2:02 p.m. **Wednesday, December 14, 1994**

[Chairman: Mr. Dunford]

MR. CHAIRMAN: Thank you. We'll call the meeting to order, please, at 2:02 p.m.

MR. SAPERS: It's 2:03 from this angle.

MR. CHAIRMAN: There's only one angle, and that's straight on.

I would like to welcome this afternoon the Minister of Health, the Hon. Shirley McClellan. Shirley, we'll ask you in a moment or two to introduce your guests and also make an opening statement.

I want to acknowledge that this afternoon we have visitors in both the members' gallery and the public gallery and just might mention to each of you that what you're witnessing today is a meeting of the standing committee on the heritage savings trust fund. Today, as you've already heard, we have the Minister of Health in front of us. Along the front benches you have members of the loyal opposition, the Liberal Party, and they of course will be directing their questions to the minister. On the second benches we have government members. You might make a note that we are more informal in these particular meetings, and therefore we are not required to sit in our own designated seats. Also, you may see that members can remove jackets. We're much more informal than if you were to come and visit us during a regular session of the Legislature. So with that I would just simply say welcome. We're glad that you dropped in and wish each and every one of you a very Merry Christmas and a Happy New Year.

Now, with that perhaps, Madam Minister, if we could have you introduce your guests and make your opening statement.

MRS. McCLELLAN: Thank you very much, Mr. Chairman and members of the committee. I'm very pleased to be here again to meet with your committee to discuss cancer research and our government's support for cancer prevention and treatment. I have asked a number of people from the Cancer Board to attend today. That was a request from committee members the last time we met; they felt it would be useful. They will certainly be happy to take some specific questions. I'd like to introduce to you Dr. Jean-Michel Turc, who is the president of the Alberta Cancer Board; Dr. Heather Bryant, who is the director of the screen test program; and Dr. Van de Sande, who is the scientific officer for the Cancer Board. I would want to thank them on your behalf for attending with me today. I think this is an excellent opportunity for the committee to discuss this very important area of research, and I'll try to keep my comments quite brief.

I should also introduce to you the gentleman to my right, Mr. Bernie Doyle. Bernie is the assistant deputy minister of corporate services with the Department of Health and is also acting deputy minister in many areas right at the moment and will be assuming acting deputy minister at the first of the year.

Medical research is certainly something that our province and our government are committed to. I think we've demonstrated that commitment through the development of the Alberta Heritage Foundation for Medical Research as well as the applied cancer research program. This program was established in 1977. We have expended about $52 million since that time in support of the program. The annual allocation for this past year, which is, I guess, what we'll primarily be dealing with, was $2.8 million. That's what it has been for the last number of years.

I'm pleased to tell you that research has produced results. Fifteen years ago the probability of a cure for many pediatric cancer cases was only 20 percent. Now it is about 80 percent, and that's due to early detection techniques and treatment programs. The key to developing new prevention and treatment programs and strategies is definitely research. Cancer research must and I believe will continue to be supported in this province.

As you know, the Premier has recently formed a science and technology portfolio, and my colleague the Hon. Dianne Mirosh is currently examining options on how we might better co-ordinate research in the province. She is working very closely with our department, and I know she recently met with the Cancer Board to discuss the future of cancer research.

We will continue to support the research efforts. I know that the Cancer Board in their strategic planning has requested increased funding and multiyear commitments of funding. Both of these requests will be considered as part of our current review of research in our province.

The Provincial Treasurer recently attended the Alberta Healthcare Association convention on a minister's availability session with me and was asked about further funding for health in research and other areas, and he stated then that Albertans must be assured that every additional dollar going to health services is improving the health of Albertans. I think that's a very key statement and probably one that each of us in this room would subscribe to. We must develop a system that is accountable and focuses on outcomes.

Certainly the underpinning of an accountable system is research. We have to have good information and knowledge to make decisions. We also have to make sure that we administer our research programs as effectively as possible. We want dollars that we have going directly to research. We want dollars going towards priorities that do reflect needs, and we have to ascertain which are the most important areas to research and study, what areas could potentially improve health the most. I'm very proud of the research community that we've had and that we continue to develop in Alberta, and I certainly applaud the efforts of the Cancer Board in promoting a top-quality research environment in Alberta.

I promised the committee members to be brief. I will stop my comments there. I certainly do look forward to your questions, as my guests do and my deputy, or comments that you might have. I'm sure they would be very positive in forwarding the efforts of research, particularly as we're speaking today on cancer research in the province.

Thank you, Mr. Chairman.

MR. CHAIRMAN: Okay. Thank you, Madam Minister.

I should have mentioned in my opening remarks the process, which I'm sure you're familiar with anyway. We will start with the opposition members and then to government members. We go back and forth. We used to talk in terms of a main question with two supplementaries. That has now been evolved actually for all intents and purposes to the fact that once a member is recognized, they really have three questions, and we haven't been particularly severe on any questioner in terms of the relationship, then, of those three questions to each other.

As well, I might indicate to you that we've looked upon the witnesses for a fair degree of flexibility. We at times have strayed from the strict parameters of the '93-94 report, but in the interests of providing information to not only committee members but to the avid readers of *Hansard* throughout the province . . .

AN HON. MEMBER: All two of them.

MR. CHAIRMAN: A member said, "all two of them." Those two live in Lethbridge-West; believe me.

We just find that it has worked fairly well. I would want to indicate to you, however, that if we have strayed so far afield that it no longer is bearing any resemblance to why you are here, the prerogative of the chair is always there to bring the question back into order, but I want to use that whip sparingly. We have not been very tough or difficult with committee members thus far, and I'd like to proceed with that sort of a situation.

MRS. McCLELLAN: Your committee has always been very gracious although very penetrating in their questions.

MR. CHAIRMAN: Okay. Let's begin with Howard Sapers.

MR. SAPERS: Thank you, Mr. Chairman. I'm wondering if this would be an appropriate time for me to read a number of recommendations into the record before proceeding with my questions to the minister, particularly because some of the comments in the minister's opening remarks relate to these motions and I would like her to have the benefit of hearing them. So with your permission, first I would like to move that

> a three-year business plan be developed regarding the priorities for commercialization of research products resulting from projects funded by the Alberta Heritage Foundation for Medical Research.

MR. CHAIRMAN: There's no comment required, Shirley.

2:12

MRS. McCLELLAN: No. It's just that that's not in this.

MR. SAPERS: No. That's not regarding . . .

MRS. McCLELLAN: Okay. This is just in general; is it?

MR. SAPERS: Yes.

MRS. McCLELLAN: Okay. These are not directed to us.

MR. CHAIRMAN: Actually, we're digressing in our proceedings just a little bit. I should also have asked if any member wanted to read recommendations into the record, and we're now going to do that.

MRS. McCLELLAN: Not necessarily pertaining to this.

MR. CHAIRMAN: Exactly.

MRS. McCLELLAN: Thanks, Mr. Chairman.

MR. SAPERS: The second motion I'd like to move this afternoon is that

> no funding in the form of venture capital be provided through the Alberta Heritage Foundation for Medical Research.

My third motion, Mr. Chairman, is that

> the Alberta Heritage Foundation for Medical Research establish as a priority funding research into evidence-based medicine, health treatment outcomes, and barriers to accessing health services.

The fourth motion this afternoon is that

> the Alberta Heritage Foundation for Medical Research immediately conduct research which will lead to the establishment of policy which guarantees access to health services.

Finally for this afternoon I move that

> the Alberta heritage savings trust fund committee encourage the Minister of Health to investigate the efficacy of chelation therapy as a treatment for atherosclerosis through the use of funding available for medical research from the heritage savings trust fund by, amongst other initiatives, assessing and evaluating existing research in this area.

Of course, that's a repeat of a motion previously approved by this committee.

There will be other motions forthcoming from our members of this committee, Mr. Chairman, but I wanted to take the opportunity of the Minister of Health being here and hearing those at this time.

With that being said, Madam Minister, welcome, Mr. Deputy Minister, officials from the Cancer Board. It's a pleasure to see you all here, and it's particularly a pleasure for me to be seeing the minister across from this side, from this seat to over there. It's a change in perspective.

MRS. McCLELLAN: I can't say that it's mutual.

MR. SAPERS: It's a very comfortable spot, Madam Minister.

