[Mr. MacDonald in the chair]

THE CHAIR: Good morning, everyone. I would like now, please, to call this meeting to order. The first item on the agenda this morning is the approval of the agenda. It's been circulated in advance to members. Can I call for approval of the agenda, please?

MS BLAKEMAN: Sure.

THE CHAIR: Thank you very much.

I would like to welcome this morning the hon. Minister of Health and Wellness, but first the approval of the minutes of the March 6, 2002, committee meeting, that also have been circulated in advance. Mr. Broda. Thank you very much.

Again, on behalf of the committee I would like to welcome the Hon. Gary Mar, Minister of Health and Wellness, and his staff this morning. Before we have the opening remarks from the minister, I would like to briefly go around the table – I believe we'll start with the Auditor General's staff this morning – and introduce ourselves for the convenience not only of the minister's senior officials but also those at the back.

[Ms Blakeman, Mr. Broda, Ms Ewart-Johnson, Mr. Finnerty, Mr. Hegholz, Mr. Hug, Mrs. Jablonski, Ms King, Mr. MacDonald, Mr. Mar, Mr. Masyk, Mr. McCutcheon, Mr. McKendrick, Mr. Menzies, Mr. Moloo, Mr. Perry, Ms Sandouga, Mr. Shandro, Mr. Shariff, Mr. Shaw, Dr. Taft, and Mr. Teixiera introduced themselves]

THE CHAIR: Thank you very much.

This is unusual, but I have a question for the minister at this time. I believe we have a few extra chairs at that end. Certainly there may be other members of the committee arriving. There seems to be ample seating up here. Would any of your other staff like to join us this morning?

MR. MAR: If they so wish. Chairman, troublemakers are always seated at the back of the room.

THE CHAIR: Okay.

Yes, Mr. Masyk.

MR. MASYK: Yes. Mr. Chairman, we have a member from the public at the back.

THE CHAIR: Would you like to introduce him, please.

MR. MASYK: Sure. His name is Mr. Torgy Odegaard, from northern Alberta.

THE CHAIR: Welcome.

Thank you, Mr. Masyk.

Now, if there are no other questions or observations, the hon. Mr. Mar.

MR. MAR: Thanks, Chairman. Colleagues, it's my pleasure to present the public accounts for Alberta Health and Wellness for 2000-2001. These public accounts also include AADAC, the Premier's Council on the Status of Persons with Disabilities, and, for most of the year, the Persons with Developmental Disabilities Provincial Board. Together we spent the first year of the 21st century addressing the problems of the present and preparing for the future. We see that balance when we look at our achievements for 2000-2001 as highlighted in the annual report.

To relieve staff shortages in the short term, additional funding allowed health authorities to begin hiring more frontline staff. At the same time, we worked with Alberta Learning and postsecondary institutions to create training spaces that would graduate more health professionals for the future. To meet the current and future need for physicians, we announced rural and international graduate medical programs and negotiated a new agreement with Alberta's physicians to keep and attract doctors. I'm pleased to note that in 2000-2001 Alberta registered 161 more doctors than in the previous year. More importantly, three out of four Albertans saw a family physician either the same day or within a week.

Efforts in other areas also had an immediate impact and long-term promise. New funding was targeted to reduce wait lists in key areas like MRIs and heart surgery. As a result, despite higher demand, by January 2001 the wait list for MRIs came down more than 2,000 people from the previous April.

To expand access to drug therapy, we added 24 new drugs to the benefit list in 2000-2001 to treat conditions from hypertension and diabetes to rheumatoid arthritis and osteoporosis. To avoid incompatible or overlapping prescriptions, care providers quadrupled their use of the seniors' drug profile program, accessing over 20,000 more drug profiles than in the previous year.

Also to meet seniors' needs, we began implementing strategies to enhance long-term care contained in the Broda report. For example, additional resources helped expand home care in this province.

To build a healthier future for aboriginal Albertans, we introduced nine new aboriginal community-based health projects to address and manage issues like diabetes and tuberculosis.

We used the Health Care Protection Act to lock the door to private delivery of insured services by law. Insured services from private providers now are available only through the public health system.

In 2000-2001 we expanded Telehealth to support present and future access to health information and care. By the end of the year we had 70 teleconference sites to help rural physicians confer with specialists in urban centres, up from 52, and 19 teleradiology sites, up from only two.

Recognizing that innovation will make the future, we approved 15 new projects under the health innovation fund, including how to make better use of nurse practitioners. In addition, we almost doubled our commitment to medical research, with $23 million over five years.

In 2000-2001 we also met current needs in protecting health and laid a foundation for future wellness. A vaccination program in Capital and Calgary protected more than 300,000 young Albertans from meningitis, and that was the first step in a provincial immunization campaign that followed. In a strong commitment to Alberta's children we developed a better information system to screen for newborn metabolic disorders, increased our support for children's mental health, expanded routine childhood vaccinations to protect our children from chickenpox, and participated in the ongoing Alberta children's initiative and the new ever-active school program. A forum examined the needs of adults with acquired brain injury, and our environmental assessment work continued, as did our participation on a national and provincial strategy in the event of an influenza epidemic.

In 2000-2001 we also worked to emphasize information and accountability. A new report, called Alberta's Health System: Some Performance Measures, gave Albertans up-to-date information on access to selected services. The Alberta Cancer Board continued to develop Canada's first complete cancer information system. Already cancer centres are using the system to schedule patient care.

In 2000-2001 we worked with other western provinces to build a shared electronic registry for health care providers, and Alberta

supported development of national standard data requirements for programs like continuing care, breast cancer screening, and immunizations.

The achievements are impressive, but are they effective? The proof is in the performance measures. In 2000-2001, 68 percent of Albertans gave our health system an overall rating of good or excellent. That was the highest rating to date and is within reach of our 70 percent target. Albertans also continued to highly rate the care that they received personally. Again, 86 percent of Albertans rated the care that they received as good or excellent. There was no change in the 64 percent of Albertans who rated access to care as easy or very easy. That shows that our many targeted efforts kept pace with the growing and aging population and with the higher demand for surgery, that is the natural result of thousands more MRI scans being performed. In the fourth quarter of 2000-2001 health authorities were performing 3,000 more MRIs than in the first quarter. It is no coincidence that 1,600 more people were waiting for joint replacements.

AADAC enjoyed greater success; 94 percent of clients reported no difficulty in gaining access to treatment services, and 93 percent of clients reported that they were abstinent or improved after treatment.

