Legislative Assembly of Alberta

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5:45 p.m.
[Chairman: Dr. Oberg]

Committee of Supply: Designated Supply Subcommittee Health

THE CHAIRMAN: Ladies and gentlemen, it is 5:45 p.m., so if we can get started, the format tonight will be that the Liberals will have the first hour, followed by the government for the second hour.

With that, I have the undertaking that Mr. Dickson will be leading off.

MR. DICKSON: Mr. Chairman, I want to make an observation and raise a concern, and it's this: I've been looking for and waiting for *Hansard* from last Monday's session, the initial go-around in terms of asking questions. Today for the first time I got in my hands a set of the Blues. This is my difficulty. There are a number of things that I want to put to the minister this evening or in the balance of this designated committee. Now, maybe the minister has already had somebody go through and number each of the pages, but you don't have the benefit of a proper *Hansard*. I'm working from the Blues, and it seems to me it really curtails optimal use of this kind of format and this kind of question-and-answer exchange. So I wanted to register my concern and indicate, just advise the minister that I'm going to be putting to her a number of those past responses. It's unfortunate we're not going to be able to do it by page number.

THE CHAIRMAN: If I can respond to that, please. The original format is four-hour format, which would not entitle you to have the *Hansard*. So by spreading out into two two-hours and having the advantage of the Blues, it's actually better than it was. They do have page numbers on the Blues as well.

MRS. McCLELLAN: But the point is I got them today too.

THE CHAIRMAN: Yes. We just received our copy, and the chairman received his copy just now as well. We do have an extra copy of the Blues, if anyone would like them.

So with that, why don't you go ahead and start.

MR. SAPERS: My first set of questions relates to program 1, departmental support services. Mr. Chairman, with your permission, I hope your interpretation about the question and the supplementals will permit me to move within the program. On that basis, Madam Minister, I notice that in line 1.1.2, which is the deputy minister's office, there is an increase of some $20,000. I'd just like to know what that relates to. It's not a significant amount, but it always catches my attention when I see corporate services budgets going up.

On the other hand, I know that there has been a commitment made to communicate more with the public, to educate the public about what's going on in health care. There's even been a suggestion that there will be a good-news campaign of sorts. But under 1.1.5 the public communications budget is down considerably from last year, and that seems a little contradictory. So I'm wondering whether there are dollars budgeted in your department that are in another line item I haven't found yet that will be used towards departmental public communications.

THE CHAIRMAN: Sure. We'll allow that as one question. Go ahead.

MRS. McCLELLAN: The major change in the deputy minister's office staff is really just wage adjustments that are normal through the grid. Also, I should say that, you know, we have had a significant reconfiguration of our department, and you would know that at one time there were nine assistant deputy ministers and now there are three. There was an associate deputy minister as well as the deputy minister; now there is the deputy minister. So there have been some reconfigurations of workloads and how we do that.

In the communications area we're doing more of our own work internally, printing our own communications, saving some money in those areas. We've reduced duplicate publications through the reorganization of Health. I think you would see that where you had nine separate entities before, now with three plus a deputy's office we're much more efficient in not duplicating publications or work. So we're able to bring that together. Those are really the areas that have changed.

THE CHAIRMAN: Thank you.

First supplemental.

MR. SAPERS: Yes. Also staying with program 1, last year you were very helpful in providing some detail regarding the expenses related to the various committees. I believe you provided some detail about some three dozen committees. There are a number listed under advisory services.

MRS. McCLELLAN: What page are you on?

MR. SAPERS: I'm on page 249 of the budget book, but it's 1.2, advisory services. I'm wondering if you could advise me as to which of the committees are being funded out of this program which aren't listed in this subcategory. This does not reflect the same list as last year. Will you provide again that detailed list of all the committees?

MRS. McCLELLAN: Working committees is what you're talking about?

MR. SAPERS: Yes.

MRS. McCLELLAN: Sure. We'll do that in writing, as we did last time, and give you more detail on any working committee that's associated with these that we have.

THE CHAIRMAN: Thank you.

Second supplemental.

MR. SAPERS: Yes. The second supplemental has got to do with probably 1.1.4, information management. Again I notice that there is a significant reduction in this year's projection over last year, and I found that curious in light of all the public debate about smart card technology, information management. So can you tell me whether or not you are in fact budgeting for a pilot project or two? If it's not coming out of this line item, where is it coming out of? Maybe you've got a dollar amount that's attached to it already.

MRS. McCLELLAN: The main reason for changing 1.1.4 is outsourcing. So we've reduced what we do in that area. In the area of health information, we're prepared to fund some initiatives that we may go ahead with this year. We are prepared in a conservative way to begin that process. And you want to know what line it's in?

MR. SAPERS: Yeah, and how much.

MRS. McCLELLAN: I'll find the line for you.

THE CHAIRMAN: Thank you.

MR. DICKSON: Madam Minister, I think it was in the fall session of the Legislature when you said that regional health councils would be set up by the beginning of April of this year. I'd like you to tell me why we don't have in the city of Calgary a health council such as you told us would be coming a number of months ago. We're almost to April now.

MRS. McCLELLAN: The regional authority in Calgary is calling them somewhat differently than a community health council. However, I will be ensuring that they do meet the terms of what a community health council would do. What they've done is involve the community in program areas rather than taking wards and areas, but we're reviewing that with them. Almost all the regional health authorities have either their community health councils in place or are in the final selection process or advertising to the selection process to have them in place by April 1.

MR. DICKSON: In the absence of a regional health council in the city of Calgary, I want to ask why it was that you'd indicated to my colleague for West Yellowhead last fall that in deciding on hospital closures and available beds, you looked at a variety of different criteria. Some of the ones I recall were the number of seniors in a particular area and so on. Given those kinds of criteria looked at and as a result of the prototype health needs assessment project report on community consultations that had been undertaken April 18, 1995, in Calgary, which went through and identified with almost every one of the criteria you'd mentioned in the House last fall, downtown Calgary would be right at the top of the scale: a large number of seniors, a significant number of problems with access, a high incidence of accidents and that sort of thing. Why is it that we're applying the criteria to closing other hospitals, but we didn't apply those criteria, Madam Minister, when you announced that you were going to close the Holy Cross hospital before the RHAs were set up?

5:55

MRS. McCLELLAN: Well, in fact we announced all the reconfigurations in Calgary about the same time as the regional health authority came into view. Those were done, as you know, with a series of investigations and reports and recommendations. You would recall we didn't accept all the recommendations. One of the recommendations was to relocate the Children's hospital on the Foothills site. In reviewing that, it was felt that that was probably not appropriate at this time. Maybe someday down the road it will be more appropriate, but they did develop a closer working relationship.

As far as the closure of the other two sites, you also know that there was a major dollar figure attached to the rebuilding of the Bow Valley centre that was felt to be entirely required at one time. Now, I have a little trouble believing that an institution can go from practically falling down and needing replacement to being okay to operate for 25 years. That's an issue that I haven't quite solved in my own mind, but that's about the way it went.

I have to remind you that the regional health authority in Calgary are still working with the community as to what are the appropriate services to be in the downtown core. They haven't decided on a site where a community health centre would be placed in the downtown core. They haven't ruled out, as I understand it, the Bow Valley centre. In fact, I'm not absolutely positive they've entirely ruled out the Holy Cross. What they have said is that the Holy Cross will close this fall, will no longer be doing the programs it has. The Bow Valley centre will close a year from now. It will close as far as doing what it does now, which is a great deal of acute care services.

If you look at some of the models, I think you might understand the concept of community health centres better. I invite you to take the opportunity to sit down with the Caritas group or the Capital authority here and look at the Grey Nuns hospital. You heard three years ago a great deal of concern about the Grey Nuns hospital: 15,000 people in a march and all of that. I've been told since that I've closed it. Well, I can tell you that between the Misericordia and the Grey Nuns their budget is somewhat over $100 million, so I know they're not closed. But I think what you'd also find is that they are indeed providing more services in some areas than they did, and they are providing more services that are appropriate to that community.

Now, the Calgary regional health authority is going through that process now of looking at the downtown. The downtown Calgary core will be a different criteria than the Grey Nuns was. Grey Nuns is situated in a community of young people. They will be looking at the type of community health centre that is more appropriate to that. I think that rather than simply decrying the closure of a set of buildings, because it is a set of buildings – I've been in it, you've been in it, and you know what it's like – or the ability to even work efficiently in it, the community groups should talk about what the downtown core in Calgary really needs to serve its health needs.

I look at the Boyle McCauley centre, that is in downtown Edmonton, that is extremely effective in serving those community health needs. I look at the plan for the northeast centre in Edmonton which has been developed by the community – Howard would be aware of that; Muriel would be aware of that – to meet those community needs, not to duplicate high-cost programs that can be better served on other sites.

I think that's what we have to do in the downtown core: work with the health authority, try to understand the process they're going through in making those determinations, and give them some constructive assistance. The status quo is not always the best.

MR. DICKSON: Madam Minister, I heed the admonition. I thought I'd been giving them constructive advice for a couple of years.

MRS. McCLELLAN: Well, I haven't seen it. Maybe you should copy me then.