The Cancer Board has been involved in some absolutely wonderful research and provides some absolutely essential and truly life-giving and life-sustaining programs and services. The one thing that we might want to pursue during these discussions is if the $2.8 million is in fact enough. The $52 million that was spent through the heritage fund to date we know has been put to good use, but there have been some questions about priorities, and there have been some questions in some sense about accountability. My first questions today relate to the Cancer Board and its relationship as a provincial board to the regional health authorities. I'm wondering if there has been in fact a plan put onto paper which will demonstrate the relationship of the Cancer Board with the regional health authorities and will clearly indicate how the research programs and the actual services delivered will be administered and where the responsibility will lie.

MRS. McCLELLAN: Do you want me to take that one first?

MR. SAPERS: Please.

MRS. McCLELLAN: Thank you. I guess more of a comment than a question. Is $2.8 million enough? I'll look forward to your further comments on that. I think we had this discussion before, and the answer is that I'm not sure that there is enough money in that figure or others for cancer research. I don't know what enough would be. It is still a very high level of concern to us. The rising incidence is of concern to us. I think what we're primarily trying to do with the efforts of the Alberta Cancer Board is to ensure that the dollars that we do have are being used most effectively, and I'm sure you'll have some questions on how we ascertain which projects will be funded and so on, to answer that question.

The question on the Alberta Cancer Board's relationship to the RHAs is very timely. I asked the Alberta Cancer Board to put together a three-year business plan for delivery of services and in that very directly show the linkages with the regional health authorities and show how they can work with the regional health authorities on delivery of cancer services in the regions. I have just received that business plan. I asked for it by the 1st of December, and I must say I received it actually a little bit ahead of that. In fact, I think I might have asked for it a little bit sooner than that.

I have not had an opportunity to complete a review of it, but certainly as soon as I do, I will be communicating back. I would prefer to give the Cancer Board and the administration of the Cancer Board the courtesy of having my answers first, but I'm confident that they are providing those linkages in that business plan. It is very critical because cancer services are needed

throughout the province. There certainly will be some services that can only be accessed in major centres, but I believe the Cancer Board has done a tremendous job of outreach services.

It's important that the regional health authorities have that support. They've met with the regional health authorities council of chairs. My conversations with the council of chairs is that they've had very proactive discussions, that the Cancer Board is very committed to continuing outreach services and to ensuring that the co-ordination of cancer services is tied very closely with the regional health authorities. You would know that now there are co-operating agreements with the Cancer Board and some of our hospitals and other areas in the province.

I look forward to having the completion of the review of that, and those comments will be directed to the Cancer Board and then certainly made available. So that has occurred, I'm pleased to say.

MR. SAPERS: Thank you. I appreciate that, and I look forward to getting a copy of the business plan once it's been revised and approved. I appreciate that.

A slightly different tack. There is a charitable foundation which receives donations that go in part to support cancer research in this province, and the Alberta Cancer Board, as I understand it, allocates or administers part of those dollars as well. If there is a distinction made in terms of funding research projects, what exactly is the distinction, and how are priorities determined between foundation-sponsored research and research that is funded through heritage trust fund money? I'm particularly concerned about this, because as you go through the list and the various areas of research supported by the foundations through the Alberta Cancer Board, it is always the case and every year it has been the case that there are many more requests for research funding than are actually awarded. I'm wondering what the differential is between the two funding pools and how decisions are made regarding priorities.

MRS. McCLELLAN: I'll answer the initial sort of generally, and I'll ask Dr. Turc to enlighten you as to how they manage the charitable donations fund. I believe you may be aware that the Cancer Board has an Advisory Committee on Research that consists of seven international oncology experts that are knowledgeable in a variety of fields of cancer research. This committee recommends and advises the Cancer Board on the utilization of the funds that we are discussing today. I think that's very important, and it's important to note the international makeup of this committee, because we do want to ensure that we're not duplicating research activities, that we're gaining the most value for our dollars. So I think that is very important, and I think we're very fortunate to have that calibre of people giving advice to the Cancer Board on projects.

Dr. Turc, if you wouldn't mind explaining how you administer the charitable donations and how they fit in overall.

2:22

DR. TURC: Yes. The purpose of the research funds disbursed from the Cancer Foundation is totally different. We are looking through the Cancer Foundation money, and last year it was about $700,000, which was disbursed specifically for the purpose of research. We are looking first at supporting studentships, fellowships, scholarships, young people that we want to keep or we want to train. They can be trained in this province or sent somewhere else. Some of the money will be used for that.

The other money is what we call bridging and pilot funding. An investigator comes with a new idea. It is very difficult with a new idea if it has not been tested to get funding from any funding agency. They will come to the Cancer Board. There is a dollar limit depending on the program, and generally it's around $20,000, six months' support, to allow the investigator to start the work. If it's promising, at that point he has some data available, he can go to a major funding agency, including the research program supervised by ACOR. I should add that the disbursement of funds is done following a peer review process and that the chairman of the peer review process reports every year to the Advisory Committee on Research to make sure that the process was followed properly and that the research really is in line with the priority of the Cancer Board.

MR. SAPERS: Thanks.

Given that we've got the Alberta Heritage Foundation for Medical Research, the Alberta Cancer Foundation, and the Alberta Cancer Board all involved in some way, then, in funding research, I'm still not clear exactly if there were competing priorities between those three groups how a decision would be made in terms of what gets funded where and how and whether or not there'd even be a partnership between two or more of those entities. I guess underlying this set of questions really is my concern that the Alberta Cancer Board may either need to exist in an enhanced way in order to ensure that there is ongoing cancer research or that because of the regionalization in health care and the existence of the foundation and the Alberta Heritage Foundation for Medical Research, the Cancer Board may not exist at all. I'm trying to determine in my mind whether or not there is any movement in one direction or the other. In other words, is the Cancer Board going to become responsible for all research specifically, or is there a chance that the Alberta Cancer Board as we know it in this province now will cease to exist at some point particularly because of the change in the administration of health care through the regionalization process?

MRS. McCLELLAN: Just to begin with, we have not made a decision to change the provincial mandate of the Cancer Board. I think that's something that has to be reviewed on an ongoing basis. Cancer is, as I've said earlier, a very high concern to us. We believe that there's been much accomplished through the provincial board. The Alberta Heritage Foundation for Medical Research does fund research mainly in other areas than the Alberta Cancer Board research areas, and I think Dr. Turc gave you some of that idea in the theme-orientated groups. It stimulates the interdisciplinary research between clinical and basic sciences from universities, from cancer centres, and from other institutions. So there has been that difference in the type of funding.

I should say that when an applicant does come forward, they are required to list all areas that they are receiving research funds from, and certainly we make sure that there isn't duplication. I can also speak with I believe utmost confidence that if a research project comes forward to the Alberta Cancer Board that would be more appropriately directed to the Alberta Heritage Foundation for Medical Research, they would direct it on. Dr. Van de Sande, would you like to add a few comments in this area?

DR. VAN DE SANDE: Thank you, Madam Minister. I think with respect to the interaction between the Alberta Cancer Board and the Alberta Heritage Foundation for Medical Research I should mention that we have an ongoing dialogue with respect to the project that we are reviewing. At some of the grant review committees of the Advisory Committee on Research we have a representative from the Alberta Heritage Foundation for Medical Research there to again ensure that there is no duplication, that we are really working together to support cancer research.

MR. CHAIRMAN: Okay. Thank you very much.
Heather Forsyth.

MRS. FORSYTH: Yes. Thank you. I'd like to ask the minister two questions if I could, please. The first one is: are there other recent advances in the treatment of cancer that are directly attributable to cancer research done in Alberta?

MRS. McCLELLAN: Yes, there are. There's one area I think of significant change and improvement, and that is in the strategies and the treatment in palliative care and in pain control. The invention of the Edmonton injector by Dr. Bruera at the Cross Cancer Institute is a case that we could cite. It's an inexpensive, self-administered intravenous injector that enables patients to stay in their own homes. There have been some recent clinical trials in colon cancer that show some possibilities for occult blood testing as an effective screening approach for colon cancer. Those are just a couple of areas that I can cite to you where there's been some recent ones. I think one very important one is the area of pain control and palliative care, which I think we've made great strides in.

Would you like to add anything? Certainly the people to my left are much more knowledgeable in the new areas.

