Legislative Assembly of Alberta

Title: Monday, March 4, 1996 Designated Subcommittee
Date: 96/03/04
6:00 p.m.
[Chairman: Dr. Oberg]

Committee of Supply: Designated Supply Subcommittee Health

THE CHAIRMAN: Okay. I'd like to welcome everyone to the designated subcommittee on Health. First of all, I'd just like to get a bit of procedural issues out of the way. As you know, this is a four-hour session. It will be two hours tonight; it will be two hours at a future date that has yet to be determined. I apologize for that, but it is quite difficult getting everyone's schedule to be okay for the next two hours. I certainly will get back to you as quickly as possible so that you can plan on the next two hours.

First of all, I'll just remind people of a couple of issues. As in Standing Orders, the minister is allowed 20 minutes for opening remarks, the opposition Liberal Party is then allowed half the remaining time, and the government the other half the remaining time. There will be a motion on the floor in a minute on that.

The other issue is that we do have people here who are not members of this subcommittee. The members are allowed to participate but may not vote. [interjections] Sorry, my apologies. They cannot participate. They can listen, and they cannot vote.

MRS. McCLELLAN: Can we identify who they are?

THE CHAIRMAN: Sure. What I can do is give you a quick list of who's on the subcommittee here: Oberg, Abdurahman, Clegg, Dickson, Fritz, Havelock, Kirkland has been replaced by Karen Leibovici, Renner, Sapers, Stelmach, Woloshyn, and Yankowsky. So they will be allowed to participate and vote. I must remind people that there will be one main question followed by two supplementals.

So with that, I would entertain a procedural motion by Mr. Havelock.

MR. HAVELOCK: Thank you, Mr. Chairman. Would you like me to just read this? I won't read the answers; I'll try and read the questions. My motion is:

> Be it resolved that the designated supply subcommittee on Health allocate the four hours allotted to it pursuant to Standing Order 56(7)(b) as follows: the Minister of Health will be given up to 20 minutes for introductory comments, the opposition members will be given the first 50 minutes and third hour to ask questions of the Minister of Health, and government members will be given the second 50 minutes and fourth hour for questions. If additional time is needed for questions, the committee could pass a unanimous motion to extend the meeting. If all questions have been asked prior to four hours elapsing, the committee could pass a unanimous motion to end the meeting prior to four hours elapsing.

THE CHAIRMAN: Thank you.

Is there any discussion on that motion? Mr. Sapers.

MR. SAPERS: Thanks, Lyle. Just for clarification. If we get to the point where we're at the last hour, which, as I understand the motion, would be the government members' chance to ask the minister questions, in the fourth of the four hours, and government members have run out of questions but the four hours have not expired, would there be an opportunity there for opposition members who may have formulated new questions based on new information elicited from the minister in her responses to use the remaining time in questions?

THE CHAIRMAN: No, there isn't, and the rationale for that is that each side has been allocated their two hours. You can use your two-hour allotment as you see fit.

Any other discussion on the motion?

All in favour?

MR. WOLOSHYN: Just one point. Excuse me. Are you saying that we can extend the four hours?

THE CHAIRMAN: Yes.

MR. WOLOSHYN: I do believe – and I'll check on that – that the Standing Orders outline that we cannot. It's up to four hours.

MR. SAPERS: I can't hear you, Stan.

MRS. McCLELLAN: He's just saying that he doesn't think we can extend, that Standing Orders say up to four hours.

THE CHAIRMAN: But it is with unanimous approval.

MRS. McCLELLAN: Well, we can't. I mean, it's going to be very difficult to do it anyway because tonight we're constrained by hitting the House at 8 o'clock.

AN HON. MEMBER: I'll get Standing Orders, Mr. Chairman.

THE CHAIRMAN: Sure, and if that part of the motion is not in order, then we will amend it later on.

MRS. McCLELLAN: Well, I'm not going to vote. I mean, I can't vote on this, but I don't think we should vote on a motion that we can't . . .

MR. SAPERS: That we can't operationalize.

THE CHAIRMAN: We'll get an opinion on that. Just hang on. We've got Standing Orders here.

MRS. McCLELLAN: Why don't we start off with an agreement to get going? We could start with the agreement to get going. I'll do my comments. You look at all your procedural wrangling, and then we could break in and deal with the motion.

THE CHAIRMAN: Sure. What we can do is: after the minister's opening comments we'll deal with the procedural motion.

MRS. McCLELLAN: That's a great idea. Can I start?

THE CHAIRMAN: Please go ahead.

MRS. McCLELLAN: Okay. I want to assure members that there are some of my colleagues here that are here because they are part of my Health budget. As we present our budgets now, while a number of these members report to me, the detail of their expenditures are in my budget. I would introduce Jocelyn Burgener, who is here as the chair of the Seniors Advisory Council; Denis Herard, who is here as the chairman of the Health Facilities Review Commission; and Bonnie Laing, who is here as the chair of AADAC. So I just wanted to make that clear, that they're not here as committee members per se.

I'd like to also introduce the department staff that are joining me today and thank you for facilitating them being at the table. I do think it'll probably make it much easier for us. Dr. Jane Fulton, deputy minister, is to my immediate right. Don Ford,

assistant deputy minister for area services, is next to Jane. Cec Lord, executive director of the Intergovernmental Issues Secretariat, is next to Don. At my left arm, just coincidentally not philosophically, is Aslam Bhatti, assistant deputy minister of corporate services. I want to thank our department members for joining us tonight.

Colleagues, after three years of hard work and tough decisions 1996 will be a year of greater stability in health. It will be a year to monitor and evaluate quality and accessibility. Original budget targets announced previously therefore have been revised, and I'm sure we will discuss that this evening.

This year's estimates show an increase of 4 percent in my department's budget over last year's budget but only a slight increase over '95-96 expenditure forecasts. As I explained when I was before you in supplementary estimates, higher than anticipated expenditures in '95-96 are largely the result of the AMA agreement, which has postponed achieved savings of $100 million in medical and drug expenditures to subsequent years. I would note once again that these savings will be achieved through new efficiencies, not through benefit reductions, and that is very clear in the announcements that we made in the agreement. I want to emphasize that one more time: savings will not be counted if they were achieved that way. So frankly we're saying that there cannot be savings attributed to that $100 million in benefit reductions.

As well, $11.4 million in additional funds were also provided in '95-96 to reduce surgery and MRI backlogs and to establish a whole nutritional therapy program. We had a very good debate and discussion – I would say maybe more than debate on that – when I appeared before you in supplementary estimates for those figures.

Health expenditures I believe have been brought under control but not at the expense of high-quality services. The efficiencies that have been realized will put this province in a better position than most others to withstand reductions in federal social transfer payments – and you note that we have not asked the regions to accommodate those reduced transfer payments – and to respond to our aging population and to address pressure points in the health system wherever and whenever they occur. The monitoring and audit system that we have in place through the Provincial Health Council will also ensure that we have that information, I believe, in advance so that we're being proactive rather than reactive in pressure points.

The government will, for example, not proceed with the $53 million planned reductions to the regional health authorities this year. Community services funding will increase $40 million, as we had planned. I'm working with the regional health authorities on the distribution of these funds. We thought it was important that we take some time to sit down with the regions and talk about how we redistribute these funds, and that process is occurring now.

6:10

We are committed to providing Albertans with the most advanced care, so therefore we are committing $15 million to the purchase of new medical equipment. Of course, these are over and above the dollars that we have available to us through lottery funding for specialized equipment. These funds will be distributed to the regions in a proportional manner. I have also asked the regions to work with me and among themselves to bring forward a capital planning mechanism for the future. I think it's extremely important that replacement of capital items be a part of their planning process. Once these funds have been allocated as well as the equipment funding and $2 million in waste management funding, all regional health authority budgets will be equal to or higher than their 1995-96 budgets. I plan to have those allocations made within a couple of weeks and most certainly by March 31.

Other priority areas will also receive additional funds. All members are well acquainted with the difficulties in recruiting and retaining physicians in some rural and remote communities across Canada, never mind just in Alberta. We therefore seek to bolster the rural physician action plan budget by $1.1 million to bring it to a total of $2.8 million. I know a number of members have had the opportunity to read the document, the report card on the rural physician action plan, and a number of the recommendations that we are bringing forward are as a result of that review.

I'm also pleased to add that Dr. Larry Ohlhauser, who is the registrar of the College of Physicians and Surgeons, has graciously agreed to chair the Rural Physician Action Plan Co-ordinating Committee. I'm confident that under his leadership innovative ways will be found to improve the geographic distribution of physicians in this province.

The Action for Health initiative, which funds health promotion activities, will see its budget grow by $2 million to a total of $6.5 million. This is certainly consistent with our goal of providing information to Albertans to enable them to take more responsibility for their health.