MR. DICKSON: Madam Minister, further to your response, if you look at page 245, you've identified your number one goal in the area of service delivery as "services are accessible." Going back to the prototype health needs assessment project in Calgary, I was part of about 200 people representing virtually every agency you could name in downtown Calgary. The number one concern that kept on surfacing was access, not allegiance to a particular site or building but access to a range of services. I'm interested in knowing what revision you have made to your plans – and when I say you, I'm holding you responsible for what the CRHA does. As a consequence of the very powerful message that came out of that assessment on needs in downtown Calgary, what changes have you made to the initial plan you'd had prior to that needs assessment?

MRS. McCLELLAN: Well, frankly, I haven't made any changes because the regional health authority has not made a determination

of what and how they're going to deliver the services that are needed in the downtown core. I mean, I have to come back to this. Work with them. They are looking at that now. It is the Calgary regional health authority's responsibility to deliver the appropriate services. Yes, access is important. But access to what services? What are the primary services that are needed in that downtown core? You know that you're not going to have five high tertiary care institutions in the city of Calgary. Would you rather have two high tertiary care institutions that have the latest technology, the best medical staff to do those high tertiary services, or do you want mediocrity on five? You simply can't today, as you know, afford to do it any other way. This is not an Alberta phenomenon. This is in fact not a Canadian phenomenon. It's a world phenomenon.

I visited, when I was in Tokyo, Japan, a city of 11 million people and looked at how they're reconfiguring how they deliver services to them. They're making choices. Not every hospital does everything. Go and see what services are in downtown Tokyo for them, member. I know you'll tell me: I don't care about that; I'm worried about Calgary. The point is: look at what Calgary downtown needs, how it can best be served, and then put it in place. That's what the regional health authority is doing now, and they have not made that determination.

The other thing is that you cannot confuse access with convenience, and while it might be nice for all of us to have the convenience, the important thing is that you have the appropriate access wherever you are in this province, whether you're in downtown Calgary or downtown High Level.

THE CHAIRMAN: Thank you.

Mrs. Abdurahman.

MRS. ABDURAHMAN: Thank you, Dr. Oberg. Just following up on my colleague for Calgary-Buffalo's question and your answers, hon. minister. Looking at the estimates: 1.1.7, population health division. I'm looking at the numbers there. How does that fit in with knowing indeed whether it's Calgary, Edmonton, Red Deer, or Grande Prairie? How does it fit in with finding what the health status of Albertans is to ensure that the appropriate programs are in place and the appropriate funding? What I'm looking for is the overall plan for Alberta Health. Where are the dollars that are being expended to look at the health status from community to community? It looks as though it's declining, the dollars in that area.

MRS. McCLELLAN: If you're looking at 1.1.7, you're just looking at the administration component of the population health division. You're not looking at the programs that are actually provided. If you recall, one of the things we said in Alberta Health was that we're no longer going to be direct service providers. We provide the dollars to the regions in population health to deliver those services, not that we do them in our budgets. The very instances that you will see there are in staffing or maybe in wage adjustments, where maybe you had somebody leave at a higher level and come in at a lower level. Those are strictly administrative dollars.

6:05

MRS. ABDURAHMAN: Well, obviously I'm not hitting in the right area. What I'm trying to get at is: what money has been expended by Alberta Health in clearly determining the health status of Albertans so that you can identify the programs required and then budget accordingly? I'm trying to find in the estimates how much money has been spent on behalf of Albertans to identify health status.

MRS. McCLELLAN: One of the initiatives you would recall was the health survey that was a benchmark survey last year. Now, that is a broad survey that looks at health status. The other is that you will find in those administrative dollars where we collect data on birth weights, live births, length of . . .

MRS. ABDURAHMAN: Length of stay.

MRS. McCLELLAN: No. I was thinking of longevity, things like that that give us the information in health status.

The other thing we're doing is asking the regional health authorities, as well, to gather and use that type of information so that they can make good choices for population health. I've used the example that if fetal alcohol syndrome is a problem in an area, then that area would be dealing with that, but we wouldn't necessarily have a provincial fetal alcohol syndrome program because it's probably not a high priority in some of the regions. I could name some that wouldn't have. If you have an intersection in a community where you have a lot of traffic accidents, do you just build a bigger hospital so that you can cure those people, or do you work on changing that intersection to lessen the number of injuries? That's what we're talking about in population health, and I know you understand it.

The regions are responsible for developing a lot of that through their needs assessment. We're responsible for the data collection and analysis. One of the areas that, as you know, we're working on is: how do we deal with health information better so that we can, one, improve patient care; two, make sure we're targeting the resources appropriately, which is what you're referring to; and, three, be more cost-effective in what we're doing? As you know, we've been studying that area as to how we can develop a better system. Everybody has data. The hospitals have it. The doctors' offices have it. We have it. How do you bring it together and use it better in decision-making? I think that's what you're talking about.

MRS. ABDURAHMAN: So what's in place from one regional health authority to another? I'll use an example where the main centres, Edmonton and Calgary, are going to be assuming a significant responsibility in certain delivery programs. How are they getting that information shared to ensure that they can meet the needs of northern Alberta, southern Alberta, or some other area?

MRS. McCLELLAN: Well, that's a very good question. Although they are assuming the responsibility for the operation of those programs, they will continue to be provincial programs, and they will continue to have that responsibility. Aslam just reminded me that the health surveillance branch in population health has 20 staff members, so we continue the surveillance role while we're not directly delivering the programs. There really is no difference in the program; it's simply who is operating it. We will maintain the overall responsibility for ensuring standards, consistency in data that's gathered, and quality assurance. That will be our role instead of actually offering the program.

THE CHAIRMAN: Thank you.

Ms Leibovici.

MS LEIBOVICI: Thank you. Health surveillance sounds like Big Brother.

MRS. McCLELLAN: Yeah. Well, it's sort of surveillance, Karen, insomuch as: how many cases of measles did you have? Did you have more whooping cough than you did last year? Has there been a polio rise? – you know, that sort of thing. Believe me, that's important.

THE CHAIRMAN: I'm going to get her. Watch. First supplemental. [interjections] I was just kidding.

MS LEIBOVICI: Good luck.

MRS. McCLELLAN: Cute, isn't he?

MS LEIBOVICI: What I'd like to do is start off actually with a couple of quotes to just set the stage for some of my questions. I'm quoting from a magazine called Health and Healing, which is a review of the Catholic Health Association of Alberta and affiliates. The article is written by a Richard Fraser, who chaired the Canadian Bar Association task force on health care as well as participated as a member and facilitator for Alberta Labour's future work project. What he says is that he believes

> the "how" of regionalization in Alberta is predominantly command and control . . . Command and control starts in legislation and works its way down through the health care system often by regulation and through the use of the adversarial process. This can cause immense frustration to people working in the health care system . . . and to members of the public who become concerned about whether or not the restructured health care system will adequately meet their needs.

He then quotes the American-based Conference Board, which is "a non-profit business organization of 2,700 companies from 60 countries." It's from a document called Across the Board.

> All of this restructuring and downsizing has actually reinforced corporate bureaucracy instead of eliminating it. Restructuring not only fails to create new forms of participation, it destroys old forms of participation that kept good bureaucracies working reasonably well in the past.

He then outlines some of the suggestions with regards to what he feels might be useful guidelines in upcoming negotiations.

THE CHAIRMAN: Perhaps if you could get to the question, please, Karen.

MS LEIBOVICI: I am. He then concludes, saying that the

> command/control adversarial paradigm will result in continued fear, anger and distrust with resulting increased arbitration and litigation, all at the expense of the health care system.

My questions are around the upcoming negotiations. I think the minister has already been warned by the various labour unions that these are going to be tough negotiations coming up. My first question is: what strategies does the Department of Health – and I would imagine it would be in conjunction with the Department of Labour – have in place with regards to the upcoming negotiations?

MRS. McCLELLAN: I'm sure that you are very aware that the Minister of Health does not participate in labour negotiations, and if she's wise she doesn't comment on them either. So I think that's where we'll leave that question.

MS LEIBOVICI: The Minister of Health, however, can set policy parameters, as the Minister of Labour has done with the ATA, in terms of looking at mutual gains bargaining. That is a role that the Minister of Health could play.

MRS. McCLELLAN: The Minister of Labour plays that in the nine unions that are involved in health, not me. That's clear.

MS LEIBOVICI: Can the minister point me to where in this budget or in any other budget are the contingency dollars for the wages for the upcoming negotiations?

MRS. McCLELLAN: The regional health authorities are responsible for bargaining. They know their budget parameters. The three-year business plan clearly lays out the program. It's updated every year. There are no surprises. The regional health authorities will carry out their bargaining.

MS LEIBOVICI: Can the minister say once and for all whether she will be setting some kind of guidelines with regards to severance?

MRS. McCLELLAN: No.

MS LEIBOVICI: No, you cannot say, or no, you will not do it?