These achievements came at a cost: $10 million for pilot projects under the health innovation fund, $24 million for equipment like renal dialysis machines, ultrasound units, and MRI scanners, and $48.7 million for new drugs and to meet a higher demand for all drugs. These and other investments were part of a $470 million increase in funding that brought ministry spending in 2000-2001 to $5.9 billion. Health authorities received the largest portion of this increase: $54.4 million to reduce wait lists, $63.6 million to compensate regional and dedicated staff who provide services to persons with developmental disabilities, $143.6 million for medical equipment, and $20 million to expand long-term care and home care.

8:41

In all, in keeping with the scope of their responsibilities, the 17 health regions, the Alberta Cancer Board, and the Mental Health Board received the lion's share of funding. Their base budgets claimed $3.1 billion, or 52 percent of all health funding. Plus the capital and Calgary regions shared an additional $320 million for providing provincewide services. Of the rest, over 18 percent of all Health and Wellness spending, almost $1 billion, paid for Alberta's physicians. Over 5 percent, or $310 million, went to Blue Cross primarily for drug benefits. Another 5.6 percent, or $334 million, supported services for persons with developmental disabilities. That included an increase of $40 million, almost 14 percent, to improve access to services. Promotion and protection initiatives like immunization claimed 2.7 percent of our spending, or $159 million. Less than 2 percent went to the ministry for initiatives like administering the health care insurance plan.

I recognize that the Auditor General has voiced specific concerns with our fiscal accountability. In his report of our audited financial statements for 2000-2001 the Auditor General continues to criticize us for not including the results of operations and net assets of regional health authorities and provincial health boards. However, health authorities are not considered provincial agencies. They are exempt from the Financial Administration Act, that governs our reporting. Therefore, we report health authority financial statements as supplementary information. The Auditor General has confirmed that we are required to follow the corporate government accounting policies and reporting practices established by Alberta Finance. We will continue to work with Finance and the Auditor General to address any concerns with those practices.

I believe Alberta's health system has reason to be proud of the achievements of this annual report. As we look to the future, the health reforms we're undertaking will build on the foundation we created at the start of this century but within our continuing ability to pay.

So, colleagues, I welcome your constructive criticism of our public accounts and your positive comments for 2000-2001. As always, the questions that my staff and I cannot address today we will respond to in writing in due course. I thank you very much for your time.

THE CHAIR: Thank you very much, Mr. Mar.

Dr. Taft to lead off the questions this morning, please.

DR. TAFT: Thanks, Mr. Chairman. It's getting to be habit forming, this.

Well, I think I'll pick up from your closing statements concerning the nonconsolidation of health authority statements or annual financial statements in your department's annual report and filing. Obviously there are two sides to the issue. I have a sense that this will be a permanent reservation expressed by the Auditor General because I don't think the department is going to change its view on this. Maybe I'll just start off with that as a question. Is there any chance, with the different views of the Auditor General and the Department of Health and Wellness, of this issue ever getting resolved, and if not, why not?

MR. HUG: Well, it's certainly an issue that goes beyond the Auditor General's office and the ministry. As you indicated, Finance has overall authority to set the corporate accounting policies, and we are working and continuing to dialogue with Finance on this issue. It is something that the financial community at large is working on, and I'm hopeful that eventually there will be some clarification of the issue and some standard set that both the auditing community and the financial community can agree to, but I don't see necessarily a solution in the short term.

Do you want to add to that, Nick?

MR. SHANDRO: Yes. Actually I think there's some good news on the horizon. The government recently has been thinking about the possibility of consolidation to make their statements more transparent. There's some evidence of this. The Department of Learning, for example, is trying to put together such a consolidated statement. Theirs is quite challenging because they have institutions like universities, who consider themselves to be very, very autonomous. Nevertheless, work is progressing in this area, and there is a group of people who are working to see how this might be achieved. So perhaps this is going to unfold in the direction of more transparency overall of assets, liabilities, net assets, as well as expenditures and revenues.

MR. PERRY: Well, on the Ministry of Health and Wellness Mr. Hug is quite correct. We do follow the corporate accounting policies as opposed to the generally accepted accounting policies when it comes to the reporting of entities, although I would suggest that there have been a number of these corporate issues that have been resolved over the years once they've been identified. So it has been an ongoing process. The point is that the departments follow basically the policies as set out by Finance, so it's something which we cannot solely circumvent.

DR. TAFT: I guess my supplemental would be: are you as a department advocating changes to allow you to behave in line with the Auditor General's wishes?

MR. PERRY: Well, the response to that is that the information is presently reported. The mechanics is not really an issue. For example, in volume 2 we have all the RHA statements. It does, though, require a collaborative approach with other ministries, and the view is that they proceed at the same time and not that one ministry advance this entity question. Essentially, we're just waiting for the time when the instruction is that we do this.

DR. TAFT: Okay.

THE CHAIR: Mr. Shariff, followed by Ms Blakeman from Edmonton-Centre.

MR. SHARIFF: Thank you, Mr. Chairman. Mr. Minister, I'd like to thank you for coming to the committee today, and I'd also like to express my thanks to your staff. My questions are in the area of the Alberta Alcohol and Drug Abuse Commission. This stems from a couple of comments that have been made by the Auditor General in the annual report on page 129, where there is some discussion about how assets and liabilities are reported and where the Auditor General makes a remark that as a result of how you report, the "assets are understated and net liabilities are overstated." I am going to the annual report, section I, pages 124 and 125, to pose my questions. First, I look at page 124, where you're reporting the liabilities and accumulated deficit, and I'm comparing the 2000 and 2001 figures. I notice that there is a surplus being reported in 2001 of about $41,000. I'm just wondering whether this is a result of how you are reporting your assets and liabilities, or if you can throw some more light on how come we had such a surplus as opposed to last year having a deficit of $873,000.

MR. FINNERTY: Mr. Chairman, it's a similar explanation to what my colleague gave on the last question. We in AADAC hadn't been following the common standard set in government in terms of writing off our assets. We had been using an asset limit of $500, and the rest of government was using $5,000. So in moving to the $5,000 limit in '99-2000, it resulted in a write-off of some $919,000 in unamortized assets. Therefore, these were expensed in that year and resulted in the figures that you see. So it's a similar situation in terms of being consistent with government policy across the board. The Auditor General has a different opinion, and it would be the same argument that was presented a minute ago.

8:51

MR. SHARIFF: I presume the change is $15,000, not $5,000. Correct?

MR. FINNERTY: Yes.

MR. SHARIFF: Then my next question is going to page 125, where the expenses for the program have increased by about $2.5 million over the previous year. Maybe you can shed some light on what initiatives were created that resulted in such an increase in the expenditure.

MR. MAR: Mr. Chairman, there were a number of initiatives: $1.4 million was an increase for the children at risk initiative; $431,000 was an increase in the area of information spending primarily due to development costs for a new client information system; $426,000 was an increase due to manpower funding for contracted agencies; and a $232,000 increase for compensation increases for addictions counselors.