For its part Alberta Health continues to reduce its administrative costs. Its staff complement will be reduced by 124 full-time equivalents.

The estimates also show that the Provincial Health Council will receive an increase of $1 million to reflect its first year of operation. If you recall, we funded them for part of the year last year.

The theme of stability is also apparent on the revenue side. The planned increase in Alberta health care insurance premiums will not be implemented. Premiums will stay at 1995-96 levels, as will homemaker fees under the home care program. Long-term care accommodation rates will also remain the same. I believe they have not changed in the last two years. So we've been able to keep them stable, certainly, I think, giving our persons requiring long-term care accommodation the best rates in Canada.

Though the Health budget is increasing, we remain committed to restructuring. Over the coming months and years we'll continue to work with our service providers to reduce drug and medical expenditures through more appropriate usage and to explore new models of primary care including alternatives to fee for service.

To close, I want to acknowledge the efforts of the regional health authorities and the health professions in achieving these past targets. These ambitious goals could not have been accomplished without the input and co-operation of many groups and individuals.

The modest increase that we are asking for in 1996-97 will be invested into priority areas that ensure quality and accessibility for all Albertans. At the same time work will continue to find other and further efficiencies to ensure that resources are spent on necessary services that have a positive impact on the health of Albertans, to integrate services to improve access and quality, and to continue the shift from a treatment-based to a wellness-based health system.

I believe I've covered the highlights of the Department of Health's budget for '96-97 and look forward to discussing the elements in further detail. I think I did it in under the 20 minutes, so we have about a seven-minute advantage.

THE CHAIRMAN: Thank you, Madam Minister. Are you

having any of the other chairmen speak?

MRS. McCLELLAN: Certainly we could if they wanted to make some brief comments on their areas.

THE CHAIRMAN: You still have 10 minutes, if you so choose. It's up to you.

MRS. McCLELLAN: I leave it to my colleagues, if they wish. In fairness to them I don't think they were really understanding that they were going to take part in this.

THE CHAIRMAN: Okay. No problem at all.

MRS. McCLELLAN: But they're ready to answer questions.

THE CHAIRMAN: Sure.
If we can move on, then, to the first question.

MR. SAPERS: Lyle, I thought we were going to get the motion on the procedural stuff.

THE CHAIRMAN: Oh, sorry. Yes.

MR. SAPERS: I'd like to clarify. The practice in previous years has been that when we talk about these procedural things, it's not against that four hours of debate time in terms of the questions. So this just extends the next session.

MRS. McCLELLAN: Well, I gave you 10 minutes out of my speech to do the motion.

THE CHAIRMAN: Yeah, we gave an extra 10 minutes there.
If I can, just on the procedural motion, the motion is in order. You can unanimously move to extend the four-hour time frame. So if I can repeat the motion, then, by Mr. Havelock: I would like to propose the following motion pertaining to the procedure we will follow for this designated subcommittee of supply.

> Be it resolved that the designated supply subcommittee on Health allocate the four hours allotted to it pursuant to Standing Order 56(7)(b) as follows: the Minister of Health will be given up to 20 minutes for introductory comments, the opposition members will be given the first 50 minutes and the third hour to ask questions of the Minister of Health, and government members will be given the second 50 minutes and the fourth hour for questions. If additional time is needed for questions, the committee could pass a unanimous motion to extend the meeting. If all questions have been asked prior to four hours elapsing, the committee could pass a unanimous motion to end the meeting prior to four hours elapsing.

Is there any further discussion on the motion?

MS LEIBOVICI: Well, if I may.

THE CHAIRMAN: Sure.

MS LEIBOVICI: According to Standing Orders 56(7)(a) and (b), that talk about the designated supply subcommittees, it seems that it's actually reverse from what you've read out there.

> A Designated Supply Subcommittee shall not consider the head:estimates referred to it for less than four hours except with the unanimous consent of the subcommittee.

Is that what you said?

THE CHAIRMAN: If you could read (b), please.

MS LEIBOVICI: "A Designated Supply Subcommittee may move to consider the estimates referred to it for more than four hours." So we can't cut the time of a designated subcommittee; we can just extend it.

THE CHAIRMAN: If I can, the motion does not refer to it unless there is unanimous consent. Standing Order 7(a) states that it can do it for less than four hours with the "unanimous consent of the subcommittee." It shall not consider it "except with the unanimous consent of the subcommittee."

MS LEIBOVICI: Correct. Okay.

THE CHAIRMAN: So you can shorten it or you can lengthen it providing there is unanimous consent.
Any other discussion on the motion? All in favour?

HON. MEMBERS: Aye.

THE CHAIRMAN: Opposed? Thank you.
Go ahead.

MR. SAPERS: On another procedural matter, Lyle. I know that you addressed the difficulty of scheduling this meeting, and I appreciate that. I know that it's tough for all of us to find another couple of hours, particularly given what's happened with estimates and the changes there. That being said, we were notified late last week, and I know that several members of the opposition caucus have rescheduled their agendas already to accommodate tonight and Wednesday night. I would like to move that the schedule that we were advised of last week, that being two hours tonight and two hours on Wednesday night of this week, be adhered to. I guess it just needs a seconder.

THE CHAIRMAN: If I can on that. It is the Chairman who makes that decision, and I will try and be as lenient with all members. We do have a conflict on our side for that evening, and I will contact you as soon as possible to get a mutually agreeable date. The unfortunate part is that this was done on much shorter notice than it usually is, and we just had some conflicts from our end on it, Howard. We will certainly try.

6:20

MR. SAPERS: I appreciate your undertaking to work towards a mutually agreeable date. Thanks.

THE CHAIRMAN: Thank you.
If we can start the questioning then. I will be taking a speakers' list. We will be having one main question with two supplementaries.

MR. SAPERS: Thanks for your opening comments, Madam Minister. I appreciate both their substance and their brevity. That's a tough act. I want to ask you a couple of questions that flow initially out of the opening comments and then move through the business plan and then move to the votes, if that's okay.

Just to start with, I think it's fair to say that there has been some confusion about the overall budget allocations to Health. Over the last couple of years there have been several sets of numbers, and that has led to some uncertainty. Now, I would like you to be as specific as you can in terms of letting me know: what did you mean specifically when you said that higher than anticipated expenses can be attributed to the AMA agreement? Was it the AMA agreement that was in place, the AMA

agreement that has just been negotiated, or is it because of the fee-for-service method of payment?

MRS. McCLELLAN: No. It is because we were not able to achieve the agreement that we had set out a year ago. If you will recall, we had a one-year agreement, and that agreement stated that we would work towards finding $100 million in savings over two years. We were not successful in that process. We have an agreement signed now that amends that agreement, I guess you might say, carries on from it and commits to finding $50 million in physician services, $50 million in savings in drugs over three years rather than two.

THE CHAIRMAN: Okay.
Your first supplemental.

MR. SAPERS: Yeah. That part I understood. The $100 million in savings, which was the target over two years, has been translated into two $50 million envelopes of hoped-for savings, and I understand that part, but it was the comment about the higher than anticipated expenses that I wanted you to comment on.

MRS. McCLELLAN: Well, certainly the higher than anticipated expenditures are in the drug program, and you know that I went for supplementary estimates last fall and again this year. We believed as a government that it was more important to keep the integrity of the program than to reduce benefits to meet those savings. So we have asked for supplementary estimates, which you participated in the debate.

I will not go into the detail on where we find dollars in our drug management, but we have had discussions in the House on savings. We've had discussions actually outside of the House on areas that I think we mutually believe we can find savings. We will be bringing forward in the very short future our plan for moving ahead with that strategy to, one, eliminate waste in drugs and, two, to deal with the issues of appropriate utilization. It is of great concern to all of us that as much as one in three hospitalizations, particularly for seniors, can be attributed to improper utilization of pharmaceutical products. So we know that the savings are there.

What we have to do is work together. I suggested to you in the House that the group that will be working on that will be the physicians, who are the people who prescribe; the pharmacists, who are the people who dispense; the consumers, who obviously consume; the pharmaceutical manufacturers, who of course produce the materials; and Alberta Health, who funds our drug programs. So we think by having that joint group at the table we will achieve those savings.

You know that the Pharmaceutical Manufacturers Association has a commitment to reducing inappropriate utilization, and we were pleased to be a part of their Knowledge Is the Best Medicine campaign, along with my colleague Bonnie Laing from AADAC as well as numerous partners, pharmaceutical associations, and others. I believe you were at the kickoff for that and saw that very impressive list of partners in that program. So that's certainly going to be a key program to launch and see results this year.

THE CHAIRMAN: Thank you.
Second supplemental.

MR. SAPERS: Thanks, Lyle.

