[Chairman: Mr. Pashak] [10:04 a.m.]

MR. CHAIRMAN: We'll give the minister a chance to get settled, and I'll call the meeting to order. Perhaps the first item we should deal with is the minutes from the last meeting. I take it they've been circulated. The adoption's been moved by Mr. Nelson. Is there any question on the minutes? Do you agree they be adopted as distributed? Agreed.

Well, today I'd like to welcome again the Auditor General, Don Salmon, and Ken Smith, his associate. Today we have the pleasure of meeting with the Hon. Marvin Moore, the Minister of Hospitals and Medical Care.

Perhaps I should just make a few preliminary remarks to the minister. Generally speaking, we try to stick as close as we can to the report of the Auditor General for the 1985-86 fiscal year. We welcome the minister to make an opening statement, if he'd care to do that, and review, I suppose, the performance of his department during that fiscal year, or we can go right into questions. Whatever you prefer.

MR. M. MOORE: Thanks, Mr. Chairman. I'll be very brief. I have had an opportunity to review the Auditor's report for the '85-86 fiscal year. I've noted again the recommendations that were made there relating to the Department of Hospitals and Medical Care in terms of the financing of capital construction and the disbursement of grants in that area; also the Health Care Insurance Fund and some comments on certain Crown hospitals and the urban hospitals project. My observations are that we have, I believe, at least by now been able to move well in line with the Auditor's recommendations.

There perhaps might be two exceptions to that. They are the difficulties of monitoring the Blue Cross Plan relative to the services provided to us by Blue Cross for coverage of seniors and others. But we're still working hard on trying to ensure that there are not any inappropriate payments to Blue Cross from the department in that area. The second area that continues to give us concern and perhaps always will is the collection of premiums under the health care insurance plan and making sure that registrations are up to date. When you're dealing with 2.5 million people with a considerable number of health care insurance billings, it's just a difficult job, but I think we're doing better there than we were in previous years.

I think, Mr. Chairman, those are about the only comments I'd like to make in opening. I'd be prepared to try and answer any questions there are. If members get too detailed, which they sometimes have a tendency to do, I may have to provide an answer on another occasion, or if the committee does not meet again and want me in attendance or is not able to meet with me in attendance, I'd be delighted to provide anything I can't provide today in writing to committee members as soon as I can get the answer together.

MR. CHAIRMAN: Well, I'm sure they'll appreciate that offer. We thank you for your opening statement. Our general procedure is to recognize a questioner and he would have a main question and two supplemental questions available to him or her. So with that, Mr. Jonson?

MR. JONSON: Yes, Mr. Chairman, I'd like to follow up on one of the remarks the minister has just made and refer to page 54, recommendation 29 of the Auditor General's report. I think the rise in health care costs is still a concern, and I would like specifically to know what the department has done with respect to recommendation 29; namely, to tighten procedures related to the registration and cancellation of health care insurance coverage. I believe, Mr. Minister, you did mention that in the general sense, but what specific things? Could you respond on that point?

MR. M. MOORE: Well, first of all, Mr. Chairman, I believe the issue is a little bit redundant now, in that under the Canada Health Act the government of the province of Alberta or any other province is required to provide medical services to its citizens whether they are registered or whether they have paid their premiums or not. So it's not a matter of our being in a position where we would not pay the doctor if they're residents of this province and entitled to receive the medical services. On the other hand, there are people who are passing through here and are not entitled to receive medical benefits that do sometimes walk into a doctor's office and obtain them without proper showing of their health care insurance cards. So that continues to be a problem, but I don't believe there's a problem with any loss to the Provincial Treasury any more. The problem is usually a loss at the doctor's office, where they believed someone was entitled to be covered and sent in the bill and then it was rejected by the health care insurance plan. So I'm pretty confident that we don't have in this area any losses of health care insurance dollars.

MR. JONSON: Supplementary, Mr. Chairman, still on the topic of the health care insurance coverage. Also on this matter, we've got recommendation 28 on page 53. Has the backlog of unprocessed claims that's referred to there been cleared up, or what is the status of that?

MR. M. MOORE: I can't answer that as of today. I know that we have laid on additional staff from time to time to try to catch up, and I believe we're doing a better job than we were when this recommendation was made. There still are times when there's a backlog of unprocessed claims, and the health care insurance people use override codes to catch up. But we're trying, again, very hard to bring that down to a minimum, and there is a development of a new claims system going on in the health care insurance plan offices that I believe will help even more yet.

MR. JONSON: Just one more supplementary, Mr. Chairman. On that point of those codes -- override codes, I guess they're referred to -- it seems to me it's mentioned somewhere in this report, the previous one or two pages, that the coding system was resulting in incorrect payments. You referred to a new coding system. Is that going to correct that problem, or what is being done about that particular problem as featured here in the report?

MR. M. MOORE: Well, as I understand the use of override codes, what happens is that there's a system over at the health care insurance plan that allows certain numbers of claims submitted by medical practitioners to go through automatically, but if there's anything that turns up that's irregular, then they are kicked out and processed in a different way. Perhaps the Auditor General or his staff could add to this or correct me if I'm wrong, but my understanding is that the override code does away with the other check, and a practitioner is paid and then later on they go back and look at what occurred.

What the Auditor was saying is that because of doing that, you've overpaid people. What we do is look at it later, when we

have time, and then correct that overpayment by deducting some from future payments to that same medical practitioner. Frankly, I agree with the Auditor. We've got to quit doing that, because it doesn't take any more time to do the checking before we pay than it does afterwards. It's a matter of catching up and staying caught up. I've asked my staff to ensure that that does occur to the extent that it's possible. Is there anything that the Auditor . . .

MR. SALMON: I think that explanation is satisfactory.

MR. M. MOORE: The layman's explanation.

MR. SALMON: Yeah, that's fine.

