[Mr. MacDonald in the chair]

THE CHAIRMAN: Good morning, everyone. I would like to call this meeting to order, please. I would welcome everyone.

First I would like to address the agenda that has been circulated to members. If there are no questions, comments, or concerns regarding the agenda, could I have a motion that the agenda be approved, please?

MR. GOUDREAU: So moved.

THE CHAIRMAN: Okay. Agreed?

HON. MEMBERS: Agreed.

THE CHAIRMAN: Thank you. I would also at this time like to welcome the hon. Mr. Mar and ask him if he could please introduce his staff.

MR. MAR: Thanks, Mr. Chairman. With me today are a number of people: my new executive assistant, Lynn Redford – this is her first opportunity to be here; Murray Finnerty, the chief executive officer for AADAC; Mr. Rai Batra, the chief financial officer for the Department of Health and Wellness; Jim Menzies, CFO for PDD; Jim McCutcheon, CFO for AADAC; Peter Hegholz, from Health and Wellness; Shaukat Moloo, from Health and Wellness; Celso Teixeira, from Health and Wellness; and finally, Michael Harvey, from Health and Wellness.

Mr. Chairman, I'm pleased to present the public accounts for Alberta Health and Wellness for 1999-2000. As always, of course, those questions that we are not able to address . . .

THE CHAIRMAN: Mr. Minister, if we could please hold off on your opening remarks for a minute, I would also like to introduce Mr. Peter Valentine and his staff.

MR. VALENTINE: Thank you, Mr. Chairman. With me today is the team in my office that looks after the audit of the Department of Health and Wellness and a number of the regional health authorities. On my immediate right is Nick Shandro, assistant auditor general, and on Nick's right are Trevor Shaw, principal, and Doug Wylie, principal. Thank you very much, sir.

THE CHAIRMAN: Thank you, Mr. Valentine.

Now, for the convenience also of both the Auditor General and his staff and the minister's staff, I would please ask that members of the Public Accounts Committee have a quick introduction. Perhaps we'll start with the deputy chair.

[Mrs. Ady, Ms Blakeman, Mr. Broda, Mr. Cao, Mr. Cenaiko, Ms DeLong, Mr. Goudreau, Mr. Hutton, Mrs. Jablonski, Mr. Marz, Mr. Ouellette, Mr. Shariff, Dr. Taft, and Mrs. Tarchuk introduced themselves]

THE CHAIRMAN: Now, the minister was very anxious to get started, so please proceed, Mr. Minister. If you wish to remain seated, you're quite welcome to do so. Thank you.

MR. MAR: Thank you, Mr. Chairman. Forgive me for my early start. I note, actually, that I sit in the Leader of the Opposition's chair. I'm sure I'll find something interesting in the desk later on.

Mr. Chairman, I'm pleased to present public accounts for Alberta Health and Wellness, 1999-2000. As I indicated earlier, for any questions we're not able to address today, of course we'll undertake to review *Hansard* and provide written responses to same.

The ministry had a different look in 1999-2000. My colleague the Minister of Community Development was Associate Minister of Health and Wellness at that time. Then, as now, he had responsibility for the persons with developmental disabilities board and the PDD Foundation. He also had responsibility for the Alberta Alcohol and Drug Abuse Commission, which remains part of my ministry. I'm pleased to speak to all these provincial agencies within the context of these public accounts.

If Health and Wellness had a different structure in 1999-2000, it was also setting a new direction. We had the recommendations of the provincewide forum on health, Health Summit '99. Our government supported in principle all the recommendations that came from the summit. We had received the report and recommendations of the long-term care review, led by our colleague the hon. Member for Redwater. We had the Building Better Bridges report on persons with developmental disabilities, which was completed by our colleague the Minister of Community Development, responsible for PDD. In January of 2000 the Premier unveiled the six-point plan for health which was designed to address emerging issues, specifically (1) improving access to services, (2) improving system management, (3) enhancing quality, (4) promoting wellness, (5) fostering innovation, and (6) protecting the public health system.

Those reports, recommendations, and plans form the backbone of the business plan for 2000 to 2002 and continue to be reflected in our new business plan for 2001 to 2003. Although these directions came while we were implementing the 1999-2000 business plan and too late to influence the base budget for that plan, they did dictate $333 million in additional spending during the 1999-2000 fiscal year that is part of these public accounts.

Technically Public Accounts looks at how we spent our budget in 1999-2000, but services in this government have never been about spending money. Rather, they are about achieving results. Funding is simply one of the tools we use to get the job done, no doubt a powerful tool but not an end in itself. The process for getting results starts with the three-year plan. In Health and Wellness every health authority is required to submit a three-year plan that supports the provincial plan and direction but meets the unique needs of the region or client base. We provide considerable support to help authorities draft and complete their plans. We work with the health authorities to set out requirements, including goals and performance measures. We provide region-specific data on population health status and service use, including provincial comparisons, and we review the plans and provide feedback. Every year we also report on our progress in achieving the targets we set for ourselves. One of the targets is a high standard of satisfaction with the health system.

The annual results report for 1999-2000 shows Albertans continue to have confidence in their public health system, with 86 percent of people who received care reporting the quality as good or excellent. We also measure how Albertans rate the system whether they received services or not. In 1999-2000, 63 percent of all Albertans rated the health system as good or excellent, the highest result in five years. Albertans who rated the system as fair or poor cited long waits or staff shortages as the reason.

One of the advantages of three-year planning is that we have the continuity of a longer view while remaining flexible to respond to emerging issues. An example is waiting lists. Recognizing Albertans' concerns over wait lists, we targeted funds so health authorities could hire 1,000 additional frontline staff to improve access and reduce waits. I'm pleased to note the health authorities exceeded that target, hiring over 1,200 new frontline staff, most of

them nurses. In 1999-2000 we also provided funding to increase the number of key surgeries, like cardiac procedures and joint replacements, to address waiting times.

To assess how the funding achieved the intended results, we also introduced a new accountability process for targeted funding. Health authorities now are required to provide detailed service volume and waiting list targets, like those for hip replacements and MRI scans, and must report on these quarterly. These quarterly reports are in addition to the annual results report that is part of the business planning and reporting process. I am pleased to report that the combination of targeted funding and quarterly reporting continues to help us track significant progress in waiting times. Cancer Board wait times now average within two and a half weeks, well below the four-week target.