Madam Minister, I think we all agree that we can save some money in places on drugs. The difficulty I have, though, is this. We've now seen the AMA agreement move from the $100 million in savings to be negotiated to a $50 million envelope or pool that's going to be somehow cut out of the drug benefit costs. But I have to hold that up against the original budget which called for, I believe, close to a $40 million reduction in Blue Cross benefits, which wasn't achieved, and the fact that for the last two quarters you have found it necessary to come to the Assembly with supplementary estimates asking for in excess of $45 million for drug costs. So we have this huge difference between what was in the original business plan and what in fact we're committing in terms of tax dollars, something in the order of an $80 million or $90 million difference. In spite of that history, you're now suggesting that $50 million is going to be achieved over the next three years as a result of the AMA agreement. Could you be specific in how that will happen, and could you give us some indication of how realistic you think it is, given that history, that this $50 million can actually be found?

MRS. McCLELLAN: I guess what was lacking before was the partnership or having all of the players at the table. If you recall, I had a committee look at how we could find those savings. I haven't released the report of that committee yet. I expect I will sometime down the road. It is an advice-to-the-minister type of report rather than a public report, but frankly the recommendations in that report, a great number of them, were totally unacceptable to this government. I guess that's one of the reasons that the commitment now is to have all of the players at the table and look at the inappropriate utilization, look at the waste, and find our savings there instead of reducing benefits to the people who access our drug programs.

Of course, you know our major programs are our seniors' group 66 program and our nongroup, and we think it's important that those benefits remain. We made some adjustments to the seniors' program last year to try and improve that program for seniors by having them pay 30 percent rather than 20 percent but being able to cap the high-cost drugs at $25 a prescription. I know that any of you who have seniors in your constituencies know that the costs for seniors for drugs can be up to $500 a month for two prescriptions if they have a particular illness. We felt that it was really important that we have that cap in there, and in the discussions that we had with seniors they agreed they would pay a little more and we would put that cap on. I think, frankly, it's worked quite well. It's a bit difficult for some seniors who have a multitude of small prescriptions. So we have to look at that.

Aslam's just correcting your figures. He says that it's actually a $45 million difference because we didn't adjust the programs that I just indicated. So thanks, Aslam. He's sharper at correcting your math than I am.

MRS. ABDURAHMAN: That's why he's here.

6:30

MRS. McCLELLAN: I think we have to really look at this together. We have to look at this program. You know that we're faced with the challenge every April and, I think it's October, when we add to our formulary. We have new drugs coming on, useful drugs but expensive drugs, and we want to be able to take those dollars that we should be spending and put them into the ability of adding new products that are proven to be useful instead of, frankly, burning them up or washing them away. So this is one area.

If the pharmaceutical manufacturers' report is even close to accurate, that there's $7 billion to $9 billion in costs – now that's

not all in drugs; that's lost productivity and things like that – that's significant. When you consider our drug use, it's probably close to $1 billion that could be attributed to Alberta alone. If you took a fraction of that for the actual drug cost, you know that the savings can be there. We also know you're not going to do this overnight, because a lot of it is education and a lot of it is working with the pharmacists and the physicians. We're looking at things like trial prescriptions, where rather than having a prescription for 30 days given on a new drug, we give maybe three to five days or seven days, and then if there's an intolerance to that or it isn't working, you haven't lost that whole 30-day supply, because it can't be taken in and used again. We know that there's a great deal of waste in that area.

We did a trial prescription pilot in the Red Deer area, and it had enough success to give us some information. It wasn't as successful as we would have liked, but it did give us some information that we can do things better. We think that by having the pharmacists, the physicians and, as I say, the others together, we can challenge some of those inefficiencies that have been there before. How long a supply of drugs do you give a terminal patient? Are you better to follow up with home care and have continuous, shorter prescriptions than to have, you know, a family having to tackle bagging up buckets of drugs and sending them for disposal? We're paying for 70 percent of that, and the consumer is paying for the other 30 percent. So there are things we can do, but we can't do them strictly through Alberta Health; we've got to have the other players involved.

MR. DICKSON: What changes do you plan on making to the Alberta Health Care Insurance Act, firstly, and to the Hospitals Act, secondly, to give Albertans the same kind of privacy protection that's afforded them by the Freedom of Information and Protection of Privacy Act? Just parenthetically I'll say that I took from a response I got from your colleague the Minister of Public Works, Supply and Services the other day that there's some change contemplated to be able to provide those kinds of protection.

MRS. McCLELLAN: I believe it was felt at the time of implementation that there was very good protection under the Acts that we have but there wasn't enough knowledge to immediately move those into the freedom of information and privacy Act and that, frankly, we needed more time to ensure that placing those in that Act would ensure the confidentiality of health information, which is a very serious consideration for this minister.

There will be work done over a period of time. We'll look at those sections of the Act to see how they could be placed or if they should be placed under that Act. I am frankly confident right now that they are better placed where they are until we have some of those questions answered. I think that probably we were wiser to make sure we knew the answers before we moved them into that Act. The work is ongoing on that with FOIP.

THE CHAIRMAN: First supplemental.

MR. DICKSON: Thanks, Mr. Chairman. Are you prepared to commit that a privacy impact assessment will be undertaken and completed by the freedom of information and protection of privacy commissioner before you commence your smart card pilot project?

MRS. McCLELLAN: Absolutely. I've said that consistently. I have said that there will not be any move forward on how we handle databases, how we handle linkages, how we proceed with utilization of health card technology unless we can ensure, as much as any of us can, that privacy will be protected. So anything that would move forward in this area will have that. I'm sure you're aware that the Privacy Commissioner's office has been invited to be involved in all of the discussions that we've had on how we deal with health information, and I think that's absolutely integral to the success of this work being done.

MR. DICKSON: I'm encouraged that there's going to be a formal assessment, though, first.

The second supplemental would be this: given that the start-up cost of a smart card program is estimated to be something under $200 million and it's estimated that there'd then be ongoing costs of $30 million to $40 million to run the system, I'd like you to particularize, Madam Minister, where the savings are going to be for Alberta taxpayers.

MRS. McCLELLAN: Well, first of all, I haven't seen figures quite that wild, but, you know, it's an unknown. You make a very good point. It's an unknown. Let's look at why we would move forward with health information technology or the use of health cards. First and foremost, it has to be to improve the quality of patient care. That has to be the first consideration. So if you were to look at this and you could not see any value or any way that doing this would improve patient care or quality of patient care, I would say you wouldn't do it.

Secondly, you should look at the fact that we don't have the type of information that we really require to ensure that we're allocating the precious health resources we have in the right ways. You read the Auditor General's report every year, and you will see him note: minister, your information . . . We have a lot of information. We have a lot of good information. We just don't have the ability to utilize it properly. Then the third consideration would be that you could reduce costs. But first has to be patient care.

So the group that we've had looking at this have involved physicians, allied health providers, I believe nurses' groups. We've had a lot of people involved in developing whether we should move ahead with this, because if we're not going to improve patient care or the opportunity to improve quality care, frankly it would be difficult to understand why you would go ahead with it.

Secondly, I think you'd want to monitor very carefully what those costs would be, and then you'd have to look at the cost-benefit analysis. It's a bit more difficult to put an actual cost-benefit analysis on quality of patient care than it is to put on allocation of resources and reducing costs, but still, I think the medical professionals can show us where good utilization of information and technology could improve patient care.

MR. DICKSON: Thank you.

THE CHAIRMAN: Thank you.
Ms Leibovici.

MS LEIBOVICI: Thank you. In looking at the goals as outlined in the health business plan, I notice that there seems to be one that's sorely . . .

MRS. McCLELLAN: Can you just sort of give me a page?

MS LEIBOVICI: Page 256.

MRS. McCLELLAN: I'm not sure I have the same pages that you have.

MS LEIBOVICI: It's in the government and lottery fund estimates book.

MRS. McCLELLAN: I've got it here. [interjection]

MS LEIBOVICI: Well, it's not here. That's why I'm asking.

MR. SAPERS: Oh, it's missing.

MRS. McCLELLAN: I've got the numbers now. What was the number, Karen?

MS LEIBOVICI: It's 256, under goals.

MRS. McCLELLAN: I run out at 252 in mine. I'll have to get my bigger book out. Oh, you're in the estimates book. Sorry. I was in my business plan.

6:40

MS LEIBOVICI: It says "Business Plan Summary" on the top.

MRS. McCLELLAN: Yeah. Okay. Got it.

MS LEIBOVICI: It indicates that the ministry is going to focus on four core businesses, and when I look at them I wonder where preventative health care and community health fall under. I would have thought that that would be one of the four core businesses as opposed to somewhere under a heading that doesn't quite jump out of the page at me. The reason I'm asking is that we're seeing an increase in poverty. We're seeing an increase in needs and seem to be seeing a decrease in the services for those particular areas.

MRS. McCLELLAN: For which areas?