MRS. McCLELLAN: The regions have the responsibility for dealing with their members. Frankly, hon. member, you should realize that instead of having all the various units that we had before, you have 17 regions now, which I think can bring more consistency than maybe was possible before. The regions are the people who are responsible for that. The Minister of Labour and I have communicated with the regional health authorities. I've made as much comment and communication on the issue of bargaining as is appropriate for a minister under the way it is set up in our area. It simply is not for me to deal with.

6:15

THE CHAIRMAN: Thank you.
Mr. Sapers.

MR. SAPERS: Thanks. Looking at program 2 and looking particularly, to start with, at line 2.0.3, allied health services, I'll note that on that line item the budget remains the same for '95-96 as compared to '96-97. Now, I'm assuming that that is still where physiotherapy will be funded from and that that's still the line item where chiropractic will be funded from. I'm curious as to how that line item could stay the same given that we've had tremendous confusion over and around the community rehabilitation program and physiotherapy across the province, particularly in Edmonton and Calgary. The regional health authorities in both of those areas are struggling to remake the physiotherapy contracts, and they're coming at it from very different kinds of approaches. Because chiropractic is funded out of that as well, there has been a reduction in the cap that Albertans can access when they go to visit their chiropractor. So I would have assumed to have seen a budget fallout that I can't find.

MRS. McCLELLAN: Okay. Let me help you.

MR. SAPERS: Okay.

MRS. McCLELLAN: First of all, one of the reasons it stays the same is because we made a commitment to the CRP program that we would pass on the dollars intact that were available in the areas, and we did. The negotiations with the regions do not affect that budget. The regions each have a dollar amount in community rehab that they can work within. The chiropractic change in cap was a recommendation of the chiropractors rather than to reduce

fees. Their program, as you know, had a cap on it, and if your utilization changed significantly, then you had to do something with it to stay within the budget. In discussions with them – and certainly I agree with them – we don't want to have many unnecessary barriers to access. Reducing the fee probably would have been an increased barrier to access.

The chiropractors, I think, are in the best position to know their program, and they felt that the majority of persons could be served within the $200 cap for services. Now, those are their stats, not mine. I guess you know that I have a little concern with entitlement programs anyway. I think they should be needs based. But we've agreed to work with the chiropractors to look at how people access their services and the best way to expend the dollars that we have there. Remember, these are outside the Canada Health Act. Many provinces, in fact most, do not fund them at all, but we think that it is an important choice for Albertans to have. So we fund both on the fee side as well as on the X-ray side for that service. That's why the budget doesn't change. That's the amount of dollars that's there.

THE CHAIRMAN: Thank you.

First supplemental.

MR. SAPERS: Okay. Under medical education allowances, Madam Minister, which is line 2.0.6, again I notice that this is a status quo budget. I may be mistaken – and if I am, I know that you will immediately correct me – but is this not the budget area that in part could help assist in recruiting and retaining rural physicians? I particularly make reference to a recommendation from the Alberta heritage savings trust fund committee, which has recommended that more educational allowances be made available to help in assisting recruitment and retention of rural doctors.

MRS. McCLELLAN: Well, you're right; I'll help you. No, that isn't the right one. But if you go down to the next one, under the rural physician action plan you will find areas there where we have increased the budget for recruitment. Under 2.0.7, $1,121,000 is the increase in fact. So that's where those really are for improving recruitment.

Can I just make one further comment?

THE CHAIRMAN: Sure.

MRS. McCLELLAN: The idea that came before the heritage fund committee was not a new idea. In fact, you would know that we already do that. The program that we have is in fact a little richer because it helps the medical students in two years at a higher amount. It's $20,000 in two years that they can receive to assist them with their tuition or costs of their education, and that program is in place under the rural physician action plan. So it's not a new idea, and we've actually expanded that somewhat this year by – if I can just finish – the programs under the aboriginal health strategy, which is an important part of it. You've heard me talk about the bursary program there.

THE CHAIRMAN: Thank you.

Second supplemental.

MR. SAPERS: Thanks. I saw the heritage savings trust fund recommendation as an enhancement and utilizing a different pool of resources as well to supplement the existing program.

MRS. McCLELLAN: What I read in that was that there wasn't a knowledge that there was one existing, and I felt rather badly about that.

MR. SAPERS: But you would know that wouldn't be the case.

MRS. McCLELLAN: I think it was.

THE CHAIRMAN: Polite banter isn't counted as a supplemental.

MR. SAPERS: All right. Under the line item 2.0.2, medical services, which pays primarily for physicians' fees – that's the pool that's been negotiated – there's been much controversy about the AMA contract. There's been a suggestion that the physicians will get a bonus or be rewarded for finding ways to cut budgets from other places in the health system as opposed to it coming out of their own pool. I'm wondering specifically: how will we know this year whether or not significant dollar savings have been achieved as a result of physicians' initiatives? I mean, there is no net reduction projected in the budget. How will we know? Maybe you could just walk us through what the accounting procedure will be.

MRS. McCLELLAN: Okay. Two things. I have to go back to your other one; I forgot to tell you what the one you asked about was. The 2.0.6 is our payment to interns in residence. We've held that the same.

On the AMA agreement, yes, much has been said and suggested. I will continue to, I think, strongly suggest that this is a very good agreement. In fact, I think it's an agreement that might be looked at as a model in Canada for co-operation between a significant caregiver in our system and the regional health authorities and government, because it does allow us to come together in a tripartite process.

What are some of the areas where we're going to achieve savings? We're not going to achieve savings by reducing benefits. That was in the news release. That's been made very clear, although I do hear when I'm out and about that some people are bandying around the idea: oh, well, they're just going to deinsure things. Whoever is saying that doesn't read well or understand the program very well, because they know that if we did that, it would not go as a credit to the savings.

One of the things that is making some progress is clinical practice guidelines. One of the areas that will be examined will be how we pay physicians, managed-care proposals that are coming forward, that will come forward. I would remind you that the managed-care scenario was brought to us by the AMA and by physicians, on the straight physician side.

The other side is the drug area, and I know we're not going to get into detail on that, but that is the other $50 million. I still hold that if you don't have the people who prescribe the drugs, the people who dispense the drugs, the people who manufacture the drugs, the people who consume the drugs, and the people who fund the programs sitting down at the same table, you're not going to achieve savings. We have got that commitment from all of the parties, and I think that is extremely significant. I've been listening to what's going on around Canada, and I haven't seen that type of initiative really advanced either. How will we know we get those savings? You will know at the conclusion of our budget year whether we meet our budget targets; won't you? But we intend to.

6:25

THE CHAIRMAN: Mr. Sapers has just asked for a clarification on his question.

MR. SAPERS: Yes. Madam Minister, it was really on that last bit about knowing. Yes, the obvious answer is we'll know when

the public accounts come out the following year. But what I was specifically inquiring about is: how will you account for that? How are you going to account for system savings recommended by physicians or savings that have come from other initiatives that have already been brought into the system? How are you going to account for those savings so that you can attribute them to this contract, this initiative?

MRS. McCLELLAN: I can assure you that the AMA and Alberta Health have a mechanism for evaluating which are savings that go to this agreement and which do not. We are very clear on areas that cannot be used towards savings, that they must be in more efficient ways of delivering services, better patient/physician knowledge and understanding to reduce unnecessary costs in the system. It's not to take away the necessary.

THE CHAIRMAN: Thank you.

MR. SAPERS: It's an instrument, then, that you can table? It's an instrument or a set of criteria that you can bring to the Assembly?

MRS. McCLELLAN: Yeah. I would expect that when its development is completed, we could. The AMA and Alberta Health are working on the formation of those documents and those terms now. I don't think they're finished though.

THE CHAIRMAN: Thank you very much. I would just respectfully say that there are 15 minutes left for the Liberal opposition. If you want to keep the speaking order the same or if you want to change it, I would certainly be amenable to that. So I assume it will be the same.

Mr. Dickson.

MR. DICKSON: Thanks, Mr. Chairman. Just going back to where I left off with the minister before. I was anxious to disabuse the minister of any sense that there was confusion between access and convenience expressed at the inner-city assessment project. The best way of illustrating that is that the first and second issues that arose were, firstly, the mental health population, and secondly, poverty. I suggest that's quite unrepresentative certainly of any of the other areas in the city of Calgary.

Madam Minister, following up on that, some questions related to mental health, forensic health services. I understand that the CRHA is contemplating building in effect a brand-new two-storey prison hospital in the city.

MRS. McCLELLAN: Pardon me?

MR. DICKSON: The CRHA is contemplating building in effect a new jail/prison type facility in one of the hospitals and eliminating certain cells they have in another Calgary hospital. I'd like some particulars in terms of the cost involved, whether any of that is being picked up by the Department of Justice or whether all of it is coming out of your budget, Madam Minister.

MRS. McCLELLAN: I know you're talking about forensic services, and I know that there has been some discussion as to the location of forensic services, but I have to say that I haven't heard that we're going to build a new forensic hospital.

MR. DICKSON: I'm sorry if I misled you. I didn't mean a new hospital but a new facility as an add-on to one of the existing three anchor sites. Obviously what I'm trying to do is get information in terms of what the cost of that is going to be and then of course on what's going to happen to the site that currently exists and has been built at considerable dollars.

