -- when somebody comes in and says, "I don't have my card," "Well, what's your name; where do you live?" and so forth -- and then have a direct link to our registry to be able to get a number. Before we jump at that, though, there are confidentiality issues that we need to be very aware of. So although we have a contract with them to keep it confidential, we have to understand that when we open this up to the rest of the system -- eventually, that's probably the best way to do it, the first point of contact in getting your data, but then we have to be respectful of the FOIP issues and the confidentiality issues.

THE CHAIRMAN: Mr. Melchin, followed by Ms Olsen and Mr. Lougheed.

MR. MELCHIN: Thank you. I'd like to address my remarks today with regards to the Wellnet initiative. Part of it comes from the Auditor General's report, pages 140 to 143. I guess the first thing is in respect to Wellnet. The Auditor General mentions on pages 140 and 141 that there was $15 million spent on Wellnet last year. I'm not clear. When did Wellnet start? How much have we spent to date on Wellnet?

The expectations of this going forward was $40 million to $50 million in our current year and potentially $630 million to develop and $230 million to operate. Now, that's the Auditor General's assessment, at least, put in there. I wouldn't mind knowing what we have spent. Where is that recorded? If I look in section 1 of your annual report, page 84, where it starts getting into the detailed analysis of the expenses, I'm guessing that it might come under program 1.0.5, and you might clarify if that's where this specific item for Wellnet gets recorded. If you could give me a perspective of what has been spent, if that's where it's recorded, and the projection going forth.

MR. JONSON: Well, Mr. Chairman, I can answer part of the question, and then I'd refer it to our staff and the Auditor General's staff as to the accounting and reporting locations in the overall documents.

In the budget year that we're dealing with, there was $20.4 million allocated overall to the Wellnet initiative. As you may be aware, we have a contract with IBM to work as the leaders on the overall design, and that was to the tune of about $3.1 million. We have projects under way totaling $4.7 million in terms of cost, and I'll list them in a moment.

You may find this curious, but we also engaged Ernst & Young to be the quality management group to sort of double- check on the overall plan that IBM was developing. You may think of this as kind of overkill, but on the other hand ultimately this is going to be very big in investment for government in a very technical area. We felt that we should have that monitoring or cross-checking in the

whole area. That's 1.5 million. Then administrative costs, Alberta Health: 1.1 million, for a total of 20.4.

The other thing we just want to indicate is the specific things that have been done through the overall strategic blueprint planning: Y2K assessment and strategy, a project which is known as triregion financials -- Aslam or Don can comment further on that -- money into telehealth, which rides to a degree on this network ultimately, and development of the pharmacy network. Those are some of the things we're proceeding with.

Now, the accounting part of it. I'm not an accountant, so that's good.

MR. BHATTI: In '98-99, the year we're in, since it's a continuation of the same topic, we intend to spend somewhere around $26 million. About $15 million will come from Alberta Health and about $10 million will come from the regional health authorities. The Alberta Health contribution of $15 million in the year we're in and the previous year that is under discussion here we expense as part of our financial statements. In terms of the regional health authorities, it's an issue of getting some concrete, tangible benefits versus the planning work. The planning work, as you know, in these types of situations gets expensed, the benefit that you're going to achieve in the future, that you can quantify at this point in time. Then you can start an amortization schedule for that.

Since Wellnet is such a new entity or concept, we're working through with the Auditor General's office and the regional health authorities to determine the future tangible benefits at this early stage to determine what should be expended and what should be amortized in the regional health authorities' statements. When you see the '98-99 financial statements, we'll be able to show you more directly either the amortized amount or the expensed amount.

MR. MELCHIN: I still didn't find out where it's recorded even in the existing year, so if we could at least have that.

I guess you've partially answered this. I would ask: in the plans going forward, how is it that the RHAs are involved in this plan, be it a joint plan, pilot projects, or otherwise? As to their concurrence with Wellnet, how are they interrelated as to IBM, Ernst & Young, or otherwise as to assessing? Is this what we really want in our regions? Are the regions onside with saying: in the past we have a concurrence with the blueprint going forward? Or is this more Alberta Health's initiative? I'm not certain as to how this has rolled out thus far in respect to developing Wellnet thoughts, plans, blueprints.

