Title: Thursday, March 24, 1994 Designated Subcommittee
Date: 1994/03/24
[Chairman: Mr. Lund]
Time: 6:03 p.m.

MR. CHAIRMAN: Ladies and gentlemen, it is after 6 o'clock, so if we could call the subcommittee to order.

We should just go through a bit of process. What I'm proposing tonight is that to start off we would have some introductions of staff that are with us. We would ask the minister to give us an overview. Then we will move right into the questions and answers, and I would propose that we start with program 1.

We will deal with each program, just with the program. We won't jump from program to program. What we did in the other one I chaired: we allowed the parties to select the second program. So if you want to go to one other than number 2, fine; then the government members will choose the next round. Of course, we've got to stick to the 1994-95 budget. We will not get off into policy, nor will we get off into philosophy. I would propose that we will have one main question and two supplementals. We will alternate back and forth. I would ask that you just raise your hand so that I can get you on the speaker list, and we will proceed in that kind of a manner.

Are there any questions or comments before we start?

MR. MITCHELL: Just one. If we were to go through each program at least once before the end of the four hours, Ty, we could then go back and revisit?

MR. CHAIRMAN: Yes.

MR. MITCHELL: Thanks.

MR. CHAIRMAN: So with that, Madam Minister, we would invite you to introduce the folks that are with you and make your comments. We will then start the questions and answers.

MRS. McCLELLAN: Thank you, Mr. Chairman, colleagues, staff, and guests. I'm pleased to be here to discuss the Department of Health's estimates.

I will introduce my staff. To my immediate left is Don Philippon, our deputy minister. Beside Don is Dave Kelly, assistant deputy minister of health care insurance. Then we have Dick Alvarez, assistant deputy minister of corporate services. We have Cecilie Lord, assistant deputy minister of health strategy and evaluation, and at the end Steve Petz, assistant deputy minister of public health. To my right is the man with the money, Aslam Bhatti, the senior financial officer of the department. Also with us tonight is my assistant, Maureen Osadchuk. I think most of you know Maureen. Oh, I've missed Bernie. How did I miss Bernie? Sorry, Bernie. That's because you didn't have a name tag. Bernie Doyle, assistant deputy minister of the mental health division, a very important part of our department. I'm also very pleased that the MLA for Calgary-Bow, the hon. Bonnie Laing, is a member of this committee, because she is also the chair of AADAC and will be able to respond to questions that may come up regarding that agency. Len Blumenthal is also here. He is the executive director, and he'll be here to assist Bonnie and myself with the questions on AADAC.

You received information on the budget when it was released, so I'm not going to go through all of the changes that were announced at that time, but I do want to make a few general comments. The overall fiscal plan provided by the Provincial Treasurer has given us all a framework and a discipline to work within. One of the major reasons for restructuring in Health – and you see that evidenced in the 1994 budget – is certainly the fiscal environment we find ourselves in. Even more importantly, even if we had abundant resources, we would still need to restructure the health system. I would just like to outline some of those reasons that are shown in our budget plan.

The changing health goals of the province, the new technologies that are emerging and have emerged, the new way of delivering services, and new knowledge that we have on effectiveness of care: all of these things have presented us with opportunities. It is incumbent upon us to develop a system that is focused on the future so that we can relate to those opportunities that are presented. I believe we have an opportunity in Alberta to create a model for Canada and indeed across the world.

One of the things that we want to talk about is what makes us healthy, and that's evidenced in the budget in the new way of delivering services. It is not the number of hospital beds or the number of services that are delivered. A deficit-free province will certainly allow us to have a healthier economy, and this will have a direct impact on the health of our population. Controlling the growth of health expenditures certainly could be one of the most important health initiatives that I undertake as Health minister. We have to change the way we do things. We've been preparing for change for some time, and I believe that change is upon us. We deliver services in very expensive ways. We also deliver services in inappropriate ways. I think that has robbed us of opportunities and will rob us of opportunities to reallocate resources to areas of greater need. We have to change the systems. We've been on a volume-based incentive system, and we shouldn't be surprised, having been based that way, that inappropriate utilization sometimes occurs.

We have not been as accountable as we might have been in the way that hospital and physician resources are used. We have tended to use hospitals and doctors to provide services that don't necessarily need doctors and hospitals to deliver them. We've built our system on treating illness, and we have not had a system with the primary focus on wellness or on promoting health. We've had a system focused around various provider groups. We need a system organized around the consumer.

We are facing challenges in our province, certainly, that are being faced in provinces across Canada and by countries around the world. We have the challenge of creating a health system that is accessible, that provides appropriate services and is cost-effective. We have an excellent system, unquestionably. We have faced issues such as universal coverage in Canada. We faced them together as provinces and in the federal government and have collectively said that if somebody needs health services, we're going to make sure they get them.

I believe we have the basic structures in place to build a managed system. We have common principles accepted by all Canadians. We've accepted I think across Canada that there are limits on our resources. For example, in Alberta we've been moving to end open-ended payment systems and to start to live within our budgets. I think our challenge now is managing our limited dollars, and that's what we're going to talk about in our budget tonight.

Moving to new government structures and to outcome focuses, I think we've agreed that we can no longer afford to fund services that do not provide demonstrable benefits to improving health.

Another key element in our budget is individual responsibility. We have to have programs based on need, not age or ability to pay. We need to give people the knowledge and the tools to lead healthier lives, and we need to get people involved in priority setting. People not only need to know more about how to be healthier; they need to know more about the cost of the health

system and the impact the decisions they make have on the system. We can create a better system and, I think, a less expensive system.

One of the areas that we're going to talk about is departmental support services. In program 1 you will note a modest drop in expenditures. I would want to point out to members that my department is also undergoing a significant restructuring so that it will improve the way we provide services to Albertans, the way we communicate with the health community, and also the way that they can support the community decision-making that we believe must occur.

Since I assumed the ministerial responsibility for Health in December of 1992, our department has moved away from the stovepipe approach to management. It is now focusing on integrated management, with five divisions providing the support previously supplied by eight divisions. Under the leadership of our deputy I am confident that the men and women that work in Health will continue to meet the demands of their jobs in the coming years.

6:13

I'll just go through these briefly, Mr. Chairman, and then we'll go right back to the first vote. Under program 2, health care insurance, this program area covers physician payments, government-funded Blue Cross payments, and other practitioner expenses. As you can see, we are reducing net expenditures in this area by over $176 million. I think this clearly shows that physicians are fully involved in reducing expenditures in health. Certainly we are working with our physicians in Alberta to look at ways to reduce those expenditures by some 20 percent over the next three years. The AMA has been a full partner in this discussion, and I appreciate their supportive role. We've seen similar support from Alberta's physical therapists, chiropractors, optometrists, podiatrists, dentists, pharmacists, and others. These professional groups have recognized that we must take steps now to use our health dollars as wisely and effectively as we can.

In program 3, institutional and community health services, items in this vote have been reorganized for 1994-95 to reflect our new regional integrated approach to health system reorganization. Rather than identifying expenditures by sectors such as acute care, public health, and so on, our estimates show a total amount for three basic areas: Edmonton, Calgary, and regional and rural. This type of budgeting allows for community input into decision-making on areas we'll be able to put dollars into where they are needed the most. They will be able to build the continuum of care to ensure that health needs are met without the administrative barriers that the stovepipe approach occasionally put up.

As we move to program 4, mental health services, as this program shows, spending on mental health services is remaining fairly constant this year, but our health business plan does outline a community-based approach to mental health care. This approach is supported by the Canadian Mental Health Association and other mental health experts, and it's one I'm very committed to. We are currently reviewing our strategic plan developed for mental health following months of extensive consultation across Alberta. Over the course of the next few years we will see a renewed emphasis on community-based mental health services.

As we move to program 5, the last program, AADAC, I am very pleased with the vision outlined by AADAC. I am also very pleased that AADAC is with the Ministry of Health. I think it seems a natural fit. I would invite my colleague, the chairman for AADAC, to make any comments on that vote as an overview now, Mr. Chairman, if she wishes.

With that, I will close my remarks and look forward to members' questions. I will make the same commitment tonight as I have in the past. If there are questions that require a more full answer that we do not have time to attend to tonight, I will undertake to provide all of the members responses to those in a very timely fashion.

MR. CHAIRMAN: Thank you, hon. minister.

So if the chair of AADAC cares to make a few comments, then we'll get into the discussion.

MRS. LAING: Thank you very much, Mr. Chairman, and thank you, Madam Minister. AADAC is very pleased also to be with your ministry these days. I'm very pleased to introduce the '94-95 estimates for the Alberta Alcohol and Drug Abuse Commission. Although these estimates continue this significant year-to-year reduction, we remain committed to ensuring that AADAC continues to provide quality services at an affordable cost to Albertans. I would like to acknowledge the assistance and direction provided by the AADAC commissioners and the dedication and hard work of the AADAC staff in meeting the challenges placed before them.

A reduction target of 20 percent, or $6.4 million, from its '92-93 base year budget of $32.2 million was established for AADAC; 11.7 percent, or $3.8 million, was achieved in '93-94 with 4.8 percent, or $1.5 million, to be achieved in '94-95; and the remaining 3.5 percent, or $1.1 million, will be achieved by '96-97. The overall reduction target of $6.4 million will be achieved through an expenditure reduction of $5 million and revenue generation of $1.4 million. To maintain a strong community presence AADAC will reduce its own service delivery by 24.1 percent, which is $5.9 million, while reducing its grants to community-funded agencies by 6.7 percent, or $500,000.

Reductions have resulted in major changes in the way that AADAC will provide services. It has eliminated mass communications and reduced its operation to concentrate on four key business areas: community services, detoxification, residential treatment, and information services. To achieve the remainder of the reduction, AADAC will focus on restructuring and integrating service delivery while maintaining service capacities with the '93-94 levels. Problem gambling was recently added to AADAC's mandate; however, the funding of $850,000 is from Alberta Lotteries and is not included in the GRF estimates.

In summary, the changes made necessary by decreasing resources are being managed to minimize the effects to achieve efficiencies in the treatment system and to encourage client contribution to the cost of their recovery while continuing to meet the legitimate needs of Albertans in dealing with addiction problems.

Thank you.

MR. CHAIRMAN: Thank you, Bonnie. Just before we move onto the questions, of course, you can see there are five programs. Program 1 is much more broad ranging, so we will have quite a bit of latitude in that program. However, together we'll keep it much more focused. Certainly the pace at which we move through programs is up to the committee members. As long as members have questions on a program, we will continue on that program. So it's strictly up to the members of the committee.

With that, we're ready to start debate. Grant Mitchell.

MR. MITCHELL: No. Muriel first.

MR. CHAIRMAN: Oh, I'm sorry. If you would please raise your hand. Okay. Muriel Abdurahman.

MRS. ABDURAHMAN: Thank you, Mr. Chairman. I certainly would like to start off with program 1, because it's the key to the basis of planning for health care delivery. The question that I would put at this time is: what studies are being used as the basis for the three-year business plan?

MRS. McCLELLAN: Well, Mr. Chairman, I'll answer that right off because it might be helpful. I think in the House I have tabled a list of the studies that have been used. I think we used as a benchmark study – sorry, you may not have been present the two or three times I alluded to this. In fact, the Speaker I think told me that I couldn't do it anymore. I started with The Rainbow Report, and we went on from there. There were a number of reports. You have, I believe, a list of them. In fact, I believe I tabled that list; did I not?

MR. MITCHELL: You did.

MRS. McCLELLAN: I did. The Watanabe report, the Mirosh report on long-term care. There was a list of – how many? Help, department – 15, 20 studies that have been used over the time frame as to the reorganization of how we deliver health services. That culminated in a decision last spring to have a major roundtable on Health to look at expenditures, reductions that we needed and to set the stage for public consultations to occur across the province.

6:23

The major roundtable was held in Red Deer. There were 10 regional conferences with full public opportunity on an evening and workshop basis on the next day. There were between 5,000 and 6,000 people who attended those regional workshops. We received literally hundreds of letters as well as briefs from people who were unable to be present. Those were documented, and I believe all members received a copy of Dr. Wagner's report, which literally is verbatim excerpts of what people told us, how they saw their health system.

From that we came to the document Starting Points, which the government accepted as a recommendation. I think all members received a copy of that. Subsequent to that, we put together a steering committee called the health planning co-ordination project, which is a committee of 17 people representative of all aspects of health care as well as from municipal representation and public including business leaders to advise us on process for implementation of that. One of the things that we want to ensure is that as we restructure our health system, we do it in a very orderly way so that we cause the least disruption to people as we move towards the new system.

We have had Action Plan, part 1, which was the first recommendations from that committee, and we are daily looking for Action Plan, part 2, which will lead us into the next stage of restructuring. That is our intention, to work with all of that very valuable information that we've received from people. So, in short, up to this past year at least 20 studies and reports plus multi others that come from other areas that you can use for information.

It's interesting for me as a Minister of Health in Canada to go to my first minister's meeting very early in my time and to understand that every minister of health in Canada is undergoing the same thing we are. They are doing it in different ways. Some are doing it very arbitrarily, some are doing it with consultation, and some are at different stages, but every province in Canada is undergoing a similar exercise, including the federal government working with us.

MR. CHAIRMAN: Do you have a supplementary?

MRS. ABDURAHMAN: Yes.

MRS. McCLELLAN: That's probably more than you ever wanted to know.

MRS. ABDURAHMAN: Well, I certainly am aware of all the studies. I'm not going to say that I've read them all in depth, but I've certainly had a cursory look at every one of them.

The question that comes to my mind is: has there been any utilization of mortality and morbidity studies done in relationship to planning how we indeed expend our moneys through the business plan in health care? It was interesting, when I started to look at the annual report just this afternoon – and I hate to do this when Lyle is sitting at the table; I'm certainly no physician – on page 15 one of the things that jumped out at me was campylobacter infection. I'm thinking from a public health perspective the cost that is to our system, and then you look down at tuberculosis, and then you go to cardiac and cancer. What I'm trying to get at, Madam Minister, is: is this information done in a way that you can use mortality and morbidity so that we actually expend our moneys to ensure that we have a wellness system?

MRS. McCLELLAN: Well, certainly, I'm going to get Don to comment a little bit more on the initiatives in the department. Obviously, that is how we do a great deal of our planning, and I think that's emphasized in looking at areas of concern to us such as cancer. You raised tuberculosis, of which we're concerned. Today is World Tuberculosis Day, and we've raised a concern in the increase in tuberculosis, something that was almost eradicated or eliminated at one time. So we put particular emphasis in those areas. That's shown in Alberta certainly in cancer through the dollars that we allocate directly to cancer research. It's one of the only areas that we have a direct area. Don, you may want to talk a little more or cease, if you wish.

MR. PHILIPPON: Well, I think one that we can point to is the major health goals initiative in the province, which focuses on particular areas where we want to improve the health status of the population, and the minister has circulated that document widely. As well, as part of our three-year business plan you'll see a major shift towards more community kinds of services, because we believe that's how you get at some of these illnesses you're referring to, by developing much more of a prevention and health promotion approach in the health care system. If you look at the health goals document, we do set some targets for the province, and that's what's sort of guiding our three-year business plan in terms of: are we making any progress or not.

MRS. ABDURAHMAN: I'm still suggesting mortality and morbidity studies should be the basis for that.

MRS. McCLELLAN: Well, I think what we're trying to tell you is that we do have that information, and it is used, and we have a fairly extensive group. I'm sorry that I did not bring with me all of the advisory committees that we have in those number of areas. Of course, we have Dr. Platt, who is our medical consultant, who as well now works within Dave's area, one of our changes in the department. All of that is taken into account. It's hard to give you one document that shows all of these, but if you

would like to have more information on that, certainly we can give you some further written comments. I think you've raised it once before, and I'm sorry I haven't answered.

MRS. ABDURAHMAN: Yes, I have.

MR. CHAIRMAN: Well, I think you really have had three. So if you want to come back to it in the next round, fine.

Ed Stelmach.

MR. STELMACH: Madam Minister, the information technology branch budgeted here to spend $7,320,000: what are we buying in terms of health services for that or for the health system?

MRS. McCLELLAN: This is one of the major projects that we're undertaking. This will give us a regional client information system. It's based on work that's already been completed for the health unit information technology strategic plan, the long-term care client information system, and the claims redevelopment project. It is being sponsored by the northwestern health region, where it will be implemented on a pilot basis this year. It's a very, very important project for us. Do you want me to go through the list of the others that are in there?

MR. STELMACH: Sure.

MRS. McCLELLAN: The pharmacy network is another one that is a joint project. It's between Alberta Health, Alberta Blue Cross, and the Alberta Pharmaceutical Association, and that will see the development of a pharmaceutical network as a first step to a comprehensive health network for Alberta. We're looking at advanced card technology options. That is in that area. We've spoken about that, I think, before. We're also looking for providing some support for area planning information support. As we have our regional areas, they will need support for information such as environment and infrastructure.

Standards Development. We're continuing to develop data standards to facilitate electronic data interchange and comparability across organizations. The electronic claim submission is another very important area. That is to try to lower the minimum weekly claim volume requirement so that individual practitioners can submit claims directly to Alberta Health. It's an area that's been identified to us as very important.

6:33

MR. CHAIRMAN: Grant Mitchell.

MR. MITCHELL: Thank you. Shirley, I'm interested in the process of regionalization, how you're going to structure that. I have a number of questions. Have you decided whether acute care hospital boards will be disbanded under the new regional boards?

MRS. McCLELLAN: Well, we look at the regional authority. I'm waiting, as I said, daily for the recommendations from the steering committee, for the recommendation on boundaries. As you know, they have been discussing with communities and putting together what would be the proposed boundaries. I have also asked them to recommend a process for the appointment of the first regional boards and a recommendation on the ultimate: whether they should be all elected, part elected, part appointed, all appointed, whatever. I'm also looking for a recommendation from them to further give us advice as to the mandate: what should the function of that mandate of that regional authority be?

You would have noticed that in Action Plan, part 1, there was a strong recommendation from the steering committee about community health councils. In the discussion, as I understand it, with the communities and certainly in the discussion that I've had across the province, there is a real desire for a community health council or something like that to provide input into the regional authority. We would see the regional authority having the major responsibility for planning and budgeting. So it would be expected that at an appropriate period of time the boards as they stand would be phased out.