THE CHAIR: Thank you.

Ms Blakeman, followed by the Member for Red Deer-North.

MS BLAKEMAN: Thanks very much, Mr. Chairman. Welcome back to the auditors general. Always nice to have your advice here. Welcome, of course, to the minister and all of the staff and indeed to our observer that's with us today.

In reading through the Auditor General's report, the frustration seems to come off the page from the Auditor General in not having had prior years' recommendations implemented and in particular around performance measurements. My reference pages here are in the Auditor General's report at pages 113, 114. The quote is:

> In particular, decision makers would likely benefit from information to know, for example, the extent to which quality improvement processes are working across the health system. They may also better know if increased spending is making a difference to quality through such measures as rates of positive outcomes from care intervention, error rates associated with care, clinical complication rates, or rates of recidivism into health services.

I understand that this was a very active year for Health and Wellness. There were a number of initiatives that were implemented in response to public demand – I got that – but I'm wondering why the department seems to be struggling to be able to implement the recommendations, particularly around useful performance measurements, that have come repeatedly from the Auditor General.

MR. MAR: Mr. Chairman, the issue of measurements is easier in some areas than in others. That's not to say that it's not important to do. It is important to do. This is something, I can say with some confidence, that ministers of health all across Canada are struggling with, as to what is the proper measurement, what is the outcome that we're looking for. We do intend to improve performance reporting through new and improved publications and communications strategies. We will lead the development of more direct indicators of service quality and costs, and I know that this is a subject matter that has been of great interest to your colleague from Edmonton-Riverview. We are currently supporting the three largest province-wide service programs – that being transplant, cardiac, and renal – in developing clinical measures, targets, and benchmarks that complement our current reporting. We are working currently on a joint project between the department and the regional health authorities in Capital and Calgary, that will begin this fiscal year, to develop and test an integrated set of measures across the continuum of service for a major health condition.

We have a revised and updated report on selected performance indicators, that will be made available to the general public, and we will publish a new major report in September of 2002 based on the agreement of federal, provincial, and territorial first ministers, that was agreed to in September of 2000, to prepare comparable reports for 14 health and health system indicators. I can say that it has been challenging to do that, and if I might give an example: when does a waiting list begin? We currently do not have information systems in our regional health authorities that necessarily record the beginning, the start, of a wait period the same way. The systems don't reflect the need that we have. You can imagine that if that's the case within Alberta, trying to find common measurements across Canada would be even more challenging. Again, that's not to say that it's not important to do. It is important to do. We are striving mightily in that direction.

MS BLAKEMAN: I may have unintentionally led the minister astray, because I was looking specifically to the year that's under examination, that being 2000-2001. So maybe I could focus on: what progress was the ministry able to achieve around this in the

fiscal year that we're talking about? You were giving me later information. I mean, perhaps you've answered the question in talking about the transplant and renal measurements that you're looking at, but I was looking for: what did you accomplish in this fiscal year?

MS EWART-JOHNSON: Thank you. I think the key issue that was accomplished during that particular time was looking at benchmarking in the provincial renal transplant program as well as cardiac and also in that particular year looking at how we better cost procedures in ambulatory care. Now, that, Mr. Chairman, is an ongoing process, but we were looking specifically at addressing those needs in that particular year of 2000-2001.

THE CHAIR: Thank you very much.
The Member for Red Deer-North, followed by Dr. Taft.

MRS. JABLONSKI: Thank you, Mr. Chairman. Well, it seems as though we are of one mind this morning, as hard as that is to believe. Laurie has already asked my first question, so I'll move on to the next question that I had. It's specifically on page 135 of the Auditor General's report. It recommends that

> the Calgary Health Region and Capital Health Authority establish . . . performance measures for surgical facility services and [then use] these standards of performance [for the] monitoring of contracted facilities.

I think this is a very, very important issue because we're going to be doing more of this. So I'd like to know what progress has been made towards this recommendation.

MR. MAR: Currently, Mr. Chairman, there are a number of performance indicators that are used to monitor contract performance, and that includes the following: the number of persons on wait lists, wait times, surveys on patient satisfaction rates, and facilities' participation rates in teaching and research activities. Comprehensive outcome-based performance measures will involve having a structured method of assessing improvement in the well-being of an individual served by a surgical facility. The department is working closely with the two regions to identify interim measures to address the recommendations of the Auditor General on this point.

MRS. JABLONSKI: Thank you very much, Mr. Minister. I wasn't able to find it in any of the books, so I might be off the path here, but one of the things that has been pointed out to me is that one of the big costs we have in our emergency system in the Red Deer regional hospital is the late-night visits of the people who have a problem with alcohol and drugs. It has been suggested that by having a detox centre, we could save a lot of money in our hospital system by having these people going to an appropriate facility rather than emergency and increasing our waiting lists and our wait times. I just wonder where the department stands on detox centres and if we can have an idea of whether or not we're going to be introducing something like that in more regions in the future.

9:01

MR. MAR: I think that as a general comment, both in the present and in the fiscal year that we are considering, we have to be prepared to look at different ways of meeting the real needs of people. To my recollection, in the fiscal year that we are looking at, I believe that the Auditor General's office was involved in a review of utilization of the emergency room at the Queen Elizabeth II hospital in the city of Grande Prairie. They came to the conclusion that a large percentage, if my memory serves me correctly about 82 percent, of people who came to that emergency room were not in fact emergencies, which suggests that there is a need to establish a different way of dealing with the real health needs but not emergency needs of people who come to that facility at that time.

There are things that we started in the fiscal year that we are talking about that have expanded now. For example, the Capital Health link line, that now serves the Grande Prairie-Mistahia region and Peace River, has demonstrably reduced the number of unnecessary emergency room visits to facilities in the area that it serves.

If I might share a vignette from last January, when premiers of Canada were meeting, I was in a taxi on my way to the conference centre in the city of Vancouver, and a cab driver asked me what I did for a living, and I told him. He then went at some length to describe how his daughter had an excruciatingly painful experience where she waited eight hours in the Vancouver General hospital to get treated for a twisted ankle. He said: what are you going to do about it? I didn't want to say that I had no jurisdiction, but I reversed the question: I asked him what would he do about it. He thought about it, and he said: "Well, it turns out that it was just a twisted ankle. It wasn't broken, but we waited eight hours to find out. If there had been a clinic attached to the Vancouver General, we probably could have been assessed a lot easier, and it would have put my mind at ease, and we wouldn't have had to have waited eight hours.

I think that commonsense approaches of ordinary people can make a great deal of sense. Whether it's treatment through something like a detox centre or a clinic or some other means, health link lines, that is all a part of primary health care reform that we started in the fiscal year that we're talking about and will continue in the present and into the future.