In addition to the quarterly waiting list reports and annual results reports, every two or three years my ministry also produces a report on the health of Albertans. The latest was the document Alberta's Health System: Some Performance Indicators. It confirmed that in 1999-2000 Alberta's health system continued to perform well. The number of physicians continued to grow. Seventy-nine percent of Albertans were able to see their family physician within a week and almost half of those within a day. The number of heart and joint replacement surgeries went up while waiting lists went down.

8:40

These public accounts are an additional opportunity to report to Albertans on the value they receive for their investment in public health care. In 1999-2000 that investment totaled $5.5 billion. That was $333 million over our base budget of $5.2 billion. And $215 million went to health authorities to eliminate health authority deficits, buy equipment, or invest in new ways to improve service delivery.

Growing demand for health services is one of the biggest issues we face today. It is not a new issue for Alberta. In 1999-2000 higher demands for physician services required us to spend $10 million over budget for the services of more physicians, and we increased funding for persons with developmental disabilities by $10 million to cover higher caseloads. Recognizing the growing demand for PDD services led this government to conduct a review that led to the Building Better Bridges report. Finally, we paid $70 million in claims for wrongful sterilization.

Our financial statements are complicated by the transfer of funds when the persons with developmental disabilities board, the PDD Foundation, and AADAC became part of Health and Wellness. For example, in 1999-2000 we held a $2.5 million grant from family and social services, the foundation's former home. That grant was to establish an endowment fund the foundation could use for capital purchases and grant expenses. In the 2000-2001 fiscal year the foundation received and invested those funds.

We also received a transfer of $55 million from the lottery fund to support AADAC's addiction prevention services, the Alberta Wellnet initiative, and health authority purchases, the high-tech medical equipment, which was on top of the $7.3 million my department provided directly for equipment.

From Community Development we received an increase of $10 million on behalf of seniors who pay health premiums and are recipients of the Alberta seniors' benefit program. We received transfers from the federal government in 1999-2000.

We received a supplementary $192 million for the Canada health and social transfer, or CHST as it is often referred to. This was the first installment of a three-year commitment of $336 million. The deferred $114 million is listed as an unearned revenue. The supplementary transfer was on top of our regular CHST. The regular CHST we received was lower than we had originally estimated. That is because Health Canada bases the CHST on income tax receipts. The Alberta personal income tax receipts Health Canada used for its budget were lower than the actual receipts we realized.

Even though the CHST was less than expected, it was $9 million higher than the previous year. The higher federal transfer shows up as an increase in our accounts receivable. In addition, our accounts receivable were bolstered by an increase of $12 million in health insurance premiums, a $7 million increase in third-party recoveries, $5 million more in recoverable air ambulance services, and a $4 million increase in miscellaneous receivables from recovering Y2K funding from health authorities. It all adds up to an increase of $74 million in accounts receivable.

Now I want to highlight some of the major liabilities in these public accounts. You will notice a $30 million liability for hepatitis C. Federal, provincial, and territorial governments together agreed to compensate Canadians who acquired hepatitis C from Canada's blood supply between January 1986 and July 1990. Nationally, the agreement totals $1.1 billion. Our share came to $30 million. We set that money aside in 1999-2000 to meet our obligation to Albertans. This total shows up in our accounts as an accrued liability.

Another liability on our books is the $22.6 million contingency should voluntary hospital operators transfer facility ownership to the province.

In 1999-2000 we also accrued a liability of over $17 million to settle outstanding or potential sexual sterilization claims. This is part of the $70 million for sterilization claims I mentioned earlier.

I recognize that the Auditor General has raised specific issues in his report, and as always I will be pleased to respond to questions on these issues. We will continue to work with Finance and the Auditor General to address any concerns over our practices.

I believe that these public accounts show good value for the funding we invested. That perception of value is highlighted by Albertans' continuing high satisfaction with the health services they receive. These public accounts show our health system was in a state of change as we welcomed provincial boards into our fold, was open to the input of Albertans as we evaluated and acted on the recommendations of several consultations, and was responsive to emerging concerns like wait lists and staffing.

Colleagues, I welcome your positive critique of our public accounts for 1999-2000. As I indicated at the outset, any questions that my staff and I cannot address today will be responded to in writing. I thank you for your time.

THE CHAIRMAN: Thank you.

At this time I would like to now call on the members, please, starting with Ms Blakeman.

MS BLAKEMAN: Thank you very much. I thank the staff and the minister for agreeing to come this morning and help us out, answer some of our questions. I'm sure there are additional staff in the galleries, and certainly they are welcome as well and any other fun seekers that came along, because this is such an exciting committee. It really is, folks.

My first question is around something that the minister touched on just at the end of his remarks, and I'll refer you to pages 134 to 136 in the Auditor General's report. That is around measuring the quality of health services. The Auditor General does point out, particularly on page 136, that measurement of quality of health services could be improved:

- reliable information on home care was not available
- some regions were not able to provide baseline data on surgeries so that increases or decreases could be . . . determined
- surgery cancellations were not reported consistently . . .
- comparable measurements of wait time for surgeries and MRIs needed more work.

My question is: what was done in this year, if the minister could be more specific, or was work done to provide a standardized formula for measuring wait times and the numbers of surgeries so that we can be assured that we are comparing apples to apples rather than apples to oranges? Can the minister comment on that?

MR. MAR: I'm sorry, hon. member. My attention had been taken away by something else, but I'll be happy to review your comments and provide you with an answer.

MS BLAKEMAN: All right. Generally we have the responses in writing through the clerk of the committee.

My supplementary question then. Given that we don't seem to have a system for measuring wait times and number of surgeries, what other methods has the department developed for meeting one of its four core businesses; that is, setting strategic directions, policy, and provincial standards for the health system? If we can't measure where we are, then how do we move forward to the future, specifically around the items that have been pointed out by the Auditor General?

MR. MAR: Again, I'll review your comments and provide a written response, if I could, please.

MS BLAKEMAN: Thank you.

THE CHAIRMAN: Mr. Shariff.

MR. SHARIFF: Thank you, Mr. Chairman, and thank you, Mr. Minister and your staff and the Auditor General and your staff, for coming out today.

I'd like to begin by making some opening reference to the Auditor General's annual report, page 6, where the Auditor General talks about performance measurement, both financial and nonfinancial, indicating that they are

> an integral part of the government accountability framework. When it is published, performance information should be audited. The rendering of an audit opinion on performance information provides users with assurance that the information is fairly presented.

Keeping that in mind, I have two questions on the Alberta Ministry of Health and Wellness report, section 1, one on page 22 and one on page 24. So I'll begin with the question that I have from page 22. If you look at the fifth bullet on that page, it makes reference that

> Alberta childhood immunization rates continued to be lower than the provincial target. No regional health authority achieved the immunization target.