MR. CHAIRMAN: A supplementary?

MR. MITCHELL: Yes. Do you anticipate that the regional boards will negotiate with the unions, that it will be the boards themselves that do that? Will they do that as individual boards within their jurisdiction, or will this be provincewide?

MRS. McCLELLAN: These are areas of discussion that the tripartite committee is dealing with right now.

MR. MITCHELL: One of the most obvious . . .

MRS. FRITZ: Mr. Chairman?

MR. CHAIRMAN: Final supplementary.

MRS. FRITZ: Can we ask these types of questions? Are these budget related?

MR. CHAIRMAN: It's bordering, but we will allow this series.

Go ahead. Final supplementary, Grant.

MR. MITCHELL: One of the most obvious funding – I won't say "complications" – issues will be taking a program like the renal dialysis program at the University of Alberta hospital, for example, which actually has a unit in Red Deer which they fund. How do you anticipate that kind of relationship being funded? Will it be costed or billed from one region to another region? Will there be some kind of continued provincially directed funding?

MRS. McCLELLAN: Well, for this year and this year's budget the funding is applied on a historic basis. So we could get into the discussion of how future years' fundings go, but I can assure you that it's clearly particularly the urban, high tertiary care institutions we have that either deliver the services such as that and others to the communities or the communities come in to access those services. We have very good information on referral patterns. We understand quite well how that funding has to occur. I don't see that being a problem. I don't have the boundaries, so I'm in a bit of a difficulty answering this, but there was a request when the boundaries were being looked at that they respected trading patterns, they provided as wide a range of services as possible, that wherever possible they included a regional hospital, and where they didn't, they identified the hospitals that they would access.

Now, as I say, I have not seen the boundaries, so I cannot comment on how well that was achieved, but that was laid out in the identifications. So I don't see that being a problem, those programs. The communities will be identifying the health needs of their area and, I believe, also identifying the best way to deliver those.

MR. CHAIRMAN: Bonnie Laing.

MRS. LAING: Thank you. On page 187, 1.1.3, health strategies and evaluation, my question is: why is health strategies and evaluation's budget increasing by $921,000?

MRS. McCLELLAN: Okay. It's a good question. The major portion of this increase of $806,000 is from reallocations within the department, so that's part of the reorganization. There are new funds: $50,000 for the ethics network and $250,000 that we committed to the Krever inquiry as Alberta's share of the costs. There was also, I should note, a net manpower decrease of $185,000. So that is why the change in that.

MR. CHAIRMAN: Supplementary.

MRS. LAING: Thank you. Could you explain a little bit about the ethics network, what's entailed there?

MRS. McCLELLAN: This is a new initiative. It's a co-operative initiative. The University of Alberta – I guess if you backed up, as Aslam's just reminding me here, the discussion really started in 1991, and 1992 was when the planning began. It was decided that an ethics network would be preferred to an ethics centre, that it would be more appropriate. That suggestion came from stakeholder comments saying that we should build on existing expertise. So there was a planning committee struck and some dollars that were provided in 1993-1994. We are providing $50,000 this year for the external interim steering committee to use in initially establishing that. They will primarily use that by developing an inventory of health care ethics, resources, expertise, and needs assessment activities in this year. So it's really furthering that project on another stage, a very important part of our restructuring.

MR. CHAIRMAN: Final supplementary.

MRS. LAING: Thank you. With the Krever inquiry, does this include the compensation package, or is it just the actual process of the trial and . . .

MRS. McCLELLAN: Alberta committed to an assistance package, and these dollars are not part of that. Those are separate.

MRS. LAING: Okay. Thank you.

MR. CHAIRMAN: Julius Yankowsky.

MR. YANKOWSKY: Thank you, Mr. Chairman. I have some questions here regarding beds per population benchmarks, Madam Minister. The first one is: will the benchmark of 2.45 acute care beds per thousand be equally applied in every region?

MRS. McCLELLAN: I think you would term that as an average. That is what we look at when we've had our discussions nationally with other ministers, that we establish a benchmark. I think that has to be because of the different types of care that we offer in the different facilities. Not all acute care facilities offer the same type of care, as you know. Some of our facilities certainly do a lot of ambulatory day surgeries and really will have very few inpatient beds, where another facility may do other types of care that do require more. So I don't think you could say that that is an average per facility in the new way of delivering health services. Also, there are distance factors that affect many places where they have to travel long distance to an institution. They may have to keep a person for observation because they cannot send them home. So I think we consider that an average, a benchmark.

6:43

MR. CHAIRMAN: Supplementary.

MR. YANKOWSKY: Yes. Thank you. My supplementary is: will the benchmark number of beds for long-term care be equally applied in every region?

MRS. McCLELLAN: Well, again no, because we have some regions of this province where we have a very young population and virtually have no senior population or very small. So you would not consider that they would want to have or need to have a similar number. This is an average. The reason we see some reduction coming in that is because we are seeing that people are staying in their homes longer. As we continue to provide more support – and you would note in this year's budget some $30 million that is being moved from the acute care side to the community, which will support people staying in their homes longer. A number of day programs that are being offered either by our long-term care centres in some cases or through private groups are also enabling people to stay independently in their homes or with their families longer. We see that increasing, so we see that the needs for the beds can go down. But again, I think you have to consider it an average, because we know the per capita seniors population is not evenly distributed across the province.

MR. CHAIRMAN: Final supplementary, Julius.

MR. YANKOWSKY: Yes. Will funding for health professional services be included in regional funding amounts?

MRS. McCLELLAN: Well, I think it will depend on the services. Certainly I would see that there would be an opportunity for regional authorities to contract services, if they wish, in certain areas. We do have fee-for-service areas, and they will, I would expect, at least in the short term continue as they are. The regional authorities will have opportunities to contract services, I'm sure, if that's the best way.

The important thing to remember is that this year the regional authorities will come into place June 1. We have asked them to develop a three-year business plan for their region, anticipating that they might have that ready for us by the middle of September. That will be an opportunity for them to review the health needs of the communities they serve, to look at the resources that they have available and the infrastructure and expertise, and to do some long-range planning for those areas to ensure that we do have that continuum of care and that we are providing appropriate care to the people, or health services. We have to quit thinking of health as just health care. Even the minister has to correct herself once in a while. The most important things to some communities may be on preventative and educational opportunities. Again, because of the differences in the demographics, the geographics, and the cultures of our province we will see those needs vary quite considerably across the province.

MR. CHAIRMAN: Yvonne Fritz.

MRS. FRITZ: Thank you, Mr. Chairman. Madam Minister, I'm interested in 1.1.6, the finance and admin.

MRS. McCLELLAN: Whoa; just a minute. Program 1.1.6, finance and admin. Okay.

MRS. FRITZ: It's on page 45. I'm in the smaller book. What I'm interested in is what the major components are of those expenditures; not all of them, just the major ones.

MRS. McCLELLAN: Well, probably the major, major one is administrative services. That's purchasing, maintenance of equipment, mailing, records management functions of the department. Probably one of the biggest expenditures in that whole area is postage. You know that song, I Get Letters? Well . . .

Another part of the high expenditure in that area is third-party liability. We do collect it, but it doesn't come into our budget; it goes into general revenue. I should explain third-party liability. This is the program that recovers hospital costs when an Albertan suffers personal injury and receives services as a result of a wrongful act of another. That's really what that one is. So there is a cost in recovery, and of course there is an amount that comes in, but that amount goes directly to general revenue. Financial operations is another large part of that, and that's primarily responsible for processing all of the payments in that area.

MR. CHAIRMAN: Supplementary?

MRS. FRITZ: Thank you. Out of those three areas that you named, which would have had the biggest increase? Was it where you mentioned about postage or under administrative services?

MRS. McCLELLAN: Well, there isn't an increase in . . .

MRS. FRITZ: I'm just looking at the overall increase and wondering where in that area it is.

MRS. McCLELLAN: The whole area had a decrease, but some areas increased. Your question is: which areas had the increases? That's what I'm just looking for.

MR. BHATTI: It would be the postage area.

MRS. FRITZ: So it would be under administrative services?

MR. BHATTI: That's the postage for the whole department.

MRS. FRITZ: What I'm leading to is just what we heard earlier about regionalization. My final supplemental then is: in the area of administrative services, do you see any of those costs decreasing with regionalization in any way? Would it affect your overall finance and admin?

MRS. McCLELLAN: I would think that it would, yes, as regions manage more of their own payments and so on.

MRS. FRITZ: Thank you.

MRS. McCLELLAN: It's been hard to estimate how much that decrease will be, because of course they will need to have some assistance or some dollars for that function as well. But we would expect it would be less than it is today.

MR. CHAIRMAN: Howard Sapers.

MR. SAPERS: Thank you, Mr. Chairman. Madam Minister, thanks for your complete answers so far. You anticipated a couple of my questions, but I have a couple left. [interjection] You were surprised, were you, Don?

MR. PHILIPPON: Not with you.

MR. SAPERS: I want to start with the business plan. You started mentioning the business plan in your opening remarks. There's a couple of the principles in the business plan that I'd like some more details on, particularly how they relate to the Canada Health Act and some of the commercialization of medicine that is being talked about in this province. In particular, I'm looking at number 5, which reads:

> Only health services having demonstrable benefit or a reasonable potential for benefit to the recipient will be publicly funded.

Then number 9:

> It is reasonable to place some limits on choice in order to achieve optimal health outcomes at lowest costs.

Keeping those two in mind, I'm wondering if you could just let me know how the private MRI clinics, the private eye care facilities, and the private abortion clinics in the province fit with those principles and, also, how they relate to the defence of the Canada Health Act. It's also in your business plan.

6:53

MRS. McCLELLAN: Well, let me make one thing very clear. Alberta has no intention of contravening the Canada Health Act. I can tell you that Mrs. Marleau has never contacted me regarding any concern, and I believe that she publicly stated on an Edmonton radio station yesterday morning that she does not have concerns with Alberta on their operations within the Canada Health Act. The Canada Health Act requires that a province provide, or that we provide, reasonable access to publicly insured, medically required services. We do that. We comply with the Act.

The private MRI clinics that operate in this province operate, as I understand, mainly for third-party insurance: WCB and others. There are no public funds in those clinics. In the other clinics which are available we do pay the professional fee, the physician's fee. I think that has nothing really to do with number 5 or number 9. You might disagree.

One of the things that the Auditor General has said is that we should have outcome measurements to ensure that the dollars we are expending on health are being expended in a way that is, I think he's saying, helpful. That's what we're saying: we should ensure that the health services we provide do have a demonstrable benefit and a reasonable potential for benefit to the recipient and that those services are the ones that should be publicly funded.

It is interesting that whenever we talk about this whole issue, one forgets that one might be considering different things to be insured in Alberta than are today, as we do. We insure or partially insure things that are not considered medically required. I would suggest to you that some preventative health measures may not be considered medically required, but they may well be worth insuring in Alberta. We do that with physical therapists. We do it with optometrists. We do it with chiropractors, and we do it with podiatrists. I would point out to you that only four provinces in Canada offer those services in a way anywhere similar to what we do, and those are British Columbia, Ontario, Saskatchewan, and Alberta. Some of the other provinces offer some in some of those areas, but many do not.

I think what we're really talking about when we talk about the principles is that we should be looking at services that do have a benefit to the citizens of our province, not just those that may be deemed medically required.

MR. CHAIRMAN: Supplementary.

MR. SAPERS: Thank you. Yes. Dr. Michael Rachlis, who's an academic physician with whom I believe you're familiar . . .

MRS. McCLELLAN: I know him.

MR. SAPERS: . . . claims that a publicly funded health care delivery system that has a single payer with a central administration is the most efficient and economically feasible health care system. I'm wondering whether or not you agree.

MRS. McCLELLAN: I think that's asking for an opinion.

MR. CHAIRMAN: Well, I'll have to rule that question out of order because we're now running into asking for opinions and into a debate between the minister and . . . [interjections]

MRS. McCLELLAN: Sorry, Mr. Chairman; we have strayed a bit.

MR. CHAIRMAN: Yes.

MR. SAPERS: Well, okay.

MR. MITCHELL: Well, we're paying the minister to think about these things. This is in her budget.

MR. SAPERS: No. I'll rephrase the question in a way that will be acceptable to the committee.

MR. MITCHELL: Maybe we're paying her too much.

MRS. McCLELLAN: Thank you. No, I don't think so, Grant.

MR. CHAIRMAN: Could we have the supplementary, please?

MR. SAPERS: In your program planning, then, Madam Minister, to what extent are you going to allow for duplication in administrative costs if there is entry into the health care market in this province of more payers in a multiple of schemes under which people can access health services?

MRS. McCLELLAN: Well, we would not pay anything in administrative costs. We do not today.

MR. SAPERS: Thank you. My final question. The federal minister also said yesterday on that radio show you were talking about that the federal government is watching Alberta and waiting for a report that will be forthcoming. I'm wondering, Madam Minister, if you will table that report in the Legislature.

MRS. McCLELLAN: I did not hear the minister say that she was watching Alberta.

MR. CHAIRMAN: I think we're going to have to stick a little bit closer to the budget.

MRS. McCLELLAN: In fact, that's quite opposite to what she told me.

MR. SAPERS: How about the report?

MR. CHAIRMAN: Order please. We're going to have to stick a little closer to the budget. I don't know how that report you're referring to relates; it's something that you heard on the radio. I think we'd better get back a little closer . . .

MR. SAPERS: Mr. Chairman, I thought you said that program 1 was rather wide-ranging and you would allow some latitude. It's a central issue in the planning and allocation of health care resources in the province. So I'd like to know . . .

MR. STELMACH: Listening to radio reports.

MR. SAPERS: Well, I didn't mention it first, Ed; the minister did. So I'd like to know on what basis you'd rule that out of order.

MRS. McCLELLAN: No, I did not mention it.

MR. CHAIRMAN: The difference between this and what happens in the House . . .

MR. MITCHELL: Mr. Chairman, the whole thing is theoretical. You haven't even defined the boundaries yet.

MR. CHAIRMAN: Order. [interjections] Order please. [interjections] Order.

MR. STELMACH: The budget estimates are for '94-95.

MR. CHAIRMAN: We have with us staff. That's something you don't have in the House. One of the main ideas of this is to look at how the dollars are spent, how they're administered. We're wandering very close to policy. We're wandering very close to asking opinions, and I think we can better use our time in this committee by sticking closer to the expenditures.

MRS. McCLELLAN: Maybe that's a motion for a return, Howard.

MR. SAPERS: Well, how about: under which line in program 1 will you be printing and distributing that report? How's that?

MR. CHAIRMAN: Grant Mitchell, you had your hand up.

MR. MITCHELL: Well, I was just going to say: point of order. Where is this rule that we can't discuss policy? Are you saying that the expenditure of this money is not based upon policy? I mean, we have doubts that it is, but if you want to confirm that now and say that we can't discuss policy – I can't believe that in fact you'd be saying that.

MR. CHAIRMAN: Well, the standing order says: "Debate must be strictly relevant to the proposed grant under consideration."

MR. MITCHELL: Yeah, which is based on policy.

MR. CHAIRMAN: I have allowed you to move into some policy that is happening this year, but when we start wandering into some report and questioning the minister about a report that someone heard about somebody else's comment on, I'm having trouble with that. If you want to do that in the House, that might be acceptable. Here the idea of having the subcommittee is so that we can have the staff in, so that you can ask direct questions of them as to how the programs work, how they're administered, and how the dollars are spent. So I just hope that we can find a way to get back a little closer to this. It's not my intent to try to rule difficultly here tonight or to be very structured. I want to keep it fairly open, but we are having some difficulty with some of the more recent questions.

So with that, Murray Smith.

MR. SMITH: Madam Minister, program 1.1.5, information technology.

MRS. McCLELLAN: Yes.

MR. SMITH: Given the fact that the large neighbour to the north is about ready to embark on a different health program . . .

MRS. McCLELLAN: To the south.

MR. SMITH: South, yeah. I've been up here too long again this week. I knew it. I get to Edmonton and I get turned around.

MRS. McCLELLAN: I can relate to that.

MR. SMITH: Wherever they are, they do share a common, unguarded border with us. I guess the question I want to key on is: in the expense for information technology of $7.3 million, which I think may tie in with the research and innovation fund as well as the finance and administration fund, have you made a make or buy decision with respect to technology at this point? How do you see those funds being spent in the next 12 months?

MRS. McCLELLAN: That's a good question. I'll make a brief comment, and then I'll ask Dick Alvarez to comment a little bit further. I think you're referring primarily to the advanced card technology that we have discussed, and certainly the U.S. are looking at moving into an advanced card technology. We are very fortunate to have Dick Alvarez in our department. Dick is well known actually internationally and has been asked to speak at an international symposium because of his knowledge in this area. Certainly I think it's good for us that other areas are looking at this, because as the volume could increase in advanced card technology, the cost could come down. That was one of the concerns we had.

7:03

Quebec has a pilot; it's 18 months since they began that pilot. I had an opportunity to speak with the Quebec minister in September, and they've just started to do an initial evaluation of that pilot. We would hope that in a few months, maybe by the end of June, they would have more information. Certainly by fall they expect to have a fuller evaluation of how their advanced card works. We felt it was reasonable to review their work rather than embarking on one ourselves until we saw some of the outcomes. Ontario did a pilot in this area, and we're not pleased with the attempt they made.

Dick, you might want to just comment a little bit more on that, if you've had an opportunity to talk to Quebec officials. I'm not sure.

MR. ALVAREZ: We will be going to see the minister in terms of their undertaking where in fact they're trying to create a record around the client as opposed to a lot of the other systems that are available, even systems in the U.S., which are created around a facility, either an acute care facility, a public health facility, et cetera. We're moving away from that in a way, and certainly here in Alberta we've created integrated health information models which have not been created, quite frankly, anywhere else in the world in terms of the blueprints that start with the data around the individual.