THE CHAIRMAN: If I can, perhaps the first question is on the cost, and the first supplemental would be on the location.

MR. DICKSON: Sure.

MRS. McCLELLAN: Okay. Any capital is in the public works budget. I don't mind discussing capital projects that have been approved, but I don't have that information for you. What I will endeavour to do for you though – I think you probably could do it easier. You're probably in Calgary more often than I am, but I can phone. I will ask the regional health authority if they can give me some information that I can give you as an update as to their planning on how they're going to locate forensic services, because the last information I have is that they have not decided that. They are exploring a number of alternatives. One is to leave them where they are in the building that they are in, which is a relatively good building, but it would depend on the utilization of the rest of the site. So I will try to get you that information.

THE CHAIRMAN: Thank you.

Second supplementary.

MR. DICKSON: I wanted to draw your attention, Madam Minister, that currently I think about 65 percent of the mental health patients that use the facility at the General hospital walk to that facility, and I guess I wanted to ask you specifically what steps you or your designate in the RHA are taking to ensure that the specific and very serious mental health needs that exist in downtown Calgary are going to be addressed on a priority basis from a number of perspectives, not the least of which are some public safety concerns.

MRS. McCLELLAN: Sure. Good questions, but again, the Calgary regional health authority has not made a decision on where a community health centre would be situated. I point you back to some centres that are already in existence that work extremely well. I mentioned Boyle McCauley here; I could mention to you Alexandra centre in Calgary, CUPS centre. You can look at the integration of many of those services which sometimes you need rather than just one service. What we see in some of the community health centres, in fact, are social services also having offices in the same area because many of the clients are also associated with social services. So if a client can receive a number of services in one area, it is better, and we're looking at new and innovative ways to provide those services better, not just old ways.

In the area of forensics, I think one of the leading forensic psychiatrists is heading up a review of how to deal with that. The Provincial Mental Health Board is looking at what services need to be provided there. They're working with the Calgary regional health authority. They've had a number of meetings looking at what they need in inpatient as well as outpatient services and where they should be placed. So, again, the decision is not made.

I appreciate the fact that you are bringing these concerns forward. The fact that I am struggling with is that you seem to be making some assumptions on some things that are done deals, and I want to caution you that that is not always in the best interests of the community in trying to do planning, to put out a message to the community that this planning is completed. As I

visit in those areas, I'm hearing a lot of that. So you spend a lot of time not very constructively. Instead of dealing with what's best for the community, you're busy telling them: "No, we haven't made that decision. No, that hasn't happened. No, that's just a rumour."

Those are very important services, but the region hasn't made the decision. Those points need to be made to the region. They've done a needs assessment. I'm sure you've had an opportunity to look at it or review it or to sit down with the regional health authorities. There are 15 members in that region, and I have found them to be extremely open with any MLA when they've asked to sit down and talk about the program. I don't think they would be any less reluctant than that to sit down with you and hear your thoughts on delivering services.

MR. DICKSON: Yet when I meet with the CRHA members, it's often a question. They say they deal with the envelope of money they get from you, Madam Minister, and the directions and constraints you impose on them.

MRS. McCLELLAN: That's true.

MR. DICKSON: Which I guess is why we're here.

MRS. McCLELLAN: That's true.

6:35

THE CHAIRMAN: If we can, that was your second supplemental.

MR. DICKSON: Certainly, Mr. Chairman.

THE CHAIRMAN: So we'll move on to the next questioner. That was your second supplemental.

MR. DICKSON: No, in fact it wasn't, Mr. Chairman.

THE CHAIRMAN: Yes, it was. Your first question was on the cost, your second question was on the location, and your third question was this last one. Correct me if I'm wrong.

MR. DICKSON: Well, that's fine. We'll move on. There are other questioners.

MRS. ABDURAHMAN: Time is very limited. This question could be very similar to my colleague for Calgary-Buffalo's, but I've made a commitment to my constituents. It's 3.3.12, the Lakeland regional health authority budget. There is much talk within the whole of the Lakeland regional health authority that the boundaries may change by the end of the month of March. The question I'm being asked is: whose decision would that be? Would it be the minister's? What say would all the other players in that region have, and how would you determine the funding?

MRS. McCLELLAN: The reason that you would change those boundaries – I've made a commitment to have a discussion with you, but I haven't done it yet. I just made that commitment last Friday because you have quite a bit of the area. The discussion on possible – and I say possible – revision to those boundaries is coming from that municipality, not from Alberta Health. I want to make that very clear. As you know, when we put the boundaries in place, we said that we would listen if people asked us to redraw the boundaries or to change boundaries because of service delivery implications.

I have had some representation from the county of Strathcona, and they've done some surveys of their community. It was interesting what they found out. They found out that a very high percentage of their community was happy with the services they were receiving, but very few of them knew which region they were in. That's probably because the majority of people from that community receive their acute care services in Edmonton. So primarily what they receive in that area are community health programs, some long-term care.

I also asked the county if they had any discussions with the city of Fort Saskatchewan, because while they are an entity themselves, that county rings them. I think it's important that you look at all of that. I expect that the reason you've heard a time line of March is that if you were going to do this, if the citizens there want to do this, if they want to change and be a part of Edmonton, fine. But you wouldn't want to do this after the process of putting new boards in place because that would just be very confusing. If you get 15 people on a capital region board and then you change the boundary, how do you decide who you take off so you can put representation from that area there?

The funding is the easy part because we know how the funding is dedicated by the population and for the services. But the bigger issue is: do they want to change their boundary? Do they want to be a part of the capital region? Does it make more sense? The people that will tell us will be those communities, and if they show the minister that this is a desire of the majority of the citizens in that area and that they've had the communication with the other communities like Fort Saskatchewan – most of the other towns are quite small, but with the people within their municipality – I would be quite open to look at it.

I intended to call you this week or catch you in the House and just apprise you of it. The mayor called me late last week on it.

THE CHAIRMAN: Thank you.

First supplemental. Hon. member, if I can, you have five minutes left.

MRS. ABDURAHMAN: What role will the other municipalities play, from Lac La Biche to Lamont? My understanding is that there's a lobby from Lamont through the government member of that constituency.

MRS. McCLELLAN: To which?

MRS. ABDURAHMAN: For Strathcona county to be moved out of our region.

MRS. McCLELLAN: No. I've had a lot of discussions with the member. No. It would have some effect on the rest of the region, but I can tell you that the Capital region, region 12, and the municipality have been in discussions together. So there is nothing that is not known by them. The only one that I felt was left out of the loop was Fort Saskatchewan in the discussions.

MRS. ABDURAHMAN: Well, my understanding is that the chairman from the Capital health region actually wrote a letter to Strathcona county, and all myself and my colleague have learned is by the rumour mill.

MRS. McCLELLAN: Yes. I think that's probably what sparked further discussion, but the fact is that this survey that was done by the county was done months ago, and the results were brought in. Those are the ones I talked about. But as I say, it will be up to the citizens, and I think what we should be worrying about is where will they receive the best access to health services, not

which region they're in. That's the bottom line, but you and I can talk a little bit more about the process. My question to the mayor in the discussions that I've had with him is, you know, how do you show me that the residents of that region want to change? That's what I need to know.

MRS. ABDURAHMAN: Thank you.

THE CHAIRMAN: Thank you. We do have two minutes of time for one main question, followed by the minister's answer.

MS LEIBOVICI: Thank you. On page 247 of Agenda '96, item 3 talks about "appropriate health workforce is available." The minister has implemented a strategy around rural physicians, which is admirable. My first question is: what strategies does she have around other health care workers?

MRS. McCLELLAN: I'm not sure if you're talking about number 3 in particular in that area, where we talk about appropriate workforce being available?

MS LEIBOVICI: Right.

MRS. McCLELLAN: I guess one of the things that each of the regions has been doing initially is a review of the human resources. They had the physical resources and of course the financial resources. Also, looking at ways that we balance the skill mixes appropriately for the type of care, if it's a caregiving situation that's there, and that is our strategy, obviously, on physician resources. The primary problem is rural, but we also have to look at the issue of recruiting specialists in the regions. It's very difficult for the regional health authorities to do the recruiting when they actually don't have any way of incentives because the payment system is through another one, unless they go into the teaching side of it. So each region is looking at their skill mixes, looking at the range of health workers they need.

As you know, we set aside $5 million to work with advanced education to make sure that the training programs were there and appropriate. I think the $15 million in the workforce adjustment strategy has worked quite well, at least from the reports that I've seen on it. That was meant to deal with: how do you retrain or upgrade or change your skill levels to meet the job requirements?

THE CHAIRMAN: Thank you very much. That is the end of time. That has been one hour, exactly, to the minute.

I would now invite Mr. Yankowsky.

MR. YANKOWSKY: Thank you, Mr. Chairman. My reference is on page 251, and it's 3.2.3. I see there's a drop of some $575,000 there from '95-96, projected expenses and so on. I'm wondering why this drop when we're doing something like hepatitis B immunizations for grade 6 students and so on. Why are we showing it? How is it possible for us to show a drop?