DR. TURC: If I may add an example for the men, because I'm sure Heather would like to talk a lot about breast cancer. We see some major developments at the present time in Calgary in treatment of cancer of the prostate. We have done this morning our fourth patient with a new procedure which is called cryotherapy. We inject liquid nitrogen into the prostate site to freeze the tumour. It's a procedure which has now been in use in some very few centres in the States for two or three years, and Calgary is now the first centre in Canada. To explain that, we don't know on a long-term basis if it will have major implications or not, but if it's working – and we believe that it has good reason to work – it will mean a giant, major savings of health care dollars to look after patients with cancer of the prostate.

MRS. McCLELLAN: This has been used on a trial basis in other areas; hasn't it? The liver.

DR. TURC: Yes. The liver has been done also.

MRS. McCLELLAN: The members may be aware of or have read of that, because it has been a longer term research project in that area.

MRS. FORSYTH: Well, I guess one of the problems that the public sees out there is the millions and millions and millions of dollars, you know, that are collected for cancer and then no immediate results, which is very, very unfortunate. My dad died of cancer, and I know the help that went in to try and get him well. It's not an immediate result, so the public doesn't see it as – I don't even know how to say it. A waste of money would be a poor word, but they're looking for an immediate result on all the millions of dollars going in. I'd like to ask: to what extent are these research dollars being used for cancer prevention?

MRS. McCLELLAN: That's a good question, and your comments are well taken too. I think there are two things we should think about here. The public is aware that there have been some great strides made. I made a comment in my opening remarks that 15 years ago the probability of care for pediatric cancers was about 20 percent. Today it's 80 percent. The other side of the coin is the new cancers that are developing and emerging, the new types, and the new challenges that we have in cancer treatment. I guess Dr. Turc mentioned the breast screening program. Certainly in breast cancer we have not been as successful as we probably had hoped we would be. Our results are not as good as they might be, and we're certainly pleased that there is some work being done in Calgary in breast cancer research by a national program.

We do expend dollars on prevention. The Cancer Board is working now to establish a critical mass of researchers with special expertise in these areas. One of the projects that we funded this year on the effects of pulp and paper mills and another one comparing cancer preventative strategies are two that are research projects just directly dealing with prevention, and those are currently under way.

2:32

MRS. FORSYTH: Thank you, Madam Minister.

MR. CHAIRMAN: All right. Now, ordinarily I would be recognizing Ken Nicol at this point, but I understand, Ken, you wish to . . .

DR. NICOL: Defer to Howard.

MR. CHAIRMAN: To defer to Howard. Okay.
Howard Sapers.

MR. SAPERS: Thanks. Thank you, Ken. Madam Minister, I talked a little bit about the screen test program for breast cancer, and I note that Dr. Bryant is here. I have a couple of questions specifically about breast cancer and the screen test program. There continues to be some degree of controversy around which age group of women will most benefit from testing, and there are new studies which of course indicate that women beginning at an age as young as 40 will benefit, that lives will be saved by a screening program. I understand that that's not consistent, though, with the parameters or the philosophy behind the Alberta screen test program. I'm wondering whether there'll be Alberta-based studies to determine whether or not we should be in fact increasing the target age group for women to be involved in the Alberta screen test program.

MRS. McCLELLAN: Well, I'm going to let Dr. Bryant answer some of this, but first let me say this. While 50-plus is our target group, no person under 50 has ever been excluded from our screen test program. We have not focused perhaps our efforts in advertising or promotion to that target area because the studies that we do have – and I've also looked at the most recent ones. There are conflicting studies in this area; there's no question about it. Diagnostic mammography is not limited in any way obviously, and certainly anyone who is concerned or has any reason for concern should avail themselves of that. But let me make it very clear that although our target area has been 50-plus, nobody has been denied screen testing in this province, to my knowledge, that is under that target age. Anyway, I think Dr. Bryant would probably just jump at a chance to speak about this program. It's an important one.

DR. BRYANT: Yes. Thank you. You are correct in saying that the program is targeted towards women aged 50 to 69. That is the case for most of the provincial programs that exist in Canada, and it's consistent with the Canadian Cancer Society guidelines. There are really a couple of reasons for targeting that age group. The first one is that that's the only age group where we actually have agreement that the test is going to be beneficial and in that age

group will reduce mortality by about 40 percent for women who actually turn up for screening. One of the difficulties with the continuing controversy and the continuing press that comes up with the controversy on the benefits in younger age groups is that it confuses women of all ages, and they begin to feel that the whole issue of screening mammography is controversial. It's important to get that message out that there is consensus. We can make a difference with women aged 50 to 69.

The secondary reason for targeting all of our information towards women in that age group is that we've found in Alberta, consistent with research done elsewhere, that it's actually women under the age of 50 that are more likely to feel that they are at high risk for breast cancer, even though their risk is much less than women in older age groups, and are less likely to know of the benefits of screening mammography. So we have to make sure that not only do women 50 to 69 get the bad news that they're at higher risk for cancer but that they get the good news that there is something they can do about it. That's what a lot of the publicity and the targeting is about.

There are a couple of other issues related to the research. Certainly you're probably aware of the Bethesda conference, which was held last year, which looked at all of the evidence to date on the age groups in which screening mammography is most efficacious. Certainly again they came up with consistent results that in women over the age of 50 screening mammography will make a difference in mortality. In women aged 40 to 49, for the first seven years they actually did a little worse in the screening group when you pool all the studies together, and then after 12 years, by which time they're all in their 50s, they do a little bit better.

The information that has recently been out in the paper is not truly a study that looks at outcomes. The information that has recently been out, I believe from Dr. Warren, who's a radiologist with the B.C. program, really intended to say that they have found cancers in women aged 40 to 49 through mammography in their program, and no one has ever argued the fact that you could find it. The problem is that we don't know if finding it earlier in women in this age group, before menopause, actually affords them any benefit in terms of mortality.

MR. SAPERS: Thanks, Dr. Bryant. My specific question was whether or not there were plans to do Alberta-based research so that we could answer that question. In fact, the advice I've had from many radiologists is that if such research were done – the fact is that there hasn't been good research to answer that question – they believe that there would be dramatic results in mortality figures as well. In fact, the onset of breast cancer, the rate of the growth and the acuity of the disease and the number of women who are at risk because of family histories is growing, particularly in western Canada.

I think there are lots of open questions. Certainly there has been confusion both in the popular press and I think in the medical community as well as to the benefits of screening mammography and who does and does not have access to even diagnostic mammography. Certainly – and I've brought this to the minister's attention, and I believe you and I have talked about it as well – women have expressed the concern that without a referral from a physician they may not be able to even go for a diagnostic mammography if they have concerns due to their own family history, for example. So there's lots of confusion, and I think it begs for some research right here in this province.

MRS. McCLELLAN: Just on that point – and I'm sure Dr. Bryant wants to comment on this too – to do research, you have to have the program, and the breast screening program in this province is new. I certainly don't want you to leave this meeting thinking that the breast screening program is merrily out there doing breast screening without collection of data and analysis of that data. That is a part of it.

DR. BRYANT: Right. Certainly a lot of the things that you referred to in your earlier comments – looking at outcome-related research and evidence-based therapy – are integral to the screening program. One of the things that we're actually discussing at this point is the fact that of the screening going on in the province, roughly a quarter of it goes on in the screening program. The rest of it goes on in the fee-for-service sector. Of that which goes on in the screening program, we have excellent information on the risk factors of the women, on their demographic characteristics, on the outcome of the screening. How many cancers are we really finding? Are we finding as many as we'd expect? What's our false-positive, false-negative rate? Unfortunately, for women who are screened outside of the program, none of that information is available, and in fact we can't even tell from Alberta health care files how many women are getting mammographies for diagnostic purposes versus screening purposes.

What we are working on right now in the committee that is currently meeting is a way to bring all screening that is done in the province into a co-ordinated screening program for a couple of reasons. One is to make sure that all women can avail themselves of the service regardless of where they live, but the second being that we start to collect information on women who previously have been having screening done in the fee-for-service sector. We cannot collect that kind of information: whether it's beneficial, what the cancer detection rate is, and so on.

2:42

Certainly the screening program is very actively involved in research. Some of our specific studies do have to do with family history and what family history means in terms of women in this age group and the screening interval that they should have. So it is integral also to the function of the program.

MRS. McCLELLAN: I interrupted the member before he really got to his question, but I didn't want to leave that important area unanswered.