My questions are: did they not achieve the target because of budgetary problems, or do you have any insight as to why those targets were not achieved? Could you please advise us on that?

8:50

MR. MAR: Hon. member, I'll review your questions as well. Thank you.

MR. SHARIFF: My second supplementary question is on page 24, where the Auditor General is reporting that

> the measure reported on page 61, Self-Reported Health Status, has been calculated based on a different methodology than the one described in the business plan and used to determine the target.

He goes on further to analyze if a previous methodology was used. I look at the rates of self-reported health status for ages 18 to 64. They are at 66 percent versus what you would have reported quite differently. So I'm wondering why there was a change in the methodology used.

MR. MAR: I'll review that, hon. member. I'm sorry.

MR. SHARIFF: Thank you.

THE CHAIRMAN: At this time I would like to remind you, please, that you can defer these questions to your staff. Thank you.

Next on the list is Dr. Taft.

DR. TAFT: Thank you, Mr. Chairman. I am in section 2 of the annual report, in the section on the statements from the Calgary regional health authority, page 66. In general, in a review of these statements I've noticed some references to a numbered company owned, I believe, as a joint venture by the Calgary regional health authority, company 703590 Alberta Inc. It indicates here that the financial statements for the CRHA, I guess, incorporate those generally. I'm wondering where the separate statements for that numbered company might be found and if the Auditor General can make any statements on the nature and size and profitability of 703590 Alberta Inc.

MR. VALENTINE: I think management should respond to the question with respect to where the financial statements are, Mr. Chairman. I'll be happy to respond to the question about the audit.

MR. BATRA: They're not part of these financial statements. The Calgary regional health authority should have them separately. We'll be happy to ask them about it.

DR. TAFT: Okay. Well, the Auditor General is the auditor for the CRHA. Perhaps he could fill in some detail on that.

MR. VALENTINE: Well, in my capacity as the auditor of the CRHA I've examined and reported on the consolidated financial statements of the region. That's what you have here. It's not customary nor do I think it's appropriate that all of the subsidiaries be separately reported upon in this material when the consolidation is reported on. The consolidation is the aggregate of all of the entities that are owned by the CRHA. It shouldn't matter in the concept of consolidation whether there are no subs, one sub, or a hundred subs.

THE CHAIRMAN: Dr. Taft.

DR. TAFT: Thank you, Mr. Chairman. Is it, then, the case that the Auditor General has not examined the statements of 703590 Alberta Inc.?

MR. VALENTINE: No. We've examined the consolidated financial statements of the region. That's what our audit report says, and that's the charge that we have. Included in that are statements of subsidiary entities to the parent organization, which is the CRHA.

DR. TAFT: But the Auditor General has not looked at the numbered

company's statements.

MR. VALENTINE: We've looked at all the transactions that we thought were necessary to opine on the consolidated financial statements of the Calgary regional health authority.

DR. TAFT: Thank you.

THE CHAIRMAN: Mr. Hutton.

MR. HUTTON: Thank you, Mr. Chairman. Firstly, I'd like to say that it's a privilege to sit on this committee, and I thank the minister and his staff and the Auditor General for being here today to respond to our questions.

I'd be remiss as an Edmonton MLA and a former executive director of the Glenrose foundation to not make a statement that I was very, very honoured to work there and that Sheila Weatherill, Susan Paul, and Anne Morrison as staff did a phenomenal job in the region, and we have the number one health authority in Canada two years running.

My question to the minister, though, is on pages 291 and 292, table IV, in the Alberta Ministry of Health and Wellness report, section 1. The annual report shows a line, "administration cost as a % of total expenses." The percentages vary between health authorities. They range from 3 percent to nearly 10 percent, and I ask the question why.

MR. BATRA: With administration costs such as corporate administration, finance, human resources, and information systems, some of the reasons for the variances are as follows. Admin costs can vary between health authorities as some RHAs have greater involvement with voluntary providers who are funded by health authorities for the delivery of health services. In such cases the voluntary provider's administration costs are included in the funding provided to them rather than as part of the RHA administration cost. By nature, larger health authorities normally have lower admin costs because the overhead is spread quite a way, across a few hundred million dollars, you know, versus a small health authority, where you do have certain fixed costs that you must pay. So it's the matter of infrastructure, but the average cost is approximately 4.2 percent across the board, with the larger health authorities coming close to about 3 percentage points.

MR. HUTTON: Thank you. I do have a supplemental. Referring to table IV, the average remaining useful life of capital equipment also varies between the regions. What steps are being taken to ensure the health authorities will be in a position to replace their capital equipment as and when needed?

MR. BATRA: We require all the parties to submit a three-year capital equipment plan that shows when and how needed equipment will be purchased. We also require depreciation costs over the years, and they are required to be submitted to us as well so that we know what the original value was, what is being depreciated, and when they will need the equipment replaced.

THE CHAIRMAN: Thank you, Mr. Hutton.
Mr. Mason.

MR. MASON: Thanks, Mr. Chairman. I just had a general question for the minister. In the previous report the Auditor General talked about the increase . . . Where is the minister?

THE CHAIRMAN: The minister has left the Chamber for a moment.

MR. MASON: Well, come back to me.

THE CHAIRMAN: Okay.
The next person on the list is Mr. Cao.

MR. CAO: Thank you, Mr. Chairman. I just want to acknowledge the fantastic job the Auditor General has provided us with in his audit report. Based on that, we have a clear understanding in asking questions regarding the operation of the large department of health. Thank you very much to the department's minister and staff for being with us today.

My question is regarding the audit opinion on the financial statement. On page 154 in his report the Auditor General once again issued a reservation of opinion on the department's financial statements. My question is: what is the department doing to address the issues that resulted in the adverse opinion?

9:00

MR. BATRA: Basically, sir, the qualifications in the ministry and across the government relate to the fact that certain costs that are provided by other ministries – like accommodation costs, telephones, et cetera, et cetera – are not recorded in our books. So that's one of the reasons.

The primary reason for the qualification in the Auditor General's opinion is that we do not consolidate the regional health authorities' financial statements into the ministry financial statements, because in general we believe they're not true agencies of the Crown as such. The Auditor General differs with us. It is a problem across the government. We and the Ministry of Finance are reviewing it, and hopefully we'll come to some resolution on it.

So those are two basic reasons that the statements are qualified. We're not the only ministry; practically all ministry statements are qualified for those two reasons.

MR. CAO: I have a supplementary, in fact going to the same line of thought. Just on page 160 in the Auditor General's report, regarding the Alberta Alcohol and Drug Abuse Commission, there is a qualified opinion audit there. My question is: why?