MS LEIBOVICI: Well, specifically, when we look at vote 3.2.3, communicable disease funding, we see a decrease of 2.4 percent. When we look at vote 4, AADAC, we also see a decrease of 2.35 percent, and it begs the question: where is the government's commitment on preventative health care?

MRS. McCLELLAN: First of all, let me start with the first part. Under service delivered: these are broad. They're not intended to be detailed on these pages, but if you look under service delivery

- Services are accessible; appropriate; affordable, cost-effective, and cost-efficient; and [the more important bullet]
- health of the population improves.

So you look at service delivery, which does that. That would be really where a lot of your health promotion would be. Your health system development and support would also have some of that, because what we're saying is that decisions about health and health services should be guided. We're saying they are "guided by necessary and timely research, technology assessment, information, and tools." So you have to have the necessary information to do those.

- new approaches and models for integrated service . . .
- community members are involved in the health system;
- accountability is demonstrated; and
- management . . . is efficient and effective.

One of the major initiatives that we have is the Action for Health initiative, and as I indicated in my opening remarks, we're increasing that by $2 million this year to a total of $6.5 million. I want to point out that that is over and above what we had in the public health side of our budget under the old structure for health promotion and wellness promotion.

The other point that you made was on communicable disease. We are transferring that program to the regions actually; we'll no longer be delivering the service. So you'll see some reduction in that area. It's the administrative reduction, as Aslam points out to me. What you are seeing in the Department of Health is that we are no longer the people who are providing the direct service. Others will be providing the direct service. We will be responsible for maintaining the standards, the guidelines, legislation, et cetera, ensuring that that is maintained, but we're not going to be in direct service delivery.

I'll give you an example of that in mental health services. For a lot of years the Department of Health has really been quite direct deliverers of mental health services. We have transferred that to the Provincial Mental Health Board for now, and that will be integrated into the regions. We will no longer be the deliverers of service, but we will be the people who set the parameters, the policies, the standards, and the guidelines, which I think is far more a government role than direct service delivery. We have our regions; we have a good many community agencies that can deliver those services for us.

MS LEIBOVICI: Can the minister, then, explain what the co-ordinated approach is going to be with the Minister of Health, the minister of social services, the ministers of, potentially, Community Development and Education around the issue of preventative health care?

MRS. McCLELLAN: We have had an excellent relationship between four departments – and I can tell you the Ministry of Justice is one that is quite inclusive in that – looking at how we can work more proactively, particularly with children's health services. We are a partner in that to ensure that we can meet the needs in children's health services. I believe that we're well on the way to doing a better co-ordination. I also believe it's going to take some time to fully implement that, because we've been in a different model for a long time. But I can tell you that I have seen a great deal of change in breaking down the barriers between departments in the time that I've been minister.

One thing that I will say frustrated me was to have to say to people, "This is not within my mandate." That really doesn't matter to the person who needs the service. I think we've moved a long ways, and I think the co-ordination of children's services is a good example of how departments can work together to do that. I think Justice has to be an important part of that as well.

MS LEIBOVICI: I understand that the minister is indicating that there's going to be better co-ordination of the services. However, the minister has also seemed to indicate that there will be a hands-off approach, that the money will be given and the minister will step aside. I'm specifically asking: what initiatives has the minister undertaken with those other departments to ensure that not only children's services but other services, for instance with seniors, are put into place with regards to preventative health care initiatives?

MRS. McCLELLAN: Well, on the children's services we have, particularly in the rural communities, in many cases people from the regional health authorities sitting on the committees for delivery of children's health services. That's I think very appropriate so that we have that interaction.

In the area of seniors' programs, a lot of the programs that are delivered for seniors in the province are health programs that are important to them. So we work, I believe very carefully, at ensuring that our regional health authorities understand the

programs.

You would know that we are moving the AADL program, the aids to daily living program, to the regional health authorities. Why? To have better co-ordination, to have better access for our people in the communities. I think one of the things when I talk to seniors – and I do quite often – that they tell me is that they want a clear point of entry. It's very difficult for them to be sort of moved from not here but here or to not here but here. I think having those numbers of places of access brought to a smaller number will assist them in their programs. It also gives the communities a better opportunity to utilize dollars for what are identified to be their community's needs.

So those are some of the specifics that we've done. AADL, early intervention programs, things like that are going to the community now.

THE CHAIRMAN: Thank you, Madam Minister.

Mrs. Abdurahman.

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

With regards to just following up on the questions from my colleague from Calgary-Buffalo, Gary, on smart cards and looking at core business 4, health system development and support, who of the health care professionals are going to have access to the information?

MRS. McCLELLAN: For health cards?

MRS. ABDURAHMAN: Health cards and whatever other tools you're going to use with the new technologies. In other words, is it just physicians, or nurses, or who's actually going to be able to use that information?

6:50

MRS. McCLELLAN: We're very much in a developmental stage of this whole area right now. We had a group look at this that was co-chaired by Mr. Herard, and they've done a rather detailed report on how they see health information moving forward in the future. I've received that report, and I'm reviewing it. I'm looking at what I might bring forward to implement, and this requires a great deal of thought. As I indicated to the Member for Calgary-Buffalo, we have to look at this on the basis of improving your quality of patient care and so on. I would hope that we'll have that type of detailed plan to bring forward in the next 30 days, but it is not something that you can move into very quickly. It's a bit difficult to give you any kind of detail because we haven't formulated all of that yet.

My answers to the Member for Calgary-Buffalo – he asked me a very direct question, and I gave him a very direct answer. That was on an impact assessment on privacy, and I've been very forthright on that throughout the whole thing. But I'm sorry that I can't give you a lot of detail yet, because we simply don't have that concluded from the report.

MRS. ABDURAHMAN: There are two sides of privacy, and physicians have jealously protected what's in their medical files related to the patients that they see. Has that whole issue of privacy between the physician and the patient been addressed so that that information has been shared into the health care information system?

MRS. McCLELLAN: Well, first of all, I guess perhaps I believe something different. I think health information belongs to you. I think my health information belongs to me.

MRS. ABDURAHMAN: I agree with you. My second supplementary will deal with that.

MRS. McCLELLAN: That's the first premise that I have. I think then you go into the larger question: of that information, what do you share with what health providers to improve patient care and quality of care? I think those are the issues that we have to talk about when we put forward a plan. As far as health data and information, it is not that difficult today to wipe personal indicators off health information to use them for analysis and so on. You do not need a person's name and address to utilize the data for how many cases of mumps there are, how many cases of measles there are, or how many appendectomies were done or so on. You don't need that. Maybe the age and gender might be something that would be important, but personal indicators do not have to be utilized there. I think the bigger questions are: what information do you use to improve patient care, how do you do that, and who do you share it with?

Generally you're right: the information has been held by physicians and hospitals. Hospitals generally help physicians compile their patient records, but I believe that health information belongs to the individual.

THE CHAIRMAN: Thank you.

Second supplemental.

MRS. ABDURAHMAN: Based on that statement, would I then have an understanding that I as an Albertan would have access to see what was on my smart card?

MRS. McCLELLAN: Yeah, and that's assuming that you would have information on your card. I'm not going to tell you today that I believe that's the best type of health card. I don't know that at this point. We looked at a lot of different cards and different types of cards. Maybe your card is more of an access card than it is for holding information, but there are so many different types that you can use.

I think you're just going to have to accept that I believe that health information belongs to the individual, and I don't believe there's any reason you can't get that today.

MRS. ABDURAHMAN: Try.

MRS. McCLELLAN: Yeah. Well, I understand that there are some caregivers who don't care to release that, but it's certainly a lot freer or easier to get than it was. That's my belief.

THE CHAIRMAN: Thank you.

Just one point of clarification. I get some looks when I say first and second supplemental. The reason for that is that sometimes there gets to be back-and-forth dialogue, so I just want to confirm which is which.

MRS. ABDURAHMAN: You're bang on, Mr. Chairman.

THE CHAIRMAN: Mr. Sapers, please.

MR. SAPERS: No, that wasn't what it was all about. I'll send you a note, Lyle. Thanks.

Just a couple more general questions before we get into the nuts and bolts of the budget, Madam Minister, if you don't mind. Could you explain the process – well, let me start the question

this way. There have been some criticisms of the budget and business plan of Alberta Health based on the fact that there is no evidence – there's nothing in the business plan, nothing in the notes – that there have been adjustments made, as it rolls along, for population change, for inflation, and for shifts within the domestic population of Alberta in terms of age or whatever. So could you deal with those criticisms by explaining exactly how it is that the business plan and the budget have been developed to account for shifts within the population and gross population changes in terms of numbers and inflation?