MR. CHAIRMAN: Okay then, Mr. Roberts.

REV. ROBERTS: Thank you, Mr. Chairman. I'd like to say at the outset how disappointed I am that this minister doesn't, like other ministers, bring department officials to help him with some of the detail here, although I guess I could also express my disappointment or sadness that the deputy minister has recently resigned. At least I take it, since they're advertising for a new one in the . . .

MR. CHAIRMAN: I'm going to have to rule you out of order.

REV. ROBERTS: Mr. Chairman, insofar as Dr. McPherson was here during this particular year under question . . .

Nonetheless, when we look at the entire expenditures for the year in volume 2, number 14.2 for the department, we see in the last year that in the entire expenditure for the health care insurance plan for the fund itself, there was in fact $191,000 that was unexpended for the fund, as opposed to what was totally authorized to spend. It's quite a difference, in fact, from the year previous. In '84-85, if you look back to that year, there was in fact $78 million that was unexpended for the entire health care insurance plan.

So we've gone from a figure in '84-85 of $78 million to '85-86 of a mere $191,000 that was unexpended, this even without special warrants or whatever. In fact, it shows that the spending through the fund was at about 99.59 percent on target. That's almost a real bull's-eye in terms of the expenditures and what was budgeted. I'm wondering about that. I want to congratulate the minister and the plan for coming so close to what was exactly budgeted, but it makes me wonder whether in fact some figures have been fudged here, since the year previously it was about 20 percent out and this year it was bang on. How does the minister account for the fact that such a drastic improvement took place in one year in terms of the cost control, the forecast planning? It shows good work. Or in fact have these figures been fudged?

MR. M. MOORE: Is the member referring to page 14.2, item 2, health care insurance?

REV. ROBERTS: That's the one.

MR. M. MOORE: Estimates, $426.161 million?

REV. ROBERTS: Right. Expended, $425 million, with a mere $191,000 unexpended. If you look at that same line a year ago, it was $78 million that was unexpended. This year it's $191,000.

MR. M. MOORE: Where is the member getting that figure from, the year-ago figure?

REV. ROBERTS: I have the volume here. The previous fiscal year.

MR. M. MOORE: Well, I don't have any information on the previous fiscal year.

REV. ROBERTS: I'm more interested in why there has been such a drastic improvement in terms of the budgeting and the forecasting and the expenditures.

MR. M. MOORE: Well, it must be the excellent work of the minister and his staff resulting in that -- I don't know -- or the Auditor General. I'm not sure who, but . . .

Let me make this comment about the health care insurance plan fund. Last year, I recall, the last date upon which we were able to put a number in the budget for the health care insurance plan was about that first week in February. So we're looking at a plan where the utilization increase may be 3 percent or it may be 8 percent. We're looking at a plan where we sometimes don't yet have an agreement with all the practitioners who bill it relative to what the billings will be. So we have to use our best guess as to how much money will be required throughout the year. We put that in, and then, even as we go along throughout the year, we monitor it very carefully and make projections with regard to where we're at in terms of expenditure and where we might be at the end of the year.

I recall during this past fiscal year, in about March-April, we passed a special warrant for some $19 million, I believe it was, that we thought we needed in the health care insurance plan because there's a backlog of about three months where a lot of claims come in that aren't . . . There'll be claims that doctors provided services in January. We don't get the claim till February or March; it's not paid till April. We're usually about three months behind in knowing exactly where we're at. Last year we passed a special warrant that we then, in the end result, didn't require of some $17 million. So to be that close -- within $191,000 -- is extremely good and a little bit fortunate. It could well be that next year we would be much more out than that on the actual number here.

I don't think it's important what exists in here in terms of underexpenditures or overexpenditures in the Health Care Insurance Fund. What is important is how well we manage the payment of those moneys, because we're obligated to pay them. We don't have any way of not paying them. When a doctor bills the plan and it's a proper billing, we have to pay it. If we don't have funds there, we have to get a special warrant. So if we overestimate the amount required, we've got unexpended funds left in there. But the important part of the whole process is to make sure that we provide a good scrutiny of the moneys that are paid out.

MR. CHAIRMAN: A supplementary.

REV. ROBERTS: Thank you. To continue to applaud the minister in the work he's doing in his department -- because when you look at the overall department for the year, there was in fact $55 million unexpended. On the bottom line for '86, there was $2.35 billion budgeted, $2.3 billion expended, with an actual

'unexpenditure' of $55 million. Again, can the minister comment on how he's been able to manage this kind of cost control, keeping within budget and under budget, for the entire department in that year?

MR. M. MOORE: As the hon. member knows, I was appointed minister in April of 1986. So this is for the year immediately preceding when I personally became involved. But I realize I'm obligated to try and provide answers with respect to what went on before. If the member goes down the list from top to bottom, he will see the areas in which moneys were budgeted but not spent. If you look at financial assistance for active care program support, the total amount authorized was $146,983,476, and there was $29,479,594 unexpended.

I can get details on the exact reasons, I suppose, for that amount of unexpended money. But in most cases in recent years, both in the active care side and the long-term care side, the unexpended funds have resulted from new hospital construction that wasn't opened as soon as we had anticipated. Again, we're looking at a January-February time line when we can put into the budget a dollar figure for opening a hospital that we anticipate opening next August. A good example right now is the Peter Lougheed hospital in Calgary. We were hoping it would open in April. It's been delayed for some length of time -- I don't know how long -- but I have to put a number in the budget now to cover the operating costs of that hospital for next year. If there are any more delays in its opening from what we anticipate now, we will have a significant amount of money remaining in our budget unexpended. And that would hold true for a good number of other areas right down the line.

The other thing that occurs every once in a while is that a hospital will be approved for a program -- a CT scanner, for example. The scanner is ordered but doesn't come on time, so it's six or eight months after our original anticipated date of start-up and it costs about $2 million a year to run a scanner. So if you only run it for three months instead of 12, we've got a million and a half dollars left over. In almost all these areas the result of underexpenditures is programs or hospitals not opening on time.