MR. BATRA: A similar response too. As an agency of the Crown they receive services as well from such ministries as Infrastructure. Those costs are not recorded. They're recorded in the ministry where they are being incurred. Hopefully, in the future, I think in 2000-2001 – we do have a schedule now. We have come to a successful resolution with the Auditor General, so that has been corrected for 2000-2001.

MR. VALENTINE: Mr. Chairman, the issue of cost allocation from those ministries which incur the cost to those organizations which receive the benefit of the cost has received a resolution that will be effective for the March 31, 2001, year-end. That will remove what is really what some people have referred to as a nuisance qualification, nonetheless an important one.

The entity is a tougher issue. I am a member of the public-sector audit accounting standards board of the CICA, the Canadian Institute of Chartered Accountants, and we are working on a project to deal with the entity question. But it's obvious from my remarks in my annual report that I view the nonconsolidations of the health organizations, the nonconsolidations of the postsecondary educational institutions, and the nonconsolidations of school boards as a serious deficiency in the government's financial statements.

Thank you.

THE CHAIRMAN: Ms Blakeman.

MS BLAKEMAN: Thank you. If I could just check a protocol question. In that we don't have the minister there and since last time we didn't accept the guidelines of the Canadian Council of Public Accounts Committees, which would have included accepting the ability to question deputy ministers and staff, can I go ahead and question these people without the minister's presence?

MR. SHARIFF: I believe the minister has just taken a short break for whatever reason. But we do have precedents whereby questions can be asked and answers can be submitted after the meeting, which has happened in the past, so I don't see any problem. If you were to ask a question, it goes on record, and we see the response subsequently. The question is still directed to the minister.

MS BLAKEMAN: Yes. I'm wondering if perhaps we should adjourn and wait for his return.

THE CHAIRMAN: That, Ms Blakeman, is an excellent suggestion, and I would like to call for a five-minute recess.

MR. CENAIKO: Mr. Chairman, can I ask what the process for questions is here? We've got people stepping in and out of line here like there's no tomorrow. I mean, there are a number of people that have questions for the individuals that are here.

THE CHAIRMAN: The process?

MR. CENAIKO: The process for asking questions, because we've got one member that's now asking a second question that's back in the line. You have a member that comes in late that . . .

MS BLAKEMAN: We accepted those guidelines last meeting.

THE CHAIRMAN: There is a process here of a member of the opposition asking a question and then a government member, an opposition member and a government member. Mr. Mason deferred his question because the minister was absent from the Chamber, and in the next rotation Ms Blakeman indicated that she had another question that she would like to put forward. That's what we agreed to last week; okay?

MR. CENAIKO: Whether you're late or not doesn't matter?

THE CHAIRMAN: Exactly. Whether you're absent or present.
Does everyone agree to a five-minute recess?

SOME HON. MEMBERS: No.

THE CHAIRMAN: Well, then, fine. We shall continue with questioning.

MS BLAKEMAN: Okay. So I just asked my question. It goes on the record.

MR. SHARIFF: Sorry to interject. With an understanding that the questions can go on record and a response will follow subsequently from the minister's office?

THE CHAIRMAN: Yes. The responses will follow from the minister's office to the clerk of the committee.

MR. SHARIFF: Correct. That's right. Just so the staff are aware that their response is not required at this stage, but it can follow through the chair back to the committee.

THE CHAIRMAN: Okay.
Again, Ms Blakeman.

MS BLAKEMAN: Okay.

MR. MASON: This is surreal.

MS BLAKEMAN: It is surreal.
All right then. I'm referencing page 132 of the Auditor General's report in which the Auditor General spends some time detailing the situation of unbudgeted funds coming into the department throughout the year. He actually points out that between January of '98 and May of 2000 "more than 25 additional funding decisions were announced" that affected this particular department. I'll quote, if I may:

> While subsequent additional funding may provide relief from immediate budget pressures, it is not conducive to good budget management since repetition may create the expectation of continuing amounts in addition to planned annual budget increases.

My question is: what did the ministry do to cope with the setup for these increasing expectations that the department would continue to get unbudgeted funds throughout the year? Was there a discussion? Was there a decision-making process to cope with this, to work it into the planning process or to put some kind of stop to it? What happened in the year that would help to alleviate this problem? I guess that's my first question on the record.

THE CHAIRMAN: Okay. Second question, please.

MS BLAKEMAN: This is bizarre. Okay. Well, then, this is not the first time the Auditor General has raised this issue of additional moneys coming into the department from announcements. What explanation does the minister have for the lack of implementation of previous recommendations from the Auditor General regarding these business plans?
I'm on the record now. Thank you.

THE CHAIRMAN: Okay. Thank you.
Next on the list is the hon. Member for Calgary-Buffalo.

9:10

MR. CENAIKO: Thank you very much, Mr. Chairman. On page 137 of the annual report of the Auditor General, in recommendation 19, the Auditor General recommended

> that the Department of Health and Wellness take a lead role in working with [regional] health authorities in reporting the costs of key service outputs.

My question, Mr. Chairman: what action does the department plan to address this recommendation?

THE CHAIRMAN: To the minister?

MR. CENAIKO: Or his staff.

MR. BATRA: We agree that health authorities need to develop a method to report cost outputs. Linking of cost outputs, in our opinion, would provide very meaningful information about the parties' operations and assist in resource allocation from there on.
We have taken two initiatives. One is that we are working with two larger health authorities to start a pilot project on product

costing. We've also taken a second initiative with one of the smaller health authorities which is also joining us.

I think at the end of the day our opinion is that one must accomplish something for the moneys we give, and in order to compare the health authorities across the board, we do need some standard costing. That does not happen that frequently in the health care industry at this moment, but we believe that in about two to three years' time we should have some standard costing where we can compare these results.

MR. CENAIKO: Thank you. Mr. Chairman, my supplementary question. The Auditor General has commented that in order to get support for costing activities in the regions, there has to be evidence that knowing costs can lead to better decisions. Is there any evidence that can help to spur costing of output activities?

MR. BATRA: The regions, for example, those who provide the provincewide services – these are high-tech, life-saving services in Edmonton and Calgary. We do have a fairly good methodology in terms of product costing. How to inculcate a similar attitude on the acute care side, where the major expenditure occurs, is a major challenge. As in my previous response, sir, I stated that we do have a pilot project started with the health authorities, and in two to three years' time we should have some measure of costing of the products and services across the board and have some standards. It's just a question of putting dollars to the deeds. That's our basic philosophy.