MRS. McCLELLAN: Well, by being more efficient in the way we deliver services. One will be the consolidation of the administration of the provincial labs. We're probably the only province in Canada that had two separately administered provincial labs, and as you know, we're ready to consolidate that administration. So there's a significant savings there, the savings that we can achieve by moving some of the grants for the AIDS or HIV program to the centre for disease control, rather than having them splintered around, and just a plain refocus of administration. That is one of the things that's extremely encouraging to us. We have been able to find that by improving the administrative structure by bringing groups together, we can lessen the duplication in administration and find our savings there instead of in service delivery, which is where we least like to cut.

6:45

THE CHAIRMAN: Thank you.

First supplemental.

MR. YANKOWSKY: Yes. Thank you again, Mr. Chairman. Some communicable diseases that were previously declared conquered and for which we in fact discontinued immunization – I'm thinking of tuberculosis, but I know there are other ones – seem to be making a comeback. Is your department watching the situation, and will there be action taken if necessary?

MRS. McCLELLAN: Yes, we monitor not only in Alberta; we watch what the trends are in the rest of Canada as well, particularly in the area of tuberculosis but indeed all communicable diseases. Quite often you'll find that if there is a trend in one area, it will probably come and catch up to you. Of course, one of the initiatives was the initiative on vaccination for hepatitis B. I think because we've had a very good immunization program, we've been quite successful in keeping our costs down in those areas. We also are looking at the aboriginal areas, because we're finding that the increase in AIDS, HIV in that area is a concern to us. We will be doing a second measles vaccination, which is new, but that is because experience has shown in other provinces that without doing that, the incidence has grown. It hasn't happened in Alberta yet, but it probably will. Your first vaccine is only, I think, about 95 percent effective of assurance. So we'll continue to have that. Although we won't be doing the actual work ourselves, we will be maintaining those standards and guidelines.

THE CHAIRMAN: Second supplemental.

MR. YANKOWSKY: Thank you again, Mr. Chairman. I'm not sure whether you have a figure for this or not or whether you can break it out of somewhere. How much are we spending on HIV and AIDS screening treatment per year?

MR. WOLOSHYN: Too much.

MRS. McCLELLAN: No.

Actually, the program is done through the hospitals, but any programs that are on education are done by the AIDS Network. We give them the grants and the same with the drugs actually. A lot of the decision-making on which drugs we fund for that are done with advice from the AIDS group. Jane just wrote down here and it may be of interest to you that the average cost is about $140,000 per patient once they're ill. It's a fairly high cost, so it is important that we do education to reduce. I think this year is the first year that the numbers have leveled or even somewhat dropped in AIDS, yes. [interjection] I want to make sure I'm right. I hope that means that the education programs are working and the incidence is reducing. The best way to do that is education.

THE CHAIRMAN: Thank you.

Mrs. Fritz.

MRS. FRITZ: Thank you, Mr. Chairman. My question's just an overall budget question, and then I want to lead to a question on

page 257. I realize just from the discussion and the debate that's been occurring that the total base budget for Health in 1996-97 will not be reduced. My question is whether or not there's an overall increase in absolute dollar terms to the total base budget for all regional health in 1996-97, and if so, what is it?

MRS. McCLELLAN: The budget for Health increased about $141 million this year. That's overall – okay? – but there are many things in that.

MRS. FRITZ: But all regional health budget is a $141 million increase.

MRS. McCLELLAN: Yeah, that's the total.

MRS. FRITZ: In absolute dollars.

MRS. McCLELLAN: That is taking into effect that we did not achieve our savings in physician services last year. That takes into effect that we're not proceeding with the $53 million reduction in operating dollars to the regions. It takes into effect that they do have the second year of their $21 million reduction in labs this year. It takes into effect that we have put some more dollars in some of the programs like Action for Health, capital equipment dollars that are there. So all regions' budgets will either remain the same or increase somewhat this year. That would be my judgment when it's all completed.

If you look at the numbers – and I see Howard peering at them closely – remember that the community dollars are not in those figures yet. Because we had made an agreement with the regions that we would sit down with them and talk about how we distribute those dollars, they're not entered in. So they're really down at the bottom.

MRS. FRITZ: Okay. Thank you. I appreciate that clarification.

My question is based a bit on what was in your answer, Madam Minister, on page 257 where it says, one of the bullets here:

> The final phase of the rationalization of the [lab] services by Regional Health Authorities will result in further savings of $21 million.

My question is: is this $21 million a reduction in the base budget for '96, or is it a recognition that $21 million was taken out by the RHAs in 1995?

MRS. McCLELLAN: Actually what happened was that there was a $50 million reduction out of lab services, but it was phased over two years. So the first reduction was made last year, and the second reduction is made this year out of their budgets. Now, the regions themselves may have achieved all their savings last year. They may have done that, depending on how their lab agreement worked. Remember, they had a year to prepare for this and then the year of implementation, and then this is the next year. Actually the way it worked: '94-95, an $8 million reduction; '95-96, a $29 million reduction; and then in '96-97 it is $21 million. The regions knew that that would be the way it was done over the three years.

THE CHAIRMAN: Second supplemental.

MRS. FRITZ: Thank you. It relates to this question as well. I wondered if there'd be any cuts to the lab sector in 1996. This is exactly what this $21 million is then.

MRS. McCLELLAN: It depends on if the regions have their program in place. Region 12 may have concluded all their lab restructuring last year, so they will not have any change this year. We're not saying take $21 million out this year. We're saying we're not giving you $21 million this year because you were to do that over the phase of the three years. A region might have done it the first year, might have concluded it. Some of the regions did get their agreements in place and achieved their savings quite quickly. They just don't get those moneys this year, and they knew that.

MRS. FRITZ: Thank you, Mr. Chairman.

THE CHAIRMAN: Thank you.

Mr. Renner.

MR. RENNER: Thank you. I want to discuss the health care premiums and the decision to freeze health care premiums. The first question really is: why was the decision made to freeze health care premiums in light of the fact that previous business plans indicated that it was an objective to increase the percentage of overall health costs through the direct premiums?

MRS. McCLELLAN: Well, our initial plan was to have health care premiums cover about 20 percent of the cost of delivering health care. In reviewing, I guess, our business plan, in reviewing the province's fiscal plan, and recognizing that we need a period of stability in our system – there is a lot of rumour out there. There are a lot of untrue statements being made about the health system. We are finding people faced with anxiety, such as seniors' groups, because they've been told things that are not accurate. We need a period of stability, and I think part of that stability is the freezing of premiums. As I say, we've managed our fiscal plan in the province overall very well.

I would also point out to you that the federal government is reducing the transfer payments over three years, health transfers of $246 million, and we are not passing those reductions on to the regions or to the health system in this province. The province is absorbing that reduction, which unfortunately a number of provinces in Canada are not able to do, and they're faced with some pretty serious decisions right now.

6:55

THE CHAIRMAN: Thank you.

First supplemental.

MR. RENNER: Thanks. On the same subject. I notice that the estimated revenue for health care premiums has increased. Presumably part of this is because of implementation. Can you give us the calendar year breakdown on what would be as a result of just increased population? How is that reflected in your original 20 percent proposal? Where do we stand on a total basis on premiums versus costs?

MRS. McCLELLAN: Well, one of the things I think you will see is that if health care premium revenue increases this coming year, it will not be because there's an increase in the premium. It will be because there is an increase in the number of people paying premiums. You know that the workforce in this province has grown significantly over the last two or three years. We're experiencing population growth in Alberta as well, and the more people that you have working in this province, earning a living, paying taxes, and so on – I think that's a healthy way to have an increase, rather than having to increase the premium itself to each individual.

Now, on the other side of that, the more people you have, the more people you have to serve as well. We've managed to find some rather significant savings and efficiencies in the way we're delivering services throughout the whole province. So our forgone revenue, I guess, from making that decision would be about $26 million this year and $59 million the next.

MR. RENNER: I think it's important that that message get out.

Finally, it's really technical, and I thought that I had a pretty good handle on accounting and starting to figure out government accounting. On page 262 it talks about revenue, and on the revenue side there are health care insurance premiums: $612 million. Now, on the expense side we have something else called health care insurance premium revenue as an expense. I'm having a little trouble in my little head figuring that one out.

MRS. McCLELLAN: I have a little problem with the way they do this page too. I really do. Let me see; I have to find the right spots here. So you're looking at the line that says health care insurance premiums: $612 million?

MR. RENNER: Right. As revenue. Then right at the bottom of the expense, just before total voted expense, it says: health care insurance premium revenue.

MRS. McCLELLAN: Yeah. We'll give you a little detail, but I can tell you what this is: accounting.

MR. RENNER: Maybe that's premiums on government employees or something like that.

MRS. McCLELLAN: No. No. Definitely not. It's the way we're doing our consolidated statements now and the way that you have to detail them. I'm sorry that I don't have that in front of me, but we'll write it to you.

MR. RENNER: Okay. Thanks.

MRS. McCLELLAN: We forgot about the aboriginal, the change in health care premiums. The other change in that is that the federal government are not accepting all their responsibilities for aboriginal people, so we also had to pick up that cost just as another part of the premium challenge. We're very concerned about the off-loading in that area. We all should be.