MRS. McCLELLAN: Well, the funding mechanism that we've had in place, and still have in place actually, has dealt with provision of services. If a region, for example, received a lot more import or if a region exported a lot more patients to another region, that's how you handled that type of fluctuation. I'm not sure, though, if you're talking more about a different type of fluctuation, if you're talking about an immigrant population or about an age/gender population or a higher seniors population or a lot younger people. Mr. Chairman, would you allow me to ask for clarification without taking his question away?

THE CHAIRMAN: Please do.

MR. SAPERS: Thanks. I appreciate that.

It's all of those shifts plus the internal shift. I mean, we obviously have age, race, gender changes. I wasn't even thinking of the interregional mix at this point, but you do anticipate my next question. What I want to know – when you come up with the business plan and the budget estimates to begin with, the criticism has been specifically that the age, race, gender, all the socioeconomic stuff, hasn't been accounted for. Inflation hasn't been accounted for; population hasn't.

MRS. McCLELLAN: Yeah. Last year when we divvied up the $40 million in community services, we allocated those on the basis of higher populations. If you recall, Edmonton got $16 million, Calgary got $16 million, and the rest of the regions and the Cancer Board and mental health got the balance of the $8 million.

MR. SAPERS: I remember we discussed that.

MRS. McCLELLAN: Yeah. So we did do it there. We're trying to reflect the change from an institutional model to a community model and the shifts in the populations in that way.

Now, I'm not going to answer your next question till you ask it. You're going to ask the question, and then I'll tell you what . . .

MR. SAPERS: No. Go ahead. Go ahead, because maybe I'll suggest another one. Please.

Okay. Well, maybe I'll ask it a different way. In the business plan there are references to health status and some of the goals, and I know that one of the measurements is improved health status. I think it's in core business 3; it's the service delivery one. But in any of the discussions that I've seen or heard or participated in in terms of developing a funding model as we move away from the past which is based on the provision of services towards the future, which is supposed to be this new model based on population and need, I don't see anything and haven't heard anything about health status. So I want to know: how can you link the business plan outcome to health status and measurement, but the funding doesn't seem to be linked to outcome?

MRS. McCLELLAN: You know that we're in the throes of developing a new funding formula, and certainly there's been a lot of discussion about a population funding formula. We also know through a lot of good statistics – we do have some good statistics – that the most dollars are spent in the early years of your life and the later years of your life, and we also know that women are a larger taker-up of health services for a couple of reasons. One is that we outlive men by 10 years. That's a fact. So, you know, I have to stand up for women.

7:00

MR. SAPERS: We just do our bit by dying quick.

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

Because of the reproductive nature of women, you do know that gender does have an impact, and you do know that age has an impact. So certainly in the development of that funding formula, which we hope will be concluded this year, more of those areas will be looked at. You have to look at those. You have to look at other indicators.

We have some experience in doing this in other places, and if you've followed Saskatchewan and their change to regionalization, they have changed their funding model. We've been looking at what they've done and how they've done it to see how well it's worked, but it's going to take probably, I would say, a few more months, short months I hope, to get those types of indicators so that we feel confident that we're funding appropriately.

THE CHAIRMAN: Thank you.

MRS. McCLELLAN: Aslam reminds me that health status and outcomes are long-term measurements rather than short-term, and I know you're aware of it.

MR. SAPERS: Okay. Thanks. I'll move away from that for now. I appreciate the answer. I'm concerned about the delay in terms of overall planning. Maybe we'll get a chance at the end to come back to that.

I want to ask a question about the Auditor General's report, the most current one.

THE CHAIRMAN: If I can, a supplemental has to follow the main question.

MR. SAPERS: Mr. Chairman, if you'll allow me, it does. I said that this was still talking about the opening comments to the general business plan, and this relates to that.

The minister mentioned the $15 million that had been set aside for capital equipment replacement. As I recall, the Auditor General's report detailed close to a $100 million deficit in the regional health authorities across the province, based on $100 million of uncapitalized appreciation.

MRS. McCLELLAN: But that's buildings.

MR. SAPERS: Well, part A is: how much of the $100 million is equipment? Part B is: how far does the $15 million go, based on the AG's report?

MRS. McCLELLAN: Well, I believe that the majority of it is in buildings. As you understand, we do not require regional health authorities to replace their buildings, but to show a true picture of costs and expenditures, you have to put that in or you're not showing a good financial picture. So it is what I would almost

call a paper figure to give you a clear indication, but you do know that the replacement of buildings comes out of the public works budget. In fact, most any major repairs of any significance come out of there as well, because we do have an area for that. I think you are also aware that system wide we had a surplus, but when you took that $100 million figure in, it looked like we had a deficit.

MR. SAPERS: I wish Aslam would stop sending you notes, you know.

MRS. McCLELLAN: Well, it's his job. If he doesn't do that, he's in big trouble.

You don't mind if I confer with my colleague?

MR. SAPERS: No. Please.

MRS. McCLELLAN: I think we'll have to split that for you – and we will – on the difference between capital and internal equipment. I can't do it just there. We'll try and split that out for you.

MR. SAPERS: Thanks.

THE CHAIRMAN: Thank you.

Mr. Dickson, you have six minutes for the question. I will allow the main question, and whatever supplemental the minister is on, I'll allow the minister to finish her answer.

MR. DICKSON: I'll make a bargain with the minister. We'll both speak quickly, Mr. Chairman.

MRS. McCLELLAN: I'll give you a real short answer to your first one.

THE CHAIRMAN: Now, let's not stretch things.

MR. DICKSON: Madam Minister, the Calgary emergency services has an outside target of a 12-minute response time. Now, we've already hit that in the city of Calgary with only one of the two major downtown hospitals closed. What has to happen with the advent of the closed emergency ward and the shutdown of the General hospital to ensure that that 12-minute response time can be maintained?

MRS. McCLELLAN: Well, first of all, they have one year to continue the work on that, and you know that the regional health authority in Calgary has not made a decision on downtown services yet. They are working on that presently. The Bow Valley centre is not scheduled for closure till next year.

I'm not sure, but I think you're aware that we have a group that is looking at emergency services in the province – ambulance services, ground ambulance – and I'm not sure if you're aware that Tom Sampson from Calgary EMS is a member of that committee. We think it's important that we look at all ground ambulance services in the province in view of regionalization, not just the city of Calgary. I can assure you, Mr. Dickson, that there are many communities in this province that would be very happy with a 13-minute response, but we don't have that.

I think it's important that we don't just look at one particular area and say that this is what's appropriate for emergency services in Alberta, that this is what it should be, and that's what that committee will do. Certainly they'll be working with Calgary, with Edmonton. When we began regionalization, the regional health authorities felt that dealing with emergency services in view of all of the other changes would be too much, and we do have, I would say, excellent emergency services in this province, which have much improved over the years. The regional health authorities had a task group that reviewed the services. I have asked Mrs. Gordon and also Paul Langevin, who is the chair of the ambulance appeal board, to sit on that committee. We have, as I indicated, Tom Sampson from the Calgary EMS, a member who led the RHA task force, and some members from outside of the major centres. We've got a pretty good pool of expertise in that group, and they will be bringing back, I would expect, an interim report and then a further report.

MR. DICKSON: I take it the minister is prepared to countenance, then, a response time in the city of Calgary that would exceed 12 minutes?

MRS. McCLELLAN: I don't believe that has to be, and I think that it would be really unfair for you, hon. member, or for the minister to try and pre-guess what the Calgary regional health authority is going to do about downtown health services or what this committee will bring forward.

MRS. ABDURAHMAN: Excuse me for interrupting you, but I find it most distracting, Mr. Chairman. I want to hear what the minister has to say, and if the members of the government don't want to hear what the minister is saying, I would ask them to leave. Their conversation is very distracting.

THE CHAIRMAN: Yes. They can't leave, but please keep the conversation down.

MR. DICKSON: I'm wondering what responsibility you take, Madam Minister, and what assistance you provided the city of Calgary, that's contemplating the purchase of two additional ambulances, at a cost of something in excess of one and a half million dollars, to be able to maintain the 12-minute response time that they have set as their goal.

MRS. McCLELLAN: Well, I guess I have to go back and say that I think we should allow this group some time to work. It is an integrated group. We are adding somebody from the city of Edmonton on this as well and working with them. We have people from our municipalities, our counties, and municipal districts working on this issue. You know that how we deliver emergency services in the province is very complex. We have municipal operations. We have community operations. We have private operations.

Generally, the funding that the Minister of Health has been responsible for in ambulance services is twofold. One was the air ambulance program, which is totally funded by the province. It is not paid for by the municipalities in any way. The second is the interfacility transfer. That is the issue that we need to deal with. How has regionalization impacted that? Are the same rules for interfacility transfer appropriate now in this changing world where we do not admit as many people to hospital? The rule of interfacility was on admissions.