MR. CENAIKO: Thank you.

THE CHAIRMAN: Dr. Taft, followed by the Member for Red Deer-North.

DR. TAFT: Thank you, Mr. Chairman. I'm in section 2 again, the statements of the Calgary regional health authority in the notes. I'm on page 68, note 24. The first paragraph of that note says:

> The Authority receives funds from Alberta Infrastructure for non-owned facilities for capital construction and facility repairs. These amounts are not reported in the financial statements. During the year the Authority received $1,600,000 . . . and disbursed [$3.1 million] for capital and facility repairs for non-owned facilities.

I'm wondering why those amounts are not reported in the financial statements.

MR. BATRA: Is it okay, sir, that Mr. Moloo answer that question? He's our expert on the health authority financial statements.

MR. MOLOO: As the note indicates, these are trust funds. In other words, these are not funds that belong to the Calgary regional health authority. They are just a flow-through. These funds are provided by Alberta Infrastructure through the Calgary regional health authority for the purposes of non-owned facilities.

Now, in the past we used to record these funds in the statements of the Calgary regional health authority as amounts held in trust as a liability, with a related asset being the cash that is being held by the Calgary regional health authority. However, on the advice of the Auditor General, who made a comment that perhaps it is inappropriate to record these trust funds as if they belong to the Calgary regional health authority, for that reason we are just now disclosing it as a note to the financial statements rather than on the balance sheet of the Calgary regional health authority.

DR. TAFT: The details would be in Infrastructure's annual report?

MR. MOLOO: That's right.

DR. TAFT: Then my supplementary question. The next paragraph in that same note:

> The Authority holds a non-interest bearing collateral mortgage with one of the non-owned facilities. The mortgage is being forgiven at 3 1/3% of the principal amount per annum.

Pretty nice deal.

> The balance remaining at March 31, 2000 is $3,540,000.

I would like more details on that. I'm wondering which of the non-owned facilities enjoys this mortgage, and if I am correct in interpreting this, it's a 3 and a half million dollar mortgage being provided by the CRHA at the bargain rate of 3 and one-third percent.

MR. BATRA: We will undertake to respond in writing, sir.

THE CHAIRMAN: Thank you.
Mrs. Jablonski.

MRS. JABLONSKI: Thank you, Mr. Chairman. Referring to the Alberta Ministry of Health and Wellness annual report, section 1, page 94, the ministry's consolidated statement of financial position – and this is for the minister or his staff – reflects $2.5 million in investments. Can you tell me what this is for, please?

MR. BATRA: In 1999 the department of family and social services provided the Persons with Developmental Disabilities Foundation with 2 and a half million dollars to establish an endowment fund. Up till now the endowment fund principal has not been utilized. They have been simply using the interest. In fact, last night at the SPC there was a decision made that the foundation will be discontinued and its operation taken over by the provincial board. The purpose is to undertake support and promote activities that will enhance the quality of life for persons with developmental disabilities through a pilot project, so that's what the money was for.

MRS. JABLONSKI: My supplemental question on that same report, on page 94. In my small business my cash on my financial statements seemed to always be in the credit position, and I knew why. On this statement the cash is in a credit position, and I wonder why for us.

MR. BATRA: The balance for the bank overdraft of $13.4 million for the persons with developmental disabilities. In March 2000 funds were withdrawn from the bank accounts of the boards to cover payments made on their behalf. The bank accounts were not replenished until April 2000, thus creating a bank overdraft. The boards did not enter into any lending arrangements nor pay any interest on this overdraft, so that's the basic reason why that happened.

MRS. JABLONSKI: Thank you.

THE CHAIRMAN: Mr. Mason, followed by Mr. Goudreau.

MR. MASON: Thanks, Mr. Chairman. Well, it's a nice feeling for me to be on this side and the minister to be on that side. I know it's totally illusory, but it gives me something to aim for.

Mr. Chairman, to the minister, I just have a general question arising from the Auditor General's annual report talking about drug costs. The Auditor General indicates that drug costs are continuing to increase, both in terms of the amount of drugs and the proportion of drugs that are used in health care generally and also in the cost of the drugs. I'm on page 129 of the Auditor General's annual report. My first question is: what proportion of the total department budget

really is accounting for all the drug costs?

MR. BATRA: We'll just find it out for you, sir, in a minute.

MR. MASON: Okay.
Then another question while I'm waiting for that. [interjection] Yeah, I'm sort of used to city council, where there's freer rein. What is being done to reduce drug costs, and specifically what can be done to promote the use of generic drugs in treatment throughout the system?

MR. MAR: Well, with respect to an analysis of drug costs, we do have a drug utilization committee that evaluates the cost-effectiveness of drugs. There are some drugs that indeed are expensive. However, they allow us to do other things and avoid other costs. For example, there are some drugs associated with treatment that allow people to recover at home instead of in a hospital. So while those drugs are expensive, they are much less expensive than compelling somebody to recover in the hospital.

9:20

Whenever drugs are added to our formulary, they go through an evaluation of not only their clinical effectiveness but also their cost-effectiveness. So while the costs of some drugs have gone up and in some cases dramatically, they do allow us to avoid other costs. So it is true to say that our costs are going up, but it is saving us costs in other areas.
With respect to the utilization of generics, that is something that we indicate we'll cover, that we'll only cover the lowest cost alternative but that if for whatever reason a physician believes that only a nongeneric is effective in the case of a particular patient, then in those exceptions we will cover the more expensive drug.

MR. BATRA: I can go back to your first question, sir. In '99-2000 we expended $261 million for the Blue Cross drug program, which is a nongroup program, and 80 percent of those moneys were spent for the seniors. Drug costs for the health authorities as well as the Alberta Cancer Board are not included. We really don't have any separate line item for drug costs in the health authorities, but I think I can take a pretty good guess at this stage. I hope I won't be held to it. There will be approximately $18 million to $20 million for drug costs in the Alberta Cancer Board alone. I'm just guessing from what's happened from 2000 to 2002 now. They're expecting almost $33 million in drug costs.

THE CHAIRMAN: Thank you.
Mr. Goudreau.

MR. GOUDREAU: Thank you, Mr. Chairman. On page 11 of section 1 of the annual report under the second bullet it says that part of the reporting functions would be to "provide information to manage and report on performance." What's being done to keep the public informed about the performance of the health system in Alberta? I'm hearing different things as I travel throughout my constituency. What programs are being used?