THE CHAIRMAN: Thank you.

Mrs. Fritz.

MRS. FRITZ: Thank you, Mr. Chairman. My questions relate to page 257, once again in regards to the Alberta Alcohol and Drug Abuse Commission expanding

> its research, education and counselling services for problem gambling by initiating specialized day treatment and inpatient programs for problem gamblers.

Before I ask the question in that regard, though, I had noticed on page 259 the province of Alberta in comparison to B.C., Manitoba, and Saskatchewan, the 1993-94 statistics and '94-95 statistics on admissions per 100,000 population. My question is: I notice that there is a slight decrease . . .

MRS. McCLELLAN: Excuse me, Yvonne. I can't hear at all because of that cross-conversation.

THE CHAIRMAN: Sure. If we could have some order. Mrs. Laing could well be the one supplementing this question.

MRS. McCLELLAN: We need to hear as well.

MRS. FRITZ: Thank you. On page 259 the comparisons between Alberta, B. C., Manitoba, Saskatchewan are listed in admissions per 100,000 population for '93-94, '94-95. I noticed that the admissions per 100,000 population has decreased slightly, expenditures decreased slightly, and I wondered what AADAC was forecasting for '96-97. Are you seeing that this will continue to decrease or status quo or increase?

MRS. LAING: As far as we can project, it should stay about the same.

MRS. FRITZ: So you're planning, then, on the status quo?

MRS. LAING: Yes, but we're also monitoring the problem gambling very closely.

MR. SAPERS: Pardon me?

MRS. LAING: I said we are also monitoring the problem gambling very closely.

MRS. FRITZ: That's where I was leading to, then, with page 257 and the area of the research, education, and counseling for problem gamblers. Knowing that's included, then, in the 100,000 population by what you've just said, is there a plan to centralize services in any way for AADAC in that regard?

MRS. LAING: How do you mean centralize services?

MRS. FRITZ: Well, is there a plan to centralize services, for example, in the larger municipalities from outlying areas and then, noticing that you are expanding in this area, consolidating this service with what's already existing?

MRS. LAING: Actually we'll be leaving them out in the communities, because most of AADAC's are done in the community, community delivery. We will be consolidating our alcohol inpatient types of programs in Edmonton from seven sites down to two.

MRS. FRITZ: Oh, okay.

MRS. LAING: The field offices will be still be there, and they will still continue to deliver the services at the community level.

MRS. McCLELLAN: One of the ways that you can keep costs down is by delivering them in the community by community agencies, but the consolidation that AADAC is contemplating is really far more on more concentrated in-patient treatment.

MRS. FRITZ: I see. Well, that clarifies some of the rumour that I've been hearing out in the communities, so I appreciate that answer.

THE CHAIRMAN: Thank you.

Second supplemental.

MRS. FRITZ: Thank you, Mr. Chairman. Also, where it says the increase by $500,000 to $1.1 million funding for aboriginal health strategy, does that include AADAC services as well?

MRS. McCLELLAN: The increases in the aboriginal health strategy?

MRS. FRITZ: Uh-huh.

MRS. McCLELLAN: No. I can give you a little bit of a rundown, if I can just find it. Part of that is in the bursary program, part of it is in dollars that go to the aboriginal communities to do more self-determination of their needs. I'm trying to think. There are about four initiatives. Boy, I'm getting more information than I can handle here. Bursaries are about $200,000. The funding through aboriginal health units: that's areas in remote communities, giving them more funding. We do that in association with the regional health authority. One of the examples of a co-operative delivery mechanism is between the Fort Chip Nunee board and the regional health authority. That's quite a unique delivery mechanism, but it works for that area, so we'll be disbursing some dollars in there.

7:05

MRS. FRITZ: Thank you, Mr. Chairman.

THE CHAIRMAN: Thank you very much.

Just a point of clarification for *Hansard*. Mrs. Laing was answering not as a member of the committee but as the chairman of AADAC. I had that question raised.

Mr. Yankowsky.

MR. YANKOWSKY: Yes. Thank you, Mr. Chairman. Again on page 251, reference 3.3.10. This has to do with the Capital health authority estimates. I see that they are down this year by some $7 million, and my first question is: why this drop in expenditure?

MRS. McCLELLAN: The expenditures that you see reduced in that line will be because of lab dollars that were taken out, lab restructuring, but then remember that you have to add back in the community dollars which haven't been allocated yet. So the community dollars don't show in that line, and the $15 million for capital is not in that line yet either because we wanted to have that opportunity for them to be part of the decision-making on the distribution.

THE CHAIRMAN: Thank you.

First supplemental.

MR. YANKOWSKY: Yes. I know this falls under the Capital health authority criteria actually, but I understand there's still a lot of shifting around and sharing of surgery facilities and clinics. For example, pediatrics: I hear it's supposed to move from the Royal Alex to the university and so on. Is this still going to continue for some time, or is it soon going to settle and be in either this hospital or that hospital and there won't be this shifting around anymore?

MRS. McCLELLAN: You raised the area of pediatric services, and I think you notice it more there because, as you know, the decision on how to deliver pediatric services in the capital city, in the Edmonton area, is considerably different than having a one-site children's hospital. So when the northern Alberta children's health services initiative came into being, there were some shifts in how you delivered pediatric services. When the regional health authorities made some of their reconfigurations that maybe seemed to be accentuated.

I think they are quite close to the conclusion of the shifts of services now, and it is certainly our hope that we'll have a year of more stability and assessment and auditing to make sure that we are delivering the services the right way, the most efficient way, and with the most quality. This will be a year where if there are adjustments that need to be made, they will be made.

So I'm not saying there won't be any changes, but if there are, they'll be more as a result of completing the business plan that was in place or making the adjustments because they have found that there is a better way. I'm sure the critics will say, "See, you shouldn't have done that in the first place." But then those same critics would have said, "See, you shouldn't have changed anything," and the health system would have just gone broke.

So I don't apologize for the initiatives of restructuring to make it better. Whenever you go into anything this major, you have to recognize that you may find that you should change things. I don't think we should be afraid to admit that we do need to change some.

THE CHAIRMAN: Thank you.

Second supplemental.

MR. YANKOWSKY: Thank you. I had quite a long discussion with a constituent last night. You mentioned the children's pavilion and so on. Now, at one time we had the Children's Health Foundation of Northern Alberta, I think they called themselves. I was asked the question last night: is this organization still in operation, and what is being done, if anything, with all the moneys they have collected?

MRS. McCLELLAN: The northern Alberta children's health board is not active. The foundation is still in place and continues to be able to raise money and use it for provision of services within the regional health authority. The role of the northern Alberta children's – I think they started out as a hospital group. That has now concluded, because the decision was made to use several sites rather than one site. Of course some of it is at the university, and there was building done at the university to include the pavilion, but most of it's been integrated into the other hospitals beyond that.

THE CHAIRMAN: Thank you very much.

MR. WOLOSHYN: Shirley, it's good to hear your sweet voice again.

MRS. McCLELLAN: You people. You're devils for punishment.

MR. WOLOSHYN: I'd like to get some clarification on physiotherapy and how it's funded and where it fits in under the Health Act, because that's one area where nobody seems to understand what's happening.

MRS. McCLELLAN: Well, one of the problems we have with this whole thing is that the community rehabilitation program is not a physiotherapy program. It is a community rehab program. We made a decision over two years ago that we were going to change the delivery of rehab dollars rather than having an entitlement program that said that every Albertan, no matter whether you need it or not, is entitled to $250 of physiotherapy. Occupational therapy, speech therapy, and those other areas were funded either through a health unit or somewhat through a hospital program, and many regions had little or no funding in those areas.

In fact, working with a committee that was of all of the

stakeholder groups – this is the part that is most difficult for me to understand – including the three physiotherapy associations – the independent physiotherapists, the Alberta association of physiotherapists, and the college – the community rehab program was designed, which said that the public dollars we expend in rehabilitation therapies will go to higher needs areas, and there will be no co-payment. If you have a higher need in this, we are going to pay for it.

Then we asked the regional health authorities to design a program for physiotherapy in their regions. I also asked the regions to work together so that there was some consistency in the programs but recognizing that different regions, because of their geographic or other makeup – we didn't want to give them something that was written in stone; give them some flexibility

Unfortunately, I have to say that the most difficulties we're experiencing are in the two cities. One, they have a lower amount of dollars because some of the people who used to have to come to the city, maybe drive 100 or 150 miles, are now being serviced out in their own areas. So naturally the physiotherapists who worked in those cities have a diminished number of clients. As well, we've put a rating on it.

The second thing we had a problem with was that the insurance companies did not understand the cutoff. We tried to clarify that so that Blue Cross or another insurer, whoever it was, an employee program would clearly know where they could come into this program. I think there was some miscommunication. There was a feeling out there that Alberta was the single payer. Well, we're the single payer for a certain level of need and up, but we are not below.

So it was fraught with problems. It's something where I'm not extremely pleased with how well we did it. I think you could lay blame, but I think everyone would have to take some share of it. The fact is that it has affected some therapists' practices. There is no doubt about that, but I think it's also a fact that there are probably more private physical therapists' offices in Calgary than there are in the whole province of Ontario. So, you know, you're going to have some change. We have not changed the fact that there are physiotherapy programs in home care. There are still physiotherapy programs in hospitals. We put all of the money that was in those various programs into one pool for that.