THE CHAIR: Thank you.

MR. MAR: I think Mr. Finnerty would like to comment further on Red Deer.

MR. FINNERTY: Your specific question about Red Deer. We certainly are aware of the need in Red Deer, and as a Crown agency AADAC is definitely supportive of the need for a detox centre in Red Deer and probably another four or five locations in the province. It's one of those needs in the health system that we all know about that perhaps when its time comes, we can provide some presentation to Treasury Board. We have been asked by Mr. Hutton's committee that is reviewing usage in the system to perhaps make a presentation to them in the sense that if we can take acute care beds out of the health care system at $400 or $500 a day and move them into detox facilities, our costs are about $90 a day. The long-term saving is substantial, so we're definitely looking at that, and we'll leave that to the deliberation of Mr. Hutton's committee.

THE CHAIR: Thank you very much.
Dr. Taft, followed by Mr. Broda.

DR. TAFT: Thanks, Mr. Chairman. Starting on page 111 of the Auditor General's report, there's recommendation 13, that expresses quite serious concerns about business planning. Now, I know we discussed this a bit yesterday in the Legislature. I would be interested in the Auditor General's comments as well as the department's comments. If we're not limiting ourselves too strictly to this time frame, we could talk about how the system worked then and how it ideally could work in terms of the planning relationships between the RHAs and the department.

My particular and obvious concern is the one of timing. When we have the RHAs submitting business plans after the budget year has

begun, after the fiscal year has begun, after the department has had to prepare its own budget, it seems there's a problem of synchronicity or synchronization there. So how would this ideally work in your view as Auditor General?

MR. HUG: Well, in this particular piece the issue is timing.

DR. TAFT: That's the crucial thing.

MR. HUG: As you indicate. Obviously a plan sets out what you intend to achieve for the coming year, and if that is not completed until partway through the year, then essentially that type of guidance is lacking. So where is the guidance? Where is the vehicle to hold organizations accountable for that period of time?

Nick, did you want to supplement further?

MR. SHANDRO: Well, yes. I think the issue of determining where you're going to be at the end of the year is best decided at the beginning of the year in terms of setting direction. I use an example of going on vacation. About the time you're ready to come back, you decide where you're going to go. Well, it's hard to run an organization that way.

In my work with health authorities they look at the business planning as something the minister requires and not something that's inherent in their work, so they just have to carry on with this sort of thing. There was also a large expectation – somebody said: it's a rainy day funding system, so we'll just wait for the showers to come when we need money. This is in the period of the audit here that I've heard those sorts of comments. I think it's important to hold the health authorities responsible, make sure they have a proper capital base to start with and that capital base is protected and then held accountable to maintaining a proper capital base.

Now, of course there's a whole large issue associated with what that capital base should be. I mean, in our review of Mistahia one of the issues, I think, that the minister earlier referred to was a lot of people practising clinical-type medicine in the emergency room. I'm not a specialist in this area, so don't count on what I'm going to tell you here, but what I'm saying is that maybe the configuration is wrong. Trying to operate a private practice downtown and also staffing the medical emergency room for one physician may be a bit onerous and also a duplication of costs. Maybe there's a better configuration that could come from that sort of thing. So that whole issue of a capital base, the vision of where we ought to get to, what the performance expectations should be all have to be seriously incorporated into a business plan and those people held accountable for that. I think that the business plans were largely used as a negotiating tool for more funding.

MR. MAR: If I may share my perspective on this, we take seriously all of the recommendations of the Auditor General's office, but of course there's a priority, and in my view this recommendation sits highest on the list of priorities to deal with. In the year that we are talking about, to the best of my recollection business plans from regional health authorities came in sometime in July of that year when the allocations in the budgets were passed in February or March of the year. So halfway through the fiscal year business plans were being submitted. The consequence of that is as Mr. Shandro has correctly characterized. I think that regional health authorities viewed business plans as being simply a requirement of the ministry rather than a real tool for planning out the activities and establishing the priorities of the regional health authority.

That is the reason why we have moved to improve upon that recommendation for the current year. The allocations were delayed in the business plans and are due at the end of this month and approval of those business plans anticipated sometime in the month of May.

9:11

DR. TAFT: So, then, my supplemental again to either or both parties would be: does the department have the resources to hold the regional health authorities accountable in the business planning process?

MS EWART-JOHNSON: I was just waiting for the Auditor General's response, and then I was about to respond. I think that's an excellent question, and we most definitely do. We have our director of business planning here today. We have dedicated resources to look at how we can increase accountability, and we do that through a whole variety of ways. We work closely with regional health authorities. We go to them on a regular basis to say: what is it that we can do to help you through this process? And it's not just a one- or a two-year contact that we make with them. We do follow-up. If, for example, they're saying that we do need time to analyze this, have community consultation, we'll say: what time do you need; how can we help you; how can we move this process forward? So we do have the resources to meet the need. We're far more diligent in follow-up and far more diligent in articulating what our expectations are for accountability than perhaps what has been in the past due to perhaps those resourcing issues.

MR. SHANDRO: I don't just see it as a resource issue; I see it as very much an issue – I mentioned the words "capital base" before – of establishing a capital base that you're going to hold them accountable for. What I'm basically saying is: have they got a configuration that is reasonable for operating, and have they got the money invested in that configuration, and how long is it going to take them to get to that necessary configuration?

If we're operating with a configuration of the past – I mean, I came from the town of Bonnyville. At one time we had two hospitals in that community. That isn't a configuration that anybody would support today, yet it had to change over time, but do we still have those? I think there have been in the past a number of facilities that had to be dealt with appropriately to bring them up to today's standard of practice. I don't think that in their existing configuration, even if they're popular with the people who are not practising medicine, they're probably not the configurations we need for adequate delivery of medical service. So I think that has to be handled as well, because if you don't handle that, it's pretty hard, then, to hold people accountable for something that they don't have the resources to work with.

I basically say that if I take a cab across town and I come to the end of the trip and he asks me for $20, I'd better hand it over to him or else don't ask him to go across town.

THE CHAIR: Thank you.

Mr. Broda, followed by Ms Blakeman.

MR. BRODA: Thank you, Chair. I have a question here. Note 4 on page 15 of the Calgary health region's financial statement states that $33.2 million is invested to be "utilized to fund future payments to operators over the next 30 years." It also states that the Calgary health region is subject to the risk of inadequate rates of return. I know, Mr. Minister, that you weren't there when the decision was made. However, it seems like 30 years down the road is a long way. Is this $33.2 million that's put in place taken out of the account? The question is: could you explain the financial arrangements, how they work, and what is the risk involved?