MR. HARVEY: The public is kept informed through the information in the annual report, through publication of a variety of reports; for example, Report on the Health of Albertans, published, I think, a little over a year ago, and just last fall we reported a number of performance measures related specifically to wait times and waiting lists for some specific services. That was a new report in December of 2000. We are planning to produce more reports like that on a periodic basis.

MR. GOUDREAU: A supplementary question. Again in the annual report, section 1, part of the ministry's six-point plan for health is to improve access to quality, publicly funded health service. On pages 47 and then 48 of the annual report the key performance measures on access indicated that Albertans were reporting having a lot more difficulty getting access to health care services, and this seems to be much more evident in the northern health regions. What's being done to improve the results on access?

MR. HARVEY: Over the last several years there's been a significant amount of funding targeted at areas where access is seen to be less than adequate. Those are specific things such as heart surgery, such as MRI access, such as hip and knee replacements and similar health services. We would expect to see a lot of change in this year's report. We've also taken some significant steps to improve the availability of physicians in the province as a whole and some particular emphasis on rural areas. Third, we are developing new information, as I mentioned in my previous answer, to communicate more effectively with Albertans about the situation related to access to health services, the kinds of wait times they can expect to experience.

THE CHAIRMAN: Thank you.
The next question Ms Blakeman, followed by Mr. Broda.

MS BLAKEMAN: Right. Referring to pages 154 to 156 in the Auditor General's report, there's a discussion of reporting and performance. Thus far I've questioned measurement, I've questioned planning, and now I'm questioning reporting. The Auditor General points to a number of deficiencies: the health authorities not being included and consolidated – a question has already been asked about that – the financial statements not providing complete information on resources consumed, a lack of consistent classification of expenses and fragmented reporting, and certain administrative costs not included in expenses. So I'm wondering what policies the department introduced to deal with these deficiencies, and I recognize that part of that question has already been asked in the discussion around the health authorities' financial statements.

MR. BATRA: The Auditor General suggests that it is difficult to relate what has been accomplished to the amounts taken to achieve accomplishment. The financial statements do not segregate costs by programs or services in a manner that easily ties them back to our objectives.
The actions that we have taken. First of all, we do agree with the Auditor General's recommendations, very well taken recommendations. Analysis includes a review of budgetary processes and how to effect links between objectives and financial performance. We do not anticipate changes until the 2002-2003 budget cycle. We have just introduced them into the structure itself, where the core program costing will be done through the estimate side of the presentations.
In the interim for the ministry's financial statements we have adopted the same presentation format as for our business plan. It's my understanding that audit principals have responded very positively to the use of this presentation, so it's our ardent hope that by 2002-2003 we will be providing much better information.

MS BLAKEMAN: Okay. As a supplementary to that then, as I go

through the key performance measures which are listed in section 1 of the annual report of the ministry in between pages 71 and 77, I'm noticing that overwhelmingly the performance measurement is based on a survey of users. As part of this redirection that the individual has referred to, in this fiscal year did you discuss a different kind of performance measurement other than that of satisfaction? In other words, were you looking at measuring whether your prevention models were in fact effective? Were you looking at whether the overall health has been improved? I know we've looked at low birth weights, for example, as a performance measurement, but I'm looking for much more detailed and many more performance measurements along those lines rather than just a satisfaction survey of individuals who've walked in or out of the doors. Is that part of the process that started in this year?

MR. HARVEY: That's a fairly long question, but the annual report, I think, shows that in the business plan for '99-2000 there were some 18 or 19 key performance measures. I'm trying to recall now, but I think perhaps five of them were based on the results of the public survey. The remainder has to do with health status in a variety of ways; for example, certain immunization programs for children, breast cancer screening rates, shift in expenditure from hospital based to community and home based, and so on. I think that's an answer to some of your question. I'd like to hear the rest of it.

9:30

MS BLAKEMAN: Well, that was my supplementary, so I'm cut off now.

MR. HARVEY: Oh, I'm sorry.

MS BLAKEMAN: Next time around. I'll come back.

THE CHAIRMAN: Thank you.
Mr. Broda.

MR. BRODA: Thank you, Mr. Chairman. I'm referring to section 1 of the annual report. On page 37 if you look at the third line and the percentage of regional health authority expense on continuing care facilities, in '97-98 there was 15.6 percent at that time, and in '99-2000 we're down to 13.6. Does this indicate a shift in emphasis by the health authority to long-term care because of that reduction? Is that what it indicates?

MR. BATRA: I think, sir, it's pursuant to your own report. With the shift from institutional to community- and home-based care, services like home-based personal support, community rehabilitation programs, assisted living, day programs, and respite care are available to a much greater extent today than before. These services and advances in technology and procedures are allowing Albertans to remain independent for much longer periods of time and thus to stay independent in their own homes. In fact, this is the thrust of the Broda recommendation.

MR. BRODA: Yes, I recognize it. That's why I asked that question, to see what's really happening according to the report here.
A supplementary question, Mr. Chairman. Based on your response again, I guess that means that the continuing care facilities should expect reductions in funding in the future.

MR. BATRA: I perhaps would refrain from making that statement, sir. I think that in terms of the funds being allocated to long-term care, it's the responsibility of our partners, namely the RHAs, and they will take appropriate action.

MR. BRODA: Thank you.

THE CHAIRMAN: Thank you, Mr. Broda.
Dr. Taft, followed by Mrs. DeLong.

DR. TAFT: Thank you, Mr. Chairman. Again, schedule 2, the statements from the CRHA, pages 69 and 70. This time I'll start on page 70. It indicates here in the table under staff compensation: "medical doctors not included above." The point of this question is finding out who this includes. Does this include primarily chiefs of medical departments, heads of medical departments, and site co-ordinators, or does it include something else? If so, what else?

MR. MOLOO: In that line item referred to as "medical doctors not included above," these are medical doctors that are assigned within a regional health authority, on their payroll. In other words, they are for all intents and purposes employees of the Calgary regional health authority, but the reference to "not included above" implies that they are not part of the management group.

DR. TAFT: Is that what we would call chiefs of medical departments and site co-ordinators, or is that something else? Do you know?

MR. MOLOO: I couldn't answer that specifically, but we could look into that and provide a written response.

DR. TAFT: Okay. How long does it take for written answers to be returned?

THE CHAIRMAN: It is entirely up to the department and to the committee through the clerk.

MR. MAR: If I might, Mr. Chairman, it would be our endeavor to try and return it within 10 working days.

THE CHAIRMAN: Okay. Thank you very much.
Next question, please.