MR. CHAIRMAN: Mr. Roberts, will you respond?

REV. ROBERTS: Yes. So the point is, Mr. Chairman, and to the minister, that the department has shown by these figures and the minister's own comments that there is a great deal of cost control, that the expenditures for the department are well under control, and yet we've heard this minister go on and on and on about the 15 percent increase per year . . .

MR. CHAIRMAN: Wait a minute. Hon. member . . .

REV. ROBERTS: The point I'd like to put: the minister has said about this year and the rate of the growth of the Department of Hospitals and Medical Care increasing at 15 percent per year, when in fact if you'd look at the actual expenditure of this particular year, there's been a scant 2 percent increase, and when you look at the increase in spending for the health care insurance plan, it's been even less. So I want to ask the minister how it is that he has not intentionally been misleading the people of Alberta . . .

MR. CHAIRMAN: Hon. member, this is not a political . . .

REV. ROBERTS: Mr. Chairman, it is with respect to the '85-86 data stats budget here before us, which shows a mere 2 percent increase in the rate of overall spending of the department from the year previously. I'm wanting to ask the minister today how it is that his comments of other times that there in fact have been 15 percent increases, that the department is out of control, how that jives with the evidence . . . [interjections]

MR. CHAIRMAN: Just a minute, hon. member. Point of order.

MR. BRASSARD: I think the hon. member is comparing apples and oranges. We're here talking about an '85-86 budget. We're not talking about the comments that are being made today, and they're irrelevant. The minister is here to defend figures he wasn't even in control of at the time, and I think his comments of today have no bearing on his reflections on the budget. I feel that the member is out of order.

MR. M. MOORE: Mr. Chairman, if I could amplify briefly to explain at any rate, because I think members are entitled to know the real facts. The health care insurance plan and the figure that's in the budget is net of revenue from premiums and the transfers from the federal government. I believe that's correct, is it not? So what you see there is not an accurate reflection of the actual expenditures for medical fee for services. Because if we raise the premiums, then the figure in here could actually be reduced, and that will show up next year in the 1987 Public Accounts because we had a significant increase in premiums. If federal transfer payments change, that would change as well, and that just deals with the health care insurance plan.

But with the overall expenditures in health care, the figures which I have presented, which had us up until the end of the fiscal year March 31, 1985, which is the year previous to this, the five years previous to that in this province, the average expenditure -- not the amount budgeted; the actual amount spent on health care -- did increase by an average of 15 percent each year from 1980 through to 1985. Now, we've been very fortunate to have gotten that under control a great deal during the fiscal year you're talking about here, and even more so in the current fiscal year.

MR. CHAIRMAN: Mr. Nelson.

MR. NELSON: Thank you, Mr. Chairman. First of all, I'd like to congratulate the minister. I think the concern about fiscal restraint but still ensuring good health care for our citizens of Alberta is commendable. Notwithstanding the remarks of the previous member, I'm sure the minister has certainly taken into account the remarks, and I for one think the minister and his department are doing an exceptional job in trying to get a very, very complex situation under some reasonable control on fiscal restraint.

Notwithstanding that, Mr. Chairman, I would like to ask the minister a couple of questions regarding votes 6 and 2 on page 14.2 of the Public Accounts book. There are two items in there of special warrants: one was $11.5 million and another one was $13.5 million, for a total of $25 million. I'd like to know what aspect of the capital construction of medical and referral centres these warrant funds were actually spent on.

MR. CHAIRMAN: 14.3 and 14.2 of the Public Accounts, Volume II.

MR. M. MOORE: The detail, according to the Auditor General,

is in the back of the book.

MR. CHAIRMAN: That's page 28.9.

MR. M. MOORE: $11.5 million -- you'll see it at the bottom of page 28.9:

> To provide additional funds to meet increased 1985-86 cash flow requirements for the Walter C. Mackenzie Health Sciences Centre and for the two new urban hospital capital construction projects.

MR. NELSON: Okay. Thank you, and I have that noted.

Mr. Chairman, a supplementary. On the same page of the Public Accounts supplementary, there's a number under transfers of $788,639. This appears to have been transferred from a salary contingency fund. What does this actually mean?

MR. M. MOORE: What page is the member referring to again now?

MR. NELSON: 14.2, Mr. Minister, down at the bottom of the page, under transfers: $788,639.

MR. M. MOORE: What is the question, then?

MR. NELSON: The question was: under the asterisk there, (b), it indicates it was transferred from a salary contingency fund. I'd like to know what that actually means.

MR. CHAIRMAN: I'll let the minister struggle.

MR. M. MOORE: I can't seem to find that information. Do you have an explanation?

MR. SALMON: Well, it's the basic concept of how the departments draw on the salary contingency fund when they are short dollars when increases are granted. They can draw on this particular fund for anything they are not able to meet within their own budget. It's a standard process for all departments to draw on that if they have to.

MR. NELSON: Can I see a verification of that? When you say a contingency fund they draw on, is that due to negotiated salary increases or is it because of increased staffing or what have you? What is the reason for that?

MR. SALMON: No. I think it's negotiated or salaries generally granted where they don't have the dollars, and it's paid out of the contingency fund.

MR. NELSON: That's all departments?

MR. SALMON: Yes.

MR. NELSON: Thank you.

MR. CHAIRMAN: Mr. Brassard.

MR. BRASSARD: Thank you, Mr. Chairman. I'd like to start out by applauding the minister and the accountability he's brought into this whole department. Speaking of accountability, I'm referring to the Health Care Insurance Fund as it applies to Alberta Blue Cross, and I'm dealing with the Auditor General's report on page 52, recommendation 27, and the question with respect to recommendations of the Auditor General regarding the . . . Has the department taken advantage of provisions within the Blue Cross to better verify the individual claims that are outlined there?