Dr. Fulton was just pointing out to me that there are 110 agencies or companies operating ground ambulances in 141 locations throughout the province. So it's quite complex. I think that it's important enough that it deserves a very, very thorough review. We have areas that requisition their municipalities quite high, that have a high requisition, and we have other areas that have virtually none. We've got hospital-based ambulances that

work very well, and we've got private ambulances that work very well. I'm sorry; there isn't just a snap answer like that. It's one that we have to take some time with.

7:10

THE CHAIRMAN: Thank you very much. I am impressed that you guys did it.

MRS. McCLELLAN: We did pretty good; didn't we?

THE CHAIRMAN: Now it's the government's side. That has been the first 50 minutes.
Rob Renner.

MR. RENNER: Thank you, Mr. Chairman. I would like to refer to page 257 of the estimates document. On page 257 are a number of bullets indicating highlights in the '96-97 budget. One which caught my eye is about three-quarters of the way down: "Rural physician action plan funding will rise by 67% to $2.8 million, including $800,000 for new initiatives." I wonder if the minister could explain what the rural physician action plan is.

MRS. McCLELLAN: Yeah. The rural physician action plan is a program that's in about its third, going into its fourth year of operation and deals with the issue of distribution of physicians. It includes physician recruitment fairs. It includes the fact that now physicians in training in Alberta will have a six-month rural rotation. It includes our locum program, which is relief for physicians in rural communities, weekend relief or educational relief.

I'm trying to think now what the other programs are in it. We have some new proposals. One is – and I mentioned in my opening comments – that Dr. Larry Ohlhauser is going to chair that committee. One of the new proposals that has come forward is to develop a network for distribution of physicians. The other one that comes to my mind is establishing additional links between the medical schools and the rural communities. We felt we could develop better linkages there. So those are a few of the areas.

Dr. Fulton just reminds me that we have $500,000 in that to each of the universities for teaching. People sometimes don't realize that a person who practises medicine in a rural community has to have a different type of training than someone who practises perhaps in Edmonton or Calgary. The reason for that is that a rural physician faces every activity. They don't know whether it's going to be a stabbing, a heart attack, a car accident, or a plane accident that comes to their door. They have to be able to deal with everything, and they do not have the support that physicians do in the major or larger centres for additional help. So their training must be different.

THE CHAIRMAN: Thank you. First supplemental.

MR. RENNER: Thank you. Given that I don't, obviously, have any question that this type of funding is necessary, I guess my concern, coming from Medicine Hat, is that it seems, depending upon the occasion, that Medicine Hat is sometimes considered rural and sometimes considered urban. Medicine Hat certainly has been fighting with physician recruitment and physician shortages, particularly family physicians and specialists. I want the minister's assurance that Medicine Hat is indeed considered part of the rural component in the context of initiatives such as this one.

MRS. McCLELLAN: Well, it almost seems that in physician distribution Calgary and Edmonton are urban and everything else is rural, because that is the way the distribution really lies today. We work with all of our regions on recruitment, but having said that, I don't want to suggest that there isn't some concern on recruitment in the two major centres as well. An important part of our agreement with the Alberta Medical Association is a physician resource plan for the province. We will have a provincial physician resource plan, and we will have each region develop a physician resource plan under the umbrella of the provincial plan. Really, that's what we need: good physician resource planning wherever we are.

We understand that Medicine Hat has an excellent medical director and that that person is working very hard on recruitment issues. It was interesting, Mr. Chairman – if I might, as a side note – when I met with medical students at the university some weeks ago and I asked them what the greatest barrier was to them practising in a rural community. I thought that might be a very good place to start with the question, seeing they were the ones that would be going out. These were the students in their last year of training.

Interestingly enough, it was not money. I know this would be a surprise to some; I don't think to many around this table, certainly, but to some Albertans. The biggest barrier was isolation, and isolation professionally, not geographically, although they do somewhat tie. They felt that after training in a large hospital for a number of years and having everything there, it was rather formidable to go out into a rural community. They did feel that the six-month rotation was good. They felt there could be more in that area. Those were generally the reasons.

There was one other that came forward from the students, and that was their need to identify a specialty very early in their training. That is a matter that has come about because of the national physician resource plan and is one that I've committed with them to look at being able to do something about. I'll just give you an example to explain that. If a physician goes out to rural Alberta to practise, is there for five years, and decides that they would like to go into a specialty, there just simply is no space because those spaces are all allocated. So the suggestion is: can we not look at some allocation for that?

There's no one answer to recruitment and retention. That's why I think the rural physician action plan is an important one and why we're putting more money into it this year.

THE CHAIRMAN: Thank you.
Second supplemental.

MR. RENNER: Thanks. On the same subject, one of the barriers that we run into is that oftentimes the physician's spouse, a husband or wife as the case may be, also has a career, which may or may not be in medicine. That creates difficulties in the smaller communities as well. That's just a comment.

The question is: in the AMA contract – and you've referred to it a number of times this evening – are there any provisions that will, hopefully, create some incentive for physicians to work along with government to try and resolve the situation?

7:20

MRS. McCLELLAN: I think the major one is the provincial physician resource plan. This really is a result of the tripartite exercise that we had on medical staff bylaws. I think that's the major thing: we'll have a provincial resource plan; we'll have regional resource plans. It is interesting that although we hear a lot about shortages of positions in rural communities – and goodness knows I know about them, because I have some of those

communities – the number of physicians in rural areas has remained quite constant and so have the areas where we have problems recruiting and retaining. They are about the same all of the time. One of the things I've been reminding the regions and the communities that talk to me about this is, "You have a role in this too; you have got to encourage people or tell people why they would want to live in your community." One of the areas you pointed out is a spouse who has a career. Are there career opportunities for that spouse in that rural community? What are the opportunities for their children for music, for sports, for education? You know, the things that are important to a family. Communities have to sell themselves as well.

Now, I have a community that sold itself to a doctor who moved out from the city to enjoy raising his family in a country atmosphere. The poor man went into a two-doctor practice and ended up in a single-doctor practice about a month later. I'm sure he does not know what it's like to live anywhere but in the hospital or the clinic. It's a big item, and we all have to, I think, participate in that one.

THE CHAIRMAN: Thank you very much.

Our next questioner is Mrs. Fritz. If I can, I would just like to have two seconds here to congratulate everyone. This is the first meeting I've been at, as a politician, where no one has smoked. So thank you.

Mrs. Fritz.

MRS. McCLELLAN: This is a health one. We don't do that.

MRS. FRITZ: Well said, Mr. Chairman. Thank you very much.

MRS. McCLELLAN: He hasn't been at our other ones before.

MRS. FRITZ: Madam Minister, my question's on page 256, under service delivery. I'm looking at the bullet where it says that services . . .

MRS. McCLELLAN: In the business plan or in the estimates books?

MRS. FRITZ: Estimates. It's the business plan summary.

MRS. McCLELLAN: Oh, I've got that.

MRS. FRITZ: Thank you. Under service delivery it says:

- Services are accessible; appropriate; affordable, cost-effective, and cost-efficient; and
- health of the population improves.

Now, my question is related. I know that you have answered this many times, but I'm still interested in this area. Given the waiting list for services and given that we know waiting lists are necessary, which you've stated well in the past, to ensure maximum efficiency and integration of facilities, equipment, personnel, et cetera, et cetera, my question is: how do you propose to measure the waiting lists and the effect? When I say that, I'm actually leading to the use of MRIs and those types of services.

MRS. McCLELLAN: In the area of MRI, I can tell you that in the two public centres for MRI they do have practice guidelines and protocols which they'll make available to you, and it's listed in a priorization. It was interesting; I was at a meeting just last night where somebody said to me, "You know, I received my MRI in an hour." Obviously, in that case the medical need was such that that was the case. If you need an MRI, they're generally delivered within 24 to 36 hours, absolutely. But how do we do that all around? I think a couple of ways. One is the development of clinical practice guidelines, which the AMA are working on with us now. The second is having the professional people lay out some guidelines for what is reasonable access.

It's interesting to us in this province that the federal government has never brought a case of access against Alberta, because generally we provide as good or better access than anywhere in Canada. Waiting lists have to be considered a part of our managed health system. We do not have an open-ended health system. What you want to ensure is that those waiting lists are not excessive and that the treatment is within a time frame that is considered by the professionals to be reasonable and correct. Obviously I believe waiting lists should be on clinical need. I believe that the physicians are the people who develop that. We're working with our physicians right now on developing some of those in cataract surgery and some other areas. It's very offensive to me that we are being penalized in the area of cataract surgery when you can receive cataract services in the province of Alberta I would say faster than any other province in Canada right now in the fully publicly funded system. We're still being penalized.

THE CHAIRMAN: Thank you.

First supplemental.

MRS. FRITZ: Thank you. I'm also interested as well, under health system development and support, in the "new approaches and models for integrated service delivery" being developed. If you could please just tell me a bit about what you're thinking of there with "new approaches and models." It's again in regards to services.