MR. CHAIRMAN: Well, this will provide the chairman with an opportunity to say that this is one of the difficulties that long preambles to questions can often have. Again we've tried to show as much flexibility in the interest of the spirit of Christmas. The fact that I did get a cookie from the loyal opposition – I'll have to indicate to you that he did not ask his second question. But in giving him that privilege, I might say to the other members that that cookie has now been eaten, and the next member will not be afforded the same luxury.

So if you wish to ask your second question.

MR. SAPERS: Thank you, Mr. Chairman. I appreciate the flexibility in which you conduct these meetings, and I appreciate the opportunity for dialogue as well. Sometimes we're a little stifled by rules.

I'm happy to hear in fact that ongoing research and monitoring are being done in the screen test program. I suppose instead of asking it as a question, I would simply request that a schedule of that research that's planned around the screen test program, the evaluative questions that are being posed, be circulated, because I'm not aware of that, and I would certainly enjoy an opportunity to review that. Perhaps that'll lead to further discussion.

A question I do have, though, about the screen test program is: is any of the research money specifically going into an evaluation of the sites selected for the screen test program – I'm thinking particularly of the site here in Edmonton – as to whether or not it made sense to site a publicly funded, population-based screening facility within a city that has so many private mammography sites? Has any evaluative research gone into that decision to site that centre here in this city? Likewise, is there research being conducted – maybe it has been conducted and not publicly reported on – that has looked at how the mobile units are being used: where they're sent, how many women have access to them as opposed to the population of women who could benefit from access?

MRS. McCLELLAN: I'll start and let Dr. Bryant continue. As you know, the screen test program is a pilot project. It is not a provincewide project at this point. We've been reviewing that project, which is what you would normally do with a pilot project, and you would decide on the basis of the results or the evaluation of that project whether it should be expanded or changed in any way. We have a committee that is working now – Dr. Bryant is part of that committee – and working with the AMA, which certainly has the radiologists from the private sector involved in that to answer those very questions. There has been a strong linkage and working relationship between the program and the private sector because the screen test program is not a provincial program at this time. It is very limited in and around this area.

I would like Dr. Bryant to comment on the use of it in major centres. I might have my own opinion on that. It might be that the profile or the highlighting of it is important wherever it is. I think that's one of the concerns that we have in breast cancer screening: it's not that it isn't available anywhere within reason; it's the knowledge that people should avail themselves of the program. So that might be my own comment in that area. I'm sure Dr. Bryant would want to comment on it being sited in the urban area and how much use there is in urban as well as the usefulness of the mobile units.

DR. BRYANT: Yes. Thank you. There are two urban sites, as you know: Edmonton and Calgary. The program started in those areas because it was started as a pilot project, and it was felt that you would reach the most women by going into the more heavily populated areas obviously. We have had some research which has looked at a number of things in terms of the Calgary and Edmonton areas. You're probably aware that one of the means that we use to make women aware of the screening program is a personalized letter of invitation. This is something that is used in other programs worldwide, and it's been found that it reaches women better than general information in the media. We have looked, for example, at the women who come in as a result of letters of invitation versus those who come in as a result of physician referrals and find that they're more like the average woman. In other words, they aren't as likely to be better educated, English-speaking women as women who come in from physician referrals. So we do have some good information that says that it's useful in reaching that harder-to-reach group.

In the areas where we use the mobile, we do an evaluation report after we've been to every health unit – obviously we'll be switching to regional health authority reports soon – which is sent to the community and to the volunteers and the physicians in the community as well. It does explicitly say: "How many woman are in your area? How many came in for screening?" In many regions it's 60 percent or greater that come in the first time the mobile van goes through.

We've also done a little bit of research which has looked at comparing our baseline survey of knowledge, attitude, and behaviours, which we did in 1990. We did it in two rural areas in addition to the urban areas. Since that time we've had the opportunity to screen in one area with the mobile van and not in the other. We've gone back and seen whether there's really a difference in terms of knowledge, attitude, and behaviours of women since we've been through with the van and have found very positive results.

MR. CHAIRMAN: I'll let your conscience be your guide, sir, whether or not you have one other question.

MR. SAPERS: I have endless questions in this area, Mr. Chairman . . .

MR. CHAIRMAN: They'll have to wait till next round.

MR. SAPERS: . . . but I think I'll pass to one of my colleagues on the committee.

MR. CHAIRMAN: All right. Bonnie Laing.

MRS. LAING: Thank you, Mr. Chairman. Madam Minister and officials, it's nice to see you here. Part of the philosophy of the Alberta Cancer Board is the development of cancer research expertise in selected areas where Alberta has specialized resources or strengths. This is a wiser investment of resources than undertaking research initiatives in all types of cancer and cancer services. What would you consider Alberta's specialized resources and strengths in cancer research to be?

MRS. McCLELLAN: Well, I would suggest, Mr. Chairman, that I might ask Dr. Turc for that opinion. With a basis of fact I'm sure that it is sort of a question of opinion.

DR. TURC: I think there are several areas where Alberta is at the forefront not only nationally but internationally in cancer research. One of the areas, which is not a new one, which has now been funded for close to 10 years, is all nuclear magnetic resonance equipment and research, which were located first at the University of Alberta I would say at least 10 years ago. It was used initially partly for service and providing service to patients, but it was used mainly for research, and the Cancer Board has supported outstanding and recognized research in this area.

The second area where again today we are at the forefront is molecular genetics and, in particular, identification of the gene which might have a susceptibility for the development of breast cancer. I should say that part of this research has not only been supported by the program from the heritage savings trust fund, but it's also supported today by the industry, which has just kicked in $300,000 to $400,000 U.S. to support this project.

2:52

Finally, there is an area where Alberta is having a leading role in the country. It's the whole area of breast cancer, not only diagnostic and treatment, where we probably have some of the best physicians for breast cancer right now, but also the whole area of epidemiology, and the breast screening program is viewed as the best one in the country.

MRS. LAING: Good. Thank you. It's also a belief of the Alberta Cancer Board that multidisciplinary research is the most effective strategy to respond to the multidimensional nature of

cancer. What are some examples of the multidisciplinary research that's funded by the applied cancer research program?

MRS. McCLELLAN: Dr. Turc, do you want to take a swing at that? Or Dr. Van de Sande?

DR. VAN DE SANDE: I'll be happy to respond to this question. For example, in the programs of molecular oncology, where we're really looking at a very fast transfer from the bench to the bedside, people are really looking at the molecular genetics aspects of trying to identify those areas in the gene normally responsible for susceptibility to cancer and to then apply those particular genes to the diagnosis of cancer. Really, the transfer from the bench to the bedside is an approach of course that we have tried to use, but we get people with different basic expertise as well as clinical expertise working together. I think the only way we can do it is by having a multidisciplinary approach to research.

MRS. LAING: You mentioned the gene that seems to be one of the problems with breast cancer. What is the current status of that research? Could you tell us? Would you have those facts?

DR. TURC: It's a day-by-day event right now. We are one of the three groups engaged worldwide in a race for the identification of the gene. We are supported in this venture by two groups in the United States. Which group will come first? We hope we will be the first one, and if it's the first one, it will be big news.

MRS. LAING: Let's keep our fingers crossed. Thank you very much.

MR. CHAIRMAN: Thank you.
Danny Dalla-Longa.

MR. DALLA-LONGA: Thank you, Mr. Chairman. I look at the financial statements. I'm not knowledgeable in this area by any stretch, but my own personal view is that I think I would support more funding from the Alberta heritage savings trust fund, at least up from its current level, certainly based on some of the other investments which have been made in the heritage savings trust fund.

Having said that, I just have some questions. I noticed in schedule 1 of your financial statements other grants of $58,671,000. I wonder if you might just elaborate on where some of these grants come from.

MRS. McCLELLAN: What page are you on? I'm sorry.

MR. DALLA-LONGA: Well, it's page 215 of the public accounts. It's the financial statements.

MRS. McCLELLAN: We don't have the level of detail that you're perhaps asking for, that specific. I can give you an overall of what grants were funded. Is that what you're . . .

MR. DALLA-LONGA: Well, this is grants received by the Alberta Cancer Board.

MRS. McCLELLAN: Oh, that were received, moneys that were taken in by the Cancer Board this year. I'm sorry; I misunderstood you.

DR. TURC: I have in my memory '94-95 data for cancer research. The disbursement this year will be over $9.5 million. So the return on your investment is basically 1 to 4.

MRS. McCLELLAN: I think what the member was looking for is a grant that you received in the Cancer Board in that year. Fifty-eight thousand?