MS DeLONG: This regards waiting lists. In business generally the way we handle waiting lists is that we want to make sure that our facilities are fully used and that we don't lose customers because people are waiting too long. Now, if you've got sort of a steady waiting list, where the waiting list is a steady three weeks or it's a steady three months, it costs exactly the same to our resources to, you know, maintain a three-week waiting list or a three-month waiting list, because it's not escalating, it's not decreasing. Is there any work being done to audit our actual cost of a waiting list? For example, how much is it costing to keep that person waiting in hospital? What's the psychological cost of people waiting? How much extra money are we having to put in because someone is getting sicker? Is there any work being done in terms of auditing that side of it?

MR. MAR: I should note that there's a western Canadian waiting list project whose results were released just yesterday, where a number of provinces and the federal government co-ordinated to put $2.2 million into a project to deal with some of those questions, not all of them but with some of those questions. I'll be happy to pass on a copy of that report to the hon. member.

THE CHAIRMAN: Mr. Mason, followed by Mr. Ouellette.

MR. MASON: Thank you, Mr. Chairman. I'm looking at page 130

of the Auditor General's annual report. He states here:

> The Department has limited information to systematically compare planned and actual drug use and costs over time. Even if the information was generated, it is not clear who takes accountability for variances and who would be responsible for . . . acting on significant variances.

Then down at the bottom he says:

> In conclusion, absence of information and clear and effective accountability relationships among stakeholders increases the risk that desired directions and results for the health system will not be achieved and full accountability rendered for approximately $1.2 billion of costs associated with physician payments and prescription drugs.

So, then, my question is: what is the department doing to make sure that they are tracking the actual drug costs over time and that when that information is collected, it's clear who is to deal with it and what they're to do with it?

MR. BATRA: In terms of our major drug costs for seniors, we do have a contractual agreement with Blue Cross. We try to assess as to what it's going to cost for the drugs next year, but it also depends upon the number of new drugs that are approved by Health Canada, and then there is continual pressure from the doctors, you know, to approve that particular product and release it in Alberta. It is pretty difficult to come in exactly and make an assessment as to what it will cost us.

In terms of the assessment process we have quite a rigid protocol for new drugs, and hopefully that will sort of keep the drug costs under control. Generally, drug costs are a major problem in the health care industry, and it's further exacerbated by the fact that now they are advertising on television. Every drug is advertised, and people get to know a lot faster than some of the doctors even do. So those are the kinds of pressures that we face.

MR. MASON: Thank you.

The question, though, is: what is the department doing in terms of its internal systems to track the drug costs and make sure that the information is dealt with so there's clear responsibility and accountability within the department for doing that and acting on it?

MR. BATRA: We do have a protocol that we enter into with the drug companies. When a drug company comes forward with a new product and an approval is given, based upon Health Canada approval already being given, from there on we try to monitor the costs, but they do tend to get away from us. It's very simple. The doctors are really the cost drivers on it; they prescribe. Even though we may have assessed that a new drug may be costing us $15 million for this particular year, it's not unlikely that it might end up at $20 million. It's a big problem. I really don't know how to respond to you in terms of putting very rigid controls on it, short of saying that we don't have money to give you any more drugs.

9:40

THE CHAIRMAN: Thank you.

Mr. Ouellette.

MR. OUELLETTE: Thank you, Mr. Chairman. In the Health and Wellness annual report, section 1, page 19, under the new initiatives:

> Alberta Health and Wellness supported in principle all recommendations of Health Summit '99 in its Response to the Final Report of Health Summit '99. The recommendations served as the basis for the 2000-2003 business plan and budget.

Can you be more specific about the directions which emerged at the summit and that are being pursued?

MR. BATRA: The directions which emerged as having broad support among the participants at the summit and have become key areas of activity include the following: access, frontline staff enhancements, telehealth expansion, access standards for diagnostics, e.g. MRIs, expansion of provincewide services – these are high-tech, lifesaving services like heart surgeries or transplants, et cetera – additional supportive living spaces in rural areas, accountability and performance, wait list monitoring for key services, Health Care Protection Act, workforce planning, Health Professions Act, physician study, strategies for vulnerable groups. These are the kinds of initiatives that we have now undertaken. Vision in strategic directions, Premier's Advisory Council on Health, health innovation fund, and primary health care transition projects: those are some things that we have undertaken.

MR. MAR: I should note that earlier on, Mr. Chairman, the issue was raised by the hon. Ms Blakeman with respect to some of the subjective measurements of the health care system that we have, including a rating of the system by Albertans.

A key issue that emerged from the subjective measurements is the issue of access. In my strong opinion, that is a legitimate issue in some cases and was reflected, of course, in the health summit and has precipitated on the part of the government a significant plan to improve access through investments in a number of areas, notably three: people, plant, and equipment.

On the people side we are training more health care professionals than ever before. Again, while this may be outside of the strict purview of Public Accounts, I should note that two years ago approximately 3,500 people were trained in health care professions. This year it'll be over 5,000. Again outside of the scope of Public Accounts, the members are aware, of course, of recent agreements struck with the Alberta Medical Association and with the nurses of the province of Alberta that have resulted in a great interest in people coming to this province as health care professionals.

On the plant side, people and members would be well aware of the hundreds of millions of dollars in capital that have been announced and are proceeding according to plan.

On the equipment side, equipment such as MRIs, renal dialysis equipment, very high-tech equipment that is required for specialized procedures have all worked on reducing wait lists.

While there has been a subjective measurement used in asking people, you know, what their issues are as it relates to the health care system, that subjective measurement has precipitated action that has yielded positive results on objective measurements such as waiting lists.

MR. OUELLETTE: My next question. The '99 summit as well as several forums since have raised concerns about the sustainability of the public health system. What success has your ministry had in '99-2000 and since that would begin to give Albertans assurance about the sustainability of the public system with all its founding principles intact?

MR. MAR: Sustainability of the public health care system I think is one of the great challenges not only for this province but across Canada. I believe it has been recognized not only by this province but by others as well, and I think for that reason the Romanow commission has now been constituted and is proceeding with its work.

In the province of Alberta approximately one-third of our provincial budget is spent on health care. In other provinces it approaches 40 percent; in other provinces it approaches 50 percent. That is a medium-term trend that cannot happen and still result in a sustainable health care system.

Notably, with respect to public accounts in this year that we are

examining, the department first had its change of name to Health and Wellness, and much more emphasis has been placed on the wellness side of the equation. A number of initiatives have taken place in that area, and I would characterize such wellness initiatives as being ways we have identified to spend money in order to save money, the idea being that there are things we can do that are interventions that will prevent demand upon an acute care system, which is very, very expensive in the longer term. Perhaps the issue of healthy aging in place would be an example of an area where we could invest money in the health and wellness of individuals in an effort to prevent demand upon an acute care system at a later juncture.