MR. M. MOORE: The short answer is yes. Whether or not it is adequate at this point in time, I don't think -- it probably is not. We could probably do an even better job there than we have been doing. I don't get quite as concerned as possibly the Auditor General does about whether or not we are overpaying Blue Cross a little bit. Part of the reason is that Blue Cross is not a private for-profit organization. It's run by the Alberta Hospital Association, and any dollars that are in there ultimately find their way into the health care system somehow or other. So in my opinion, it's not quite as difficult a situation as if we were paying those moneys out to a private for-profit insurance company.

Nevertheless, from strict auditing principles we need to be certain that our funds are being expended properly. I think we're doing better, but I think we need to do even better yet to monitor the Blue Cross fund.

MR. BRASSARD: A supplementary then. Has your department developed a procedure to check the reasonableness of claims, as recommended by the Auditor General in the report, on an individual basis?

MR. M. MOORE: Again, I think we've improved considerably from when this report was issued.

MR. BRASSARD: Then a final supplementary. Have you made any progress in balancing the registration and claims as recorded on computer tapes?

MR. M. MOORE: Again the answer is yes. We've made progress but certainly haven't completed everything we want to do.

If I could just say, Mr. Chairman, one of the problems with the Blue Cross coverage is that it is very difficult for us to monitor everything that is sent in to Blue Cross. For instance, on extended benefits for seniors, we pay ambulance services, drugs, et cetera, et cetera, et cetera. We have to depend on a whole lot of people in the system to be honest. While you do some monitoring, it would be entirely impractical for us to make certain that every claim we paid was checked right back to the fact that the person receiving that benefit actually received the services. That's one of the reasons why I've been insisting that we need to look very carefully at ensuring that people are signing the bill in every case. It even applies in the health care insurance plan for medical services and other medical practitioners who bill the plan.

I think we have to get back to the point where there's more of a system of checks and balances in the expenditure of government funds by individuals who receive those benefits, because the government can't simply employ more and more people to watch over a system that isn't being watched over by the people who use it. So my theory has been to place more emphasis on individuals, to ensure that they tell us by way of their signature that in fact they did receive the services we're being billed for. Because we simply can't employ enough people to check on all these things.

MR. CHAIRMAN: Mr. Moore.

MR. R. MOORE: Thank you, Mr. Chairman. Several of my concerns have been addressed in these first few questions, but anyway, to the minister: Alberta Urban Hospitals Project Management Ltd. is a unique setup. It's a company incorporated under the Alberta Business Corporations Act, I note here, and the minister of hospitals and medicare is the sole shareholder. The Auditor recommended to the deputy minister's conclusion of the '86 audit there that the department of hospitals and medicare

> take steps to ensure that Alberta Urban Hospitals Project Management Ltd. complies with requirements of the Financial Administration Act.

Are we doing that now?

AN HON. MEMBER: What page?

MR. R. MOORE: On page 54 of the Auditor General's report, section 2.16.3.

MR. M. MOORE: Mr. Chairman, the only response I could give to that question is that as Minister of Hospitals and Medical Care it would always be my intention to comply with the requirements of the Financial Administration Act, and it would always be my intention that department staff would as well. However, there is always the possibility of inadvertent noncompliance with the Financial Administration Act because there are a lot of rules involved. But so far as I know, there is no further problem with the urban hospitals project not complying with the Financial Administration Act. But the Auditor may wish to comment on that; I don't know.

MR. CHAIRMAN: Mr. Musgrove.

MR. MUSGROVE: Thank you, Mr. Chairman. On page 14.2 in volume II we have a term that's called financial assistance for long-term chronic care. Now, I'm not sure whether that is auxiliary hospitals or nursing homes or both of them, but in the entire vote there was $10.6 million that was unspent. Would that be because there was a facility built that was not opened when it was expected, or is that in capital figures?

MR. M. MOORE: Page 14.2?

MR. MUSGROVE: Vote 4.

MR. M. MOORE: Vote 4.

MR. MUSGROVE: Now, the votes 4.1, 4.2, 4.3 budget was $186 million, and there was $176 million, approximately, spent. That, as I say, could possibly be for some facility that was built and expected to open at a certain time and the opening was delayed, or it could be . . .

MR. M. MOORE: I think there were two aspects of the surpluses that existed there. Some of it undoubtedly related to budgeting for beds that didn't open. But under program support there was quite a bit unexpended because we introduced under the . . . Members will recall that the Hyde report on nursing homes gave us some new directions to go in terms of providing program support in nursing homes. The area of providing physiotherapists and occupational therapists and that sort of thing was budgeted for, and we're running into the same problem again this year. Then there was a shortage of those professional people, and nursing homes and auxiliary hospitals weren't able to hire them. We don't flow the funds unless the actual service and the nursing care is provided. Some of that would be related to the fact that we weren't able to have the professional people in place to utilize the funding.

MR. MUSGROVE: Yes. I see that a portion of that is about 30 percent underexpended in vote 4.1. In vote 4.2, long-term chronic care, an unexpended balance of $2.7 million: could the minister explain why that was?

MR. M. MOORE: That would simply have been not flowing all of the funds because of fewer beds being open. That's a very small amount on $173,588,105.

MR. CHAIRMAN: Further supplementaries?

MR. MUSGROVE: No, thank you.

MR. CHAIRMAN: Mr. Fischer.

MR. FISCHER: Thank you. My question is on financial assistance, and you did answer part of it, about the $29 million unexpended. But in vote 3.1 there was a transfer of $21.8 million. Could you elaborate on that a little bit and explain what it was about?

MR. M. MOORE: Again, that will be in the back of the book, I guess. Do you know what page those transfers are on? No, Mr. Chairman, I would have to get that information for the member. I don't have it.