MR. DALLA-LONGA: Fifty-eight million.

MRS. McCLELLAN: Million, sorry. Fifty-eight million dollars that were received. I've got to find the page here before I . . .

DR. TURC: That's our operating budget.

MRS. McCLELLAN: Yeah. Now I think we're catching where you are. I still haven't found it.

MR. DALLA-LONGA: I didn't mean it to be a trick question.

MRS. McCLELLAN: Well, no, and it probably shouldn't be. I have my book arranged a little bit differently. I'm sorry. I don't have the pages numbered the way . . .

MR. CHAIRMAN: I think Diane has a copy here of what he's referring to.

MRS. McCLELLAN: That's what we need. Thanks, Diane. This is the designated grants that the member is talking about that we received. As a whole, his question is not directed at the funds that we're talking about here. They are the funds that are external to the Cancer Board budget, and the gentleman wants to know where you get the money. He's not really referring his question to what's before the committee. This is beyond that a little. Well, it is, but we're really here to discuss the $2.8 million.

MR. DALLA-LONGA: Which is the number right below it.

MRS. McCLELLAN: But you want to have a listing. I think what would be fair to do is to give you that on paper, because it's not a single.

MR. DALLA-LONGA: Yeah.

MRS. McCLELLAN: This is a combination of many grants.

MR. CHAIRMAN: I think the committee would appreciate that, and just to help with that process, then, if you wish to provide it to Diane . . .

MRS. McCLELLAN: Sure. We'll provide it through the secretary on to members, as we will with any questions or comments. I believe the first questioner, Mr. Sapers, asked for some detail that we'll provide that way as well. We'll review *Hansard* at the conclusion.

MR. DALLA-LONGA: Thanks. I read with interest your annual report. The words "research funded by government" these days have a special meaning for me. I'll just share a little story. I happen to have invested in some shares in a company a little while ago for some new technology, a new product that was funded to a large part by government dollars, and then somehow that technology drifted off into the public sector. Now, as it turns out, I made a lot of money in that stock. So as an investor I felt happy, but as an Albertan I didn't think that was right.

MRS. McCLELLAN: Of course you returned it. Your conscience.

MR. DALLA-LONGA: No, I didn't return it.

MRS. McCLELLAN: Sorry; I couldn't resist.

MR. DALLA-LONGA: It's making up for my cost of my investment in being an MLA.

In any event, I guess what I'd like to know is: is there an opportunity for commercialization of any of the technology that's developed, the processes? What are we doing to ensure that the tax dollars that were spent to develop this technology – that we benefit from it, that it doesn't get out into the commercial world? Not that I'm against commercial, but the people that spent the money should be deriving the benefit.

MRS. McCLELLAN: Well, certainly I think Dr. Turc commented earlier about commercialization efforts that they do embark on. You might want to just enlarge a bit in that area.

DR. TURC: We feel it's extremely important for us to be able to work with the industry and to access revenue on a continuing basis from the industry because of some of the work which has been done in our facilities. The minister did mention the Edmonton injector at the beginning of her comments. There have been since the Edmonton injector several commercialization agreements signed with our industry dealing with reagents – for example, monoclonal antibodies – which have been prepared in our facilities. On these clones that I was discussing a few moments ago, we have also negotiated a fairly comprehensive agreement with industry to secure revenue from the utilization of the test, secure revenue from licensing. So if that's working, I think the Cancer Board has been quite diligent in ensuring that in fact we will have appropriate return on our investment. In fact, in our negotiations with a company who has an interest in the clone, I can tell you that the negotiations were very long and that industry in the States felt that the Cancer Board was really demanding far more than the U.S.-based research organizations, for example.

3:02

MR. DALLA-LONGA: Just maybe following along that a little bit further: what's to stop any of the executive at the Cancer Board from some day venturing out and using some of the technology that was developed, which is what I've seen happen not with the Cancer Board but with some of the other boards that this province has been funding? What sort of nonparticipation or noncompetition agreements, if any, are there that would prevent that sort of thing from happening? I'm not paranoid about it, but I think this is something that has to be addressed.

DR. TURC: It has been addressed. For example, the intellectual property of the invention belongs to the Cancer Board, not to the inventor. The inventor will receive a share from the profit made by the Cancer Board as recognition of the transfer of property from the individual to the Cancer Board. So really the intellectual product which comes as a result of the research made by our investigator belongs to the Cancer Board and will rest with the Cancer Board unless the board decides to sell to a third party.

MRS. McCLELLAN: I'm sure you meant the board, not the administration.

MR. DALLA-LONGA: Yeah.

MR. CHAIRMAN: Okay. Thank you.
Carol Haley.

MS HALEY: Thank you very much, Mr. Chairman. I'm interested in the difference between the facilities in Edmonton and Calgary: the Tom Baker centre and the Cross Cancer Institute. Can you tell me from a Cancer Board perspective if the management is different in the two sites, or are they both handled in the same way?

DR. TURC: The principle of management of the two sites is the same. Having said that, there is a major difference between Calgary and Edmonton. Edmonton is a comprehensive cancer centre providing on one site everything from research to diagnostic treatment, an inpatient facility, a small but very active inpatient facility which allows a professional to provide the full scope of services to the patient. At the Tom Baker in Calgary, because of historical reasons we do not provide diagnostic services. We are purchasing diagnostic services from the Foothills hospital, both lab and radiology, and that's working quite well. We provide all treatment on an outpatient basis in now very cramped facilities. We do not have access to inpatient facilities at all, so our physicians have to beg and ask recognition by the Foothills to be able to see their patients in their inpatient unit. We have no control over the quality of care. We have no control over the nursing care. I think this thing alone explains a major difference of attitudes that you will have among the staff in Calgary versus Edmonton.

MRS. McCLELLAN: I think, just in addition to that, though, it's fair to say, Dr. Turc, that there has been some good meetings between the regional health authority and the Cancer Board regarding the Tom Baker site and the inpatient services, and they're dealing with that in their collective business plans.

MS HALEY: Thank you very much for the explanation.

I guess that leads me to my second question, which is: have you as a cancer board done any kind of surveying of the patients that have gone through the two different sites to find out how they feel about the service that they have been getting at the two sites?

DR. TURC: You always have to look at a patient survey with some question. Yes, we have done some surveys, and, yes, consistently the survey rates higher at the Cross. The satisfaction of the patient will be higher at the Cross than at the Baker. In fact, if you read the report of the Health Facilities Review Committee, between the lines you will see also that the Cross is coming always as outstanding and the Baker is coming as good, not outstanding. So for me it means something. There is definitely a difference of perception. You just have to go through the door of the Cross and through the door of the Baker, and before you meet anybody you will already find a difference.

MS HALEY: I really do appreciate your honesty, because I have got constituents who have dealt at both, and there is no comparison in the way they feel about the treatment and care that they get.

That leads me to my last question, and that is: what are we doing in Calgary to try and turn that around so that they're both outstanding?

DR. TURC: As the minister just indicated, we are in negotiations with the region. We believe one of the solutions is to start to give full control to the care provider for the delivery of cancer care through the allocation of a few beds for the exclusive use of the Cancer Board. That's something that we are negotiating with the region.

MR. CHAIRMAN: Okay. Thank you.
Mike Percy.

DR. PERCY: Thank you, Mr. Chairman and Madam Minister and officials. My question relates to the issue of commercialization. This was a topic that we had broached during the discussion of the Alberta Heritage Foundation for Medical Research: funds put for venture capital or for commercialization. I guess it strikes me that the area of least comparative advantage for the funds is in fact towards commercialization, because there are venture capital firms out there. In fact, Alberta has a relatively strong venture capital industry and start-up industry. I would like just to get a handle on: what is the nature of the commercialization? I understand that there's risk-sharing in place through the patent and a share going then to the researchers. So my first question, then, relates to: what's the criteria for moving from clinical trials, which are a form of commercialization, to commercialization? What are the benchmarks?

DR. TURC: It's a complex question. The clinical trial cannot be seen as commercialization. The clinical trial is something which will allow the industry to test a product that the industry owns or a third party will own. They will come to us, and they will say, "Look, we have this drug; we believe it might have some effect." We will be acting totally independent from the industry carrying the clinical trial.

Now, if you look at, for example, a molecular product coming from the Cross, from our basic research – and we believe that following some initial research at the animal level there is some interest, and we believe that in fact it is particularly appropriate to continue some of this research at the human level – we will probably go to a phase 1 trial and phase 2 and phase 3.