Now, every time we come to a decision on software, our policy typically is to buy, if possible, rather than making it from scratch. In terms of buying, a lot of the products in our hospitals, health units, et cetera, are U.S. based products because of the particular market share that they have. But what we've been able to do over the last couple of years in Alberta basically is that in developing these integrated models we have also developed some standards, and it's very critical that we have data standards that are able to apply data consistently across the various stovepipes at the individual. That hasn't been basically done before as we've seen Albertans flip in and out of a health care system, whether they go to a doctor, whether they go to a hospital, whether they go to a health unit. You don't have that continuum of care. You don't have that continuum of rapport that is brought together, and that is such that it could happen. We see certainly the health costs as one opportunity to allow that to happen, where you start to capture that type of data which is made available at the point of service. Together with that we're clearly building the telecommunication networks which will help to implement the cards and make data available to the provider of the service to provide that quality of care.

Again, as we look at putting the pieces in place, we look to see whether we can buy before we make them. If there's no opportunity to buy, then we're going to make them. We've certainly been approached by private-sector companies who want to take out blueprints and, together with government, build some of these systems to export and market in other jurisdictions.

MR. SMITH: In this year's budget, how much of program 1.1.5 will be in research and development and how much of it is basically hardline, either software or computer applications?

MRS. McCLELLAN: I'll have to find the breakdown in the elements.

MR. ALVAREZ: It's about a million dollars that will be for the former. We do in the department run over a hundred systems. Whether they've been developed as a claims system, registration system, the Aids to Daily Living system, the home care system, the food system, all of those are processed either on mainframes or microcomputers, and all of those dollars are budgeted in the seven point something million that you're seeing. So in terms of a lot of the innovative major projects the minister talked about, the split is about $1 million to $1.5 million.

MR. SMITH: Do you see this budget line staying consistent throughout the term of the business plan?

MRS. McCLELLAN: I think we could see some shifting in it.

MR. ALVAREZ: We're seeing it going up in fact, Madam Minister, as we're looking at goal 4, which is basically making more and better data available at the point of service. We are seeing a bigger investment into the whole area of information.

MR. CHAIRMAN: Okay. Muriel Abdurahman.

MRS. ABDURAHMAN: Just call me Muriel, Ty.

MR. CHAIRMAN: Well, I'm only doing that for *Hansard*. So if you don't mind, I'll use first names.

MRS. ABDURAHMAN: No. Just call me Muriel.

I'd like to just address capital investments but in a broader perspective, Madam Minister, than in this . . .

MRS. McCLELLAN: Do you have a line in the budget for that, Muriel?

MRS. ABDURAHMAN: Well, I was going to use – it says purchase of capital assets, but it doesn't quite fit in there. Then I was looking at . . .

MRS. McCLELLAN: I don't know what area you're – I don't have a capital budget except for equipment.

MRS. ABDURAHMAN: Basically what I was wanting to ask you was in strategies and evaluation. I could tie it into there, 1.1.3. The question is: how do Alberta Health and public works relate to each other when it comes to making major project decisions specifically for Health?

MRS. McCLELLAN: The recommendations for projects come to Alberta Health, and Alberta Health work with the project proponent. Once a project has been decided to proceed with, it moves to public works for the actual building.

MRS. ABDURAHMAN: Who makes the actual decision? Is it Health or public works?

MRS. McCLELLAN: Health does. There is a set of guidelines and criteria and so on for projects, and there's of course a difference, depending on what the project is.

MRS. ABDURAHMAN: For example, we see in public works this $47 million that's identified for Health. How, through Health, would we be able to tell what those projects are? Also, how are maintenance dollars identified to expend in the health care system?

MRS. McCLELLAN: Well, the maintenance dollars in the system are built into the existing budgets. It's in their operating budget, whether it's a long-term care or a hospital or a health unit. This year, as you know, we've had a freeze on capital projects, and the freeze is continuing as we move into the regional planning areas. So the opportunity is there for assessment of the infrastructure to ensure that it is suitable for how the services are going to be delivered. There are no specified projects in Health other than the ones that are in progress now. Those are in public works' budget. [interjection] Well, as Aslam just pointed out, if the roof falls off or you have a severe problem, we do have a budget to look after those types of repairs.

MRS. ABDURAHMAN: Well, that leads nicely into my final supplementary.

MRS. ABDURAHMAN: How do we, through the business plan or through Health budgeting, prevent facilities from getting to the condition we see, for example, at Westlock hospital or Alberta Hospital Edmonton? How are you going to prevent that happening in the future?

MRS. McCLELLAN: Well, certainly, I think, through the regional planning process, through ensuring that regions are looking at their needs and shifting needs. I think that by asking areas to have three-year plans for how they deliver services, that will be of benefit too.

Don also points out that if we were in the right vote, which I don't think we are . . .

MR. PHILIPPON: That's public works.

MRS. McCLELLAN: Oh, that's public works. There is an upgrading vote in there as well, and that is for repairs or changes.

MR. PHILIPPON: And that's been increased quite substantially this year over last year, from $20 million to $30 million.

7:13

MR. BHATTI: The public works department itself has a branch called the maintenance branch. The sole function of that branch is to go and visit the facilities and look at the electrical, the plumbing, and so forth, to keep it up to standard and replace it as they go along, not just for hospitals but all provincial buildings as well. So in terms of the regular maintenance or upgrading, these types of things, the Department of Health doesn't get involved at all; it's the function of public works. But when a facility is to be upgraded to a substantial extent in terms of an addition or new beds and so forth, the policy decision is made within the Department of Health. The actual construction is done by public works.

MRS. ABDURAHMAN: Thank you, Mr. Chairman.

MR. CHAIRMAN: Lyle.

DR. OBERG: Thank you, Mr. Chairman. My question is on 1.2.1, the health services research and innovation fund. I was just wondering if you could give me a quick overview of what some of the projects were that were funded by that fund.

MRS. McCLELLAN: We have not funded any projects yet in 1994-95. We have a competition annually for these dollars, and the grants are awarded, I would expect, sometime in the next – I'm trying to deal with last year and then this year to explain how we do it. I should get Cec to do this. The 1994-95 competition comes with a call for proposals in about June.

Is that not correct, Cec? June of this year?

MRS. LORD: The recommendations go to the end of February, and the decisions are made before the end of the year. The program has been in place for about two years, so we have funded two sets of proposals, approximately 13 this year and about eight or nine last year. These grants are for two to three years, so it will take two to three years before we see the first results. To date most of the projects have been in the area of – for example, we have a project that was approved for the brain injured: how to improve community support programs for brain-injured people who live in rural Alberta. That's just one example. Other studies are much more technical and have to do with cost-effectiveness of measures in hospitals. So there's a wide range of proposals that have been funded. We do have a list of all the projects that have been funded, and we can easily supply that to you.

DR. OBERG: No. That's fine.

MR. MITCHELL: We'd like that. We'd like that for sure.

MRS. McCLELLAN: Yeah. Anything we pick up from *Hansard* we'll give to you.

MR. CHAIRMAN: Supplementary.

DR. OBERG: Thank you, Mr. Chairman. I see that there's an increase of close to $200,000 between '93-94 and '94-95. Could you perhaps give me the reason why that is, when we're cutting back on everything else?

MRS. McCLELLAN: Yeah. Those dollars have been included to allow for some projects in outcomes research. As I indicated

earlier, it's certainly been recommended to us that we pay much more attention in that area. Certainly as one of the persons who attended each, I think, of the roundtables that we held across this province and read the copious number of submissions we've had, there was a strong, strong recommendation from all of those areas that we dedicate more resources to outcomes research. That's what we're looking at in that area.

MR. CHAIRMAN: Final supplementary.

DR. OBERG: Thank you, Mr. Chairman. I was just curious – I think this might be an obvious question – is there a crossover between the health services research and the heritage fund money?

MRS. McCLELLAN: No, they work very closely, actually, to ensure that there is not duplication. There is a committee that reviews all of the projects, and they ensure that there is no duplication in what a medical foundation might provide research for. I think this is much more specific to really what the title says, health services, for the medical foundation really does more on the medical side.

MR. CHAIRMAN: Grant.

MR. MITCHELL: Thanks, Ty. Shirley, the issue of direct access to physiotherapists. The other evening you mentioned that you're working out money issues. I wonder whether you could be more specific about what those money issues might be.

MRS. McCLELLAN: No, not really. What I said the other evening, I should explain. When I met with the three associations to discuss the interests of direct access, there were a number of areas that we wanted to discuss. One of them was funding, because today the physical therapists are on partial insurance, and there is a cap, which we just implemented this year. When we put the cap in, we said that we would see how it would work. So we met, and we talked about those issues. The associations are meeting this weekend, I believe, and will be meeting with me within about two weeks of that meeting to discuss those areas. So I really would prefer that we continue that discussion.

It really is nothing onerous; it's just how they would be funded. When we had to cap those dollars to stay within our budget, we asked the physical therapists for their advice as to how to manage that cap. They gave it to us. We implemented it. It's been in place for a period of time. It's appropriate that we review it and see if that was indeed the right way. So when they have the opportunity to review it with their membership and bring it back, we'll have a better idea if that's the best way. So it's not that it's anything that – it's just that I do not have the information or the advice from them.

MR. CHAIRMAN: Supplementary.

MR. MITCHELL: Yeah. Thanks, Ty. Some of them are operating under the impression, some being in executive capacities, that you had specified a July deadline by which direct access would be implemented. Can you confirm that?

MRS. McCLELLAN: I didn't give a time. I said that as soon as we possibly could deal with the issue, we would. If it could be before then, I would be happy. But we simply agreed between the minister and the physical therapists that we would look at all of the areas that needed to be looked at and we would come to a decision as quickly as we could.

MR. CHAIRMAN: Final supplementary.

MR. MITCHELL: Yup. They're operating under the assumption that it requires only a regulation change, which can be done by order in council. Is that your impression? So this could be done the day after the Legislature stops sitting. That is to say, we wouldn't have to wait until the fall, until next year for legislation.

MRS. McCLELLAN: I'm sure that it's just a regulatory change.

MR. CHAIRMAN: Bonnie Laing.

MRS. LAING: Thank you. I'd like to ask about vote 1.2.3, the health facilities review committee.

MRS. McCLELLAN: Just a minute; I have to find it. Okay.

MRS. LAING: I would like to know what the average number of investigations are that they do, say, last year and this year.

MRS. McCLELLAN: That may be one number that we'll have to bring you. I'm sorry; I don't have it. We should have asked the chairman of that committee, Mr. Herard, to be present to assist us. But I will give you that information.

MRS. LAING: All right. Thank you.

MRS. McCLELLAN: I would only say that the number has increased somewhat.

7:23

MRS. LAING: Supplementary. Do the inspections occur on a regular rotation, or is it complaint driven?

MRS. McCLELLAN: There are both. There is a regular inspection done, and if there is a complaint raised legitimately, then that is investigated.

MRS. LAING: I notice that there is a reduction. Is that through fewer inspections or cost containment measures?

MRS. McCLELLAN: Actually, I think there's a slight increase of $2,000.

MRS. LAING: I was looking at this one where it says comparable $408,000 to $364,000.

MRS. McCLELLAN: Yes, but that's from 1992-93. There was a decrease in the '93-94 estimates, and there is a slight increase in '94-95.

MRS. LAING: Good. Thank you.

MR. CHAIRMAN: Howard.

MR. SAPERS: Thank you, Mr. Chairman. I want to go back to the business plans again, Madam Minister. Under principle 5, when the business plan speaks of a demonstrable benefit, it leads me to think about the new rules around physiotherapy. As I understand it, once an individual Albertan has reached their cap on insured services, there is an appeal process that they can go through. One of the points of the appeal is whether or not their increased utilization of physiotherapist services will lead to a demonstrated improvement in their health. I would like to know

whether or not you will be examining that appeal process, because of course for some people requiring physiotherapy what physiotherapy allows them to do is maintain their health and avoid hospitalization or acute illness?

MRS. McCLELLAN: Well, the appeal committee, the people who deal with the appeals are very knowledgeable people. Indeed, it is the physical therapists themselves. There are three members, Don, on the appeal committee?

MR. KELLY: That's right.

MRS. McCLELLAN: It is the physical therapist, the actual person who is dealing with the patient, and a doctor.

MR. SAPERS: But are their hands not tied by that policy that it has only to lead to a demonstrable improvement?

MRS. McCLELLAN: I don't think so. What I think is really being identified is that there is maintenance that a person can do themselves. Actually, the appeal is for seniors primarily, who have for the first time had a cap. In this I would say that 75 to 80 percent of the appeals have been dealt with with no problem. We will be reviewing how that operates. However, I again would remind you that Alberta is one of four provinces in Canada that does offer this as an insured service, and once a person has reached their cap, private insurance can take over to pay that benefit. Again British Columbia, Saskatchewan, Ontario, and Alberta do offer partial insurance for physical therapists. So I guess we believe it's important.

MR. SAPERS: Before I move on to my supplemental, Mr. Chairman, I just want to make sure I am clear in the answer that the appeal is not limited simply to improvement but that maintenance would be allowed.

MRS. McCLELLAN: Well, no, I don't think that's what I said. I said that one of the concerns is that it does lead to improvement. I think the way the appeal is handled is the correct way. It is the physical therapists themselves with a physician that look at the individual's program and states whether they should continue. I am quite sure they look at it that if a person did not receive the service and deteriorated, they would consider that continuing the service would lead to improvement. There is an amount of maintenance that a person can manage either themselves or with family members. That is not what it was intended for. I think the key is – you have to come back to the key – that the appeal process is handled by the physical therapist and the physician. It isn't the minister or somebody else that's making that decision.

MR. SAPERS: That's not the point that I'm trying to clarify.

MRS. McCLELLAN: Well, it's the point I'm trying to make: the decision-making is in the appropriate place today.

MR. SAPERS: But perhaps on the wrong issue.

MRS. LAING: Could we ask what line you're on? I'm sorry.

MR. SAPERS: No, because it wasn't to do with a line, Bonnie. I said that it had to do with principle 5 in the business plan.

Also in the business plan on principles 7 and 8 – I won't bother reading them into the record; people can find them – I would just like to know, Madam Minister: on what basis will you be making the determination of who is the lowest cost provider and in what circumstances and how will that vary by region?

MRS. McCLELLAN: Well, it's a principle that we're encouraging the use of appropriate services at the least cost by a range of qualified providers. I think the key word is qualified. I believe that the regions will make a number of decisions as to how they provide services. We'll certainly encourage them to use a range of qualified – I think that's the key word – providers to provide that service. We did receive a great deal of input on the use of alternate providers. That was important to Albertans. What we've agreed to in our business plan is that we will look at that and explore it.

MR. CHAIRMAN: Final supplementary.

MR. SAPERS: Well, I wasn't sure the answer was complete. Yes? No?

MRS. McCLELLAN: It wasn't a yes or no question, so it didn't get a yes or no answer.

MR. SAPERS: No. I know it wasn't a yes or no question. I wanted to know how you were going to do it. I didn't want you to restate the principle.

My final supplemental. The business plan, page 7, goal 1, strategy 5 says that you're going to realize a $100 million savings basically through dealing with physicians' fees. However, in the communication that you as minister have sent to AMA you talk about a $200 million savings in physicians' fees. I'd just like to know which it is. What are we striving for this year and over the life cycle of these business plans: $100 million or $200 million?

MRS. McCLELLAN: Well, I think it's quite straightforward, so I'm going to let Dave answer.

MR. KELLY: It's basically both.

MR. SAPERS: It's both?

MR. KELLY: Yeah, that's right. The $200 million is composed of a 5 percent compensation reduction, which is the better part of $50 million, restructuring laboratory services, which should produce in the order of $50 million, and $100 million on similar items as listed in the business plan.

MR. SAPERS: So the $100 million is half of the $200 million. It's not two different items.

MR. KELLY: That's correct, and it does not include the compensation reduction of the laboratory restructuring.

MR. PHILIPPON: On page 7, which you're referring to, the $100 million does not include the compensation reduction of 5 percent and it does not include the laboratory restructuring. Those are found elsewhere in the business plan, and that's how you add it up to $200 million.

MRS. McCLELLAN: Does that help you?

MR. SAPERS: Thank you. That was helpful. That was a good answer.

MR. CHAIRMAN: Yvonne.

MRS. FRITZ: Thank you, Mr. Chairman. I'm interested in what the role is of the Mental Health Patient Advocate in 1.2.2.

MRS. McCLELLAN: The Mental Health Patient Advocate's office is really what it says. He is there as an advocate on behalf of mental health patients. I think that Mr. Doyle could give you probably a briefer overview of what our Mental Health Patient Advocate's mandate is.

MR. DOYLE: The mandate is incorporated in the Mental Health Act, and it provides for advocacy on the part of formal patients that are hospitalized in the mental health system.

MR. CHAIRMAN: Supplementary.

MRS. FRITZ: Thank you, Mr. Chairman. I'm also interested in the '92-93 annual report where it says on page 6 the 10 leading diagnoses of patients. The second is anxiety and depression, and the fifth is depressive disorder. What I'm interested in is: I notice that there's a reduction in funds, actually, in the mental health patient advocate's office, and I'm wondering if you're still meeting those needs in the community with that reduction in funds.

7:33

MRS. McCLELLAN: Well, the mental health advocate really deals with formal mental health patients, so that is quite different. The formal patient is a person who . . . [interjection] Yeah. So it's not for services in the community. I believe that the reduction is because of a staffing change in the mental health advocate's office, and I believe he feels that he has adequate resources to deal with the numbers of clients that he serves.

MRS. FRITZ: Okay. Thank you.

I'm also interested, then, in how many cases would be handled in a year.

MRS. McCLELLAN: Gee, I would probably have to get that number for you from the mental health advocate. I don't have that at my fingertips, but I would be pleased to do that.

MR. CHAIRMAN: Muriel.

MRS. ABDURAHMAN: Yes. Is it all right to move to program 2 now?

MR. CHAIRMAN: I've got at least one more person.

MRS. ABDURAHMAN: Well, I can do another question on program 1.

MR. CHAIRMAN: Well, it's up to you folks. You folks drive it, so if you want to move on to another program . . . [interjection]

There's one more on this side. Murray.