MRS. McCLELLAN: There are a number of those. One that I think all members would be quite interested in is the CHOICE program, which has been piloted by the Capital health authority. It looks at patient choice as to who they receive their services from.

We know there are new models that are available, but we also know there are some models that have been around that have never been adopted very much farther out. I look at Boyle McCauley in downtown Edmonton, which has had an integrated model of delivery of health services for some time, but it didn't really catch on beyond the inner city to the extent that I think it should have. There is an example in Calgary too: the Alexandra clinic. CUPS clinic is another one. So we've had some examples around, but we've really never expanded those into the other areas. They've been seen sort of as inner-city models rather than, I think, models that most people would choose if they were available to them.

We see more of those developing through the community health centre concept, and that's one that can be used. I'd encourage you to look at the CUPS program in Calgary, look at the CHOICE program in Edmonton. Dr. Fulton is just reminding me of the northern communities where nurse practitioners or nurses with extended training are offering CHOICE. So we have a number of models that can work.

One of the challenges I think we have is to make sure that the regions share their models and their successes. I was pleased when I participated in the opening of their first conference this year; they presented us with a book of successes. In that book of successes are some of the models of how they've changed the way they deliver services, but we have to make sure they continue to share that.

THE CHAIRMAN: Thank you.
Mr. Yankowsky.

MR. YANKOWSKY: Thank you, Mr. Chairman. My question is found on page 251, reference 3.2.4.

MRS. McCLELLAN: Oh, boy. Just a minute. Oh, Aslam's fast. He's got it. Okay; 3.4, out-of-province hospital services?

MR. YANKOWSKY: Out-of-province hospital services. I see there's quite a large increase there. First of all, what kind of services are we talking about here?

MRS. McCLELLAN: Medical services, hospital services.

MR. YANKOWSKY: Hospital services?

MRS. McCLELLAN: Yeah. They can be areas where we send somebody out of province for service or they can be where people are out of province when they become ill, and we pay for their services.

7:30

MR. YANKOWSKY: We're showing an increase of roughly $3.2 million, which is a fairly large increase when we see that everything else seems to be going down. What is the reason for this increase?

MRS. McCLELLAN: I would suggest to you that the largest increase here is for infant transplant.

MR. YANKOWSKY: Pardon?

MRS. McCLELLAN: Infant or children – pediatric transplant.

MR. YANKOWSKY: Oh, I see.

MRS. McCLELLAN: When we send a child to Loma Linda, the cost is considerably higher than when we provide the surgery here. So that's what the largest part of that is.

MR. YANKOWSKY: I see.

THE CHAIRMAN: First supplemental, or is that your second supplemental?

MR. YANKOWSKY: I had my main question and first supplemental. I guess we're at second supplemental now.

THE CHAIRMAN: Second supplemental then.

MR. YANKOWSKY: If I could ask you to maybe do a little forecasting here, are we possibly looking at a continuing increase in this area of out-of-province hospital services? Can we look to another increase next year and succeeding years?

MRS. McCLELLAN: It's very difficult for us to say. That is quite volatile. We have a lot of people who holiday outside of our province for extended lengths of time. They happen to be of an age group that can have health problems, maybe a bit more than some other age groups as well, and while we always encourage people to have out-of-country medical insurance and so on, there will be circumstances that come up where we have to assist in that area.

We also can't, I don't think, gauge the number of transplants that we may have to do outside of the province either. That depends on a lot of things. It depends on organ availability. The biggest barrier to transplant is organ availability more than anything else. We are working on a contract . . .

MR. SAPERS: Jon, Yvonne, please.

MR. HAVELOCK: Please what?

MR. SAPERS: Be quiet.

MRS. McCLELLAN: . . . with Loma Linda to try and get a better, more favourable price for those services, but it is extremely expensive to send a child there.

MR. YANKOWSKY: Thank you very much.

THE CHAIRMAN: Thank you.
Mr. Havelock.

MR. HAVELOCK: I'll speak loud so the hon. Mr. Sapers can hear.

Madam Minister, I have some interest in the AMA agreement and in particular the tripartite process which has been charged with the responsibility of basically coming up with $50 million in savings through managed care. I have not heard much on the status of that, and I wonder if you could just update us on what's happening with those discussions and what, if any, initiatives have been implemented in order to try and realize some of those savings.

MRS. McCLELLAN: Well, the discussions are, I'd say, progressing with AMA. It usually takes a little bit of time after an agreement is signed off to begin the implementation. It may have been some time since we proposed an agreement, but it is not a long time since the doctors accepted that agreement. We ourselves have to not think back to December; we have to think to the end of January when that agreement was accepted. It would be a little bit presumptuous of us to start implementing an agreement that they had not agreed to. So, remember, the doctors voted on that agreement and accepted it in later January. But the commitment is to work towards that. I think the groups are meeting and setting out their strategic directions to get that under way, Jon, but it really is only about a month since we had that agreement finalized.

THE CHAIRMAN: Thank you.
First supplemental.

MR. HAVELOCK: Actually, I'd like to change horses.

AN HON. MEMBER: You can't.

MR. HAVELOCK: What do you mean I can't? Of course I can. Unless Mr. Sapers objects, I can do whatever I want.

THE CHAIRMAN: If I can. We have been a little lenient on the direction of questioning.

MR. HAVELOCK: Yes. I'd like to actually discuss physio. I know it somehow relates to managed care and doctors.

MR. SAPERS: And it used to be part of the health system too.

MR. HAVELOCK: That's right.

Madam Minister, the issue of physio is still something that actually is creating some difficulty certainly in my constituency, and in Calgary generally there's still some confusion as to who qualifies. There are some people who feel that they should be covered and aren't. I know that we've had numerous meetings with the physios on this issue. Can you again tell us what steps are being taken to perhaps rectify some of the problems that people are experiencing in accessing physio services?

MRS. McCLELLAN: The first action that has to be completed before we're going to, I believe, take some of the confusion out of this, is to have the review of the rating tool, and that was scheduled for the end of March. Dr. Fulton reminds me it was April. Well, April isn't going to do. It's got to be sooner. I just talked to some physios today about this and made the commitment that we would do it sooner. My department will just now have a mild case of apoplexy, because this is a big job. But it has to be done sooner.

The confusion really lies with the insurance companies. If there's any way to make things more complex than they need be, this program is a prime example of it. There is no excuse for what has occurred in that program, in my view. We transferred all of the money that we had in those areas to the program. We divided it among the regions, and each region was told to develop a plan that was appropriate. We had all three physio associations working on the development of that plan: the college of physios, the independent physios, and the association as well as the speech therapy people and the occupational therapy people.

It seems that all of the problems are in the area of physiotherapy. It's not in the area of occupational therapy. It's not in the area of speech therapy. Frankly, it's a significant change. I believe we have more private practising physiotherapists in the city of Calgary than they do in the whole province of Ontario. So it is a big change. It's a big change for a lot of practitioners and for a lot of people who have accessed. But I also know that there are only four provinces in Canada that provide these services.

I believe it's time all of the participants came together and made this thing work. That's my message to them now. I met with the council of chairs. I've told them I'm disappointed that they have not been more collaborative in their approach to this, which we had asked them to do.

I'm concerned that there is a different fee schedule in different regions. I don't think that was necessary, but the program principles are right. We should be paying for higher needs in physiotherapy. Physiotherapy, occupational therapy, speech therapy are not a part of the Canada Health Act. They are an added service that we believe in Alberta is important, and we commit over $40 million to make our point. That's just in that program. That is not the physiotherapy that's included in home care, and it's not the physiotherapy that is in the hospital program. This is additional. Those dollars should be going to people with high needs.

So the principles are right, and we should and will make sure that the players come together and get this thing settled. While I have sympathy for the physiotherapists, I have more sympathy or empathy for the people who are trying to access services and are being told a number of different things. We gave direct access to physiotherapy because we thought it was important that people could access that program directly. We felt the physiotherapists themselves were quite qualified, more than quite qualified, to say what treatment regime a person needed. Frankly, this has just become far too complex.

THE CHAIRMAN: Thank you.

Second supplemental.

MR. HAVELOCK: Yes. Thank you. Despite a burning desire to ask a question about defunding abortion, I'll ask something else.

MRS. McCLELLAN: Pardon?

MR. HAVELOCK: I thought that might get your reaction.

Madam Minister . . .

MRS. ABDURAHMAN: He skipped kindergarten. That was his problem.

MR. HAVELOCK: Thank you.

. . . I understand that the Liberal opposition has recommended that physician remuneration be actually driven down to the regional level. I've had a number of calls of concern on that from physicians, again, in my community.

MRS. ABDURAHMAN: You've been dreaming or smoking something I think, Jon.