MR. FISCHER: Okay. The other question I had was on the $2.2 million special warrant, and that's in vote 3.5.

MR. M. MOORE: That should be listed in the . . . Yeah, that's to provide funds for the Alberta government's contribution to Steve Fonyo's Journey for Lives. That's contained on page 28.9. So it's our matching contribution to the Steve Fonyo run.

MR. FISCHER: That's all, thank you.

MR. CHAIRMAN: Okay. Mrs. Mirosh.

MRS. MIROSH: Thank you, Mr. Chairman. I believe my original question has already been answered, but I wanted to ask the minister: the difference between the community-based hospital facilities and the rural community-based hospital facilities -- is that the total expenditure for the rural community-based hospitals in vote 6.7 on page 14.2?

MR. M. MOORE: Well, I believe the community-based hospital facilities listed in 6.6 -- I stand to be corrected on this, but I believe that's for over 40 beds, and the rural community-based hospital facilities is for under 40 beds. It's an arbitrary division of expenditures, but you could add the two together. If you go right to the top of that list there, in terms of the expenditures in hospitals operating, you'll see 6.3, major urban medical and referral centres. Now, that is, generally speaking, your hospitals in Edmonton and Calgary; 6.4, other referral centres, would be your Lethbridge, Grande Prairie, Red Deer, Medicine Hat type. Specialized health care would be things like the cancer, the Glenrose. Then community-based facilities would be all of the

other hospitals, divided between those that are under 40 beds and those that are over.

MRS. MIROSH: Thank you.

MR. M. MOORE: I should say that the members can find a good description of that in the budget documents when they are handed down, because we list the actual hospitals that are under each of those votes.

MR. CHAIRMAN: Mr. Ewasiuk.

MR. EWASIUK: Thank you, Mr. Chairman. To the minister: my question is on page 14.5, and it's vote 2.0.4. It deals with the out-of-province hospital costs. I guess I have a perception that we seem to be sending more patients out of province for medical aid. I notice you spent $21 million. Is it the minister's perception that that in fact is happening and there is a tendency to send more people out of province? If it is, why is it we are doing that? Why can't we accommodate them here in our own province?

MR. M. MOORE: We're actually providing more and more medical services in this province than we were previously. Things like CT scans and, most recently, magnetic resonance scanning equipment at the University of Alberta hospital have allowed us to retain the people here and do work here. The whole heart/lung transplant program just introduced a little over a year ago has resulted in people getting services here that they otherwise would have gone out of Alberta for.

But the problem is that as medical technology grows, there are more and more things being done. Up until recently one never heard of transplanting a heart in a newborn baby. There's now one been transplanted into a baby from British Columbia and another one from Alberta that members are aware of within the last couple of months at Loma Linda hospital. That never occurred before. There will be on those kinds of things several hundred thousand dollars expended. That is out-of-province hospital costs; it shows up in here. So that keeps growing simply because there are more medical procedures being done in other centres now that people want to have carried out.

The rule is that if the medical service is available in Alberta, we don't pay for it outside of this province, but if it is not available here, if it's a treatment or a procedure that's deemed to be not available here and it's available elsewhere, then we pay for it. So it can get pretty expensive because U.S. hospital costs, as members know, and medical services costs are quite a bit more than they are in Canada.

MR. EWASIUK: Are we doing anything to offset that by having those procedures practised here?

MR. M. MOORE: Well, I said U.S. costs are higher than they are in Canada, and that's true. All of these costs, of course, aren't expended in the U.S. In fact, the majority are likely expended in Canada, at the Toronto Sick Children's hospital or whatever.

There's a limit to what we can do. For example, just the establishment of a heart transplant program is an expensive set-up. It wouldn't be cost-effective for Saskatchewan, for example, to establish a heart transplant program when they can pay Alberta for the residents that receive the heart transplants here. The same applies to ourselves. There are some kinds and types of medical procedures that we're better off paying out-of-hospital costs to some other centre and have the expertise all in one place than to try to develop here. So we tend to try to share the development of expertise. We all do cardiovascular surgery in terms of bypasses and so on, but there are certain procedures that we would not try to duplicate because it costs more than using the services of some other out-of-province hospital.

I think generally there is a pretty determined effort in Canada to try to make sure that we can provide most of our medical services in this country rather than going south of the border, but we don't deny people medical treatment that can be obtained in the United States, and most of it occurs there if it's treatment we don't offer here. One exception to that, and it's an important one: we don't provide the costs of experimental treatment in other jurisdictions.

MR. EWASIUK: That was my next question, if there was a criteria for experimental treatments outside the province.

MR. M. MOORE: The difficulty there is that if you've got an experimental treatment going on in New York, they have, obviously, enough patients there to do the experimenting on, and it's not very practical for us to be paying the air flight costs and so on to get our patients there for an experimental treatment. So we have a policy of not paying for experimental treatment. The difficulty lies in determining when a treatment moves from being experimental to practical, and that's not always black and white. So you sometimes get arguments between the health care insurance plan and individuals who say, "I want to get paid for this treatment," but it's a question of whether or not it is an approved treatment and no longer experimental.

MR. CHAIRMAN: Would the members agree to permitting Mr. Brassard to ask a supplemental on this line of questioning?

HON. MEMBERS: Agreed.

MR. CHAIRMAN: Are you agreed that Mr. Alger as well be . . .

HON. MEMBERS: Agreed.

MR. CHAIRMAN: Agreed? Okay.

MR. BRASSARD: Just one question, Mr. Minister. I know there have been a couple of cases in my constituency where people have gotten caught out of town in emergency operations. It's been very expensive, yet the health care paid for what would normally be covered within Alberta. Would that figure fall into this figure too: the cost of picking up emergency services performed while out of province?