MR. SMITH: Thank you. I was just trying to save the hon. minister a million dollars. Is there any reason, Madam Minister, why we can't move the research and innovation fund over to lottery estimates and put it under the health and wellness initiatives of the Wild Rose Foundation – and medical innovation programs, services for problem gamblers, the Calgary handi-bus?

MRS. McCLELLAN: I'm only going to deal with the one area. I think you suggested a whole bunch of them.

MR. SMITH: No, I'm just saying that the question I have is: would it not make more sense to centralize your initiatives in research under one umbrella fund?

MRS. McCLELLAN: Because we feel that outcomes research is so important, I think we will make the case for leaving those research dollars in the Health budget where it is, I would suggest, more stable. It is a very, very important component of our three-year business plan, and it is very important to meet the goals that we have set out to have that type of outcomes research. As well, as Cec outlined, some of our projects are three-year projects. We're just into them, and we would like to see that stay in a very stable environment. We think it's pretty important.

MR. CHAIRMAN: Supplementary.

MR. SMITH: Thank you, Mr. Chairman. It's because of that importance in outcomes that the research and innovation fund is subject to a 20 percent increase in funding.

MRS. McCLELLAN: Well, yeah, that's part of it, but I think there are some other tests. I guess that was just $200,000.

MR. CHAIRMAN: Final supplementary.

MR. SMITH: Well, actually, I think I'm going to ask a question. Everybody on the other side wants to move on, but I still would like to get the answer to this. Could we find out if the administration costs are greater in either the health and wellness initiatives from the lotto fund, or are they greater in the health services? Which is run more efficiently?

MRS. McCLELLAN: The health services innovation fund is very low cost to operate.

MRS. LORD: It's very low cost because the provincial advisory committee on health research is entirely volunteer.

MRS. McCLELLAN: Yeah. You can't get much more efficient than that.

MR. CHAIRMAN: Are there any other questions on program 1? If not, Grant, was it program 2 that you wanted to move to?

MR. MITCHELL: We'd like to do program 2, yeah.

MR. CHAIRMAN: Okay. Muriel.

MRS. ABDURAHMAN: Yes. The line is 2 . . .

MRS. McCLELLAN: Can I just sort and move to 2 now? I'll do this so that when we go back to 1, I'll be able to find what I have. Otherwise, I'll lose it.

Okay.

MRS. ABDURAHMAN: I've identified program 2.2.1. What I'd like to know is: who will decide what are essential and what are nonessential services, and will there be legal protection for the health care workers who will make a decision in that area?

MRS. McCLELLAN: Pardon? Could you just help me?

MRS. ABDURAHMAN: Who will decide what is essential and nonessential in health care?

MRS. McCLELLAN: Yes, I understood that part of it.

MRS. ABDURAHMAN: Then because that decision has been made, health care professionals who have to make it, will there be legal protection for them?

MRS. McCLELLAN: This is in 2.2.1?

MRS. ABDURAHMAN: I'm tying it to the basic care.

MRS. McCLELLAN: Oh, under basic health care. I think you must be referring to a recommendation in the Starting Points document, not really to my budget. Because under this there is a range of basic health services that are insured here.

MRS. ABDURAHMAN: That's what I'm assuming.

MRS. McCLELLAN: Those are medically required services that are insured through Alberta health care insurance.

MRS. ABDURAHMAN: Who will make that decision of what will be covered and will not be covered?

MRS. McCLELLAN: Well, all medically required services are covered, and in addition we do cover some others. Now, I know that I see a little bit of consternation on the hon. member's face, but I think that I would just recommend that you read the Canada Health Act – I'm sure you maybe have at some point – and look for the clarification of what must be covered.

MR. CHAIRMAN: Supplementary.

MRS. ABDURAHMAN: There's no point in pursuing it.

MRS. McCLELLAN: Well, unless you are referring to Starting Points, because today we provide insurance for medically required services in the province of Alberta.

MRS. ABDURAHMAN: Who determines what is medically required?

MRS. McCLELLAN: The physicians.

MRS. ABDURAHMAN: The physician? When the physician determines it's not medically required, where does the protection come in if it's deemed after the fact that it was required?

MRS. McCLELLAN: Well, frankly, we've not run into that, so it's a bit of a hypothetical question for us. I think it's an ethical question. It would be the College of Physicians and Surgeons that would pursue it.

MRS. ABDURAHMAN: A final supplementary. I mean, obviously it's being redefined. So if it's being redefined, who's redefining it?

MRS. McCLELLAN: Well, that was my point: that your question you were relating to has nothing to do with this line in the budget. You are relating to a discussion.

MRS. ABDURAHMAN: Well, that's how you're paid.

MRS. McCLELLAN: No, but you are relating to a discussion in – well, maybe you're not; maybe you're relating to how we arrive at insured services and the negotiations on what is insured and not insured.

MRS. ABDURAHMAN: Un huh.

MR. CHAIRMAN: Well, I'm having a little bit of trouble.

MRS. McCLELLAN: Well, I'm having trouble trying to figure out whether that's what the hon. member wants to talk about.

MRS. ABDURAHMAN: Well, you know, I can refer it back to the principles.

> Additional health services not based on significant need will be available, but will require a partial or full direct financial contribution from the consumer.

So who's going to define what is and what's not?

MRS. McCLELLAN: You are talking about the business plan, not my budget. [interjections]

MR. CHAIRMAN: Order. Order please. I'm having real difficulty, and I think we've now determined that in fact this is something that's in the future.

MR. SAPERS: No.

MR. CHAIRMAN: Well, then the minister has answered what is in the budget on 2.2.1.

MRS. McCLELLAN: The physicians decide.

MR. SAPERS: February 24, 1994. I think it's the '94-95 business plans, Ty – I think.

MR. MITCHELL: Ty, you're spending money right now. You know, Lyle's committee is looking at redefining essential and nonessential services.

MRS. McCLELLAN: No.

MR. MITCHELL: Isn't he? He says he is.

7:43

MRS. McCLELLAN: Perhaps, Mr. Chairman, I can just handle this very quickly. The Starting Points document recommended that there be a process – I think it recommended a commission – to identify basic, or essential, services. What the steering committee has been asked to do by the minister is to define a process and to make a recommendation on that, not to define or redefine health services. I have not received that recommendation from the steering committee. I would expect I will in the next short time. I had asked them to try and have that to me by the end of February. They contacted me and said that it was a very complex matter and they would like a little bit more time, and I've agreed to that. So that has not been done.

MR. CHAIRMAN: Bonnie.

MRS. LAING: Thank you. I wanted to ask a question about 2.2.6, the out-of-province health care services. Okay? My first question would be: where would these patients be going for service primarily?

MRS. McCLELLAN: Well, probably out of the country, most of them. The majority would be out of the country. Or are you talking about just out of province?

MRS. LAING: Out of province.

MRS. McCLELLAN: Okay.

MR. KELLY: It's just Canadians traveling mostly.

MRS. McCLELLAN: Yeah. That's Canadians traveling. But it's out of country where most of the service is received, not in other provinces.

MR. KELLY: Most of it is just in country, tourist and business trips in Canada.

MRS. McCLELLAN: In Canada.

MRS. LAING: In Canada?

MRS. McCLELLAN: That's where they are.

MRS. LAING: There is the cap on how much – right? – that's covered. Are there criteria for authorized treatment out of province, say, for special conditions which we cannot treat in Alberta?

MRS. McCLELLAN: Yes. There is an expert committee that reviews requests for out-of-province treatment, and where the treatment is not available in Alberta that would be where those are approved.

There's something wrong with this. [interjection] I think she got what she wanted anyway.

MRS. LAING: My last question. There is a reduction forecast for this year. Would this be due to the drop in the cases or the actual cap that's now on payments?

MRS. McCLELLAN: It's actually more due to the cap on the patient-day rate.

MRS. LAING: Okay. Thank you.

MR. CHAIRMAN: Grant.

MR. MITCHELL: Yeah. I'm interested in the new billing format. There's been a number of issues that have arisen on that.

MRS. McCLELLAN: Complaints?

MR. MITCHELL: Yeah. One of the initial problems – I think Lyle asked a question about this in the House last session, and I just thought it should go further – was that doctors' offices have got versions of this, piles of it, much of which wasn't very useful to them – perhaps that specific doctor. They would get that absorbed, and they'd get another draft of it. They'd have to throw out the other one. I wonder whether you could just tell me how that could happen and what you've done about it.

MRS. McCLELLAN: Well, whenever you put anything in like the new claims – and it hadn't been updated for how long?

MR. KELLY: Twenty years.

MRS. McCLELLAN: Twenty years. I think you could expect that there might be some disruption. I'm trying to think of how many billings we have a day. Is it something like . . .

MR. KELLY: A hundred and fifty thousand claims a day.

MRS. McCLELLAN: From 145,000 to 150,000 claims a day. So this is not exactly a simple thing. There are a number of codes. There are a number of reasons for changing them too. To ensure you have better data: I think that was one of them. Whenever you change a system that is as complex as that and has as much activity as that, you're going to have a few bumps. Actually, I would say that in the dealings that my office has had with physicians – and I do hear from most of them that have a problem – we've been able through in-service with staff from Alberta Health. They were quite prepared to go out and work with physicians to handle that changeover. We didn't change it all at once. We sort of tried to make the transition easier. I just have to go back and say that when you take a system that was 20 years old and you upgrade it to today, yes, there were some bumps, and I think we've been able to work with the physicians who are having problems and deal with those concerns. It's unfortunate, but I think they were also understanding. It's a pretty complex system.

MR. MITCHELL: I still have complaints that the companies they have to hire, for example, will submit and then it doesn't work, so the department tells the doctor that their company has submitted improperly, their consultant. The consultant tells the doctor that no, no, the government hasn't absorbed it properly. My experience has been that when you get that kind of thing, it's nice to sit everybody down in the same room. I wonder if I had a case like that whether I could sit down with David Kelly and my doctor and just have that discussed.

MRS. McCLELLAN: Well, sure. If you really wanted to have fast service, just bring it through the minister's office, Grant.

MR. MITCHELL: So we could, all three of us, sit down and work that out?

MRS. McCLELLAN: I'll call Dave and he'll look after it, as he has with all of the cases we've had.

MR. CHAIRMAN: A final supplementary, Grant.

MR. MITCHELL: Yeah. What was the thinking behind extending emergency funding to all physicians even if they asked not to receive it?

MRS. McCLELLAN: Dave, help.

MR. KELLY: Any physician who asked not to receive the advances did not receive them. The sense was that when the new system came up, for most practitioners there'd be a two- to three-week gap when they wouldn't be paid. We pay practitioners weekly, and we didn't wish any practitioner to go without his cash flow during that period. We also anticipated that for most practitioners there'd be another two-, three-, four-week period before their claims were submitted and running reasonably smoothly. What we did was we decided during that period to ensure that all practitioners were getting at least 75 percent of their average weekly payment, averaged over the previous six months. So when a practitioner's claims during that window didn't reach the 75 percent level, we added an advance, and we've since recovered those amounts.

MR. CHAIRMAN: Okay. Lyle.

DR. OBERG: Thank you, Mr. Chairman. I just have a question on the premiums. They've gone up around $75 million, if I read that correctly.

MRS. McCLELLAN: Is this on . . .

DR. OBERG: Line 2.2.2.

MRS. McCLELLAN: Okay, got it.

DR. OBERG: They've gone up around $75 million. With the recent announcement of the seniors paying health care premiums, how much of that is due to that, and how much is due to raising the premiums?

MRS. McCLELLAN: Well, in that we've had an annualization of the increase that we put into premiums in September, it would be about $18 million. We have had some in-population growth. It's about $9.8 million. We have a rate increase coming on July 1, and that would be quite significant, about $25.7 million. That is offset, I should say, by about 13 and a half million dollars, because as we increase the premiums, we also increase the subsidy level for people who are on lower incomes. As the premiums go up, so does the subsidy level, so we offset about half our gain in that. We have put in a conservative figure for seniors because we were not certain at the time of doing the budget what the final decision might be. It's at about 32 and a half million dollars.

MR. CHAIRMAN: Supplementary.

DR. OBERG: No. That's fine. Thank you.

7:53

MR. CHAIRMAN: Julius.

MR. YANKOWSKY: Thank you, Mr. Chairman. I have a few questions on Blue Cross, Madam Minister. I take it that it falls under vote 2.2.4, possibly 2.2.3. There are some questions regarding the savings to the government under the new regulations for seniors. My understanding is that a savings of $45 million is anticipated, $15 million through not paying dispensing fees and the remaining $30 million is kind of fuzzy. Is this $45 million figure correct?

MRS. McCLELLAN: Well, I think you're looking at – I'm having trouble. Where's your $45 million, Julius? Just help me.

MRS. ABDURAHMAN: Page 10 in the business plan.

MRS. McCLELLAN: In the business plan. Oh, okay. Sorry. So you're looking at a three-year figure there.

MR. YANKOWSKY: Well, I'm not sure whether it's a three-year figure.

MRS. McCLELLAN: Yes. That would be over the three years, because the business plan is a three-year plan. So $15 million is part of that, and that's the change in how we pay pharmacists.

MR. YANKOWSKY: Okay. How do you plan to save the $30 million over and above the $15 million savings in dispensing fees? You mentioned some of that already.

MRS. McCLELLAN: Okay. One of the areas of savings is in the least cost alternative program. I'm going to get Dave to – because most of the rest of it's in the administration side of it.

MR. KELLY: Okay. We're going to cut our administrative costs. We believe there are some significant savings we can make on the administrative side. We have contracted Blue Cross, and we think we can make some substantial savings there in terms of the cost of running the program. Secondly, we did introduce the least cost alternative purchasing program. We think over time there are further savings that can be made on the cost of drug materials, and we're looking very hard at that. Thirdly, we're looking at drug utilization very seriously with the pharmacists and with the physicians to try to cut down on the prescribing of drugs that may not be entirely necessary. Those are the three areas in which we hope to make significant savings.

MR. CHAIRMAN: Final supplementary.

MR. YANKOWSKY: Yes. For many seniors who will pay more for their prescriptions under the new plan, this will be another hardship. What do you suggest that they do?

MRS. McCLELLAN: Well, we're certainly open to discussing this issue. One of the reasons that we certainly moved to a flat dispensing fee was because we have a number of seniors who are on high-cost drugs who find it very costly at the 20 percent. That is of concern to me. You would remember that the $9.70 is a maximum fee that we set, not the fee. It is a maximum fee. So that meant for seniors who can be on drugs that cost $250 to $300 a month, there are significant savings to them under this program. As Don just reminded me, there are 25 percent of our seniors in this province that are on those high-cost drugs. That's a very significant amount. Certainly I've been made aware of cases where their drug costs can be $500 a month, and these drugs are very important to them for quality of life. It's a considerable hardship. So, for example, for that particular senior who was in that case, they would paying $100-plus a month. Under the new program they would pay $19.20. That's considerable. Again, if there are better ways to achieve the insurance so that our seniors are not faced with those extreme high costs, I'm willing to listen.

MR. YANKOWSKY: Thank you.

MR. CHAIRMAN: Murray.

MR. SMITH: Well, thank you, Mr. Chairman. The best I can figure, Madam Minister, is that it looks like you're running the health care insurance program with about a 4 percent G and A cost, which is quite laudable, considering that there has been some criticism.

Could you explain to me what the practitioner support services and the rural physician action plan are under 2.1.4 and 2.2.7?

MRS. McCLELLAN: The rural physician action plan . . .

MR. MITCHELL: Did she explain what G and A is, general administration?

MR. SMITH: At 4 percent she didn't have to.

MRS. McCLELLAN: I just took the compliment, and I was not going to comment because I don't get a lot.

On the rural physician action plan those are dollars that are in the program to try to address the concerns that we have about distribution of physicians in the province. Part of it – and I should say that this program is in its third full year – is for the internship program which is very important, where our interns go out into a rural hospital to train for a period of about six months. Another part of it that's very important to the rural physician action plan is the locum program. Many rural physicians are single physicians in a community. By single, I mean they're the only physician in the community, and they're on 24-hour call, many times seven days a week. This enables them to get away either for a break or for educational upgrading. There are 16 initiatives under that program, but I would say that those are probably the most important ones. The initial assessment, if you had an opportunity to read a little report card which was called Pockets of Good News, which was sort of an update, a two-year report card of the program, does show that we are having some success with the program. The rural physician action plan was always looked at as a program that had long-term benefits and attempted to do some short-term strategies. But it would appear to us that it is working. I think we can learn some things from the report card or the Pockets of Good News, that perhaps we can enhance that program and improve it so that our physician distribution in the province is appropriate to the needs in the province.

I think you might have had one more.

MR. SMITH: Practitioner support services, 2.1.4.

MRS. McCLELLAN: Okay. I'm going to let Dave have that one. I'm running out of – can you help?

MR. KELLY: Yeah, that's the staff within the practitioner services division who monitor physician payments, provide support to the licensing and disciplinary functions of the College of Physicians and Surgeons, provide economic analysis, health economic support to negotiation committees, and similar such functions.

MR. SMITH: How many full-time equivalents are in that, Dave?

MR. KELLY: There would be approximately 15. I don't have the exact number in my head.

MR. SMITH: Ty, am I on my final supplementary? Thanks.

Okay. Computer systems support, can you also tell me what that is?

MRS. McCLELLAN: I'm going to let Dick handle that. Oh, Aslam will do it. He's all ready.

MR. BHATTI: That's just running the claims system, the processing.

MR. SMITH: That's strictly clients.

MRS. DACYSHYN: Mr. Sapers will be next.

MR. SAPERS: Thank you.

MRS. McCLELLAN: Who's next?

MR. SAPERS: That would be me.

MRS. McCLELLAN: That would be you?

MR. SAPERS: Yeah, it would be me. Well, let's start off with just a general comment about the business plans again, and I am talking about program 2. The business plans call for a move towards the insurance plan being more of a true insurance plan. If a decision was made that 20 percent is a reasonable target, then premiums will be based on 20 percent of the cost of the plan. I guess my first question really is: on what basis was it decided that 20 percent on the revenue side would be reasonable? Why isn't it 10 percent? Why isn't it 50 percent? Why isn't it 17 percent? Where did that come from?