MR. PERRY: Mr. Chairman, what's being referred to in this observation is what was commenced in July of 1999: the private partnership arrangements where we had gone to, I guess, the market to see if private businesses, nonprofits would be interested in the construction of long-term care facilities. Essentially, there's a contract between the regional health authority and these providers, and in this case the funds are advanced through Alberta Infrastructure on a long-term basis. The risk, of course, is: what does the world look like 30 years down the road, and what does the investment market bear?

So it's an appropriate observation. However, the RHA in this case, the Calgary health region, has a fairly sophisticated investment strategy. We'll be watching out for this, and they will manage their cash flow as they do for basically all their projects. Essentially, it's the P3 arrangements that we are entering into now.

MR. BRODA: Okay. Thank you for that answer.

Not to pick on Calgary regional health authority, I have one on Capital health.

MS BLAKEMAN: Go ahead.

MR. BRODA: Capital health authority's financial statement discusses a loan of 3.7 and some change million dollars to a developer to build a new Allen Gray facility. The note says that the loan will be forgiven. Why would we forgive a loan? Is it a private developer, or who is it?

MR. PERRY: Yes. Again, the Auditor General may want to add commentary on this. Essentially it's the same program. It's one of the other mechanisms used in the private partnership, but the loan is essentially the remuneration that the folks who had constructed this will basically – by forgiving, that'll be their compensation over the next period of time, the next 30 years in this case. It's a type of a mortgage arrangement, but it is the cash infusion, again, over the period of time because all of the facility is not being used, particularly by the health authority. So it's their way of remunerating for their costs.

MR. SHANDRO: I can just supplement it. There are basically two ways of paying the capital costs of a private developer. One is to have him finance the building, and then you're going to pay it through some operating agreement. Since the government advanced the money to the health authorities, some decided that they're going to park the money in a bank, get that private developer to take out a loan, and then they're going to fund the developer as he operates. Another arrangement was: instead of the developer going out for a loan, we have this money, so we'll invest it in the project through the developer, and we're going to pay him through, what is used, this word "forgiveness." It's basically an operating payment as it goes forward. Basically, there are less steps involved in that arrangement, because the developer doesn't have to go for an outside loan and the risk of interest volatility isn't there.

THE CHAIR: Thank you.

Ms Blakeman, followed by Mr. Masyk.

MS BLAKEMAN: Thanks. When I look at the Measuring Up document from 2000-2001 on page 62, goal 1, "Albertans will be healthy," we have a goal, I'm assuming, of accessibility of health care services. In fact, what it's showing is that steadily between '96 and 2000 Albertans' ratings of their ease of access to health services has dropped in the "very easy" and "easy" categories and has increased in "a bit difficult" and "very difficult" categories. They're not monumental leaps, but they are certainly incremental. Obviously there's a perception from Albertans that access was getting more difficult, and I'm wondering: inside of the fiscal year that we're examining today – I'm the only one interested in doing that – can the minister talk about what areas were identified by the department as being particularly difficult? Obviously Albertans were responding to some kind of survey question, saying: we find access more difficult. The department must have done work to say: where? Where did you pick off that the access areas were most difficult?

MR. MAR: I think that one of the areas in this particular fiscal year before our consideration that really came up was in the area of magnetic resonance imaging, MRIs, and we did significantly increase the number of MRIs. Now, over a three-year period – and I don't remember when this three-year period started – we would have done perhaps 30,000 in year one, 40,000 in year two, 50,000 MRIs in year three. So it was over that period of time, I think, that MRIs were a very, very significant issue with respect to access. I think that's probably the reason why there was a small spike in the number of people who perceived that there was an access issue, and it is admittedly true that some people were waiting significant lengths of time for MRIs.

9:21

Now, the good news is that we've managed to bring that down fairly dramatically. Within that fiscal year I think we dropped the number of people on the wait list for MRIs by thousands; I think 2,000. I can perhaps be corrected by my deputy if my recollection is incorrect. In that fiscal year we did make investments in, what I would broadly categorize, three areas: in people, in plant, and in equipment. On the people side, as I indicated in my notes at the outset, we did work with the Department of Learning to increase the number of people that we train in our postsecondary system: physicians, nurses, and other health care providers. We did make a significant investment in that in working with the Department of Learning.

We did make significant investment in the area of facilities. So, for example, we did act upon what's known as the Broda report, prepared by our friend from Redwater, dealing with issues of long-term care and improving home care. We did have capital that was spent in facilities in this province that would improve capacity, and we did spend money on equipment. To my recollection, the increase in the budget for equipment in that year I think was in the magnitude of $150 million, and again I stand to be corrected by my deputies if I'm incorrect; the purchasing of new MRIs, as an example.

Let me say that when trying to deal with the access issue, it is always a challenge to strike the balance among those three inputs: people, plant, and equipment. For example, you cannot buy an MRI without preparing the capital facility to house it. I mean, an MRI is not something that you can just park in a room. It requires significant capital infrastructure to house it. You cannot operate it without MRI operators, and of course having operators to operate MRIs – they are in high demand and in short supply throughout North America. So that combination of trying to find the right balance of people, plant, and equipment is always a challenge, but we think that in the fiscal year that we are looking at, we did strike that balance. So we have dealt with access issues, although there was a spike in that year, and I think it was predominantly because of the MRI issue.

MS BLAKEMAN: Okay. As my supplemental, then, you've talked about the pressure points and reacting to the pressure points around

access in this fiscal year. Were there improvements that the department made that you feel you didn't get credit for? They weren't front-page news, but nonetheless you felt that good work was done there and nobody noticed?

MR. MAR: Well, indeed, I think very good work was done. I don't know if it wasn't noticed. I think that Albertans have recognized that we have a good system. I think that it's a good system, and as I've said occasionally, it's excellent. I think that people have recognition of that, and it's demonstrated in the surveys where they talk about the actual service that they received and their overall perceptions of the health care system. So I wouldn't go so far as to say that it is unnoticed by Albertans. I think that it is noticed by Albertans. I think it is appreciated by Albertans. They know that it is a costly system, and I think that it also has recognition outside of this province.

I believe that one of the key reasons why we have been successful in recruiting health care professionals to this province is because of the system that we have. As I indicated in my notes, in the fiscal year that we're looking at we had 161 more physicians than we did the previous year. Over that period of time my recollection is that the increase in the number of physicians to this province was about 16 percent, and the increase in the number of specialists was about 11 percent. This was at a time when the average increase in the number of physicians in the rest of Canada was at 3 percent. So we have done a good job of recruiting people from other places, and I think that a key component of that is because of the recognition that we do have a good system.

MS BLAKEMAN: Thanks.

THE CHAIR: Thank you.
Mr. Masyk.