MR. M. MOORE: If some individual is holidaying in California and becomes ill and has to have, for example, a bypass operation or an angioplasty or something, we pay for it at the rate that we would pay for it in Alberta. We have a fixed rate for hospital beds that's based on the size of the hospital -- $400 a day or somewhere in that order -- plus we have a rate for the operation itself for the doctor's services. That would be listed under out-of-province hospital costs.

I should add that quite often the rate we pay, which is what it costs in this country exclusive of the capital costs of building the hospital, sometimes is only half of what it costs in the United

States. It's extremely important that anybody who is traveling purchase insurance coverage to cover the amount that we don't cover. It's also extremely important that they read the insurance policy, because some of them are not valid. For example, if a person has a heart condition and goes outside of Canada and then gets into a hospital situation, has to have a bypass or something of that nature, then some insurance policies will read that they do not cover a known or chronic medical condition, so the individual is out of luck. So it's important that they read them very carefully, and it's also important that they get the coverage.

MR. CHAIRMAN: Mr. Alger, I was about to recognize you anyway, so if you want to ask a sup and get into another line of questioning, that's fine.

MR. ALGER: Thank you, Mr. Chairman. The question was asked by Mr. Brassard, really, but I just kind of worried about people in an emergency situation, like broken-legged skiers and that sort of thing, or appendicitis, for instance. You never know when you're going to have that. I kind of wondered if we're covered if we're away in the States, for instance. That would all be covered by our Alberta plan, wouldn't it?

MR. M. MOORE: When they're out of province or out of country?

MR. ALGER: Well, out of country. If we're in Aspen, Colorado, skiing, for instance, and I broke my leg, would you pay the bill?

MR. CHAIRMAN: We're showing a lot of . . . I think that's a question you could ask of the plan itself. Is that related to the expenditures?

MR. ALGER: It's related to this section, yes. Mr. Ewasiuk was asking: where does this money go when it's out of province? I'm wondering: do you cover people with broken legs and appendicitis, for instance?

MR. M. MOORE: Well, we'll start right on the ski hill. We won't cover the cost of the ski patrol that comes up and picks you up and takes you down to the bottom of the hill, and we don't pay the cost of transporting you from there to the hospital. But once you arrive at the hospital, if it's an active treatment hospital, we pay the rate that it would have cost us in a hospital of that size in Alberta, which may be less than what that hospital in Colorado charges. We then pay the doctor who examines you and so on the rate that we would pay a doctor in Alberta, which may again be less than what that doctor charges you.

So, yes, we do pay, but people have to remember that ambulance costs oftentimes are very extensive. We have cases where people fly up into the Northwest Territories to go fishing or whatever and wind up with a heart attack and have to be flown back to Yellowknife, and we don't pay the air ambulance cost.

MR. CHAIRMAN: I'm sure this is a very interesting and informative discussion, but could we get back to the Public Accounts for the fiscal year ended March 31, 1986?

MR. ALGER: Don't feel bad, Mr. Chairman; it's all in the $23 million, and I just kind of wondered what it covered. Am I questioning now?

Mr. Chairman, to the minister. The Auditor General has made several suggestions in recommendation 32 on pages 58 and 59 of his report with respect to computer generated billings at the University hospital. They're very poignant suggestions, and I wondered whether or not there's been any action taken to resolve the problems identified in this series of suggestions.

MR. M. MOORE: That's on which page again?

MR. ALGER: It would be the Auditor General's report, right at the bottom. Recommendation 32, Mr. Minister.

MR. M. MOORE: Okay. The response of the department on that recommendation is that computer program changes are now being fully tested prior to implementation, and the accounting department is being provided with the test output data for review to ensure that programming errors do not go undetected. All changes in addition to that will be approved by the vice-president of finance.

The second part of that has to do with outpatient registrations. They will be integrated with the proposed accounts receivable system, which is planned for implementation after conversion of the inpatient accounts receivable system. In the interim revenue due to the hospital for emergency outpatients is being reviewed to ensure complete and accurate billings.

System changes have also been implemented to highlight records of injuries that could result in billings to the Workers' Compensation Board, and staff have been made aware of the importance of identifying those cases.

The internal audit department will also undertake to review these and other issues, and a comprehensive review of the revenue system in the hospital for patient charges and special purpose funds is planned for 1987.

MR. ALGER: That's good news, Mr. Chairman.

My second question would be with respect to recommendation 31 on page 56, and it might be a little more touchy. Have proper steps been taken there to ensure that all the financial reports issued by the Alberta children's hospital comply with the regulations established by this Legislature? It would seem there's some differentiation in how to account for purchases at that hospital, or there were, and I think you've probably got that straightened out.

MR. M. MOORE: Well, two things. First of all, certainly that situation was one that should not have occurred, and we've taken steps to ensure that it doesn't occur again. But in addition to that, the Alberta hospitalization benefits regulations were amended in March of '86 so that the minister can now make payments in respect of approved capital equipment in whole or in part during the fiscal year in which approval was given or in the fiscal year immediately following. That amendment will resolve the problem in conjunction with the funding commitments that lapse at year-end. In fact, then, what occurred in the case of the children's hospital is now, under the new regulations, allowed to occur. It wasn't previously, and that was wrong for that to have occurred. The resulting pointing out of this by the auditors resulted in us establishing a new regulatory procedure.

I should say one other thing about equipment. I found it to be rather inconsistent with good money management that we provide equipment grants from our hospitals department to individual hospitals on a fiscal year basis and require it all to be

spent or refunded, because what happens is that everybody's scrambling around in the last two months of the year trying to find ways to spend dollars. That, from my point of view, is certainly not the best way to manage funds. So I'm looking at trying to create a system whereby we would provide hospitals with capital grants for equipment on a formula basis and allow them to retain them year after year as long as they're eventually spent on equipment. So they could retain the funds over a couple of fiscal years and the interest thereon and buy a bigger piece of equipment or save it for equipment that might break down or something later on.