Generally at the phase 1 trial we are still on our own, because what we are trying to do is basically: how toxic it is, and how well supported it is. But you are still not trying to find the answer: what is the efficacy, and are you making a difference? You are just trying to make sure that you are not making things worse because of the utilization.

When you have passed this stage, at that point you need to find a partner who will have the ability, first, for mass production, which we do not have, and someone for commercialization and marketing. We do not have this possibility. So at this point, when we know that we have something, it is not yet 100 percent sure, so there is still a risk for the investor. At the same time, it's not appropriate for the Cancer Board to invest money anymore because it's not our mandate to go in the manufacturing business or to go in the marketing business. We are trying to identify the partner, to negotiate the deal, and at that point, really, we transfer the ownership of the product to the industry.

3:12

DR. PERCY: Okay. There was a misunderstanding on my part. When I saw the term "clinical trials," I hadn't realized that it was third-party only and that no in-house procedures in fact were being financed in that route. So when I look at section 5, Contributions to the Development of Research Partnerships, this is in-house work that you've nurtured to a certain stage, and now you're trying to partner in the commercial sector. Is that how I'm to interpret that?

DR. TURC: That's correct.

DR. PERCY: Could you just describe for me then – the full patent rights belong to the Cancer Board, and then each employee of the board has signed an agreement. Is it at the discretion of the board? How is the allocation of shares, in a sense, in the patent determined? Is it discretion, or is there a fund?

DR. TURC: We have a patent policy, and around the patent policy is a little bit of flexibility to try to meet the requirement of a specific situation. The goal of the Cancer Board is to move to a one-third, one-third, one-third formula when we are starting to get money from the industry, after we have reimbursed the board for all the expenditures: patent expenditure, lawyers, and so on. So the board is getting the money first. When we have reimbursed the board for all the expenditures which have been incurred as a result, we are splitting the revenue one-third to the investigator, one-third to supportive research in the laboratory of the investigator, and one-third to support research within the Cancer Board. Now, that's the ideal formula. Sometimes because of some specific situation and because of precedent in other environments, we have to move up to 50 percent for the investigator and 50 percent for the board. Our preferred formula is one-third, one-third, one-third.

DR. PERCY: Thank you.

MR. CHAIRMAN: Denis Herard.

MR. HERARD: Thank you, Mr. Chairman. I will have to ask for the chairman's indulgence here a little bit because I'm not sure I can relate this truly to the 1993-94 report. We have talked about screening and mammography and so on, and we've talked about prostate cancer, and I just would like to take that one step further. It's something I'm sure the chairman will probably understand, because as we get older, men tend to think about prostate cancer more often and usually earlier in the morning. I'm wondering if the incidence of prostate cancer is anywhere near the incidence that we find in terms of breast cancer in women and whether or not there should be some sort of a screening program for men and prostate cancer.

MRS. McCLELLAN: I think that's a subject that is certainly surfacing more and more now. Obviously, there's been, I think, a concerted effort on breast cancer screening for some time or diagnosis or treatment. Not as much attention, probably, has been given to prostate cancer. I don't know whether Dr. Bryant or Dr. Van de Sande want to comment on the requests for research programs or the availability of them in Canada. In fact, in Canada we don't deal in research in cancer; we really deal internationally and monitor what's occurring everywhere in these areas.

So who would like to take a swing at it? Dr. Bryant?

DR. BRYANT: Sure.

MRS. McCLELLAN: I'm trying to save Dr. Turc. He needs some health care. I appreciate him being here. I don't want to wear him out.

DR. BRYANT: You're quite right; the problem of prostate cancer is important. There aren't quite as many prostate cancer cases diagnosed as breast cancer cases, but it still is very high and an important problem for men in the province.

The reason why there hasn't been screening program interest in terms of prostate doesn't come from the perceived importance of one disease versus the other; it comes from the fact that with breast cancer screening we have the benefit of about 25 years of research that tells us that we can make a difference in mortality. With prostate cancer screening we don't have any evidence at all

that screening for prostate cancer is going to make any difference in terms of the man's chance of dying from prostate cancer. Because the treatment for finding out that you might have prostate cancer, which you would never have known about if you hadn't gone in for a screening test, can be something that causes very severe side effects for the man involved, it's important that we research this appropriately.

What has been done is several research projects right now in Canada. A request has gone forward for a multicentered clinical trial of prostate screening. Alberta isn't one of the sites that will be involved in the pilot, but we have indicated that we would be very willing and able to participate should the pilot of that study work out to go to a full-scale trial. The other thing we are looking at is some of the attitudes of physicians and of men themselves to prostate cancer screening, and we are developing research in that area as well. In addition to that is the research Dr. Turc has already mentioned in terms of treatment of prostate cancer. So there are a number of fronts we are trying to push forward on while we wait for the results of screening studies.

MR. HERARD: Thank you very much and thank you for your indulgence.

I'll now go to a question that I think relates more closely to the item at hand. It won't come as any surprise, of course, that there's been a lot of debate with respect to the screening program. I know that the program is new, and of course so is the government's policy of trying to get out of the business of being in business, so I know it won't come as any surprise. You've probably had this question a thousand times: why do we need to have a screening program that is operated within government rather than a screening program that is operated through the auspices of all the radiologists that we already have all over the province? I mean, what benefits are there to this method of doing a screening program versus using the private sector to do it?

MRS. McCLELLAN: I'm going to take the first swing at that because I think it's really a policy question, and I think it's a good one. I want to say, Mr. Chairman, that I am really pleased with the questions in this area because it's very timely. To have the input of your members as to their thoughts on the breast screening program is important to us. I don't want to pre-empt what my committee is going to come back with. I remind you that the committee is an all-lady committee, which I think may be appropriate. It is led by Dr. Margaret Kirwan, who is the past president of the Alberta Medical Association, who represents the radiologists in this province, certainly people from the private sector, from the Cancer Board.

I want you to understand very clearly that it isn't a matter of power or turf or ownership. What we want is the best program that is available for women in this province, and that is the effort that our committee is working on now. I wouldn't be surprised if there's a blend that maybe is the most appropriate. I would remind members that radiologists are not situated everywhere in the province. While it might be very suitable and useful in the larger centres – and certainly the private sector is used a great deal in the outlying areas – they're not everywhere there. Every person in this province is important regardless of where they are. This issue is not simply a one-community issue. I think what we want to do is develop a program that is cost-effective, that is efficient, that reaches the most clients that we can. In some ways it is easier for government-sponsored programs to reach people, through the efforts of the Cancer Board with advertisement and promotion and perhaps in other ways if we can improve access to information, easier for them to reach the clientele than it might be for private-sector people. A great deal of the problem in availing people of the screening program is not lack of opportunity as much as it is lack of knowledge of need. So that's an important part of it, the promotion efforts.

3:22

I'm really looking forward to the report and the advice and the recommendations that that group bring to us. I think by the blend of the group – and again I have to reiterate that having met with all of the players more than once over the last year in us attempting to move forward with a decision on this, the commitment of all of the people involved, whether they be from the private sector or from the Cancer Board, is that we have the best screening program developed for this province that's possible, whether it's a utilization of both, either/or, or a combination. I think that's what they'll come back with, and I'll be pleased to bring that forward when I have those results.

I don't know, Dr. Bryant, if you want to add anything as a member of the committee.

DR. BRYANT: What we're trying to do is talk about the things that are programmatic. Why were programs started in the first place? Well, because women's groups as well as scientific groups were saying that we needed to collect information on the quality of the service we were providing, the number of cancers, the women who were reached and were not reached, and that involves provincial co-ordination so that those things can be collected. I think we've already talked about the kinds of things that we need to know about the screening going on. We're trying to separate those issues from what I think you're referring to, which is the implementation. Who actually performs the mammograms and reads them? There are some things that have to be done centrally, but certainly the Cancer Board is aware that the implementation is something that the regions should have some say in. In areas where women are remotely placed, the implementation of that to meet their needs might be different than it is in the major cities. There are 43 mammogram units between Edmonton and Calgary and probably not enough women to keep those busy.

MR. HERARD: Thank you very much.

MR. CHAIRMAN: Don Massey.