MR. MASYK: Thank you very much, Mr. Chairman. In the annual report several measures are from a survey of Albertans. This is one of the reasons why I brought our guest in from rural Alberta, Mr. Odegaard. In a way he's the ears to the rails. He listens for which way the train is coming, so to speak. Regardless, how are these results obtained, and who does interviews and how frequently?

MR. PERRY: If I might answer that, Mr. Chairman, Alberta Health surveys these folks annually. The sample size is about 4,000 Albertans selected randomly, and they're asked questions about the quality of health services, how easy, how difficult it was access these services, and their own personal rating of these services. Since 1996 we have used an external resource. It's the Population Research Laboratory at the University of Alberta. The other point is that these are fully disclosed. The reporting is to the public each year, and this information is available.

MR. MASYK: Thanks.

One of the results of the survey was that Albertans reported more difficulty getting access to health facilities and getting health service. What is being done to improve these results? I was wondering, if it was all right with the chair, if Mr. Odegaard could bring a perspective to the table, being from the public. Or is that against the rules?

THE CHAIR: No.

MR. MASYK: Okay, that's fine, Mr. Chairman. Anyway, can you tell me what's been done to improve the results of getting health service access?

MR. MAR: This is really a follow-up on the question asked by Ms Blakeman, and we are obviously concerned about the results of people's perception of accessing the system. We have targeted significant amounts of dollars to specific health services where access is particularly critical, and that would be in areas like heart surgery, joint replacements including hips and knees, and the one that I mentioned earlier, MRI diagnostic services. We've also taken significant steps to improve the availability of physicians. I think that our agreement with the Alberta Medical Association has also been an important key to retaining the physicians that we have and recruiting new physicians to come to the province.

Developments like Wellnet and Telehealth installations are also helping improve access, particularly as it relates to specialists. Through these Telehealth installations rural physicians are able to access consultations with specialists that may not reside in rural Alberta. We have developed and published new information for the public concerning access to specific health services, and we focused in particular on facts about waiting lists for those services so that we can better inform Albertans about access to services.

MR. MASYK: Thank you, Mr. Chairman.

THE CHAIR: Thank you.
Dr. Taft, followed by Mrs. Ady.

DR. TAFT: Thanks, Mr. Chairman. I'm on page 134 of the Auditor General's report, recommendation 20, which deals with conflict of interest issues. Again, the Auditor General's staff might want to comment or any of you comment. The recommendation is to enhance the conflict of interest process by extending disclosure requirements to staff who presumably aren't covered by the policies that were in place at the time. I take it that's what is meant by extending it to senior management. Were there concerns that came to your attention that prompted your recommendation to extend those conflict of interest policies?

9:31

MR. SHANDRO: At the time that we were reviewing it, there were no transactions that had followed through the surgical service contracting process as they were in the process of being negotiated, but we hadn't had any completed contracts at that point in time. So our examination was limited to examining the process they had in place at that time, and basically the processes that were there said that if you were involved in negotiation of contracts and so on, you had to do these disclosures. If you weren't involved, then there was no requirement to make those disclosures. But we're taking a broader perspective. When you're running a program, a health program or so on, and are responsible for others who are negotiating on your behalf, we feel that there's the risk of self-review when you're reviewing a program wherein you didn't negotiate the contract, but an organization in which you have an interest is delivering services. Of course, you have abstained from negotiating the contract or signing the contract; nevertheless, you're still responsible for oversight of that particular program area.

So we saw a number of risks that had to do with things like advocacy, risk, representing your employer as an officer of an organization even though you had abstained from the specific contracts when you were acting as the employer's agent, as well as having an interest. We want to see some process strengthened around those areas.

DR. TAFT: Okay. Then my question on this, I suppose also to the Auditor General, is: did you or your office look at other standards

for conflict of interest from outside of these particular jurisdictions? I'm thinking, for example, of other medical colleges or legal rulings. There are some interesting legal cases on conflict of interest in medical situations in Canada. Did your office look at those sorts of precedents, or is it just based on your general knowledge of the issue from your background in auditing and accounting?

MR. SHANDRO: I guess if you just depended on my general knowledge, it would probably be detrimental to a good recommendation. What we did is a considerable amount of research to establish the criteria. Not only that; we employed outside parties both in accounting and in legal areas to give us proper advice as well as to work with us to examine those processes. So they acted in conjunction with our own staff in terms of looking at the processes that were there to see that they would be the most appropriate in the circumstances.

DR. TAFT: Okay. Thanks.

THE CHAIR: Thank you.
Mrs. Ady, followed by, again, Ms Blakeman.

MRS. ADY: Thank you. I'm also in the unusual position of having Laurie already ask my question, but I would like to expand on it as well. Mary Anne and she and I are all on the same page this morning.

I'd like to go back to the access question if I could. My question stems from the Auditor General's report, page 121, where you're beginning to talk about how the Auditor General said that "time rules do not work." I heard you talk about better access and MRIs and some areas and some things that you're doing in telehealth and better recruiting, but I'd like to go back for a moment just to the family doctor.

We have Health Plus. I know that none of you has ever heard me say this, but I have an awful lot of constituents, 80,000-plus, and we have one primary health facility down there, which is Health Plus. I'm hearing that five doctors are leaving the practice in the next few months and that they had over 52,000 walk-in visits there alone, just people coming beyond their normal visits to the doctor. I continue to hear from constituents who are having a very difficult time finding a family doctor just because of the numbers that are moving into the province, for one thing. I remember going to see a skin doctor down there not too long ago, and I was in examination room 48. I thought: how could he have 48? I don't know if it was. I might be exaggerating, but it might have been 48.

AN HON. MEMBER: Cindy never exaggerates. It's against her religion.

MRS. ADY: Yes, it is.

At the time I thought: I'm in examination room 48. But, you know, it worked pretty well. He used his nurses very well. He did do things that I felt in some ways actually created the opportunity for me to be seen quicker than if I'd been in a waiting room waiting. The people he had surrounding him in their scope of practice was pretty broad, and they were helping quite a bit.

I guess my question on this page is that it talks about how time rules do not work, and they're speaking in here about eliminating the "brief" versus the "limited." My concern is that the doctors that we do have down there – we need to see more people more rapidly at this point in time. When you turn the page, you talk about how innovation is required. I guess my question surrounds: what kinds of thing are we doing in that area to try and improve this? If it's not a time rule that we can use, what innovations could we use – I know we've discussed some in the Maz. report – and things that could perhaps help? Obviously we can't recruit any faster. We can't stop people from moving into the province any more than we do, nor do we want to. But the family doctor and the access: can you comment on that?