I think that would be much better management of the public taxpayers' dollars, if you tried to eliminate as many situations as possible where hospital boards or other are trying to spend money at the end of a fiscal year simply because it's going to be taken back.

MR. CHAIRMAN: A further supplementary?

MR. ALGER: Mr. Chairman, I'm probably out of order, but I'd like to know whether or not the minister has any record or does the Auditor General have records or are they alerted to the fact that a lot of people donate great amounts of funding to our hospitals for various reasons? It has nothing to do with the Auditor's report. Does it come into the knowledge of the Auditor, any of our foundation funds and stuff like that?

MR. M. MOORE: We have a system whereby hospitals can establish foundations to receive donations, which are then recognized as being tax deductible. A great deal of money comes in that way. We could do much better in Alberta than we do, and again we're looking at trying to improve our system in that regard, to provide better incentives for people to provide donations.

MR. CHAIRMAN: Mr. Jonson asked permission to raise a sup on this line of questioning. Is that correct?

MR. JONSON: Yes.

MR. CHAIRMAN: Are you agreed, first of all? I mean, we're . . .

HON. MEMBERS: Agreed.

MR. JONSON: Thank you, colleagues. Mr. Chairman, in the Auditor General's report there are two or three recommendations, two of which have been referred to in these previous questions, which deal with -- I think you'd call them the data information systems or the electronic systems as they're applied to management information and billing. For instance, there's also recommendation 30, which recommends the setting up of a steering committee for the data base of the two cancer institutes.

My question to the minister would be: is there an effort made within the department to try and develop common programs and common procedures such as is recommended here for the two cancer institutes? It would seem to me that if there was an overall plan, that might straighten out some of these billing problems.

MR. M. MOORE: Well, we followed -- you're referring to recommendation 30, the Alberta Cancer Board?

MR. JONSON: Yes, Mr. Chairman, and I guess I'm trying to broaden it to what might be a similar kind of problem cropping up in a couple of other locations.

MR. M. MOORE: With respect to the Alberta Cancer Board, we've got a steering committee there that's chaired by the board's director of finance, and it has representations from the Cross Cancer Institute here in Edmonton and the Tom Baker Cancer Centre in Calgary. They have met on a continuous basis to develop a strategy for the implementation of those information systems. There is some sharing of that sort of thing amongst other major hospitals as well, but the technology in this field grows so fast that it's hard to develop a standard and say that this is what everybody's going to get.

I think the best work is done in the area of ensuring that in the hospital system overall there is some compatibility in computer systems. That kind of thing is done by the Alberta Hospital Association, who have a pretty active program of assistance, particularly to smaller hospitals. By smaller I mean the 108 hospitals or so that are 100 beds or under across the province. They do some good work in trying to make sure that there is some compatibility between systems and not too much duplication.

MR. CHAIRMAN: Mr. Shrake followed by Mr. Ady.

MR. SHRAKE: Thank you, Mr. Chairman. I see on page 14.2, under reference 3.2, 3.3, 3.6, 3.7, we've spent about $1.33 billion; then under 4, 4.01, 4.02, 4.03 is $186 million; and then under 5.2, 5.3, and 5.4 we've got about $108 million. I gathered this is our hospitals, our auxiliary hospitals, and our nursing homes.

Do we have any handle on what is our average cost, just roughly, of our beds per day per patient in the hospitals and the cost of the beds per day per patient in the auxiliaries? And what is our provincial subsidy per patient per day in the nursing homes?

MR. M. MOORE: Well, right now it's an average, in an auxiliary hospital, of the total operating costs, about $110 a day. The long-term patients there that have been assessed and have been there more than 60 days will pay $14 for the standard ward. It costs about $110 a day.

The average costs in a nursing home are about $52 a day, so an auxiliary hospital is about double a nursing home right now.

MR. SHRAKE: But the active treatment: what kind of a figure do we have there?

MR. M. MOORE: Well, the active treatment hospitals vary a great deal. The lowest cost operating hospitals in Alberta for 1986, the last year for which I have complete figures -- in fact, this public accounts year we're talking about -- were for those hospitals between 25 and 50 beds. They operated at a rate of about $295 a day per bed, between 25 and 50 beds. Then it gradually rises above that, in part because the larger hospitals do more highly specialized work and take care of patients who require more nursing care than they do in some of the smaller hospitals. But in addition to that, the administrative costs in larger hospitals tend to climb a little bit from the smaller ones because you have people assigned to specific areas and perhaps not as tight a control on administrative costs as you do in a small hospital.

They rise up to -- the University of Alberta hospital is just over $800 a day. It is the highest cost operating hospital in the province except for the Alberta children's hospital in Calgary, which on a per bed basis is higher yet. But it's an inaccurate way to look at the children's hospital cost, because they have such a very large outpatient system there and a lot of staff who work totally out of the hospital even in terms of providing services. So the per bed basis isn't a factor there. It's true as well that any teaching hospital, and certainly the University of Alberta with their large teaching and research component, should be looked at differently as well. In addition to that, it has some very highly specialized areas, so the operating costs there are reflected in those unique things that they do.

MR. CHAIRMAN: That's very useful information, but does the member have a concern about the way moneys are spent in these areas?

MR. SHRAKE: Yes, I was just leading up to this, Mr. Chairman. I just want to try to get some kind of a handle on how much per day, because this is the bulk of the budget that they were looking at today. Back in '86 the Alberta Hospital Association, after one of their conventions, requested that they be allowed to charge extra money for the private beds, which I guess they're allowed to do under the Canada health system without running into any problems. I don't see any figures anywhere that show up for that, so I gather we didn't allow them to charge a little extra. I think they were talking about $10 or $15 extra or something per bed for the private beds or a unit charge for semiprivate.