8:03

MRS. McCLELLAN: Well, I think we thought that would be a reasonable amount for people to pay for health care premiums and aim for 20 percent of the cost. I do not think that one-fifth of the cost of the health care system being supported by people that use it is unreasonable. Maybe you do.

MR. SAPERS: No. I want to know on what basis.

MRS. McCLELLAN: Well, that was the basis.

MR. SAPERS: Was it just a gut feeling that 20 percent would be okay, not 22 percent or 18 percent?

MRS. McCLELLAN: No. There was a feeling that that would keep our premiums within a fair range and it would be a target cost.

MR. SAPERS: Based on what? Average income? Percentage of disposable income?

MRS. McCLELLAN: On what we charge today and what we receive today as to the support of our budget. Our premiums are about one-tenth; we're about one-tenth of our budget now. We are going to bring our health care budget down. In doing those calculations and looking at what we pay today for premiums and our target for what our budget would be, one-fifth of the cost would then be covered.

Aslam just said, "And rightly so." I should point out again that our subsidy levels are increasing proportionately; as Aslam said, by 30 percent in some cases. So while we are moving to that target, we are ensuring that lower income persons either pay no or partial premiums. So we're protecting the lower income people.

MR. CHAIRMAN: Supplementary.

MR. SAPERS: Thank you. Under 2.1.5 how much will it cost to collect the premiums from seniors?

MR. BHATTI: Right now we spend about $3 million with the collection agencies to collect all nonsenior premiums. We feel that under the new seniors' benefit program we will be only collecting premiums from the full-premium paying seniors, and they will be at a level of income that we believe there won't be an additional cost associated with it by raising the subsidy levels as well.

MR. SAPERS: So the administrative infrastructure is sufficient.

MR. BHATTI: Oh, certainly, and there won't be an increase.

MR. CHAIRMAN: Final supplementary.

MR. SAPERS: Thank you. Under the same vote how about collecting arrears?

MRS. McCLELLAN: I think that's what Aslam was talking about: the arrears.

MR. SAPERS: You were talking about arrears, not seniors?

MRS. McCLELLAN: No. When you said the cost through collection agencies.

MR. SAPERS: No. The cost of collecting the premium from seniors was my first question.

MRS. McCLELLAN: I know, but I think when Aslam talked about . . .

MR. BHATTI: No, it won't cost us any more except for postage for collecting seniors' premiums. I was describing collecting arrears, as was indicated, and that won't be any more as well.

MRS. McCLELLAN: Yeah. I think he misunderstood you. The $3 million in collection agencies is for collecting arrears, not for seniors. We do not see, other than postage, any change in adding the seniors. We already have the administrative infrastructure in place.

MR. SAPERS: How much of the $3 million goes to collect . . .

MR. BHATTI: I'll correct myself. The $3 million is totally for collecting arrears from people who have not paid their health care insurance premiums. It's provided to a collection agency, and their expense is about $600,000 in terms of following up on premiums.

MR. SAPERS: Okay. Thank you.

MR. BHATTI: The rest of it is just done through systems.

MR. CHAIRMAN: Okay, committee, we are about halfway. Did you want to take a five-minute break?

MRS. McCLELLAN: No.

AN HON. MEMBER: Yes.

MR. CHAIRMAN: We will adjourn for five minutes. So we'll be back at 13 minutes after.

[The committee adjourned from 8:08 p.m. to 8:13 p.m.]

MR. CHAIRMAN: Committee, we've had our five-minute break. We'll call the committee back to order.

Grant, do you want to proceed, please?

MR. MITCHELL: Yeah, I do. That would be great. Thanks.

MR. CHAIRMAN: Go ahead.

MR. MITCHELL: Shirley, I have a question on the memorandum of December 2, 1993.

MRS. McCLELLAN: Of?

MR. MITCHELL: Of understanding between the doctors and the physicians and you. It says here:

> The general compensation reduction will be accomplished initially by utilizing reserves which will have been built up in the Health Care Insurance Fund.

I just was wondering how much that would be, whether that's going to be significant to the doctors.

MRS. McCLELLAN: Oh, Dave, what is the figure? You understand what it is.

MR. KELLY: It's just under $15 million.

MR. MITCHELL: It's $15 million.

MRS. McCLELLAN: Just under it.

MR. CHAIRMAN: Supplementary.

MR. MITCHELL: Yeah. I have a really specific supplementary – this is very specific – with respect to the billing system, understanding that it is to be very flexible now and it has much more apparent flexibility for the kinds of functions that are performed. But there is a problem, we think, with developmental pediatricians who do psychiatric assessment. Is there a code now, or what do they do?

MR. KELLY: I'd have to take notice of that.

MR. MITCHELL: Could you do that?

MRS. McCLELLAN: Yeah, sure.

MR. MITCHELL: Okay. Those are really the two that I wanted to ask in that particular area.

MR. CHAIRMAN: Final supplementary.

MR. MITCHELL: Actually, no. I just had those two. Just a minute; I want to check here. I just had those two, really. Oh, yes, there is. Have you made specific decisions, which seem to me to be going in different directions, one, to allow midwives to bill through the health care system, and two, to ultimately deny – I guess that's too strong a word – to discontinue physiotherapists' billing through the health care system?

MRS. McCLELLAN: No. There hasn't been a decision made, to the best of my knowledge, as to how midwives are going to be paid. We are developing the regulations right now.

There has not been a decision to deny physical therapists to continue to operate. What we have talked about and do talk about in our business plan is developing a community rehabilitation service, which is one area. Those are some areas that physical therapists and I are going to be talking about in a couple of weeks, as to how they want to be paid.

MR. CHAIRMAN: Muriel, did you . . .

MRS. ABDURAHMAN: Are we on vote 2?

MR. CHAIRMAN: Yes. We're still on program 2.

MRS. ABDURAHMAN: Still?

MR. CHAIRMAN: Okay. Howard, did you want in on this vote?

MR. SAPERS: On program 2? Well, sure.

MRS. McCLELLAN: You don't have to, Howard, if you don't want to. It's okay.

MR. SAPERS: Shirley, I can't help myself though.

On Blue Cross coverage: questions about the new regulations. I just don't have in my notes here which line it is, but I'm sure somebody . . .

MRS. McCLELLAN: Well, ask the question, and I'll try to find it.

MR. SAPERS: Vote 2.2.5, the $45 million savings that's anticipated.

MRS. McCLELLAN: We just did that.

MR. SAPERS: You just talked about that?

MRS. McCLELLAN: Yes, we did. That's the $15 million that Julius and I spoke about. Forty-five million dollars is over three years, $15 million a year, and it is in changing how we handle the fees. So we did, didn't we, Julius?

MR. YANKOWSKY: Yes.

MR. CHAIRMAN: Do you have a supplementary?

MR. SAPERS: Then that question of mine has been satisfied. I'll just talk to Julius.

MRS. McCLELLAN: Yes.

MR. CHAIRMAN: Are there any other questions on vote 2?

MR. MITCHELL: Yeah, I have just a couple of things to ask, if I could: the whole issue of direct access for nurses.

MRS. McCLELLAN: Which line is that?

MR. MITCHELL: Are you leaning towards nurses billing the health care system?

MRS. McCLELLAN: Well, I would say that I'm not leaning in any direction in that I have not had a proposal from nurses suggesting that they would wish to bill the health care system.

MR. CHAIRMAN: Supplementary.

MR. MITCHELL: Yeah. With goal 4, page 19. There are a number of areas that emphasize the individuals' accountability and responsibility for the maintenance of their own health. But in a wellness-directed system, in a preventative health care system you can see that there's a role for doctors as well as nurses to play in counseling or in areas like smoking, alcohol consumption, exercise, and so on.

MRS. McCLELLAN: Seat belts, helmets.

MR. MITCHELL: Exactly. The system isn't particularly structured in any way really as an incentive, not that doctors need an incentive, or to support that kind of initiative. What kinds of thoughts have been given to that?

MRS. McCLELLAN: Well, certainly we've had discussions with the AMA on that. Doctors are very interested in working in preventative health and education. I think what we're really looking at is how all health providers can come together to ensure that those initiatives can come from perhaps a multidisciplinary area of support rather than the way we're doing it now, where we have specific nurses doing this, doctors doing this, and so on. There may be better ways to target those areas of concern. How we develop our information systems is very important. I said in my opening comments that it's important for us to give people the information to make choices as well, and we have to look at how we do that. That's something that could be a shared responsibility.

I think that when we look at the promotional initiatives, then we can look at the multidisciplinary. We've seen that. The pharmacists have initiatives where they have come out with programs. They ran a 30-day one on the wise use of drugs. They get involved with the veterinary association on the Great Drug Round-up every May. There's a great awareness when people see all of these drugs that have been really wasted – well, I don't know whether they were wasted; they've been purchased and not utilized – one, for safety, we think, particularly of children getting ahold of them but for anybody getting ahold of them. So we've seen the pharmacy association work on initiatives like that. I believe from the discussions I've had with all the professional organizations that they're all very keen on getting involved in wellness. Those are areas that we want to work together on and also, I should say on that whole area, on a national basis.

We do have a national strategy for education. Alberta has really played a lead role in developing some of the information. With the federal minister we've been looking at educational programs that are common to Canada that we could all use, rather than each province developing them on their own, 10 and the territories, 11 times, and then perhaps be able to use the parts of it that are just specific to your province. You may have some particular areas. I think that's an excellent strategy for us to work on on a national basis. We spoke about that in September at our meetings that we had, and that will be an area that we will continue to work with: health promotion.

MR. CHAIRMAN: Final supplementary?

MR. MITCHELL: That's fine. Thanks.

MR. CHAIRMAN: Okay. Are there any other questions on vote 2? Julius?

MR. YANKOWSKY: Yes. I have questions on out-of-country health care.

MRS. McCLELLAN: Which one are we going to? Oh, we're still in this one.

MR. YANKOWSKY: On 2.2.6. Now, when this was introduced last year, I guess the estimated savings were set at about $5 million in the first year. Do you have any figures or breakdown of the out-of-province savings thus far and out-of-country savings?

MRS. McCLELLAN: We have an estimate for next year, but I think Julius's question is: do we have any estimate of what we have saved since we implemented the program?

MR. YANKOWSKY: Yes.

MR. KELLY: Do you want me to take it?

MRS. McCLELLAN: Sure.

MR. KELLY: Well, we think we reduced our expenditures by approximately the amount, that when the bills are in for the year that's just ending, that that will be the case. It didn't affect out of province. Most of the out-of-province costs are simply Canadians traveling in the country for pleasure or business and to see doctors or visit hospitals elsewhere in Canada.

8:23

MRS. McCLELLAN: We have reciprocal agreements with most of the provinces in Canada.

MR. KELLY: All except Quebec.

MRS. McCLELLAN: All except Quebec, yeah.

MR. CHAIRMAN: Supplementary, Julius?

MR. YANKOWSKY: Yes. Does your department monitor the cost of private health insurance which Albertans must purchase when they travel outside the country?

MR. KELLY: We have done some surveys. We don't monitor it, but we do from time to time do a survey.

MR. YANKOWSKY: You have just done some surveys on it. You have not monitored it.

MRS. McCLELLAN: What would you be looking for in that, as to cost or availability?

MR. YANKOWSKY: Well, it's kind of a little bit of each, I guess, there. Mostly cost.

MRS. McCLELLAN: Well, I'm sure we do have that information. Certainly most of us individually do have that information. If we travel out of country, I hope we all purchase additional insurance.

MR. MITCHELL: Aren't we covered?

MRS. McCLELLAN: Not out of country.

MR. CHAIRMAN: Final supplemental.

MR. YANKOWSKY: No, that's all.

MR. CHAIRMAN: Are there any other questions on vote 2? If not, does the Progressive Conservative caucus have a choice? They have the choice. Do you have a preference which vote to go to? Do you want to go to 4? Which vote do you want to go to?

MRS. LAING: Vote 3 for me.

MR. STELMACH: Let's go to 4.

MR. CHAIRMAN: Vote 4? Okay. We're on vote 4. So who's leading off on vote 4?

MRS. LAING: I am. Okay. On page 193, line 4.1, program support . . .

MRS. McCLELLAN: Which one is it? I'm sorry, Bonnie.

MRS. LAING: Program support.

MRS. McCLELLAN: There's an airplane flying over right now.

MRS. LAING: It's the one that none of us can go on.

MRS. McCLELLAN: In 4.1?

MRS. LAING: Yeah. Program support.

MRS. McCLELLAN: Okay. Got it.

MRS. LAING: It seems to be fairly even, doesn't it, from last year?

MRS. McCLELLAN: Yes.

MRS. LAING: What types of things would be included in program support?

MRS. McCLELLAN: For mental health services program support?

MRS. LAING: Uh huh.

MRS. McCLELLAN: Bernie can take some of those areas.

MR. DOYLE: Within general administration we have three divisions. One is the service development and delivery division, and there are head office people, consultants, and so on in that category. We also have service support systems, and that deals with the financial information systems. We also have a branch called research and evaluation and suicide prevention, and those dollars are in that section.

MRS. LAING: Okay. And I notice that you've pretty well kept them about the same.

MR. CHAIRMAN: Supplementary.

MRS. LAING: Thank you. What is the strategy for suicide prevention that is used, say, provincewide?

MR. DOYLE: We have 11 programs. Two are provincial programs, and they deal with education and outreach. We have nine outreach programs that are funded by head office to nine community agencies. These community agencies set out their goals and objectives through a contractual arrangement. We look specifically at outcomes in those areas. So they're funded on an annual basis.

MRS. LAING: What would be the cost or expenditure for a distress line that's run 24 hours? Would that be the type of service that's funded through those community agencies?

MR. DOYLE: In some cases it is. I have haven't got the exact cost, but we can get that for you.

MRS. LAING: Okay. Thank you.

MR. CHAIRMAN: Muriel.

MRS. ABDURAHMAN: Yes. Moving to the mental health, particularly the institutional as it's been laid out in the program . . .

MRS. McCLELLAN: Do you have just the number for that?

MRS. ABDURAHMAN: Well, we're looking at 4.3 and then we're looking at 4.2, and I was wanting to tie the two together. When we're looking at regionalization, Shirley, why are we seeing a separation in this delivery system continuing?

MRS. McCLELLAN: The reason that you would see it continuing is because at the time of preparing budgets for this year we did not have all of the information available from the Mental Health Strategic Planning Advisory Committee. We have talked about that. The Mental Health Strategic Planning Advisory Committee did a complete series of meetings in the province, prepared a plan for us, and presented it to us. We are in the process of looking at that plan and having the steering committee look at that plan to see if there is a way for it to work within the regional health services. Certainly clearly, if you look at the business plan, you would see that we are moving to the integration or continuum of care in mental health services so that the community and the institution are linked much closer.

MR. CHAIRMAN: Supplementary.

MRS. ABDURAHMAN: Yes. Following on that and going into the institutional psychiatric delivery system that's not under this program, how is that all going to tie in? I'll use some examples. How would, say, the psychiatric program at the Royal Alex relate to Alberta Hospital Edmonton, and how are we going to make sure that that continuum is there?

MRS. McCLELLAN: Bernie might want to talk about it. I think we're getting ahead of where we are right now, but we do have some thoughts on how that is going.

MR. DOYLE: As the minister mentioned, there is a mental health strategic plan being considered. One of the possibilities there is that for a time-limited period we would have mental health authorities look at all of the dollars in the two mental hospitals as well as the programs in the acute care general hospitals and the community and tie that together and look at balancing the system. There are things that we want to do within that plan. We want to balance out the system to ensure that there are enough dollars moving into the community to deal with mental health in the community. We know we can keep more people in the community if we have appropriate services. So we want to be able to reallocate some dollars.

We want to look at controlling those dollars or having the community control those dollars in one envelope or at least having some protocols to deal with the dollars specifically in the acute care hospitals so that we can balance out the system. We would then be providing a continuum that the service recipients could understand and work with as well as the service providers. So the hospitals would be key in that, but they would be working in a very connected fashion to the community mental health services.

MRS. ABDURAHMAN: You mentioned the envelope, Bernie, and the question that I would ask is: how are you going to protect that envelope inasmuch as some of the mental health delivery system will still be under the acute care hospitals, like Grey Nuns or the Royal Alex? How are you going to ensure that that money isn't diverted into another area?

MR. DOYLE: Part of the work of the mental health strategic plan was working with the CEOs of the general hospitals and getting them to understand the continuum. Now, we haven't got all the protocols worked out, but we've certainly made some headway in getting them to buy into the need to understand that they're a critical part of the overall system. So that's what we've done to date. We know that we've got a lot more work to do on it, and when we know which way we're going with the mental health strategic plan, I think we can get into that more.

MRS. ABDURAHMAN: Thank you.

MR. CHAIRMAN: Lyle.

DR. OBERG: Thank you, Mr. Chairman. I have a slightly different question, Madam Minister, on the suicide prevention program. If we went to program 4.2.2, we see that there's roughly a $315,000 drop in the suicide prevention program. I would be the last person to say that you can judge a program by the amount of money that you put into it, but could you just tell me a little bit about why there was that drop?

8:33

MRS. McCLELLAN: Sure. If you look at 4.2.2, you see a reduction. A slight amount of that reduction is the impact of the 5 percent reduction in salaries and fees and benefits. However, the larger amount – if you turn over and you look at 4.2.5, community agencies, you would see quite a significant increase. There was a very significant transfer made from the crisis intervention services area over to the community agencies. So it's really a transfer; it's not a decrease.

DR. OBERG: I see.

MR. CHAIRMAN: Supplementary.

DR. OBERG: Thank you. One of the problems with any program such as suicide prevention is establishing whether or not it really works. I was just wondering how we're addressing this. You know, I'm sure it does. Are there guideposts that we look at, or is there anything we monitor on it?

MRS. McCLELLAN: I'll let Bernie talk about that program.

MR. DOYLE: We've been really aware of the need to look at how we can measure outcomes and that with the various information banks that we can get into. We did bring all of the major stakeholders – we had a group of 80 people – together in the fall of this year to look specifically at that, to see if we could get more of a hold on their accountability along with the outcomes. So we've got a major report that's in the hands of all the nine agencies. We've also got requirements that they show us on a quarterly basis their progress and their outcomes. We've raised the level of awareness. We've I think provided them with more detailed information on how to use that information with schools and with other agencies, hospitals, police, and so on, that are running into suicide attempts.