7:15

I'm still hearing concerns about contracts and differences in salaries or contract prices between one region and another. I think that's a bit inexcusable. I think they could have agreed on a fair price. I think for some of the physiotherapists for example in Edmonton one of the problems – it might have looked like a good solution at the outset, but it became a problem – was that they decided to all come together, and it didn't seem to work as well as it did in places where the regions just put out sort of a contract or a request for proposal from a region. So they got off late on the mark, and actually the really unfortunate part of it is that the loser is the client, the person who needs the service, because of this confusion.

We've agreed to review the rating tool. I've asked that we step up that review, because we believe the principles of the program are sound – it should be needs-based, not entitlement – and we need to get the discrepancies out of the program as quickly as possible.

MR. WOLOSHYN: Thank you, Shirley. I agree with you. It should be needs, not entitlement. I'm also glad you touched on a problem that I'm having with this whole business, and that's the $250 front end. I feel very strongly that WCB insurance and Blue Cross recipients should cut in at the bottom level, right at the beginning. There should be no cushioning for it, simply because what's happening is they're starting to download and they're taking advantage of the supposed confusion and not paying legitimate claims. I feel that the government, through the health authorities, is losing quite a bit simply because of that first $250. Would the department, through this committee or whoever is reviewing, seriously consider being very firm on the insurance claimants and then having that needs portion addressed to really where it is needed for sick benefit, not accident associated?

MRS. McCLELLAN: Our department has had a number of meetings with the insurance companies to try and settle this issue with them, and hopefully they will come to an understanding and agreement. I frankly don't believe, until we complete the assessment of the rating tool and ensure that it is accepted, that we will solve all of the problems with the insurance, because you've got to feel comfortable with your cutoff. I understand their side of it. They've got to clearly understand the terms and conditions on which they operate as well. So I think we'll have that, I hope, by the end of March. My department thinks I'm being a little hard on this, but I'm getting a little tired of the thing myself.

MR. WOLOSHYN: Getting back to that, I do think very strongly that the insurance companies will not co-operate with you as long as they have the option of getting the first kick at the bucks. Would you, then, consider – and I don't know if this has been a part of it. One of the people earlier alluded to the physicians saving us moneys. They are the gatekeepers . . .

MRS. McCLELLAN: Not in this.

MR. WOLOSHYN: No. They are gatekeepers. They determine whether physiotherapy need is a result of an accident or not.

MRS. McCLELLAN: Well, not really any more. We grant direct access to physiotherapy, so we have a number of people who determine it.

MR. WOLOSHYN: No, but the point is though – I don't have a problem with direct access. You can go the needs route. However, if there is a person who is a victim of an accident, whether it be work-related or otherwise, then the doctor certainly must be the gatekeeper of that. That could be part of the screening mechanism and it could be part of the unforeseen savings to the system, if these people were directed straight into physiotherapy by the doctors and the billings went to Blue Cross, WCB, and so on, and the other direct access left to the people of the other category. That's just a suggestion, Shirley, that I think could be considered.

MRS. McCLELLAN: Yeah. I think, though, that clinical practice guidelines for some things are what's really important. We have a doctor in the room. I have heard an orthopedic surgeon say to someone who needed knee surgery that there would be no physiotherapy required when they left the hospital. I've heard others state that they were going to need – this was a patient being told – up to five to six weeks of physiotherapy. I think what that tells me is that we need some clinical practice guidelines that deal with this. You know, you've got a problem. It's the same problem in drug dispensing. The people who are prescribing – that money doesn't come out of that pot; it comes out of another one. So if we were to have that.

The other thing. Aslam's always sharp on the money side. He reminds me that when we conclude the legislation on third party,

we will recover the money from car accidents.

MR. WOLOSHYN: But, Shirley, I'm not so sure that we will unless we really keep track and those doctors kick in right at the beginning, before that $250.

MRS. McCLELLAN: Yeah, but it'll only be on third party, wrongdoers too.

THE CHAIRMAN: The final supplemental was just had.
Mr. Renner.

MR. RENNER: Thanks. Earlier, Madam Minister, you were talking about decisions that had been made and decisions that were under discussion. I want to touch on another area that there seems to be some confusion on, and I'm hoping you can clear it up. We've heard all kinds of statements in the media lately about the implementation of smart cards and how much the program is going to cost. One would assume from reading those newspaper stories that that decision has already been made, and if so, I'd like to know where it appears in your budget.

MRS. McCLELLAN: Well, there hasn't been a decision made, but we have acknowledged all the way through our business plan that health information is extremely important to good management of the health system. We have been monitoring a smart card, if you want to call it that, a health information card project that was occurring in Quebec for the past two years to look at the pluses and minuses of that. We put in place a health information network committee to give us some advice on how a health information network might work in Alberta.

I think it's a little unfortunate that there has been some prior information put out that is not entirely factual, because once it's read, it becomes real. One of the things that I have said unequivocally – I said it at our last session here to Mr. Dickson and I say it again today – is that the confidentiality of a person's health information is going to be paramount in anything going forward. In fact, you know, in looking at the report and looking at information that I have, probably you can secure people's health information better in this process than you can as it is today. All of us have seen the folders sitting around on desks. They are stored in a cardboard file in a room, sometimes in a box, and I'm not feeling all that confident.

MR. WOLOSHYN: Who cares?

MRS. McCLELLAN: Well, you know, if one ever became an issue, they would care. Somehow we think that if it becomes electronic that will be worse. Probably today your bank information is more secure because you have it in a different system than you did when you carried your passbook around and probably dropped it a few times.

We started the process in Alberta a year ago by putting out individual numbers for everyone. Everyone has a health card today, so you've in essence got it. What you need to do now is say: how do you use that? That will be the next step: how do you use it? Is the cardboard card all you need? Can you go to a higher level card that may have a bar code or something that allows you, the holder of the card, to access your health information? Those will be the next steps. Yes, we have put some modest amounts of money in our budget for proceeding cautiously with further examination of how we could deliver this.

7:25

MR. RENNER: Have you in your three-year business plan given consideration to the eventual implementation cost? Would that have to be financed internally, or would you propose that at some point in time you would have to come to the Legislature and ask for extra dollars? Just exactly how do you propose to implement the idea?

MRS. McCLELLAN: The very clear expectation of Treasury Board and of the Legislature is that the dollars will be planned for in advance. I think that although you can learn some things from other people's projects, you also have to learn some by experience. This is not a science that is out there in a general way, but neither is it totally unknown. Many hospitals are computerized and have health cards. Foothills hospital has had a health card for, I don't know, 15 years that I know of, that they've used for access when you went there. So there is some knowledge in this area. We have some idea on costs, but I think that's one of the things that we want to monitor very carefully. If it's going to cost too much and it isn't going to improve patient care or the ability to target resources or indeed save us some money, why would you want to do it? It's too early to have all of the answers for that.

MR. RENNER: Finally, with the regional health authorities having so much impact and so much at stake in the overall delivery of health services, how will the implementation of some kind of data information cards impact on the RHAs themselves? Will they be involved in any of the discussions or the implementation?

MRS. McCLELLAN: I think they have to be involved, because they carry a great deal of the information that's required to have good health information and they're a big part of completing your individual health record. So the regional health authorities certainly will be involved in any discussions. They almost all have linkages. They all have reporting that they have to do to us now. So they're interested in looking at how they can streamline or be more efficient in that reporting function. There are a lot of nuances to it.

MR. WOLOSHYN: I've got an idea for you, Madam Minister.

MRS. McCLELLAN: Oh, good.

MR. WOLOSHYN: You and I agree on the odd thing: one, that needs-based is better than entitlement. Is that correct?

MRS. McCLELLAN: Yeah.

MR. WOLOSHYN: That's the first question. Now I'll get into my preamble. We know that if you have an entitlement, you're inclined to want to use it, and if you pay for the entitlement, you want to use it more. Consequently, mere psychology and human nature being what it is, we have a health care system that generates the use of it, and then we get into accusations of abuse, overuse, and all those things which I don't want to enter into. I don't care if I get an answer but just a consideration of the view of taking, for example, the premiums as a starter and having a rebate system to the public if they don't access the system.

MRS. McCLELLAN: Well, you're going to get an answer. It's been explored and so has a deductible and so have a number of other things, but, you know, if you did that, you'd have to put so many conditions on it. If somebody has a chronic illness, somebody who's asthmatic, they're going to use the health system more. You have someone who gets cancer. I mean, many of these things can't be controlled by the individual. We know that

people use the system the most in the first year of their life – well, that's certainly out of their control; I don't think the first year of your life you've got much control – and the last 10. We know that women use it more. So are you going to penalize them because they carry a heavier load because of their reproductive nature? You know, these are things that are facts. They're medical facts. The fact that women outlive men by 10 years . . .

MR. WOLOSHYN: You've just investigated and thrown in a whole bunch of irrelevant factors.

MRS. McCLELLAN: No, no.