MR. JONSON: Mr. Chairman, just one general comment, and Mr. Ford can give you the direct answer. In the whole Wellnet initiative there has been consultation ad nauseam, to the point where I have become a bit impatient as minister. Although I really value the work that's been done, I've said: let's get on with some specifics. So that's the direction that's been taken, but Don can tell you about the structure.

MR. FORD: With respect to the structure, we have established a senior reference committee which has representation from many of the regions, and the people representing the regions are there on behalf of all the regions. We have representation from other major providers: the AARN, the Pharmaceutical Association, the Alberta Medical Association. We have representatives of the research community, and we also have at that table Alberta Health representation and representation from IBM and Ernst & Young. So all of the issues that are being brought forward are discussed at that larger table.

At a subtable, called a technical reference committee, we have representation of the chief financial officers, chief information officers, and others at the local and regional levels who contribute to the project development, to the costing, to the business cases that need to be brought forward to the senior reference committee. That senior reference committee is chaired by Dr. Tom Noseworthy.

9:37

So the involvement of the regions is immediate, and they're engaged actively. As projects are brought forward, they sign off as a collective on the importance, the order, the merit, the time frames, the expenditures, and then they expect, through the senior reference committee, tracking on those. The projects are occurring in their regions day in and day out, so they have also that immediate response and immediate activity.

For example, the triregion project, which is Calgary, Edmonton, and Red Deer, is looking at common financials and common HR. Along the lines of some of the other questions that have been asked is: how do we in a more consistent and robust and immediate fashion track some of these issues? Well, we have to have a common set of documents from which we draw the information. The triregion is the first pilot in trying to have common financials, common HR stats so that we know how many of what we have where, doing what, being compensated at what level, and that kind of information. The regions are actively involved in that.

THE CHAIRMAN: Thank you. I must add that I listened carefully to the questions, and the questions were not directly trying to get into policy, plans, and new directions. He was asking about the history, so we try to stay with the history as much as we can. I know it's difficult spending all your days in planning for the future, not dealing with the past, and then coming here and having to deal with the past, but that's unfortunately how we have to do it here.

MR. MELCHIN: Does anybody know where it was recorded in '98-99? Where would I find that?

THE CHAIRMAN: Yes. That would be -- you could subsequently bring it back to the member, I'm sure, to identify the specific location, to our colleague the accountant.

Ms Olsen, followed by Mr. Lougheed.

MS OLSEN: Thank you. I just want to go back and talk about performance measurement and reporting because I'm not sure that I made myself fully understood in asking the questions. The Auditor General's report identifies some gaps in relation to performance information relating to the care of people not visible. In my last questions you focused on a couple of things that I talked about, so I'm just going to broaden that a bit.

The examples of input measurements such as nursing care hours per patient, proportion of qualified staff to acuity of care required, and the ratio of professionals to support staff are examples of the types of performance indicators or measurements that might be developed or sought after by the Auditor General. Process measurements, output measurements, and patient outcome indicators are also part of the Auditor General's report. Not to focus specifically on waiting lists or any of those specific issues but in the broader context, taking into account those variables, what has the department done, Mr. Minister, in relation to assisting RHAs in developing performance measurements?

MR. JONSON: Well, Mr. Chairman, perhaps I could -- I can't ask a question back; I know that. But I would reflect on this, and that is that . . .

THE CHAIRMAN: If, Mr. Minister, it's to clarify the question to narrow the scope of your answer, certainly that's in order. We're not that formal, so if you want to find out what the nature of the question is, just feel free. Debate we don't need because it's answering questions, but if you must, certainly feel free.

MR. JONSON: Mr. Chairman, when the issue was raised previously, I took the tenor of the question to mean -- and I appreciate that direction; that is, that we need to work on measures and targets which are as specific as possible in terms of patient care. This is why I said that we are working on -- let's take the whole area of waiting lists. We do want to reduce waiting lists in the most critical areas, and if we can come up with what is deemed to be the proper standard or the realistic standard there, this is something we want to have as a direction in our overall planning in Alberta Health and with the regional health authorities.