DR. MASSEY: Thanks, Mr. Chairman. Madam Minister, may I start with a comment about the report and compliment you on it. It's well written. It doesn't have a lot of jargon, and it states things clearly and simply. I wish some of that could be shared on a wider basis. The bench to bedside continuum, trying to point out the need for research to spread across that continuum I think is important. I could address my questions through one of the projects, and that is under section 4, the development of a research data base. It was a grant of close to a hundred thousand dollars, $98,850. Can I ask: how is that related to existing data bases that scientists and researchers would be using? Does it become part of a larger data base? What is its status?

DR. TURC: This is a project which was developed after really a lot of consultation and discussion between the Department of Health and ourselves. You will certainly have been aware during the year and the debate about these programs that there have always been major concerns about duplication. How do you know that what you're doing here has not already been done somewhere else? It certainly was also a concern of the Department of Health. We felt that it was important to establish a system which would

allow a registry of all cancer research activities provincially and nationally. When today you want to know who is doing this kind of research, you have nowhere to go. You have to go to the NRC, ask the NRC, or you go to the NCIC, ask the NCIC, but you have no central bank of data to provide information on research projects which have been done five or 10 years ago or today. That's the purpose of this program.

MRS. McCLELLAN: Dr. Massey, you or Ken would probably recall that we've done something similar with agricultural research for that very reason: so people can access it on a more timely basis. I think this is a similar type of challenge that we have. We've depended a lot on the interrelationship and discussions with the researchers and the groups who are looking at research projects, to have to go out and hunt down whether this is indeed being done somewhere else.

I have to say that Alberta has really been a leader in the development of health data bases, health information networks. It is something that we've been very concerned about over a period of years in this province, not isolated to cancer. A health information management strategy on a national basis is one that we were very strong in the leadership of, in developing that. It's very difficult to evaluate what you're doing if you don't have a good data base, as you both well know with your backgrounds. You have the added challenge, I suppose, in health information of protecting the confidentiality of information and ensuring that that information is only used in an appropriate way. You would recall a debate we had in the Legislature in the past session on access to some files by certain areas, and of course that is the concern that is always raised: can you protect that? So it complicates, perhaps, having a data base, which may not seem as complicated in the world where you don't face that one critical area.

DR. MASSEY: I'm surprised that something else hasn't been done to this point. I mean, it's quite amazing that the field would be that far along without it.

Could I ask, then, about the $98,000. There's an administration line of 100 and some odd thousand dollars at the beginning. Is administration taken out of that grant too, out of the $98,850 available to that researcher? Would part of that grant be allocated for administration, or is that already taken care of?

DR. TURC: No. The grant of $98,000 here was for the sole purpose of the development of this project. It has nothing to do with the administration budget.

DR. MASSEY: So the individual grants throughout here don't include a percentage off the top for administration or administrative purposes?

DR. TURC: No. If I may, I should say that the Cancer Board feels very strongly and has been opposed consistently to the concept of overhead. Most of the research facilities today will take between 10 to 25 and up to 40 percent on top of the grant to manage the affairs of the institution. We believe that if as an organization we are not prepared to provide the infrastructure to the researcher, we have no right to be in business.

DR. MASSEY: Great. Yeah, it is super.

The last question I have is: how would a professional or, say, a scientist in a related field get on to this data base? How do they learn about it?

DR. TURC: I will have to provide you the information.

DR. MASSEY: Okay.

MRS. McCLELLAN: Is it completed now?

DR. TURC: Yeah, it's completed. I don't have the data myself.

3:32

MRS. McCLELLAN: We will make sure, Dr. Massey, that that gets to you through the chair.

DR. MASSEY: Thanks very much.

MR. CHAIRMAN: Thank you, Don.

MR. WHITE: Madam Minister, my questions will centre around an interest area of mine from former activities in the health care business. It centres around home care. The question is simply this. With the advent now of much more reliance on home care under the new models that are being proposed or in fact being implemented, intravenous chemotherapy in the treatment of cancers is being provided much, much more in the home. What form of research or monitoring of your own have you to recognize the effectiveness of the delivery of this service?

MRS. McCLELLAN: I may ask the experts from the Cancer Board to talk more about the cancer program, but as you know, we have a parental home therapy program. I believe the first one was really pioneered by the University of Alberta hospitals, and it has been quite successful. As to the ability to utilize that program in cancer treatment, I have to admit that I am not up on that. I did mention to you earlier about the strides we've made in palliative care for pain relief in home therapies.

Do you have some insight?

DR. TURC: Yes. We have been involved in these activities mainly for pain control and palliative care. We are not involved as a direct provider, but we are involved as a teacher, coach, facilitator, co-ordinator. Our palliative care people are working with primary care physicians and the home care program. In fact, we have both in Calgary and Edmonton. The nurses on staff have a duty to reach out to the community and the home care program to ensure that cancer patients will have indeed a continuum of care. So we are not a direct provider, but we are working with other providers now as a region to ensure that in fact, when it's appropriate, care could be provided as close to home as possible or at home if it's possible.

MRS. McCLELLAN: If I could just add to that. One of the critical reasons for having the Alberta Cancer Board prepare their three-year business plan showing the interaction with the regions is to ensure that we don't miss that co-ordination between home care for cancer patients and follow-up, maybe not the word "miss" so much but that we don't include that in the co-ordination of home care. One of the problems that we've had in delivering home care is that we need to manage it in the multidisciplinary, whether it's discharge from a hospital, whether it's for people who are staying longer in their homes because of home care, or whether it's palliative care. I think palliative care is one area where we are really moving ahead improving the ability for people to be provided for in the home. I was looking for the name of that; I'll find it if you want to go on.

MR. WHITE: I'll move on to another subject that's not related directly to home care. That was answered rather well. In the

financial statements there's a considerable amount of funds expended annually by the Cancer Board, and in fact only a small portion of it is funded by the province. How does the province come to the conclusion that $2.8 million consistently is enough or is too much or is not enough? How is that judgment made?

MRS. McCLELLAN: Are you talking about just the research funds?

MR. WHITE: Yes, just the research portion, the $2.8 million.

MRS. McCLELLAN: But a number of the expenditures of the Cancer Board, not research, are funded by the province in the financial statements. So you're looking at a research section beyond that. As Dr. Turc promised an earlier questioner, he would provide the detail of where they receive those funds from.

I think your question is: how does the province decide that $2.8 million or the $52 million that we've provided up to this point is enough? I think I said earlier that I don't think we've said that. We've committed a number of dollars to specific cancer research. There is other research obviously available, but we've made a commitment of those dollars. We've been able to hold the line and continue the level of funding in that area, and I think it's been very well used. We can show pretty good value for those dollars that have been expended.

I am certainly prepared to sit here and discuss and defend with my colleagues from the Cancer Board how those were expended, but I don't think I could sit here in any good conscience and say that that's the right amount. That's the amount we have. We appreciate that commitment. Not all areas of this country are as fortunate to have dedicated funding. You have to understand that the commitment we have made, even though it may seem like a small amount to you – I mean, it's not small, but it's small in the full scope – has attracted other dollars to this province and other research projects because of the continued commitment and the stable commitment that we have shown and the importance of this. I mentioned an initiative in research in breast cancer that came to Calgary – it is in Calgary, isn't it, Heather? – that we received through federal funding certainly because of the recognition of the work that is being done in this province.

So I think we have to also look at those dollars attracting other dollars. They attract researchers because of the stability. That's very important in research, that researchers have some stability and see some stability, because they're putting in a considerable commitment. I think it's enabled us to attract very top-notch researchers and bring other dollars as well.

MR. WHITE: Mr. Chairman, the other two areas of the question. One, the confidentiality of the research was asked about and answered earlier. Then the last question, although it can't be given completely because of the nature of government funding from year to year, is: is there some assurance that you can give Albertans, be it through either the Alberta heritage savings trust fund or through some other means, that the consistency of this amount of funds that has been made available for this purpose will be there? You've answered it in part.

MRS. McCLELLAN: Today I am before, with my colleagues, the Alberta heritage savings trust fund committee. It's certainly our intention here to collectively impart to you all the importance of cancer research in this province. I can't speak strongly enough about it. I have tried, as difficult as you know it is for me, to be reserved in my comments to give you the opportunity to hear directly from the people from the Alberta Cancer Board. I think this is a tremendous opportunity for you to receive information from them. I can tell you that I am very strongly committed to ensuring that we continue to have cancer research in this province, health research in this province in whatever form or funding that it can come from.