MR. CHAIRMAN: Final supplemental.

DR. OBERG: Thank you, Mr. Chairman. I apologize for this last question. I realize it's taking a very complex issue and putting it down to a simple term, which is not good, but have we seen a decrease in the number of suicides in Alberta?

MR. DOYLE: We're looking at a trend. Now, we did see an increase, but the trend is not on the increase. We can provide you with actually an interesting report from Stats Canada and other information that we've been collecting, but the trend is now looking better for the province of Alberta.

DR. OBERG: Thank you.

MR. CHAIRMAN: Grant.

MR. MITCHELL: Thanks, Ty. I wonder, Shirley, whether you could comment on what steps you've taken to respond to the Children's Advocate report, which was quite damning about the level and quality of mental health services for children.

MRS. McCLELLAN: Well, I think I'll have Bernie talk about the actual responses to the report that we're working on.

One of the things that we are working very hard on in Health is ensuring that we are working more closely with social services, with Justice, perhaps not so much in that area but certainly in other areas, with Education. One of the concerns we have had with children of high needs, whether it be in the mental health area or other areas, is that needs were maybe not being met as well as they should have been because of the lack of perhaps integration between the departments. So over the past year the four departments have worked very hard in that area.

Looking at mental health services for children, I think the key for mental health services in Alberta for all Albertans, certainly including children, is getting the mental health strategic plan in action, ensuring that we have a mental health plan that the regions can utilize. Our concern right now is that the way mental health services have been delivered has been quite fractured and has not really had the continuum that was required. I think mainly how we can deal with that is by having a good mental health plan for Alberta, and children's services of course would be part of that, Grant.

I think the Mental Health Strategic Planning Advisory Committee did a very fine job of traveling around the province listening very carefully, accepting briefs to deal with this issue to give us some advice as to how we can integrate services, how we can work between the institution and the community, how we can support families, in particular, that have children with mental health difficulties. Our challenge now and in the next three years is to get that plan in action and to actually see the positive results that can come from it. I think that work is supported by the Canadian Mental Health Association, by the Alberta group. We've had discussions with them about that, and we simply have to move ahead with that plan this year.

I don't know whether Bernie wants to add anything more.

MR. DOYLE: We've dedicated very specific resources to working with the commissioner for children's services, and we're looking specifically at mental health services for children. We've also got similar resources focused on working with the initiative around the provincial pediatric plan. I sit on the committee of assistant deputy ministers looking at the co-ordination of services to children within Alberta social services, Health, Justice, and Education. We've got a lot of work in progress, and this is beginning to merge. When we settle out what we're going to do with the mental health strategic plan, I think it will fall into place.

MRS. McCLELLAN: Finally come together.

MR. MITCHELL: In your heart of hearts, Bernie, do you think that you're doing enough, that you've got the resources you need to meet the problems that are in that area?

MR. DOYLE: If you look at the number of initiatives that we're involved in, if we look at the combination of those resources and streamline them and co-ordinate them better, I think that we'll have a much better service. I think that's agreed upon by people who are in the field and certainly in pediatric services and in some areas of children's mental health services.

MR. CHAIRMAN: Final supplementary.

MR. MITCHELL: Yeah. Well, this isn't just children's mental health services here. You talk about streamlining and being efficient. How is it that decisions can be made about layoffs at the Alberta Hospital, about potential for integrating Alberta Hospital and Grey Nuns without any kind of real regional plan, without any kind of proper regional authority in place to oversee that that would happen properly?

MRS. McCLELLAN: Well, on the Alberta Hospital, Edmonton itself has had a strategic plan. That has been developed. Of course, certainly part of that strategic plan is in how they deliver services and more community-based grants. So I think that part is done.

I think I've said very clearly that we do have to get this plan in action, and of course that's why we went forward with the strategic advisory committee last year. We recognized that we needed to improve our mental health planning and delivery of services and to ensure that we were expending the dollars we have in the best way. I think we've got that advice; now we have to get it into action. That's this year.

MR. MITCHELL: But Alberta Hospital is cutting, and we don't have even the allocation of the new community-based funds.

MRS. McCLELLAN: Oh, I see. You mean the $30 million additional.

MR. MITCHELL: Yeah. It's not being put into place, so how can it – I mean, you can't sort of have your cake and eat it too. You can't say that they're cutting because we got community based, and then you don't have the community based in place.

MRS. McCLELLAN: Alberta Hospital Edmonton is only acting in areas that they can support in the community. I have every confidence in the people at Alberta Hospital Edmonton that they are confident that they can deliver the services either in the acute care setting or in the community when people are moving into the community at this point. The question is: how many more could we serve in the community if we had more resources? Maybe it's not more resources; maybe it's how we're utilizing the resources we have today, but we could utilize them better. That's the challenge we have.

8:43

MR. CHAIRMAN: Murray.

MR. SMITH: Thank you, Mr. Chairman. I hope I'm as fortunate as the member of the opposition at slipping in as many questions.

MR. MITCHELL: Supplemental.

MR. SMITH: That was a rhetorical statement.

MR. MITCHELL: Oh, that wasn't the first question?

MR. SMITH: I hope I'm as fortunate.

Madam Minister, on votes 4.3.1, 4.3.2, 4.3.3., and 4.3.4: I'd like to tie them into goal 2 in the business plan.

MRS. McCLELLAN: Just a minute. I'm flipping paper here.

MR. SMITH: Yeah. On page 9 and on page 14. Goal 2, strategy 3: "Move toward consolidation of mental health services." Then in "Future Role of Alberta Health" on page 14, the bottom four lines:

> During the next three years it is envisaged that the overall staff complement . . . will be reduced by approximately 45% from its 1992/93 staff complement. The right sizing strategies . . .

and so on. Can you tell me, Madam Minister: how much of that 45 percent will accrue from the divestiture, and how much of that 45 percent will accrue from departmental staff reductions?

MRS. McCLELLAN: It's about 600, just under 600. The member's other comment was: how many are from the department? About 25 percent of that.

MR. ALVAREZ: Twenty-five percent from the divestiture and 20 percent from the department.

MRS. McCLELLAN: Twenty, 25 out of the 45.

MR. SMITH: Twenty-five percent from the divestiture and 20 percent from the department?

MRS. McCLELLAN: Yes.

MR. SMITH: Could you outline briefly the process of divestiture – or at length.

MRS. McCLELLAN: Right as soon as Don comes back. It is complex. It's something that has to be done in a very orderly manner, and there are a number of processes that you have to put in place. As you know, we have done the transition in Rosehaven at Camrose where Bethany care is operating all of that institution. There are a number of things that you have to do. One of the things, though, that we have made very clear is that Alberta Health is getting out of direct delivery of services, and we will be having the services delivered in the community. In mental health many of our services are delivered now by community agencies. I think we have some 51 mental health clinics.

MR. DOYLE: Fifty-one clinics and 40 mobile clinics.

MRS. McCLELLAN: Much of the services that we deliver in mental health are delivered by community agencies today.

MR. CHAIRMAN: Final supplementary?

MR. SMITH: No. That's okay, Mr. Chairman. Thank you.

MRS. McCLELLAN: Do you want to hear about how you go about divestiture? Because my deputy is back, but he's not paying any attention to me.

I just had a very good question from Mr. Smith on the process of divestiture. We're talking about Raymond and Claresholm, and he wanted to know what type of process you go through on divestiture.

MR. PHILIPPON: Well, Bernie can help out here.

Okay. First of all, we have some experience with this with Rosehaven. You've covered that?

MRS. McCLELLAN: Well, I just said that we had the experience.

MR. PHILIPPON: Yeah. Of course, there are a lot of complications in terms of titles to property. There are complications in terms of different unions and so forth. We went through that with Rosehaven, where it was transferred to the Bethany care centre in Camrose.

In the case of Claresholm and Raymond, which we were looking at, certainly it's part of the mental health strategic plan. They advocated the establishment of numerous mental health authorities around the province, which would be quite inconsistent with the overall approach to health authorities that is being discussed more generally for Health. So we're looking at a phasing-in approach so that the divestiture could happen over a period of time, but ultimately mental health services would be totally integrated with other health services within the health region. We might have to take a step to phase it in before we do that, meaning that the secondment – right now the staff at Claresholm and in the clinics are all Department of Health staff. They may have to stay on the Department of Health books for a little longer before we're ready for the actual divestiture to the new boards once they're established.

MR. CHAIRMAN: Okay.

Julius?

MR. YANKOWSKY: Yes. Thank you, Mr. Chairman. Madam Minister, I have just one question or so here under vote 4.2. They say that about 77 percent of residents in long-term care facilities suffer from some form of psychological problems. That's page 47.

MRS. McCLELLAN: Is this in the element details?

MR. YANKOWSKY: Element details. I'm just wondering if there are some funds available somewhere in 4.2 to meet the needs, be it counseling or whatever, of these seniors.

MRS. McCLELLAN: In long-term care?

MR. YANKOWSKY: Yes.

MRS. McCLELLAN: Bernie, do you want to give that?

MR. DOYLE: There are a number of dollars in the long-term care budget to take care of those persons in long-term care suffering from mental illness. There are a number of psychogeriatric programs that are funded through the long-term care program. There are outreach programs as well that relate both to the long-term care programs and to the community with psychiatric components to them.

MRS. McCLELLAN: We have the Alzheimer's programs that are specialized in some of our long-term care facilities as well. Certainly from some of those areas they are learning more about helping in other facilities.

MR. DOYLE: One of the major projects that we've had under way for the last 12 or 13 months has been looking at continuing care for persons with mental illness, primarily elderly people. So it talks about the relationships between long-term care and the mental health sector and how they're going to work together in the future and some of the initiatives that have to be taken because of the demographics indicating that we've got more older people in the province and we'll have more incidences of mental illness among those people. So we've got a lot of work going on within the various sectors.

MR. YANKOWSKY: I was going to ask about Alzheimer's, but the minister has already touched on it, so I'll just let her expand.

MRS. McCLELLAN: Bernie might want to elaborate a bit on some of the initiatives in the Alzheimer's area, because I think it is an important area.

MR. DOYLE: We've worked very closely with the Alzheimer Society in doing public education and worked with them in relationship to what's available for families with persons suffering from Alzheimer's. We just last year did a major publication conjointly with the Alzheimer Society which was very well accepted by people who required that kind of information.

MRS. McCLELLAN: I should just mention the Capital Care, the Dickinsfield project that they're raising funds for right now. It just kicked off.

MR. DOYLE: Well, that's another one of the projects in recognition of that particular need for that population that I think will be a good in-house program and will also have community outreach attached to it as well.

8:53

MR. CHAIRMAN: Final supplementary?
Howard.

MR. SAPERS: Thank you, Mr. Chairman. I was happy to learn tonight, Madam Minister, that you've gone beyond reviewing the strategic mental health plan and in fact you've made a commitment to putting it into action, I believe is the way that you put it. I'm curious to know if that means you've made a decision whether or not the strategic mental health plan will be implemented in its entirety, meaning that it will be kept outside of the regional process which is about to unfold, or whether it will in fact be integrated immediately into these new regional authorities?

MRS. McCLELLAN: Well, I think Bernie alluded to that or Don did earlier in saying that it would appear to us that there needs to be a step in there. Certainly I think ultimately the strong desire will be to have all health services integrated in a regional plan.

Bernie, you commented on the step process – I think it was you; maybe it was Don – that we would have to take because we do not have in place today something to hand to the regions.

MR. DOYLE: It was the recommendation of the Mental Health Strategic Planning Advisory Committee that the ultimate goal would be to integrate with the rest of the system.

MR. CHAIRMAN: Supplementary.

MR. SAPERS: Thank you. Given that the ultimate goal would be to have it integrated, then, I would imagine it would follow that there'd be more of an integration of institutional care and community care so it's more of a continuum. So I'm curious. The budget doesn't seem to reflect that. In fact the budget reflects . . .

MRS. McCLELLAN: That was Muriel's first question.

MR. SAPERS: Well, I'm coming back to it.

MRS. ABDURAHMAN: I'm glad he's going to come back to it as well.

MR. SAPERS: Yes, I thought you might be. The budget still reflects this real, clear demarcation between institution and community. At what point will the budget follow that principle? Another way of putting it would be: how have you prepared to implement the strategic plan?

MRS. McCLELLAN: Well, I think I answered that question in saying that when we prepared the budget, we did not have anything that we could put, so we've shown it that way. These dollars could be moved at any time in the year if we were ready to do that. They're within the same area. But I think it's important to do it right. The mental health strategic advisory committee and the mental health associations in this province worked on it and have been working with us since have put an inordinate amount of effort into creating a mental health strategy for this province. So that's number one with us, that as we move forward to implement their recommendations, we do them right, not that we get it looking in the budget just right, because we can move those dollars when it is appropriate. Don may want to comment.

MR. PHILIPPON: Well, I could just comment a bit. This was covered when I was out. This is the first year you see the mental health hospitals as part of one vote for that very reason: to give us an opportunity to move easier in the year. You'll also note that there's a pilot project under way in central Alberta in Ponoka that is trying to move towards integrating institution and community. So we're moving along that line, and we talked about a step before full integration. That's what we're talking about: how we can get a better balance of the resources before we actually have the regions take on the full responsibility.

MR. CHAIRMAN: Final supplementary.

MR. SAPERS: Thank you. Well, I'll put it this way. We can't tell from the details, we can't tell from the budget about the strategic mental health plan. There's no place in the document that says: line item, strategic mental health plan, this is how much it's going to cost. What assurance is there, then, that dollars are being set aside in your department to implement the strategic mental health plan this year?

MRS. McCLELLAN: Well, the dollars are in our mental health budget in our area. The mental health strategic plan does not call necessarily for a whole bunch of new dollars. It talks about how we deliver mental health services. We do deliver mental health services today, although they may not be in the best way. The mental health strategic plan will give us that advice. I think Bernie commented on that. Really what they talk about is how

we are distributing and how we are using our resources today and how we can do them better. That's what the mental health strategic plan when ready for implementation will do. This is, I think you know, a very complex area.

MR. CHAIRMAN: Bonnie.

MRS. LAING: Thank you very much. Looking at 4.2.4, approved homes, there seems to be a reduction there. What would be the reason for that reduction? Is there a cap, or is there less need for those homes now or more difficult to find people to do it?

MRS. McCLELLAN: Well, it is a transfer of funds, and Bernie might want to explain why we did that.

MR. DOYLE: We decided to go with a contract in Provost rather than a grant, so we moved it to another area. The service is being provided but just being provided differently administratively.

MRS. LAING: Well, approved homes, though, aren't they all over the province?

MR. DOYLE: They are all over the province, but they're administered out of different areas.

MRS. LAING: Oh, I see. Okay.

As you say, with the community agencies I know that you are certainly co-ordinating and co-operating with Family and Social Services and Municipal Affairs through the Calgary housing committee, and one of the initiatives that has been developed there is the use of some of the social assistance money to help pay for the support as part of the housing. Is there room for those types of initiatives in the budget now?

MR. DOYLE: Well, we've had ongoing discussions with social services in regards to that, both on the level of personal support benefits and AISH for specific requirements like housing and basic needs. I think we're arriving at a better understanding of what people with mental illness really need as far as basic needs to survive in the community.

MRS. LAING: That housing component is very important, and without the support it's back to square one for a lot of people.

MR. CHAIRMAN: Final supplementary.

MRS. LAING: All right. Thank you very much. Mental health clinics, are there more of them now in the community, a less formal institution, more use of volunteers, sort of an outreach type? Are we coming to that type of a focus?

MR. DOYLE: Well, we have 51 clinics across the province, and from each of those clinics we try to get volunteers and we try to get more of an outreach. We also have 40 mobile clinics, and these are where the clinicians travel to different parts of the province that don't have those services. We're trying to keep people moving out and keeping our staff moving out into the community with agencies and with hospitals so that we do have that linkage, also with home care social services and Municipal Affairs. If we don't have that linkage, we aren't able to provide the necessary service, because those services are coming from different agencies.

MRS. LAING: Well, that's good to see. Thank you.

MR. CHAIRMAN: Muriel.

MRS. ABDURAHMAN: Yes, I'd like to go back to 4.3.3 and also tie it back to community services. I'd certainly agree with you, Madam Minister, that we've got to do it right, but when I look at program 4 and what I call the premature downsizing of Alberta Hospital out into the community, I get concerned because I honestly don't see the resources there to meet that need. I want to broaden it out inasmuch as you've got places like Counterpoint House, you've got correctional institutes that have got wrongly placed people in them that are actually mentally ill. I am wondering: how are you working with correctionals in coming up with program 4 funding so that the adolescents that have fallen through the cracks and are now in the care that is funded by correctionals through the Justice budget – does it continue to happen and result in people wrongly being placed for the rest of their lives? I don't see any reflection of that in the Justice budget or in program 4.

9:03

MR. DOYLE: Well, we're certainly aware of the issue, and we've been working with Justice on a regular basis. Another meeting is going to take place tomorrow morning as a matter of fact with Justice, social services, and Health. We've got the contract with Alberta Hospital Edmonton to provide financial services to young offenders and to adults. We've also got a major contract with Calgary General hospital to provide the same for the correctional services in the south. So we're trying not to let those people fall between the cracks.

If any of those people who end up in the correctional centres can be classified or certified as formal patients, then they are moved either to Alberta Hospital Edmonton or they're moved to another facility. So we've got a lot of connection, and we're maintaining that connection. Some concerns have been raised to us by the Schizophrenia Society, and we have convened meetings with Alberta Hospital Edmonton, the Justice system, and our staff to sort some of these things out and to look at the populations that are actually in the correctional centres.

MRS. ABDURAHMAN: Supplementary, Mr. Chairman. Following up, then, on the lack of services for children and adolescents and looking at the need for pediatric psychiatrists, has there been any thought, as you've done under program 2, for a rural physician action plan? I don't see anything in this addressing the shortage of psychiatrists, particularly pediatric psychiatrists.