Now, in this last question it seems that the member is saying: well, okay, but there's this other area that we should be working on. I'm not sure what the other area is. I don't quite understand the question.

MS OLSEN: I just wanted to frame the question broader than just specifically waiting lists. I wanted to ask the minister about the broader performance measurements. The Auditor General has highlighted in his report -- and that might be helpful. If you turn to pages 138 and 139 in the Auditor General's report, you'll see on page 138: "Typically, performance information relating to the care of people is not visible." His recommendation is to develop those indicators. That's what I was trying to ascertain, and from your previous answer it indicated to me that you weren't aligning with the Auditor General's notion that these types of indicators exist. That's what I'm trying to determine. Do you want me to repeat the question?

MR. JONSON: No. I appreciate that, Mr. Chairman. I appreciate the response. I am aware of the comment of the Auditor General, and we will work from that end. I don't want to get myself in trouble with the Auditor General's department, but I think what we need to do, quite frankly, is, yes, we need to do what the Auditor General is stating in the report, but we would like to follow it through further, because the bottom line should be measurements with respect to the quality and quantity of care being provided. While the number of nursing hours can be related to that, if that's what we're talking about here and that should be a performance measure, so are the LPN hours, the support worker hours, the physician services. If that entity that is providing that service is getting good results which are measurable with respect to the patients, that is where I'd like to go, quite frankly, in terms of developing our whole system of measurements and accountability.

THE CHAIRMAN: Will there be a supplementary answer by the Auditor General's department?

MR. SHANDRO: Certainly we want to be helpful to the department and to the regional health authorities in this area. I sympathize very much with the difficulty that we have in this area, because when you report something like average length of stay, if we're not careful, we can do the system damage with that type of reporting. Let me explain why.

We are developing new techniques that don't require maybe even admission to hospital, but if they do require admission to hospital, they may not require the same length of stay as, say, with the previous invasive surgery or complex methods that were used previously as compared to the new methods using drugs and noninvasive surgery. It becomes, because of the new technology, in fact a far simpler operation. I'm not a medical expert, but I can see the developments here that technology and new advances in drugs are providing. Why should we be spending 10 days in a hospital for something that is very simple and very easy to deal with under the current technology? In other words, if we see a drop in the average length of stay because of advances in technology, that should be a positive measure.

9:47

Now, for those people who will then take the measure and say that average length of stay is dropping and this is strictly because of dollars and not care for patients, that's sending the wrong message. It's misinterpretation of that performance measure. It is for that reason that we really don't want to measure so much the inputs and activities but focus more on what the outcome is. What are the results of the process? Did the person who needed the service come out with the proper service that provided him quality care? Whether there were so many nurses or so many days in a hospital is a matter of how you can figure your service delivery aspect, and that is, I think, of more importance to those people who design the service delivery process than it is to somebody who's trying to measure their performance.

The measurement of performance should be focused more on what is produced and what the outcome is rather than the activities and the sorts of things that we quite often measure in terms of the number of nurses. For example, we're moving now to multidisciplinary teams, which means that possibly some of the professionals that were previously providing certain services are being replaced by other people in a multidisciplinary team. So the traditional ratios and so on are bound to shift, and that is as it should happen.

THE CHAIRMAN: Thanks for that broad explanation.

Mr. Lougheed, followed by Ms Blakeman and Mr. Klapstein.

MS OLSEN: Don't I get a second question?

THE CHAIRMAN: That was one long question. That was one long answer too.

MS OLSEN: We have to have some points of clarification.

THE CHAIRMAN: Okay; you need a supplementary to that. Supplementaries are allowed.

MS OLSEN: Thank you, Mr. Chairman. I'll make this second question easier, Mr. Minister.

THE CHAIRMAN: Please.

MS OLSEN: Why has Alberta Health failed to ensure that performance indicators or measurements are being established and utilized by decision-makers to meet specific service standards? That again is a highlight from the Auditor General's report. Because I like the Auditor General's report, my questions come from it.