I think we can demonstrate that we've been effective. I think we can demonstrate that we've made a difference and we've made some improvements. We don't have to demonstrate the need; it's there. Cancer is one of the rising causes of medical treatment and concern in this country. I think the efforts in research and prevention as well as in treatment, in understanding the disease as much as we can, are the answer to lowering the incidence.

So I can give you my commitment as a minister. I think our government has shown their commitment by dedicating funds through the Alberta heritage savings trust fund, and I'll certainly look forward to your committee's review of the utilization of those funds.

3:42

MR. CHAIRMAN: Thank you.

I believe, ladies and gentlemen of the committee, we've just been lobbied very dedicatedly and sophisticatedly, and we want you to know we appreciate that.

Okay. Bonnie Laing.

MRS. LAING: Thank you, Mr. Chairman. On page 17 of your annual report you mention two research projects on the prevention of cancer, one in pulp and paper mills and another on a comparison of cancer prevention strategies. I'm sort of surprised at what I would think is a more minimal amount in that area. Would these two have been chosen over several others, or would there just be a few that are presented each year for consideration for funding?

DR. TURC: I can't recall specifically if we had four or five project requests. What I can tell you is that we are supporting cancer epidemiology with over $1.5 million of research money, and epidemiology and prevention are becoming popular. As a result, it is easier these days to find some money from a funding agency outside the Cancer Board to support this kind of research, and we are certainly asking our investigator to apply outside. Certainly Health Canada – is that the name? – has a lot of programs to support epidemiology, and we are taking every advantage of it.

MRS. LAING: So there's a lot of funding going on other than what's shown here?

DR. TURC: Yes.

MRS. LAING: One of the projects seems to be one of determining the effectiveness of a communication strategy in relaying preventative measures. I just wonder: is this the type of research which could be used in a communication strategy for prevention of lung cancer caused through smoking? I feel that's a very difficult area to seem to have an effect in, especially in certain groups. I just wondered if that was kind of a focus of where this research may lead.

DR. BRYANT: That's certainly one possible application of that. There are research projects, certainly in terms of smoking prevention and cessation, going on at the Cancer Board which don't appear here because they are some of the ones that are being successfully funded through other agencies. But, yes, that would be one of the potential applications.

MRS. McCLELLAN: I think the others are in the workplace.

DR. BRYANT: That's right.

MRS. McCLELLAN: You know, there are a variety of areas that they are looking at in that study as well.

MRS. LAING: All right. Thank you very much.

MR. CHAIRMAN: Ken Nicol.

DR. NICOL: Thank you, Mr. Chairman. Hon. minister and staff, one of the questions that came up – you kind of alluded to it a minute ago in one of your responses – dealt with where you go from here, kind of thing. The Premier and the Treasurer in their presentations before this committee have alluded to the review of the heritage fund that is ongoing as of last week. I notice in looking at this research allocation that it's coming directly out of the expenditures or the incomes of the heritage fund as opposed to an endowment such as medical research, Farming for the Future, the education scholarships. This program is potentially more in jeopardy, depending upon the outcome of the public hearings on the heritage fund. Is your staff and the cancer research council going to be making a request, say, for an endowment to be created to protect their $2.8 million?

MRS. McCLELLAN: Well, I can tell you very seriously that, you know, I haven't considered that at this point. I think what I said earlier is that we are committed in the Department of Health in the government of Alberta to ensuring that we have the best availability of research in this area that we can. Probably the most important thing isn't where it's funded from or how it's funded; it is that you do have the programs. I think, though, one thing that is of importance to the research program again is the stability. As you would know, that is always a concern of research. It's really the only way to maintain good research and continued research and attract good researchers: to have that sort of stability.

I can't in any way project what a review of the heritage fund might bring, and I think we should follow that review. I think it's important that the people of this province do have a voice in how those dollars are expended. I think we will have to demonstrate – I think we have, as I've said before. The chairman suggested I was lobbying. I think what I was really saying, from a strong and very sincere feeling, is that these dollars have been well utilized, that we have made a difference in Alberta, and I think we have to continue to say that. I think we have to let the people of this province decide whether dollars are used appropriately from that fund. I'm sure that will be a part of the review but doesn't lessen the commitment of this minister or the Cancer Board to research, to prevention, to treatment of cancer in this province. A bit hypothetical, Ken.

DR. NICOL: Yes, it is. It is hypothetical, but . . .

MRS. McCLELLAN: It is, yes, and it's important.

DR. NICOL: You know, I'm a strong supporter of education, health care, and research as a growth factor for Alberta, and this is one of our research areas that leads very much to the potential for benefits both to our health and to our commercial sector.

MRS. McCLELLAN: That's right.

DR. NICOL: We have a two-pronged benefit we can get by supporting the type of research that is conducted by this council, so I was just wondering if there was a process in place where Albertans were going to find out more visibly and actively what was going on. Until I came into the Legislature and got involved – you know, you really don't understand where the funding comes from for these kinds of things. You have this big picture of a pot of money in Edmonton that just gets doled out. Now we see some of it in jeopardy, and this is the reason I brought it up. I hope there's going to be a strong statement on behalf of this council in the distribution paper that's going to be going out to all households in January, and I would recommend that you and your staff make sure that that's included there.

MRS. McCLELLAN: I appreciate your advice. I think the Alberta Cancer Board has tried very hard to let the public know what they are doing. Somebody commented on the document and how well written it is. I think it's something that anyone can pick up and appreciate what is in here. It's very user friendly and well written. It is always difficult, because many times these things do not come to our attention till we're personally faced with this disease or if we're involved in the community that provides treatment or something like that. I understand that as much as we send out information on the Alberta heritage trust fund, unless you have a direct interest in what is in there, it's hard to capture attention. I guess it's something that we all should talk about more, the positive things and the good things that are occurring out of those funds. Ken, I appreciate your support for it.

DR. NICOL: Mr. Chairman, I'd like to beg your indulgence in making a very large diversion from my second supplementary on this.

MR. CHAIRMAN: You're from Lethbridge. It's okay.

DR. NICOL: Thank you. We southerners stick together; right?

My next question deals with some of the comments that have previously been made in connection with the breast cancer screening and that that's been going on. Dr. Bryant, maybe this is something that you can deal with. There was a reference made to an increase in western Canada. Are there data that are showing up now in your screening which indicate there is a different level of susceptibility to breast cancer because of geographic factors that are not associated with, say, smoking or some of the other habit-type characteristics that have been pinpointed?

3:52

DR. BRYANT: Throughout the world there is more breast cancer in countries that we see as highly industrialized versus those that aren't. If we look at the three major risk factors for breast cancer, the first is age, the second is having two or more relatives with breast cancer, and the third is where you're born. Women who are born in North America and northwest Europe have much higher rates than the rest of the world. The rates have been slowly going up, about 1 percent per year for the last 20 to 30 years. Within Canada for as long as we've been measuring it, there has been an east to west gradient in cancer. There's less breast cancer, really, in the Atlantic provinces than there is in the rest of Canada. We don't know why that is exactly, but we presume that it may follow along the same routes as cancer prevalence. Where economics are a bit better and industry is a bit better, there's more breast cancer. We don't know why that is. Certainly some of the research that we're looking into in terms of causes for breast cancer looks at readily identifiable things. For example, occasional use of alcohol has been linked as one of the things, but it probably doesn't account for that. Certainly the breast cancer research fund

nationally is looking at strategies to look at other environmental causes for breast cancer.

DR. NICOL: What about rural?

DR. BRYANT: There is a little more breast cancer North America-wide in urban areas than in rural areas.

DR. NICOL: Thank you.

MR. CHAIRMAN: All right.

MR. WHITE: We have just some recommendations to read into the record.

MR. CHAIRMAN: Okay. Do you want to go ahead and read those?

MR. WHITE: On behalf of my colleague Howard Sapers . . .

MR. CHAIRMAN: He read those.

MR. WHITE: He did? Oh, he did them off the top; right. Good.

MR. CHAIRMAN: Okay. Any other recommendations to be read? No?

Well, then on behalf of the committee, Madam Minister, I would like to thank you and your staff very much for coming and also to wish you a very Merry Christmas and a Happy New Year. Further, again on behalf of committee members, Merry Christmas and Happy New Year certainly to *Hansard* and of course to our able assistant, Diane.

Now, we'll look for a motion to adjourn, which means we are adjourning until Wednesday, January 25. All in favour? Carried.

[The committee adjourned at 3:58 p.m.]