MRS. McCLELLAN: Well, I guess the difficulty is in recruiting. It's one thing to look for moving physicians. You have enough physicians. It's the allocation. We don't have enough psychiatrists. It's not where they're located. We have a shortage in that area. We don't have a shortage per se of physicians. We may have a geographic distribution problem, or we may have a problem in some speciality areas, physicians in oncology and some of those areas. We have a shortage of psychiatrists, whether they be pediatric or otherwise. What initiatives could we take in Alberta to recruit more here? If you have some suggestions – it's usually places like Alberta Hospital Edmonton that do that recruiting.

MRS. ABDURAHMAN: We'd have to get the co-operation of the college of physicians and immigration.

MR. PHILIPPON: There's been a lot of talk as well about increasing the number of training positions for psychiatrists, and Cec is working on some committees where that's being looked at right now.

MRS. LORD: It's actually happening right now. There is something called the postgraduate medical education committee, which has the deans of the medical schools on it. We have agreed, in fact, to reallocate a training position in medicine to psychiatry. I believe there's at least one more physician being trained already this year and of course one each year, so that will begin to increase it.

MRS. McCLELLAN: On the national physician resource really all we can do is look at training positions. Of course, that is a subject that is sometimes debated, as to whether you should.

MRS. ABDURAHMAN: With regards to social services, where we see young children, who for some reason the medical profession don't want to label, end up under social services for psychological care, and they go into clinical programs. The outcomes are not taken into consideration or tied into a social services program that is calendarized. I'm wondering: are we working with social services to start to see that these young people get proper clinical treatment?

MR. DOYLE: Yeah. That's one of the big issues that we're discussing in the assistant deputy minister's committee on coordination of services to children: how we can stop that kind of labeling and that kind of limitation on services to children. So we're looking at it from a procedural point of view and also looking at the legislation.

MRS. ABDURAHMAN: Thank you.
Thank you, Mr. Chairman.

MR. CHAIRMAN: Grant.

MR. MITCHELL: We'd like to go to program 3.

MR. CHAIRMAN: Are there any other questions? You want program 3? Grant, would you start it?

MR. MITCHELL: Do you want me to start? Thanks. There's so much to discuss in here . . .

MRS. McCLELLAN: You're faster than I am. You knew where you wanted to move. Just let me find it in my book and on my sheet.

MR. MITCHELL: There's so much to discuss here, so I'm glad we have some time. It seems like this is maybe the hard rule, a lot of what's occurring. I'd really like to pursue home care. I'm concerned that in seven days – is it seven days now? – acute care funding will be cut dramatically in Edmonton and Calgary. It's already been cut significantly, and it needs the support of home care and community-based care funding. The argument is made – I don't know whether exclusively by the minister but certainly by members of the regional council here – that we can get to the level of British Columbia's bed utilization. But the argument seems to deny that British Columbia spends twice as much per capita on home care alone. How can you expect $100 million to be cut, putting inordinate pressure on acute care facilities, without having in place the program that will allow some of that pressure to be relieved?

MRS. McCLELLAN: Well, first of all, you cannot assume that there is not a system in place. We have over the three years reallocated $110 million, $30 million of which is available in this funding year. So now indeed if you can deliver those services less expensively in the community than you can through acute care – and I believe it to be so – those resources are there. The system is there to have a fine home care system, which has been expanding in this province. I think we can look at our home care system with a great deal of pride. We started out with a system that was, I think, confined to an area of the population – we were looking at seniors. We expanded that to under 65, and I think we've been quite successful with that expansion. Certainly over the last short years, we've been expanding it to accommodate assistance to people for early discharges. That can expand.

One of the important things that I think we have in place is a work force adjustment strategy to ensure that we do have the right people for the right job in the right place at the right time, and we will move to that. I believe that our acute care facilities believe this is the right move. If you take the time to visit particularly the acute care facilities in Edmonton and Calgary, you will see that they have planned for this – less inpatient beds, more day surgeries, more ambulatory care – because indeed that's the right thing for the times. I believe that the system has been preparing, and I think they know how to respond. It's not like it has just all of a sudden started. This has been moving towards it.

MR. CHAIRMAN: Supplemental.

MR. MITCHELL: Thanks, Ty. You know, the key element that you mention is this work force adjustment plan that's held out to solve so many ills, yet we've just seen more layoffs at the Royal Alex yesterday. There are concerns with physiotherapists being laid off. Both nurses and other health care professionals, physiotherapists as well, will play a key role in how home care will evolve and support. How can it be that this level of layoff is occurring without that work force adjustment program being in place?

9:13

MRS. McCLELLAN: Well, you saw a redeployment of a number of workers as well in the Royal Alex downsizing or the changes that they have made.

MR. MITCHELL: I saw early retirements and 91 actual layoffs and some transfers within the hospital.

MRS. McCLELLAN: Yes. So it's really not a massive layoff in a system the size of the Royal Alex. What the acute care facilities are doing: as they downsize, yes, there will be changes. I mean, there have to be. We don't need those numbers of beds. We have more people working in some areas and less in others, and that will continue as the system changes, but there are opportunities in the community, and we are certainly seeing a lot more community support. We're seeing individuals beginning to set up their own groups where they serve home care under contracts or whatever.

Don was just making a note here – that is an important one that I would have overlooked – that over the last 18 months there's been a 50 percent increase in acute care early discharge home care services. That is very significant.

MR. MITCHELL: Where, in the study here?

MRS. McCLELLAN: In the system. It's in the province.

MR. PHILIPPON: But primarily Edmonton and Calgary.

MR. MITCHELL: I think that's in my next question.

MRS. McCLELLAN: Those are where a lot of our high tertiary care and really a lot of our secondary care occurs as well.

MR. MITCHELL: What about rural Alberta? The argument's made that people are discharged from the U of A or Foothills. They go back to their local community. They're discharged too early, there's not adequate home care, they end up being readmitted, and there's no link made, one and two. The $110 million has been committed to Edmonton and Calgary, but there's no evidence of what's been committed . . .

MRS. McCLELLAN: No, no. That is incorrect.

MR. MITCHELL: Is it? How much is going to rural?

MRS. McCLELLAN: There are additional funds for outside of these areas as well. I guess I would have to say that anytime you have as many services provided in a day as we do in Health, in our system, you're going to run into the odd problem. I would say that our institutions and the health care workers in them and in the community are doing a very fine job. I believe most of the institutions – and I would step out and say all of them – have a very good discharge plan. That doesn't mean that they aren't working to improve it or can't.

I'm a rural member and live as far from a high tertiary care as you can get and still be in Alberta, barring 15 miles. We have a very fine home care system in what is a very sparsely populated area; I'd say as much a challenge as many of the northern areas. So it's a matter, certainly, of working together, but we have fine home care support, whether it's on discharge from an acute care situation or whether it's enabling people to stay in their homes. We find that the age of people going into long-term care is increasing greatly because of that. We find the inpatient days coming down significantly, and I would venture to say that the day of long hospital stays in acute care for Albertans is at an end, and that is very positive. That is very positive. We want to continue to support that.

We've talked for a long time about shifting resources from acute care to the community, and we've actually done it this year.

MR. CHAIRMAN: Ed.

MR. STELMACH: Thank you, Mr. Chairman. I'd like to ask a number of questions heading into the work force programs that you have implemented. But before we get to that, would you be able to tell us, Madam Minister, approximately how many FTEs have been deleted from the health sector as a result of the funding reductions over the past two years?

MRS. McCLELLAN: Over two years?

MR. STELMACH: Yes.

MRS. McCLELLAN: Well, if you use the assumption that approximately 70 percent – I think it's closer to 73 percent – is for manpower, the FTE positions might be in the range of about 2,700. However, we know that is not an accurate number, because many times these are vacant at the time or other things that make it up. We would say that our estimate of the number that are affected over two years is between 1,000 and 1,500.

MR. CHAIRMAN: Supplementary.

MR. STELMACH: Thank you, Mr. Chairman. How many more FTEs can we expect to be removed in '94-95?

MRS. McCLELLAN: Well, we would see that there could be quite a large number in '94-95. There are a number of things that will impact that. We have taken a 5 percent reduction in the compensation package from all of the providers, so that was one area. Certainly we are not in the position to say whether there will be voluntary severance programs in various areas. Certainly we know that there will be new job opportunities in health in the community. So I would say that there will be significant change in the work force in 1994-95.

MR. CHAIRMAN: Is there a final supplemental?

MR. STELMACH: Thank you. I know that you have often expressed a need to be compassionate to those workers who have been displaced because of the shift from institutional-based care to community-based. Element 3.1.4 has a provision for work force programs. What kind of programs are we investing the dollars in?

MRS. McCLELLAN: Well, we have a fund of $20 million that's been established. Of this, $15 million has been allocated for work force adjustment and $5 million for restructuring and retooling of the education system, because it's recognized that there'll be new skills, different skills required for some of the jobs in the future. The types of programs that will be available are going to be determined by a joint process, the tripartite committee, and that is of union, employer, and government. So what those programs will be will depend on the decision of that tripartite committee.

MR. CHAIRMAN: Julius.

MR. YANKOWSKY: Thank you, Mr. Chairman. Madam Minister, I have some questions regarding long-term care. I believe it falls under 3.2, 3.3, and 3.4 of the elements.

MRS. McCLELLAN: Okay. I'm ready.

MR. YANKOWSKY: There have been dramatic rate increases in long-term care, like a 17 percent increase last August, and we're looking at another 16 percent increase this April. Can you tell us why the rates are going up so dramatically?

MRS. McCLELLAN: Well, first of all, let me assure you that we still have the lowest rates in Canada.

MR. YANKOWSKY: Yes, according to the chart.

MRS. McCLELLAN: Well, that's important, because the rates in long-term care in Alberta are indexed to income. If a person is receiving full GIS, guaranteed income supplement, OAS, old age security, and the Alberta assured income program, they will pay only a percentage of that so that they have dollars left. I think that's really important. These are indexed. These are to provide lodging costs. There are no health costs in those charges. I think by indexing them to that income, we're ensuring that people can, indeed, still have some dollars left if there are personal needs that can be accommodated. There are provinces

in Canada, and in fact I think operated by Liberal governments, where the charges for long-term care can run over $3,000 a month. Because they are indexed in Alberta, they are kept down and you are assured . . .

9:23

MR. MITCHELL: I thought we were leaving politics out of this.

MRS. McCLELLAN: Well, I'm making a point, Grant. You know, we do have a lower rate. I was challenged on the exorbitant increase, so I have to ensure that the hon. member is aware of what the rates are indeed in other provinces in Canada.

As I said, certainly those fees do not cover the cost of lodging per day in our institutions, and they're not intended to. I do believe that by staying with an index, we will always ensure that we are not charging more than people can pay and that we are still leaving them some dollars. Today in Alberta in a private room it is my understanding from an operator that you would have $135 left. Don says that it's $119, but my person tells me as an administrator that it's $135 left over. I think the key is that we do index it. It is on income, and that is for the highest rate. Also, we have very few standard rooms in the province. Steve, could help me on standard rooms. We have very few, much fewer standards than we do semiprivates and privates. Most of our rooms are semiprivates now.

MR. PETZ: Don perhaps can help with that.

MR. PHILIPPON: All of the newer facilities are semiprivates. A lot of the privates have been upgraded through renovation projects. There are very few standard rooms left in the system. Four-bed wards, that's no longer the quality of life you want in a long-term care facility, so those are being phased out.

MRS. McCLELLAN: We should also say that if there is a situation where it is a difficulty for a person – and that can arise where there is a couple, and one is in long-term care and one is at home – we do everything we can to ensure that we can have some flexibility there, because we do not want those people to have to leave their homes because of the cost of a spouse in long-term care. We're very sensitive to that too.

MR. CHAIRMAN: A supplementary.

MR. YANKOWSKY: Yes. Are we indeed going to just one type of accommodation? Because the increases in the standard rooms have been around 17 percent, the semiprivate has been around seven percent, and the private about three percent, so the gap is closing.

MRS. McCLELLAN: Sure it is.

MR. YANKOWSKY: Are we soon going to have just one type of accommodation?

MRS. McCLELLAN: Well, I think you'll probably very soon not have a lot of standard rooms; that's the four-bed rooms. That's what Don was commenting on. I put Steve on the spot, and that shows you how tired I'm getting, how late it's getting. Grant and I look about the same. We do have very few of those, and we will have less, because they are not the type of room or quality of life that people want for people in those institutions. That's really the reason.

MR. YANKOWSKY: Okay. I have another question.

MR. CHAIRMAN: Your final supplementary.

MR. YANKOWSKY: Yes. There has been talk and so on of lodges and nursing homes going to the assisted living model. Is that correct?

MRS. McCLELLAN: Well, I don't know whether you'd say nursing homes. We have some assisted living models, yes, developing in the province. I think they're an excellent model. I think the important thing for older people or for people who need long-term care, whatever age they are, is that they don't have to make moves. Moves at that point in a person's life or situation are very hard on them. What they look at in an assisted living model in some of them is where it's really meant to be your home, and if you have health problems, those are accommodated in them. They're built to accommodate if you need a wheelchair at some point, if you need handrails, hand assists, and certainly to have the health access. I think they're a good model. The Good Sam Society has an assisted living model that is not for seniors; it's for any age. It certainly looks like an excellent model and an excellent project.

MR. YANKOWSKY: Thank you.

MR. CHAIRMAN: Bonnie.

MRS. LAING: Thank you. Madam Minister, on 3.5.6, the dental treatment services, what types of services are included in this category?

MRS. McCLELLAN: We'll let Steve handle it. He hasn't said anything all night even though I tried to get him into long-term care.

MR. PETZ: Those are services provided in some parts of the province where there are low-income people who have trouble getting access to services, and the health units priorize services for that target group as well as some prevention and education services.

MRS. LAING: So would that be through the health unit?

MR. PETZ: Yes.

MRS. LAING: Are seniors able to access this program? Is it for normal dental work?

MR. PETZ: Most of those services are provided to children or primarily to children.

MR. CHAIRMAN: A final supplementary.

MRS. LAING: All right. I'll change then, because that's destroyed my line of questioning.

On 3.5.3, the early detection of breast cancer, some of the radiologists have been to see me, and they feel that they can provide the service more economically than the provincial screening program. Would you have any point of view on that?

MRS. McCLELLAN: Well, the provincial screening program is really a pilot, and it isn't really a provincial program because it only operates in part of the province at this time. There was some discussion as to whether this screening program was appropriate or whether it could be delivered better in another

way. I felt it was quite an important area as breast cancer is certainly one of the leading causes of death, and certainly the leading cause of cancer deaths of Canadian women. So I asked the advisory committee to be reactivated. This is really the committee that came forward with the proposal on how to deal with breast cancer initiatives and screening. I've asked them to review and evaluate the program to look at how the program could be delivered and to bring me back some advice. I expect to have that quite soon, and we will be making a decision as to whether to expand the program, whether to deliver it another way, pending what they say. I should say that there are two radiologists on that committee. In fact, they're the only group that does have two, so I think their views are well represented.

MRS. LAING: Thank you.

9:33

MR. CHAIRMAN: Howard.

MR. SAPERS: Thanks. Not knowing how the regions will be defined and not knowing what they'll ultimately be responsible for, how do you know that the amount in 3.4.1 is enough, and on what basis will it be allocated?

MRS. McCLELLAN: Well, we know what areas receive today in Health dollars, and really the allocation is on a historic basis.

MR. CHAIRMAN: Supplementary.

MR. SAPERS: Well, not yet.

MR. CHAIRMAN: Yes, there is yet, because you did get an answer to that first question.

MR. SAPERS: But I'm sure that one of the officials from the minister's department wants to supplement the answer. I'm positive of that.

MR. CHAIRMAN: Supplementary.

MR. SAPERS: You can't blame me for trying.

How will tertiary care and tertiary programs be funded under the regional model? Or will the highly specialized programs still be offered on a strictly provincial basis and budgeted for separately?

MRS. McCLELLAN: Highly tertiary care operates in Calgary and Edmonton really, essentially in this province, and they will be accommodated within those budgets. Come back to a historic basis.

MR. SAPERS: Okay.

MR. CHAIRMAN: Final supplementary?

MR. SAPERS: Don't rush me.

The current split between acute care and community care and the fact that the demarcation is being eliminated really between that – within a region how will the decisions be made that this money will still go to an institutional facility even though that institution may be more and more involved in home care and community care versus a more traditional community-based program that otherwise would be getting that same funding?

MRS. McCLELLAN: I'm sure the hon. member is asking that question for the enlightenment of all others present, because I think he was present at a number of the roundtables, and I'm sure that he paid close attention and picked up on all of these things.

MR. SAPERS: One more time with feeling.

MRS. McCLELLAN: Yeah. A regional authority that is put in place will be asked to bring back a three-year business plan on delivery of health services to that region. They will be asked to do an assessment of the health needs of their communities, and they will be asked to do an assessment of the infrastructure and the delivery services that are available, and they will be asked to develop a plan for delivery of those services.

As I said earlier, the community health councils that were a recommendation, which is becoming a stronger recommendation as we hear from communities, will certainly have input into that. The Department of Health will set standards and guidelines, as we do today. That would be our role. I have every confidence that the people in the communities that will be on the regional authorities can do the planning, certainly can do the needs assessment. I would suggest to you that the people in those areas are much better qualified to make those types of decisions than somebody in Edmonton for them. I think it's a role of the department to be there to support them, to assist them with expertise wherever they need it, whether it is in planning or alternate delivery methods or information.

I can certainly tell you that in my community they are very capable of identifying the health needs, of probably telling us very capably how those services could be delivered very efficiently in those communities. I'm confident that my community isn't the only one that has that capability in the province. I think they all do. I think we have to very much believe in the people of this province to take hold of this. You were at the roundtables. That's what they want.

MR. CHAIRMAN: Lyle.

DR. OBERG: Thank you, Mr. Chairman. My question is on . . .

MRS. McCLELLAN: I thought he was going to supplement my answer, for goodness' sake. I thought there wasn't enough feeling or something.

MR. SAPERS: I have a fourth supplemental, though, if Lyle doesn't want it.

MRS. McCLELLAN: I'd better hear from Lyle for a while.