THE CHAIRMAN: Please allow the minister to . . .

MR. JONSON: Mr. Chairman, with caution I would just say that in terms of the overall theme of the Auditor General's statement, I think we've said two or three times that we acknowledge and are working on the need to further develop performance measures and assess outcomes for the health care system, and I'll just leave it at that.

THE CHAIRMAN: Terrific.

Moving right along, Mr. Lougheed, followed by Ms Blakeman and Mr. Klapstein.

MR. LOUGHEED: Thank you, Mr. Chairman. Certainly I'd be remiss not to thank you for your earlier comments about keeping to the reports from the past and not getting into policy. I have been surprised. Usually you're so dictatorial and autocratic and keep us in line so rigidly here, and you've allowed a lot of straying, I believe, today. In spite of the fact that you've said that we aren't formal here, we know you've kept us very formal in the past.

THE CHAIRMAN: Just before we move on though . . .

MR. LOUGHEED: You're not supposed to get into debate, Mr. Chairman. Let's just move on to the question.

THE CHAIRMAN: That's true, but I do the best I can with the questions. The answers I don't really have control over what's proper. It's the answers that -- I think perhaps I'll make mention to that at this point to subsequent members from the executive before us, and then it'll clarify it off the top. How's that? A reasonable solution or not?

MR. LOUGHEED: As usual very, very good.

Referring to the annual report, over on page 64 we have some statements of revenues and expenditures. The difference isn't great regarding fees, permits, and licences, a difference of a matter of about $15 million between budgeted and actual. Can you clarify a little bit more? I assume fees refers primarily to premiums and would embody the largest part of that number, but what else would be included in permits and licences?

MR. JONSON: We're dealing with page 64?

MR. LOUGHEED: Right.

MR. JONSON: Quite frankly, the increase there in terms of the amounts that you quoted -- we have more people in the province. There's been more people coming into the province becoming part of the health care system, paying their premiums. There's also I think, related to the overall economy, a proportionately lesser number of people who are requiring premium subsidy under the health care system. So the difference of $15 million that you're referring to is mainly accounted for by those changes.

Further, in terms of a specific part of your question, Aslam I think can comment on that.

MR. BHATTI: Your question also related to what are other permits and fees and so forth. This is a general title that's to all departments. So if you're in Municipal Affairs, it refers to motor vehicle licences and so forth. For our department it's specifically health care insurance premiums.

MR. LOUGHEED: Permits and licences?

MR. BHATTI: Yes. Fees, permits, and licences is a catchall type of phrase for various government ministries.

MR. LOUGHEED: Okay.

Your comment about growth and so on. If we go over to page 76, where it talks about gross premiums, it doesn't reflect that. The numbers went down from '97 to '98. How come that would happen?

MR. JONSON: Mr. Chairman, that is correct. This is due to the fact that the federal government for a number of years paid in Alberta health care premiums on behalf of our aboriginal people. They discontinued that, so in 1997-98 over '96-97 we have to reflect that discontinuance in the money flowing to us. We no longer have that revenue flowing in.

THE CHAIRMAN: Ms Blakeman, followed by Mr. Klapstein.

MS BLAKEMAN: Thank you very much. Y2K. Oh, big smiles all the way around. Two very specific questions. I'm wondering what steps have been taken by the RHAs in the fiscal year which we're examining to ensure that sufficient staff and time are made available to test and to replace equipment and systems and manage all of the risks around the run-up to 2000.

MR. JONSON: Mr. Chairman, I think the member is identifying a major area of activity and concern for us during the past year. All the regional health authorities are giving this all the priority they can. They are having their equipment tested, starting with and giving priority to the equipment which has a direct relationship to the safety of patients.

I must say that this activity is worldwide, I guess, but certainly nationwide. There has been a real challenge and a higher expense than expected in getting the qualified people to do the testing, to do the assessments. I feel that in Alberta, with the overall commitment of money that has been made, we're doing as well as anywhere else in terms of doing a thorough assessment of this situation and, where needed, replacing the equipment or the devices or the networks.

In terms of the specific administrative structure, Don . . .