MRS. McCLELLAN: No. It's in one of your press releases on physician . . .

7:40

MR. HAVELOCK: Yeah, you guys actually put that out, Mrs. Abdurahman.

MR. SAPERS: I didn't know it was part of your budget though. That's all. But that's okay.

MR. HAVELOCK: Well, of course it has a budget impact. I'm just wondering, Madam Minister: would you comment on that suggestion and the budget implications?

MRS. McCLELLAN: Well, first of all, I will say that any decision on how we change the way we remunerate physicians will be done in consultation with the Alberta Medical Association as per our agreement. There has been some discussion that the regional health authorities should have control of physician remuneration. I think that would be quite arbitrary, and I don't believe that we would reach that agreement with our physician population on a short term.

I do believe that the regional health authorities do need to become far more integrally involved in physician recruitment and retention. I believe that through the tripartite process that we have in that agreement, Jon, we will manage that much better. I didn't answer the second part of your question on the tripartite. We have done some preliminary work on terms of reference. The three parties haven't met yet because of scheduling of the other two parties, being out of town for sort of two weeks consecutively. We're planning on meeting this month. But that is one area that I believe has to be dealt with.

There's also a concern by the regional health authorities – and it's quite valid – that physicians be paid for the value of the work they do. I've said on more than one occasion that I'm concerned about what I consider the rather low pay that our emergency room physicians get for the type of work they do. I believe that if we could get more work done on the relative value guide, that we in Alberta Health have committed I think a great number of dollars towards getting developed, then we'd get some of those questions

answered, and the regions would have to be a part of helping us come to some of those answers.

THE CHAIRMAN: Thank you.
Mr. Woloshyn.

MR. WOLOSHYN: Thank you, Mr. Chairman and Madam Minister. I'd refer you to page 257, the second highlight from the bottom on the highlight sheet. I'd preface my question by starting out by saying that the restructuring of the health care system has been difficult, and as we know, we're in the midst of it. The health authorities, as indicated by the previous questioner, have had some difficulty in some areas implementing the programs that we've wanted them to.

Also, the fact that disease control or monitoring, whatever you want to call it, across all four borders is a universal provincial issue – I would like you to indicate to us the direction that you're restructuring. On the establishment of a new centre for disease control, who will operate it, and how will it improve the current system of disease control?

MRS. McCLELLAN: One thing I can assure you, as I did earlier to one of the opposition members, is that the Ministry of Health will remain the persons who set out the guidelines, the standards, and the policy for that, but the actual service of that can be contracted to someone. For example, the tuberculosis and STD clinics will remain as dedicated provincial resources. We think that's important.

On the issue of administration, we don't think you need several administrations for these. For example, in our provincial labs we have two full administrations. You probably don't need that. You may need the volume of lab, but you don't need that much administration.

We would like to focus on effective delivery of services and do it within our regionalized system. We're going to be transferring some of the positions that we've had into this area. I can assure you that the quality control and so on will remain, but the direct delivery of this service won't be through our department.

THE CHAIRMAN: Thank you.

MR. WOLOSHYN: If the guidelines of policy and the control of the service delivery, if you will, are going to be remaining in the hands of Alberta Health, which I totally agree with – and I certainly agree with keeping TB and STDs as a stand-alone, separate unit under Health, and that I believe is what I heard you say – then I would conclude that there's not going to be a per capita funding process on this but that it will be funded to regions as the need requires, as the variations – for example, as the need for control arises here and there. Or are we going to throw a block fund at a region with no accountability?

MRS. McCLELLAN: I'm not sure I followed all that, but just give me a second to try and sort it out.

Aslam thinks he's got figured out what you are concerned about. I think I indicated that we will continue to have dedicated provincial resources, but we in Alberta Health will not be the service deliverers. We will contract that to, for example, the Capital health authority in this area to deliver, to provide that service, but we will make sure that those dollars are dedicated to that service. They can't be moved into other areas. We will remain responsible for standards, guidelines, ensure that those are adhered to. Did I get pretty close?

MR. WOLOSHYN: Pretty close, pretty close.

THE CHAIRMAN: Thank you.

MR. WOLOSHYN: On that same line, then, I would hope that the answer to this next question is a flat yes: that there be sufficient staff with sufficient authority retained by Alberta Health to have direct control over the activities of the services that are being provided by the health authorities under this particular mandate so that (a) the money is going to the right place and (b) the desired activity in fact occurs, whether it be a mass vaccination program or whatever. That would be a yes or a no?

MRS. McCLELLAN: We can give you a flat answer of yes to that, and we can tell you that that budget is structured such that we can respond to an epidemic if it's needed. We hope that it won't be, but that's included in it.

MR. WOLOSHYN: Thank you.

THE CHAIRMAN: Thank you very much.
Mrs. Fritz, for a question. We do have seven minutes remaining, so please go ahead.

MRS. FRITZ: Thank you, Mr. Chairman. My question is on page 257, the third bullet from the bottom of the page. It says:

- The Alberta Alcohol and Drug Abuse Commission will expand its research, education and counselling services for problem gambling by initiating specialized day treatment and inpatient programs for problem gamblers.

I wondered if you could please . . .

MRS. McCLELLAN: Give you some idea about how . . .

MRS. FRITZ: Well, no. I'm thinking about how to ask this, because I know you're going to say no.

THE CHAIRMAN: You can't both ask the question and answer it.

MRS. FRITZ: I have seven minutes, Madam Minister.

MRS. McCLELLAN: I know you do, and I want you to get every minute of it.

MRS. FRITZ: Actually, I would like you, please, to comment on the budget for this program.

MRS. McCLELLAN: Okay. I'll ask Mrs. Laing, the chairman of AADAC, to give some comments first.

MRS. LAING: As you are aware, the budget was increased to $1.87 million this year through the lottery funds, and part of the strategy of prevention is to do some research. So they will be establishing those programs as a sort of pilot project to use as research and to develop some programs in that area.

7:50

MRS. FRITZ: Just a supplemental to that. Will the education programs be through the school-based system as well, or will it be on-site?

MRS. LAING: It'll be partly, and some will also be on-site. They'll be developing special materials for the different gaming

facilities that we have. So there will be educational material targeted towards the gaming activities.

MRS. FRITZ: Thank you, and thank you, Mr. Chairman.

THE CHAIRMAN: Thank you.

We do have time for one more quick question for four minutes, and this will go to Mr. Renner.

MR. RENNER: Thank you, Mr. Chairman. Actually I have a quick question, but it is probably not that easy to answer. I want to deal with prevention. I think that no one can argue that the best way to save money in a health care system is to have people not using the system. I notice that you have increased the budget for Action for Health for prevention and promotion by $2 million. My concern is: what measurement techniques are in place to ensure that the dollars that are spent on prevention are spent in a productive way? How do we know that we're getting a bang for our buck and we're not just spinning our wheels on prevention?

MRS. McCLELLAN: I think it's an extremely good question. When we went into health promotion programs, we said that, first of all, we weren't just going to hand the money over: you've got to come up and tell us what the program is that you're going to do. Secondly, it's just not enough to identify that perhaps it's teenage pregnancy you consider an issue or a concern in your region so you're going to do an education program on that. It's not simply good enough to put the program in place and say, "There. I did it."

We are requiring that the regions do an evaluation of their programs and an assessment and that it's ongoing. The same with tobacco programs, whether it's cessation or whether it's education programs. If they feel an issue is teenagers beginning smoking in school and they put programs in place, they have got to do a monitoring and evaluation of those programs and, if they aren't working, adjust them, not just say, "Well, we tried" and that's it. One of the problems that I believe we've had in health promotion programs is that we haven't done an evaluation to see if we've made a difference.

Now, on some we know that's a long-term exercise. If you look at the heart smart program that was jointly provided by Health Canada – and we were quite pleased to be a participant in it – those are longer term programs, but you can evaluate whether people are changing their habits, whether they are eating smarter, whether they are following this. We've got some very good pilot projects. I'm trying to think how many there were in the heart program. I think there were 15 plus some others that were outside the program.

So the evaluation of these health promotion programs is extremely important. It's important for one other reason: if they have a program that works, they can share that and say, "Hey, you know, we tried this this way, and it worked." It may not be right for every region, but they can learn from each other and share.

I tabled some Action for Health information that we have, and I think it shows that there are some rather innovative and aggressive things being tried by some of the regions.

THE CHAIRMAN: Thank you.

MR. RENNER: How much time do we have left?

THE CHAIRMAN: Half a minute.

MR. RENNER: Given that there's not enough time, I would move that we dispense with the final minute and that we adjourn.

THE CHAIRMAN: Thank you. All in favour?

HON. MEMBERS: Agreed.

THE CHAIRMAN: Opposed? Thank you.

[The committee adjourned at 7:54 p.m.]