MR. MAR: Let me quote the former minister of health, Dr. Dennis Furlong, from the province of New Brunswick. Dr. Furlong practised medicine for many, many years, probably about 20 years, and is now the Minister of Education for that province. He said that people always talk about the importance of a family doctor, but nobody ever talks about the importance of a family nurse. He would pose the question: why are we not making better use of health care professionals other than physicians?

Dr. Frank Pasutto here at the University of Alberta, the dean of pharmacy, would pose the question: who knows more about drugs, a physician who at best will take one half-year course during the term of their training or a pharmacist who studies it for five years and then makes a living out of understanding drug interactions and how they work? Those two rhetorical questions posed by Dr. Pasutto and Dr. Furlong I think suggest that we need to look at primary health care teams.

Perhaps the next time you're in front of a medicentre – and I've done this myself with my physician. I've looked at the people who have come in the door, and my physician, my own physician, would say that even from a lay perspective you could probably be pretty accurate about who really needs to see a doctor, which would be a fairly small number of people going to the medicentre, versus those who could actually get advice from a family nurse or from a pharmacist and so on. But right now we don't really have a way of remunerating for services provided by someone other than a physician.

My doctor here in Edmonton is named Dr. Wong. My dentist in Calgary is named Dr. Wong. Dr. Wong in Calgary, Leo, has an office where he has four or five dental hygienists. Nobody ever questions that those dental hygienists are competent to do certain things in my mouth, and we have a way of remunerating Leo's office for services provided by someone other than Leo. When I go to Dr. Wong here in Edmonton, my physician, we do not have a way of remunerating services provided by a nurse or some other health care professional that they are competent to do. We do not have a way remunerating for services provided by someone other than Paul, my physician.

So in order to improve access, if we are to say that our current system is going to continue, we can confidently say that there will be insufficient access, that we will not have enough doctors to deal with the needs of people. You're right that we cannot recruit enough to run the current iteration of the system, so we do need to look at ways of bringing other health care professionals into the equation for the delivery of health care. This has been a focus of interest for ministers of health across Canada. What does primary health care reform mean? How do we bring other health care professionals into a primary health care team and deliver services so that a patient sees the right person at the right time at the right place?

9:41

MRS. ADY: Thank you. Just in supplement, in the short term we of course have those processes under way to try and look at some of those things. When you're working with the Minister of Learning, are we going to be training more doctors in the future as well? Is that something that's on the horizon as well?

MR. MAR: Again to the best of my recollection, in the year previous to the year that we are talking about – and again I can stand to be

corrected by my deputies and perhaps by written response later – we had approximately 3,700 people training in our postsecondary system in health care professions. In the year that we are considering, a significant investment was made in training, and the number of people jumped from 3,700 to over 5,000 people training in our health care professions. That included an increase in the number of physicians training. It included international medical graduates having a residency program and LPNs and nurses as well. So I can provide by written response the increases in the numbers, but of course we won't see a physician that started in that year for some number of years to come. Physicians are expensive to train. Again to the best of my recollection – and this is perhaps outside of my scope and more in the Minister of Learning's scope – to train a physician, a GP, costs between $600,000 and $800,000, and to train a specialist will cost between $800,000 and $1.1 million. It will be years before people who start in training today emerge to become part of our system, and hopefully we can retain them when they do emerge.

MRS. ADY: Thanks.

THE CHAIR: Thank you.
Ms Blakeman, followed by Mr. Hutton.

MS BLAKEMAN: Thanks very much. The minister just gave me an opening that I have to walk into. I'm picking up on the previous member's question. If the minister can speak that way about nurses and nurse practitioners, about pharmacists, where do midwives fit? Why is there such a problem getting midwives integrated into our system here? There have been studies. There have been pilot projects. Why doesn't this seem to be working? Is it that the doctors don't want to co-operate? Is it the government philosophy that they're not interested in this? Is there a problem finding a fee schedule to include them under health care? I've been working on this for six years. I'm still working. If that's the attitude about other health care professionals, that it would help with access and would help with a smoother moving system, why the problem with midwives?

MR. MAR: Well, you've already identified some of the challenges, but I can say that government philosophy is not one of the challenges. The government philosophy in the delivery of health care has to be that the lowest cost competent provider of a service be the person who provides it. Needless to say, there are many challenges when it comes to establishing who has a scope of practice to do what. One of the best examples of that is the three O's: opticians, optometrists, and ophthalmologists. Opticians want the ability to do sight testing. Optometrists will say that there will be eyeballs rolling on the streets of Alberta if we allow that to happen. Then you have optometrists who want the ability to prescribe topical medication to take redness out of eyes. Ophthalmologists will say: there'll be eyeballs rolling on the streets of Alberta if we allow that to happen. I think that the approach that we've taken with the Health Professions Act will go a long way to alleviating those things.

Right now there are, to the best of my recollection, approximately 23 midwives working in the province – perhaps you know different, Ms Blakeman – and the evidence that I have seen from research done at the University of British Columbia is that for women who are assessed as having low-risk pregnancies, when dealt with by a physician versus being dealt with by a midwife, there is no difference in the outcomes. So the question, then, is: if the outcomes are the same, who is the lowest cost provider of that service? If it can be demonstrated to our expert panel that the outcomes are the same but that the cost is less for services by midwives, then that is perhaps something that should be covered. So for the expert panel as envisaged by the Mazankowski council, the Premier's council on health care, it's not just about delisting services that are currently covered. It is also about: what services can you add to the system that are cost-effective? It may be demonstrated that midwives satisfy that test.

MS BLAKEMAN: I'd like to continue this dialogue, but it's not appropriate in this setting, so I'll pass on the supplementary.

THE CHAIR: Mr. Hutton, please, followed by Mr. Cenaiko from Calgary-Buffalo.

MR. HUTTON: Thank you, Mr. Chairman. The hon. Member for Edmonton-Centre referenced earlier what fiscal year we're in, and we're talking about 2000-2001. Using a rural analogy, which usually works best in our caucus, we know that the milk is spilt and the cow is probably dead, but we do know that the dairy industry is alive and well. So we may jump back and forth in my comments and questions here.

In 2000-2001 I was executive director of the Glenrose Foundation and realized, in a small way, the complexity of the health care business provider for the clients of Alberta, and I commend the ministry on the policies that are set out and the delivery by the 17 RHAs and the Cancer Board that they do. But I didn't know until I was elected of one area that the minister is responsible for, and that's AADAC. As the elected official from Edmonton-Glenora I have been very, very impressed with the ministry's policies and how they are being delivered by AADAC, because I have an inordinate number of people with alcohol problems around the Saxony in the centre of my constituency. So I just wanted to make that comment. I look forward to working with Mr. Finnerty in my new role as chair of Collaboration and Innovation and look forward to his presentation.