MR. FORD: In terms of what was done specifically this year, this was really the first year of full identification and understanding. The predominant activity was the assessment of the coming to terms as to the magnitude of the issue and getting a sense of what equipment was there, what its state of readiness was. In working with IBM and others, they more or less created that context within which it was that we made the determinations of the funds that would be made available. They began to turn staff attention to it. They began to use consensus testing processes between regions. So that was the predominant activity during that year.

MR. BHATTI: Just to add to that, though, we are further ahead than most of the other provinces in Canada. As a matter of fact, that assessment we did in '97-98 is being utilized by other provinces, because they now find themselves in a very short period of time. So they're using that assessment to do their work as well.

9:57

UNIDENTIFIED SPEAKER: Are we getting royalties?

MR. BHATTI: We're not getting royalties unfortunately.

THE CHAIRMAN: Does the Auditor General have some comment on the Y2K?

MR. SHANDRO: Yes. I would say that in my work with the RHAs they're involved in due diligence processes which involve an outside party to review their exposures and determine if their risks are being suitably addressed. That's an excellent initiative that I think should be recognized.

MS BLAKEMAN: Okay. I appreciate the steps that were taken in this fiscal year. I guess I'm a pessimistic optimist.

MR. SAPERS: That makes you a Liberal.

MS BLAKEMAN: Yeah, it does.

My follow-up question is: in this fiscal year what contingency plans were developed as your fail-safe -- in case it doesn't work, what contingency plans were developed there for the RHAs to handle the emergency situations? I had a constituent talk to me about her concerns about that, so I'm wondering what contingency plans were developed in case it doesn't work.

THE CHAIRMAN: In the scope of the reporting year that we have before us, not the current year.

MR. JONSON: First of all, during this budget year this was really, I think, contingency planning. The whole business dealing with Y2K is an initiative which involves providing for contingency and the prevention of problems. But in this particular budget year there was not a great deal of expenditure that can be identified with: if this contingency plan doesn't work, what do we do then? However, across government -- and my staff here can probably elaborate, and I guess health is the one of most concern -- the overall area of correcting the Y2K problem is also related to and, if you would, backed by some of the disaster services planning that is being done on a broad basis, and this would refer to everything from power companies to a number of other things in government. Perhaps the Auditor General or perhaps Don would want to comment further there.

MR. FORD: With respect to the disaster preparedness it's really part of that overall process, so early on as this was being identified, contacts were being made with major power suppliers, water suppliers, suppliers of equipment. Most of the regional health authorities have disaster preparedness plans, and they were looking at those again in the context of what happens if we don't have access to these. In some ways they even have done some preparedness planning as a result of the ice storm that occurred in eastern Canada, and they've done some meeting with officials that were involved in that event to also understand some of the things that might not have otherwise been considered. It was really part of the disaster preparedness that is part of the ongoing activities of all the regions as it related to what might be the implications of Y2K. So that was the early activity that occurred in this year.

THE CHAIRMAN: Okay. Ladies and gentlemen and our guests, the time for the committee has expired.

AN HON. MEMBER: On, no.

THE CHAIRMAN: Oh, yes, it has.

We have one item of business to deal with. The chair has received a written notice of motion that should be read into the record and dealt with at subsequent meetings. Mr. Sapers, would you be so kind as to read your motion?

MR. SAPERS: Okay, Mr. Chairman, and thanks to our guests. My notice of motion presented today at the standing committee reads as follows: that

> the Standing Committee on Public Accounts be given the authority to conduct a follow-up review of the Auditor General's investigation of the government's involvement in Alberta Treasury Branch's refinancing of West Edmonton Mall, including the ability to call witnesses and subpoena relevant documents.

THE CHAIRMAN: The notice has been given. There are copies. There are questions as to the scope of the review and all of that, but that'll be dealt with at subsequent meetings, not now. Hopefully, Mr. Shariff and I will have time to discuss the matter in the interim.

A motion to adjourn?

MR. HLADY: Yes.

THE CHAIRMAN: Agreed? It's carried.

[The committee adjourned at 10:02 a.m.]