DR. OBERG: Program 3.1.5, equity interest: I see that the numbers are the same. Just refresh my memory, because I think I asked the same question last time. The equity interest is the money that is paid to the voluntary hospitals; correct?

MR. PHILLIPON: Correct.

DR. OBERG: I see that the number has stayed the same. My first question: is that on a long-term contract basis that includes depreciation, or is it a rental basis? What kind of arrangement is it?

MRS. McCLELLAN: I'm going to let Aslam deal with the equity interest issue, if that's all right, Lyle.

MR. BHATTI: Basically it's voluntary hospitals, largely religious hospitals, and so forth. They started in the early days. They've put in some money in terms of getting the hospitals going. In 1959 the government wanted to recognize the contributions made by them. At that time, we took the value of what the religious organizations put into them and said that we have the first right of offer for purchase if you ever want to get out of it. To recognize your equity, we'll give you 3 percent interest each year. Okay? So this is the interest payment component to all of these organizations. There are about 24 of them right now.

MRS. McCLELLAN: I think the question is: why doesn't it change?

DR. OBERG: Right. If I may, just on that. Assuming that the initial payment was for the buildings, there should be a depreciation component to it, and I'm just questioning if that is there.

MR. BHATTI: A lot of it is land related, and we take the historical value of the land at that time. We don't want to recognize the current value, and a lot of it is the amount of actual money they've put, you know, into certain programs and so forth. You're correct; a lot of that lease expired. But the point is that they have put that in and the government has decided to recognize their equity. So there is a value to that facility even though the equipment might have expired long ago.

MR. CHAIRMAN: Okay. Final supplemental.

DR. OBERG: Thank you. I guess what I'd like to do, then, is get to a very specific one that you don't need to tell me any numbers about. The only reason I'm doing it is because I know it's a new hospital. The idea is St. Mary's hospital in Camrose. It was completely redone. Are there still equity interest payments going to that group? Do you want to get back?

MR. BHATTI: I'll get back to you. That's probably the best.

DR. OBERG: The only reason I'm asking that is because it's a new hospital, and I'm just curious.

MRS. McCLELLAN: Yeah. We'd have to check that. It is not our policy to enter into new equity agreements now. When it changes hands, if we take them over, we pay them out, and that's it.

MRS. ABDURAHMAN: I'd like to go to 3.1.8. My question is: how will ambulance service be incorporated within the regional boards acknowledging that they represent private, municipal, unionized, non-unionized groups and there's such a variance in level of service across the province?

MRS. McCLELLAN: Okay. The ambulance services that you see reflected in my budget are the ambulance services that we pay for.

MRS. ABDURAHMAN: Yeah, I realize that.

MRS. McCLELLAN: So Alberta Health pays totally for the air ambulance system in the province, one. Two, we pay for interfacility transfers. So what you're seeing reflected there is what we pay for, and that's our air ambulance program. It's about $10 million, $9.255 million. The interfacility transfers will still be included in the global budgets.

9:43

What I have suggested is that when the regional authorities are formed, their discussions should include ambulance services as well as FCSS as well as lodges as well as others. That does not contemplate that those services will be taken into that. That's to ensure that when you have a region, you have some services that are provided by others. You have to have those services to have your health system run. We do not contemplate, at least in the short term, any change in the way ambulances are operated.

Ambulance dollars are paid in a couple of ways from the province: one, in unconditional grants, part of an unconditional to municipalities where ambulance, police, and fire are put into an unconditional grant and the municipality decides what they allocate; by requisitioning. The regional authorities do not have that authority, or I don't contemplate them having that authority at this time.

So when we talk about ambulance services being a part of it, we're talking about, one, the ones we are responsible for now and, two, that they must have that discussion to ensure that they do have those services available in their community. They're offered, as you said. Sometimes they're hospital based. Sometimes they're private. Sometimes they're municipal. There are many ways, and they're funded in many ways.

MR. CHAIRMAN: Supplementary.

MRS. ABDURAHMAN: Yes. Going to the business plan on page 8 then, enhancing rural emergency health services transportation, it makes me wonder out loud or ask you with acknowledgement to 3.1.8: we will pay for ambulance transfers, but what's going to happen when we're looking at enhancing emergency services with regards to ground? Because what we're hearing out in rural Alberta, at least what I'm hearing, is that the ground ambulance services are being threatened inasmuch as they are not being able to pick up enough business because of the air ambulance service. So if we're going to enhance it, how is that going to happen?

MRS. McCLELLAN: One of the things is that air ambulance is only to be used when it is most appropriate to use air ambulance. It's not as a substitute for ground.

MRS. ABDURAHMAN: But that still doesn't go. How would it enhance?

MRS. McCLELLAN: Well, it does come with what you've just told me, that people are saying that air ambulance is taking away from ground ambulance.

MRS. ABDURAHMAN: That's what the ambulance authorities are saying.

MRS. McCLELLAN: If that is the case, they should be making that case to the Department of Health, because air ambulance is not intended as a substitute for ground ambulance. Air ambulance is to be employed when it is the way to transport a patient, certainly not as a substitute. So I do not see that air ambulance will be taking away from ground ambulance. If a person can be transferred by ground, that's the way they're to be transported. I think it is vital that we have improvement in our rural emergency transport, and we're seeing that occur where we're having certainly much upgraded ambulance transportation, additional equipment that was not common. We have to see an improvement in that.

MRS. ABDURAHMAN: If you'd allow me, Mr. Chairman, I've just a point of clarification for 3.3. Does the Edmonton area health services include Fort Saskatchewan, Leduc, Devon funding?

MRS. McCLELLAN: Those boundaries have not been defined. In our budget it's the Edmonton area.

MRS. ABDURAHMAN: But how, then, could you arrive at that number?

MRS. McCLELLAN: Well, in our budget that is the Edmonton health services area. We have had in place our Edmonton Regional Planning Council for some time, and included in that, outside of the actual boundaries of Edmonton, is St. Albert. That's the only thing that's included in there outside of Edmonton city proper.

MRS. ABDURAHMAN: So Sturgeon health unit wouldn't be in there.

MRS. McCLELLAN: No.

MRS. ABDURAHMAN: Okay.
Thank you, Mr. Chairman.

MR. CHAIRMAN: Murray.

MR. SMITH: Thank you, Mr. Chairman. As the night wears on, I continue to be impressed with the minister's knowledge.

MRS. ABDURAHMAN: Watch out. He's wanting something.

MRS. McCLELLAN: We're really worried right now.

MR. SMITH: In program 3, community health services, I wonder if the minister would outline to me how women's health issues would be integrated into this vote.

MRS. McCLELLAN: In the whole program?

MR. SMITH: Uh huh.

MRS. McCLELLAN: I guess that more likely they would be integrated in the area health services. We're very fortunate in Alberta to have quite a strong women's health program in Calgary and in Edmonton. In fact, looking at some outreach work being done by one of the health centres, one of the areas that I know women's health delivery is looking at right now is how they could do more outreach programs, because there is a concern that communities remote from the major centres do not have those opportunities, particularly for education and prevention.

Other than that, we look at health programs. We do have the special program for the early detection of breast cancer, which is a provincial program. But I would suggest that the women's health programs will be integrated into the regions.

MR. SMITH: Through regional funds.

MRS. McCLELLAN: Yes.

MR. CHAIRMAN: Supplementary.

MR. SMITH: Well, thank you, Mr. Chairman. Actually jumping to vote 3.1.7, medical education allowances, $36 million, which has been constant from last year, could you tell me what they are?

MRS. McCLELLAN: Don's going to tell you.

MR. PHILIPPON: This is basically the component in teaching hospitals where you have part of the faculties of medicine essentially performing a teaching and a service function. There are a number of categories of those. For example, all your residents, people training to be specialists are paid out of this. The interns are paid out of that. There are some other administrative costs paid out of that to support the medical faculty. So we're talking here about people that are primarily based in Edmonton and Calgary, a lot of them at the Foothills, at the university hospital – but not only there; they're at all the other hospitals, the teaching hospitals.

MR. SMITH: Just as a point of clarification, does that also include the nursing faculties?

MR. PHILIPPON: No, it does not.

MR. CHAIRMAN: Final supplementary.

MR. SMITH: Thank you, Mr. Chairman. On to my final supplementary. I also wonder if the minister would tell me in vote 3, on the same line as women's health issues, how palliative care would be recognized through this vote and if in fact there would be a restructuring of the vote as the business plan carried through to more focused, specific funds on that particular segment of health care.

MRS. McCLELLAN: Well, today palliative care is delivered in a couple of ways: one, in an institutional setting but perhaps becoming more often in a home setting. Again, I would see those programs being expanded through their regional authority and the identification of the need, as-needed basis in the community. What I am understanding of palliative care is that there is a strong need for a linkage between the institution and the community and certainly between the physicians and the community. So it will occur through the regional authorities, and I think the funding priorities for those initiatives will come in that area. What? Don's giving me some notes here. Oh, he's pointing out that last year there was a 17.3 percent increase in home care for palliative care. So I guess that emphasizes the fact that it is moving far more to community based.

9:53

MR. PHILIPPON: Maybe just one other comment I could provide is that a lot of the questions tonight have focused on the community services, and remember this is a reallocation of dollars that's going to take place. When we talk about the $110 million, we're talking about $30 million this year. Certainly palliative care is an area that we see the need for some reallocation of dollars to the community for.

MR. SMITH: Thank you very much.

MR. MITCHELL: I'm sitting and adding up, sort of assessing what it is that these regional boards are going to have to do and the task that will confront them now. We don't know who they're going to be. They don't know who they're going to be. They don't know what areas they're going to represent. We have no idea how they're going to be selected. We know that they're going to, say, in the case of Edmonton and Calgary have to adjust the interaction of multitudes of acute care facilities and other boards within their region. We have no idea of the work force

requirements today and four years and five years from now. They're going to have to confront immediately in Edmonton $55 million worth of cuts and immediately in Calgary $45 million worth of cuts. They're going to have to do something with home care and community-based other care services, but they have no idea what that's going to be or how it's going to be allocated. I'm saying to myself: is this a full-time job, and what kind of staff are they going to need to have helping them?

MRS. McCLELLAN: All I can say is: oh, ye of little faith. First of all, I take what you say very seriously because I think you're forgetting something in this process today. We do have a system, and on June 1 that system is not going to instantly disappear like the magic rabbit or whatever it was in the hat. We will still have a system. We have boards and agencies that are delivering services today, and on June 1 they are not going to likely disappear. There will be a transition time. It will be very few days – I would hope very few days: comment to the committee co-chair and member – that we will have the area boundaries. These are not going to be a big surprise to the areas, my dear colleague, because they are the ones who are recommending them. I have to remind you that there are many parts of this province that have been operating on this basis for some time.

MR. MITCHELL: But they're not recommending, and that's the fact.

MRS. McCLELLAN: They are.

MR. MITCHELL: Is that why Lou Hyndman's in it?

MRS. McCLELLAN: No, no. Lou Hyndman has nothing to do with the areas.

So these will be in place, and the process for the appointment of the first boards will be in place. The interesting thing is that we're going to get that advice from the community to the steering committee and back to the minister. Now, I know there is a difference of philosophy in that area. I believe very strongly in receiving that advice from the communities. I do not believe that the Minister of Health should dictate all these things, and I am willing to be a bit patient. So on June 1 we will announce new authorities. They will understand quite clearly their mandate. There has been an outline of that given in Action Plan, part 1, which went out in January. I've had a great deal of interest expressed to me through letters as to people who are interested in serving on these.

MR. MITCHELL: Has Howard written to you?

MRS. McCLELLAN: Not yet.

We have said that we would ask them to develop a three-year business plan. So the planning will occur over a period of time. We do have a system in place. You will still access your health care on June 15 the way you do today, and I think to have a concern out there from people about anything otherwise is really unfair. It is going to take some time for the system to restructure and to adjust. We've got to, certainly, as the Department of Health be there to support them. But believe me, give these communities some credit. They are willing to be self-reliant. They are willing to make the decisions, and I can assure you the health care delivery will continue in this province better and I believe more efficiently. We'll have a quality system that is contemporary, visionary and, importantly, affordable.

MR. CHAIRMAN: Supplementary.

MR. MITCHELL: Yes. Thanks. This is an example to illustrate my question about how you actually exercise authority. Say that the regional board in Red Deer decides that it doesn't want to pay the regional board in Edmonton for the provision of dialysis services.

MRS. McCLELLAN: They won't do that. It won't be done that way, Grant, not that I see anyway. I maybe didn't make myself clear when Howard asked the question, I believe it was, on tertiary care, and I guess that's when I used the term: funding on a historic basis. We know the programs that are there today, and as you know, there are a number of programs that we fund to the tertiary care hospitals on a program basis. They are not on a global basis. In fact, the renal program is funded in a program fund.

MR. MITCHELL: Only part of it.

MRS. McCLELLAN: Well, that's right, and they can outsource. In fact, today some of the rural communities cost share those renal programs. So those arrangements can still occur, but we do know what the referral rates are and referral patterns are. We have a pretty good indication of how many procedures we do in certain areas, and we will have to fund that way. To have funding follow a patient – now we're talking in theory. The chairman's going to rule us out of order. But it's pretty hard to do that. You don't preplan a heart attack. It's not like registering for something. So I think we have to look at dealing with it on a historic basis. I think we have to look at the number of procedures we provide and where we provide them. Frankly, there is a lot of thought that many of our hospitals are underutilized and that they could be providing more services and taking some of the strain off our high tertiary care hospitals. I think that's something we should look at, and I think that's something the regions will look at.

MR. CHAIRMAN: Final supplementary.

MR. MITCHELL: Shirley, in answer to my first question, you said that the Minister of Health shouldn't be dictating solutions, that those should come from the community. Just the other day Ralph himself suggested that he'd move in and close hospitals in health care. Is this Ralph freelancing, or is this yet another model of regional decision-making?

MR. CHAIRMAN: I have to step in. That's getting a little bit off the topic.

MRS. McCLELLAN: Well, I can comment. If it comes to opening or closure of hospitals, the Minister of Health does ultimately have that responsibility. What we're doing now is looking at the utilization.

MR. MITCHELL: So you're fighting with Ralph for that.

MRS. McCLELLAN: No. We're looking at utilization of our facilities.

MR. MITCHELL: Okay. Thank you.

MR. CHAIRMAN: Ed.

MR. STELMACH: Thank you, Mr. Chairman. Under institutional community health, program 3, 3.1.1 and 3.1.2, under general administration there's $5 million and in program management about $23,000. Are those both really under the umbrella of administration?

10:03

MRS. McCLELLAN: Well, the two administrative components I think you're referring to: one is general administration and one is program management. General administration includes all the administrative components of acute care, long-term care, public health and also has the staff that was formerly in our estimates as hospital services branch. That's a general administration area. We're combining all of that now, and they work in a team approach.

In the program management, that's the staff within acute care, long-term care, public health that are responsible for program development and operations. These could be related to family health services, specialty services, communicable disease control, home care, environmental health, emergency health, all those areas. Also in that area, if I'm correct, there is some purchase of vaccines, and I believe the early detection of breast cancer program is in that area as well.

MR. STELMACH: There seems to be an increase there from last year. Could you give us a reason why?

MRS. McCLELLAN: Yes. That $2.5 million increase is for systems development. Its better information and more coordinated approach is really what we need for a more efficient and effective system. So we are allocating some more dollars for that.

MR. STELMACH: The last one, 3.1.6, human tissue and blood services: there is an increase in that element of about $3 million.

MRS. McCLELLAN: I'm going to let Aslam look after that one because the high purity products is a bit technical.

MR. BHATTI: That's the amount of money we give to the Canadian Blood Agency for providing blood through the Red Cross system to all the Alberta hospitals and so forth. The increase is specifically related to the introduction of high purity products for people who are haemophiliacs and that need coagulation products.

MR. STELMACH: Thank you.

MR. CHAIRMAN: Committee members, we are very, very close to the end. I wonder if the minister cares to make any closing comments.

MRS. McCLELLAN: I would simply say that we've had four hours, even taking the five minutes off for the break. Obviously, for a department as large and as complex as the Department of Health I think I want to compliment the committee members on the use of the time. I believe very sincerely that all the committee members are very interested in the changes we're making in the health system and how we deliver health services. I found it a very interesting evening. I hope that if there are questions we haven't been able to cover, members will feel free to bring them to our attention.

The restructuring of this health system is not something that will occur overnight. It's going to take a great deal of effort, and it's going to take effort on all our behalfs. I think if we work together in these efforts, we'll better serve the health needs of Albertans. So I simply thank colleagues for their input. In some cases I noted some advice, and I take that as it was intended. We will very carefully, Mr. Chairman, go through *Hansard*, and if we can see areas where we could more fully answer the questions that were raised, we will. I look forward to the wrap-up of these estimates in the House when they're called. I'll tell the committee now that I won't take time at that time to answer the questions we may have missed tonight; I hope we can do those before that time so that if there are wrap-up comments, we can spend the time in the House dealing with them.

It's a very important year for Alberta Health because this is a year of action which has come from several years of planning. It's very important that we move along the process together.

MR. MITCHELL: I'd just like to say thanks very much, Shirley. I know this is grueling for you, and we really do appreciate your effort and the quality of your preparation.

MRS. McCLELLAN: And my staff.

MR. MITCHELL: To each of your staff members I want to extend the same congratulations. It was very, very good of you to take the time with us. We certainly do appreciate it.

Thanks, Ty.

MR. CHAIRMAN: Well, I want to take this opportunity to thank the minister. I think there was a lot of information tonight. Certainly once again you demonstrated how you understand the whole big picture, and I think that's extremely important. I want to thank the staff for their participation. It once again was very interesting, and a lot of information came forward.

I want to thank the committee members as well. I think it was a very good evening. Certainly all committee members showed they are deeply interested in the health care system and how we can restructure it together and come up with a system that we can afford and that is a number one health care system.

So with that, I must close with saying that under Standing Order 56(7) debate is now concluded on the consideration of the Department of Health's '94-95 budget estimates, and the chairman of the subcommittee shall report to the Committee of Supply when so called to do.

Thank you very much.

MRS. McCLELLAN: Thank you, Mr. Chairman.

[The committee adjourned at 10:09 p.m.]