My question has absolutely nothing to do with that. I would like to turn to page 130 of the Auditor's report for the financial statement: funding for health authorities spread among different programs and detailed scheduled department expenses. Why doesn't the department have clear and understandable financial statements?

9:51

MR. PERRY: Mr. Chairman, clearly, back in 2000 – I even get confused with the year after going through the budget yesterday. It's best described as a work in progress. We have recognized and the Auditor General and Alberta Finance have commented – and this goes back to the days of program budgeting where we show budgets in different areas, and that gets consolidated at some point into the financial statement. We recognize that, and particularly when it comes to RHA funding, for their simplicity and for their predictability they need to see what the total pot is for an RHA. So in this budget, probably more so in this budget – again, we're talking 2002-2003 – we are highlighting through the budget, which will translate into the statements, a clear picture as to what the funding is by program. There are some limitations in terms of what you can and can't report, and it's very high-level information that we consolidate. We've acknowledged this, and we are working with the other parties to improve the reporting, which will improve the predictability.

MR. HUTTON: What was the reason for the large increase in write-offs from $30 million to $44 million from 1999-2000 to 2000-2001?

MR. PERRY: Mr. Chairman, the program is the health care

insurance program. Again, working with the Auditor General in that year, it was recognized that the provision for bad debts for collections was too low. I think this has been a reported item for several years leading up to that point. In that year we put in a onetime provision. The write-off program has an actual write-off, the cash loss, and an estimate of what the provision should be for the upcoming years. So it is an accounting treatment, and it is expensed in the particular year. That was a catch-up time, and we're now on track. We are including in this year's budget an adequate provision for write-offs and bad debts.

THE CHAIR: Thank you. I would like to acknowledge the graciousness of Dr. Taft. In light of the time, Mr. Cenaiko has not had the opportunity to question the department this morning.

Mr. Cenaiko.

MR. CENAIKO: Thank you, Mr. Chairman.

> The past year was both eventful and rewarding . . . Health service delivery starts with the trained professional . . . We expanded the toolbox of care our professionals use . . . Programs need equipment and facilities.

These quotes are taken from the minister's message. Inherently they need the staff to perform the critical role in health care. As a board member of the Calgary health region for over seven years it was always a fine line in determining the mix between full-time and part-time staff. What direction has the ministry taken? It has been a challenge for the human resource leaders in the province to look at what direction they should be providing and that mix between full-time versus part-time versus the call-out costs that each region has been challenged with. The stress has always been a mix between the percentage of full time versus the percentage of part time, the ability to call out individuals when you need them, and also the ability to run your programs with the required staff that you need when it's not the flu season, so to speak.

MS EWART-JOHNSON: Mr. Chairman, if I may answer this question. I think the aspect of human resources in the health care industry is one that is of interest to all of us. The regional health authorities and the Cancer Board as well as the Mental Health Board have really taken, I think, a lot of time to look at what are the key issues facing their staff in the last number of years.

You will note – and I'm turning my mind now to 2000-2001 – that that was prior to the negotiations with the nurses, but it was involving negotiations with other groups. When you look at the full-time or part-time ratios, regional health authorities of course do have the authority to select which particular provider they wish to have. I think you will find in health care that typically there is a casual pool, a part-time pool, and then a full-time pool. There was a real, I think, need by providers and organized labour to increase the number of full-time people in the workforce, and that was something that was quite critical to the last two rounds of negotiations with the licensed practical nurses and the registered nurses with the United Nurses. I think both employers and unions have addressed that in their minds, looking at not only benefit packages but looking at what makes the most sense for the work environment.

You will understand, too, that full-timers versus part-time people do have that obligation and dedication to the workforce, but that does sometimes restrict the employer in their staffing ratios so that they may require more part-time people to cover on weekend shifts or off shifts. So that issue is left solely to the discretion of the employer in how they staff their particular units. There's nothing in legislation that does dictate any staffing breakdown, and I think that depending on whether you're an acute care facility, whether you happen to be a clinic or auxiliary, that will dictate your staffing arrangement.

MR. CENAIKO: Thank you. No further questions.

THE CHAIR: In light of the time, that concludes the questioning today. Certainly on behalf of the committee I would like to express my gratitude to the minister and to all his staff.

MR. MAR: If I may, Mr. Chairman, I thank the committee for its good questions, and as I indicated, those questions that we were not able to reply to we can respond to in writing. I will also take into account the comments that I made, and if I've made errors, I will also correct them by written correspondence in due course.

THE CHAIR: Thank you very much. If those written questions could be addressed to the clerk, we would be very grateful.

I'd also like to thank the Acting Auditor General and his able staff for attending this morning as well.

I would at this time like to remind all members of the committee that the next meeting is, of course, Wednesday, April 17, and the Minister of Finance and the Minister of Revenue will be present at 8:30 sharp.

I would like to now, please, excuse the Auditor General and the minister and his staff. There is item 6 on the agenda. We will deal with that in 30 seconds. Thank you.

Item 6 on the agenda, Location of Future Public Accounts Committee Meetings. Is there any discussion?

MR. HUTTON: I move that we keep it here.

THE CHAIR: Mr. Hutton moves that we remain on the fourth floor here. Is there any discussion on the motion as presented by Mr. Hutton?

MR. CENAIKO: I see that the setup of the room has been altered somewhat since our first meeting here. Again, the concern that I do raise is that there still are staff members in the back that do have to fumble with some of their books, so as I mentioned to the deputy chair, is there the possibility of looking at tables that may be half the width, an 18-inch table, that they could at least rest their books on and/or dig through items if they need it? Could that be provided for some of the staff members in the back? I did see that we did have some public here, and I thought that was excellent. That's the whole idea behind Public Accounts.

10:01

THE CHAIR: Yes. I did encourage members that if they're uncomfortable at the back – perhaps I wasn't specific enough – there were empty chairs around this table. No one took us up on the offer.

DR. TAFT: They are too self-conscious.

MS BLAKEMAN: They are never going to move up.

MR. CENAIKO: Yeah, and I don't think they should be sitting at this table either.

THE CHAIR: Okay.

MS BLAKEMAN: But they do have this ledge, Harvey. I don't know if you've noticed that.

MR. BRODA: I notice they're not sitting at it, though.

MR. HUTTON: We can't be all things to all people.

MR. CENAIKO: I'm sure they can find the 18-inch tables. I think

the improvements here are greatly expanded since we first started, and I think this is fantastic.

THE CHAIR: Okay. Thank you. If there are no other comments, then, all those in favour of the motion as presented by Mr. Hutton? Those opposed? Motion carried. So we will remain in this facility.

Can I have a motion, please, for adjournment?

MR. CENAIKO: So moved.

THE CHAIR: Mr. Cenaiko. Thank you very much.

[The committee adjourned at 10:03 a.m.]