THE CHAIRMAN: Thank you, Mr. Minister.
Ms Blakeman, followed by Mrs. Ady.

MS BLAKEMAN: Thank you. I think I'm following up on what the minister was just speaking about, but I did get distracted for a minute, so I apologize.

Once again I'm working my way through pages 136 and 137, going back to the Auditor General's recommendations about measurement of what's happening related to planning. In particular I notice the comment – he's talking about improved measurement and reporting – that "while progress is being made, the challenge remains of providing information so that decision makers can better understand what is happening to the quality of health services." There's a further recommendation about timely reporting and then the department taking "a lead role in working with health authorities in reporting the costs of key service outputs." Are we able to get a bit more detail on how the department is following through? What plan does the department follow through to achieve what's being recommended by the Auditor General?

MR. BATRA: First of all, mam, we do agree with the Auditor General's recommendation once again. We accept that more timely business plans and annual reports would comply with legislation and improve accountability. However, some trade-off can be expected between the timeliness and quality and completeness of data for that report. In addition, tools to deal with reporting may create other problems. We have issued a new financial directive for quarterly reporting in 2000-2001 that tightens the quarterly financial reporting time lines to 45 days. The requirements have been expanded to provide more information on the financial programs' progress and status with the health authorities.

Relative to your question that the ministry should take a lead role in working with the health authorities in reporting the costs of key service outputs, once again we agree with the Auditor General's recommendation. As I mentioned earlier, the ministry has taken two initiatives to support that recommendation. We have established a financial indicators task group comprised of representatives from the health authorities and the ministry. We have developed a set of financial performance indicators that now form part of the health authorities' annual reporting requirements. These indicators will be continually improved as we learn more from the data that comes in. Again, we have a pilot study of rural and urban regions, commenced in January 2001, on how to utilize existing costing systems to know the cost of certain services provided in those regions.

9:50

MR. MAR: Mr. Chairman, I can't help but comment on the irony of the question, that we are now looking at public accounts that are nearly two years old.

MS BLAKEMAN: We agree.

As a supplementary to that then. When I look back at these performance measurements that are here – and I hear you talking about a financial indicators committee – when I look at these, what's being described is what the department is doing as compared to what it is achieving. I'm in section 1 of your report on page 72. One of the performance measurements referenced earlier was measuring the percentage of women 18 and over who report having a pap screening test. Okay. That's what you're doing. But are you looking at performance measurements or indicators that would tell you that as a result of these tests you're catching it earlier and have fewer women that are developing advanced stages of that particular kind of cancer? Moving from what you're doing to what you're achieving.

MR. HARVEY: I believe for this particular annual report we report as well on deaths due to cervical cancer, which relates, I think, directly to that measure.

MS BLAKEMAN: Okay. I had a bit more global question. That was a specific example to a more global question.

MR. MAR: Well, I think that's a point that's very well taken, because in my view it is important to report on activity, but it is just as important, if not more important, to report on results. I think that in a desire to place greater emphasis on wellness, your point on reporting on the results is much more critical. Smoking would be a good example. Are you a smoker?

MS BLAKEMAN: Yes.

MR. MAR: In that case, it's an excellent example. In the case of smoking, we know that approximately 23 percent of young people in this province of high school age smoke. That should come as an alarming statistic to most people. I think we know with some certainty what the effect, what the result will be in a do-nothing scenario. It will result in a certain percentage of those young people who are smoking suffering from all kinds of smoking-related diseases. If we are to do more than just pay lip service to wellness models, then we should look at what we can do or what we should do to intervene and then record with some objective measurements of results what we've achieved by those young people not smoking. So I think, Mr. Chairman, this is a very important point, that we do need to place greater emphasis on the reporting of results if we are to do more than just pay lip service to a model of promotion of wellness.

THE CHAIRMAN: Thank you.
Mrs. Ady.

MRS. ADY: I thought the clock might run out, but it hasn't. When I first told my husband that I was serving on the Public Accounts Committee – he's an accountant – he just about fell off his chair laughing that I would be here. I find it amusing too, but I am someone who likes to see bottom lines and big pictures. That's what I understand when numbers come together.

On page 139 of the recommendations made by the Auditor General it recommends that

> the Department of Health and Wellness develop a process for reporting the full cost of delivering health [care] for the population of each health region of Alberta as a means of supporting business [plans] and the accountability of regional health authorities.

Is that process now in place? Can we see bottom lines for different health authorities?

MR. BATRA: The cost of regional health authority operations does not by itself constitute, in our opinion, the cost of health services made available to the regional population. For example, the physicians' payments are not allocated to each region. Similarly, provincewide mental health and cancer care services are not allocated to each regional health authority or the region itself. As a result, transparency or a means of getting information to support business planning, resource allocation decisions, and accountability of health authorities is not given to health costs on a regional population basis.

MRS. ADY: I don't have a follow-up.

THE CHAIRMAN: Okay.

MR. SHANDRO: It's our opinion that in order to understand the operations of a particular region, you need to know what resources are being consumed in that region. I know systems typically like to report on a funding basis as opposed to a performance basis in terms of resources they've consumed in delivering services. I'm happy to report that the Capital health authority is intending to incorporate that in their financial reports for the coming year, have plans to put that in on a full-cost basis as a schedule to their financial statements, so I think there is some progress being made in this area. Hopefully over time this will happen across the province.

THE CHAIRMAN: Thank you.

DR. TAFT: Do we have one minute, Mr. Chairman? I have a quick yes or no question.

THE CHAIRMAN: At this time no.

Seeing that it's 10 o'clock, I would like to thank the minister and his department for coming this morning, also the Auditor General and his staff. I would remind the minister, please, that all written responses come through to the clerk of the committee.

Members, please note that the next meeting is Wednesday, May 9, and we will have two ministers present: the Hon. Pat Nelson, Minister of Finance, and the Hon. Greg Melchin, Minister of Revenue.

At this time I would like to please call for a motion to adjourn.

MR. MAR: If I may, Mr. Chairman, before we adjourn, I want to convey a sincere and humble apology for my brief absence earlier. It was not in any way in contempt of the committee, but I do apologize for that.

Thank you.

THE CHAIRMAN: Thank you, Mr. Minister.

A motion to adjourn?

MR. BRODA: So moved.

THE CHAIRMAN: So moved. Thank you.

[The committee adjourned at 10 a.m.]