MR. WOLOSHYN: The issue is, very simply, if you need it, you've got access; if you don't need it and don't use it, you get a rebate. I don't see anything to do with women, with cancer, with year 1, with year 21. This has been proven by various studies . . .

MRS. ABDURAHMAN: Who's in charge, Mr. Chairman?

THE CHAIRMAN: This is his last supplemental.

MR. WOLOSHYN: . . . where if you have an entitlement, for example, to sick days, those will get used far greater than the ones that don't have it. So all I'm suggesting, without throwing in all these other fairness things, is: don't use it; you get a rebate.

MRS. McCLELLAN: The problem is, though, that this is an insurance program. This is a philosophical question. Fine; I would probably get all of my health care premiums back every year for the last 10 or 15 years. But there are other people who through no fault of their own have a chronic illness or become ill, and the other part that bothers me is that there's a definitive tie between people with lower incomes and health costs. They probably need the rebate more than I do, even though they access the system more. I mean, we've looked at this. We've looked at deductibles. We've looked at all kinds of things. How do you pay somebody not to be well?

The other thing that would concern me is that while we're worried about them accessing the system too much, I might be worried that they wouldn't access it when they should. So it's an idea that you can explore, but I can tell you that there have been papers written on it, and there have been studies done. A deductible, if you were going to do anything, would be fairer, but you can't do that under the Canada Health Act, so that doesn't work. If you spent more on educating the public on how to use the health system – and you're right; people will say, "Well, I paid my health premiums; I should go and use them." They've got to understand that their health premiums are 16.8 percent of it and the rest is going to come out of their pocket in taxes, because the only other way we have to fund the system is through income, in our tax systems.

THE CHAIRMAN: Thank you very much.

We have no more speakers. We have 10 minutes left.

Mr. Renner.

MR. RENNER: Mr. Chairman, my understanding of the rules that control this committee is that with unanimous consent of the committee we can rise prior to the allocated time. So at this point I would ask for unanimous consent of this committee to suspend discussions at this point.

THE CHAIRMAN: Thank you.

There's been a question raised. Any discussion?

Mr. Sapers.

MR. SAPERS: We're so close to the appointed hour, Mr. Chairman, and we've got *Hansard* here, and we've got the departmental staff here and the minister is still wide awake. I would like to suggest that in the remaining couple of minutes, if any member of the committee has a question, they be allowed to raise that question.

THE CHAIRMAN: Mr. Sapers has put forward some discussion on it. Under Standing Orders that would have to be agreed to unanimously, and if he wants to put it to the table, I would certainly entertain that motion.

MR. SAPERS: Could I ask one other question?

THE CHAIRMAN: Sure.

AN HON. MEMBER: Wait a second.

THE CHAIRMAN: Just hang on. We do have a motion on the floor, though, on that one.

MR. SAPERS: Right. It's about the motion.

THE CHAIRMAN: With your permission, Mr. Renner, can we deal with Mr. Sapers' motion first? Because if his motion passes, then your motion becomes superfluous.

MRS. McCLELLAN: But if his motion passes, he can't give his.

THE CHAIRMAN: But somehow I don't think it will until this one is dealt with.

MRS. ABDURAHMAN: On a point of order, Mr. Chairman. There's a motion on the floor. Can we vote on it?

THE CHAIRMAN: Yes. There is a motion.

MR. RENNER: Let's vote on the motion on the floor.

THE CHAIRMAN: Fair enough. All in favour of the motion on the floor?

SOME HON. MEMBERS: Agreed.

THE CHAIRMAN: Opposed?

SOME HON. MEMBERS: No.

THE CHAIRMAN: Mr. Sapers has a motion on the floor.

MR. RENNER: That being the case, then I have a question.

THE CHAIRMAN: Yes? Okay. Mr. Renner.

MR. RENNER: Thank you.

I want to draw your attention to 3.3.21, and we've touched on it tonight, but I would like to expand on this: community services. It came up; it's $40 million.

7:35

MRS. McCLELLAN: Good question.

MR. RENNER: That is something that you have discussed, the fact that this was put into the budget. I do have concern in that it's showing as a separate item in the same area as the budget allocations to the RHAs. I would feel much more comfortable had it been preallocated to the RHAs, and I would like to know why it's not allocated to RHAs and how you plan to allocate it to RHAs.

MRS. McCLELLAN: Okay. Last year we did include it with the RHAs' budgets. This year we felt that it was important that we have some discussions with the RHAs on the methodology of distribution. You know that we do have a funding methodology committee working and looking at how we fund in the future, and we wanted to have some discussions with the regional health authority, if there were some principles that we could use in this that distributed it in a way that was seen by all of the regions to be fair. Last year I guess what we did was split it $16 million for Edmonton, $16 million for Calgary, a million for the Cancer Board and for the Mental Health Board, and then we divvied the rest of it up sort of by the size of the region or the community programs they had. It would be interesting to see if we can't come up with a different way, and actually when I spoke with the regional health authorities about this, they were quite in agreement. They've also agreed that we will have the allocation done by April 1, which is the start of the budget year, and they will know then how they're doing it.

Interestingly enough, when you start the discussion and you allow the regions to get involved in the discussion, there isn't one or two options; there are as many as nine, I think, that they're exploring. So I think that it is good to have that discussion and to get more feeling of ownership of how dollars are distributed in the region. We'll continue to probably have more to say about how they use those dollars, Mr. Renner, once they help us with the distribution.

THE CHAIRMAN: Thank you. First supplemental, and I must remind the two members that there are five minutes remaining.

MR. RENNER: Is there someone else who has a question?

THE CHAIRMAN: No, I meant the minister and you. You have your first supplemental and then your second supplemental.

MR. RENNER: My first supplemental, then, is with respect to the community services funding. I guess I'm concerned that we are not having a good enough co-ordination across the board when it comes to home care services, specifically housekeeping services and health home care services. I'm not sure that there is enough co-ordination in place between all of the service providers. While we have this pool of dollars there presumably for the health side, there are a lot of people who can do very well in their homes, but they need assistance in homemaking, not in health services. Yet I don't see those services being co-ordinated well enough through the RHAs. I wonder if you could explain how you propose to do that.

MRS. McCLELLAN: Well, it is up to the RHAs to do that. We set the policies and the parameters, and we subsidize the program. We think that the regional health authorities should do that. I think one of the unfortunate things in that area is that there is a misunderstanding, and you heard it probably in the Legislature in the last two or three days, where there were some very – well, I'd have to say statements that were not based in fact upon examination. There is a home care program, and it has components. We probably should have a different name for the top of it, because there are no fees, but home care is known in that area as nursing or medical services provided in the home.

The homemaking side of it is a program that we've had in place for a while that we subsidize. The client pays $5 an hour, and that covers things like shoveling the walk, doing dishes, vacuuming, getting groceries, having meals brought in: things that allow people to stay independent. There is a cap on that that says nobody will pay more than $300 a month for that, and the fee is waived if a person can't afford it. This program is very much driven by the regions themselves because they keep those moneys, too, that they collect to improve and expand their program. So it's unfortunate that there is some misunderstanding.

There is a limit in home care of $3,000 a month. At some point you have to say: if somebody needs more than that, are they better off being in a full-care situation? They're tough decisions, but those are things you have to do. Each client is assessed, and then the level of care isn't that everyone gets $3,000 – if they get $2,000 or $1,000 – it's how much care they require in that range.

I think our time is almost up, but I'll answer your question on the expense side of that. It is from collecting of premiums. It's really the cost of collecting them there.

The last thing is that we will write any explanations that are required beyond this as quickly as we can.

Thank you.

THE CHAIRMAN: Thank you very much.

MR. RENNER: Mr. Chairman, can I make a motion now?

THE CHAIRMAN: You certainly can. If I can, Mr. Renner, I have been asked for a very quick, nonquestion comment from Mr. Sapers.

MR. SAPERS: Yes. Thank you.

THE CHAIRMAN: I'm sure he will keep it nonpolitical.

MR. SAPERS: Well, gee, I'll do my best.

I wanted to acknowledge, first of all, Mr. Chairman, your co-operation in sticking to your commitment to find a time that was mutually convenient to both sides of the House. This committee had to be set and reset and reset again, and I appreciate your co-operation and that of the minister.

I'd also like to say that other than the bit of nonsense around the Standing Orders, which I think tends to diminish some of the spirit of co-operation, especially in the dying minutes of the proceedings, I have found this to be a useful process. I want to thank the minister for her answers and for the participation and co-operation of her staff over what's been a new process for us, splitting it over two days. Thank you.

THE CHAIRMAN: Thank you, Mr. Sapers.

Mr. Renner, I would certainly entertain that motion now.

MR. RENNER: Thank you. Mr. Chairman, pursuant to Standing Order 56(8) I move that the designated supply subcommittee on Health now conclude discussion and debate on the '96-97 estimates of the Department of Health.

THE CHAIRMAN: Thank you.

Any discussion? All in favour?

HON. MEMBERS: Agreed.

THE CHAIRMAN: Opposed? Carried. Thank you very much.

[The committee adjourned at 7:43 p.m.]