MR. M. MOORE: Mr. Chairman, there's a fixed amount by regulation that hospitals can charge for private and semiprivate rooms when they are asked for by the patient and when they are not medically required. If a patient needs a private or semiprivate room and the doctor says that the patient should be in a private room, there is no extra charge. But if the patient wants a room, even though they don't need it, then there's an extra charge. That doesn't show up in the public accounts because -- well, it may in a Crown hospital, somewhere in the totals. But that's revenue that's earned by the hospital and utilized in their system without any reference to the public accounts.

MR. SHRAKE: Well, I'm sorry; I don't fully understand your answer there. Have we allowed them to take up the amount charged on these private beds, and does it show up in this budget somewhere?

MR. M. MOORE: No, it wouldn't. We allow hospitals to charge, as I just explained, for private and semiprivate rooms under certain conditions, but it wouldn't show up in here because what you see on page 14.2 is the amount that was authorized to be provided to the hospital, and any revenue they earn would be on top of what's in these public accounts.

That may not be the case with respect to the Crown hospitals which are reported on here if it gives total revenue of the hospital in there. It wouldn't be the case with respect to the Auditor's report on Crown hospitals. It would also include, I presume, revenue earned by them in various ways. But it won't on other hospitals because the Auditor doesn't report in detail on other than Crown hospitals.

MR. CHAIRMAN: Mr. Ady, followed by Mr. Roberts.

MR. ADY: Thank you, Mr. Chairman. The minister spoke a little while ago indicating that it was certainly his intention and the intention of his department to try and comply with the Financial Administration Act. I just have a question as a follow-up on that. It's on page 54 of the Auditor General's report. It noted that the Alberta urban hospitals projects management had failed to appoint accounting officers, and that was in contravention to that Act. Has that been rectified, or are we going to see it on the Auditor General's report again next year?

MR. M. MOORE: That's on what page?

MR. ADY: Page 54. It's 2.16.3, second paragraph.

MR. M. MOORE: The information I have is that, yes, accounting officers have now been appointed and, as of September 1986, functioning in accordance with the Financial Administration Act.

MR. ADY: Thank you. My other question was asked by another member, so I don't have a supplementary on that.

MR. CHAIRMAN: Mr. Roberts.

REV. ROBERTS: Thank you, Mr. Chairman. Again, it's hard to try to be a real ogre with some of these figures realizing the cost control that's in the department already at almost every level and the surpluses that were seen in the amounts underexpended. But with respect again to the health care insurance plan, though the Auditor has talked about the amount that is paid by the consumers, I have some questions about the suppliers.

I know that last year when the minister was before the Public Accounts, he was talking to some degree about how much moneys could be saved if we could more carefully monitor doctors who are fraudulently billing the plan. We've had incidences of doctors ending up in court who have criminal charges and also the College of Physicians and Surgeons going after doctors who are prescribing drugs in kind of a drug ring that's around the city of Edmonton here.

Can the minister outline within the health care insurance plan and its administration how much the doctors are being monitored in terms of their billing of the plan to determine that in fact it is genuine and not fraudulent?

MR. M. MOORE: There's a pretty extensive monitoring of the billings of medical practitioners to the plan. First of all, it goes on on a daily basis, and we were talking a little while ago about override codes and so on. The plan, when it accepts billings from doctors, reviews them very, very carefully, and a lot are rejected and additional information is asked for and sometimes quite often payments are not made because there are inappropriate billings.

In most of the cases where there are inappropriate billings, it's not fraudulent; it's simply errors in billings, although we do detect from time to time patterns of inappropriate billing that appear to be deliberate. In that case, our health care insurance plan reports the matter to the College of Physicians and Surgeons with details, who then investigate the matter and decide what disciplinary action to take against the medical practitioner. That's a pretty good system because the disciplinary action that they have to take at the college is usually the removal of the practitioner's right to practise medicine.

Recently, however, there's been a growing number of cases where the courts have overturned or altered the decision of the College of Physicians and Surgeons, wherein they have removed someone's privilege to practise medicine in this province because of fraudulent billings. I've had discussions with the college about that matter, and it was decided that we should take a somewhat different approach in some cases. The removal of the right of an individual to practise medicine because of improper billings doesn't relate to that doctor's medical skills. It's not always, in my view, the best way to go.

So I wrote a letter to all physicians in Alberta two or three months ago, indicating that in future when we detect fraudulent billings, after consultation with the College of Physicians and Surgeons, we may use a section of the Health Care Insurance Act that allows the minister to withdraw the right of the individual practitioner to bill the health care insurance plan. They will still be able to practise medicine, but they can't bill the plan. And that's going to result probably in a much better situation in some cases than removing the right of the practitioner to practise medicine at all. We haven't utilized that particular section of the Act yet, but it would certainly be our intention to do so if that occasion arises.

REV. ROBERTS: And you'd make the names of those doctors public?

MR. M. MOORE: I beg your pardon?

REV. ROBERTS: You'd make the names of those doctors public, as you said last year you were going to do?

MR. CHAIRMAN: We're getting a little bit away from expenditures; we're getting into policy issues. If we could bring it back to expenditures, I think the committee would welcome that.

MR. M. MOORE: I'll answer that question anyway, if I can, Mr. Chairman. It's an important one. If we do suspend doctors from the right to bill the plan because of fraudulent billings, indeed the names of those doctors will be made public.

REV. ROBERTS: On another supplies side of how the moneys are being spent to supply hospital services, again, though it wouldn't be fraudulent or irregular, there are often cases in which patients are admitted to hospital or not discharged from hospital when in fact maybe they should be. So the criteria about admission and discharge is often unclear. I'm wondering in vote 4, active treatment, how much money was spent in this year on developing ways of ensuring that patients who are in hospital indeed need to be in hospital. That is with reference to the diagnostic related groupings or the case mix index or other ways to determine that a patient really needs to be in a certain bed receiving certain treatment.

Also hospitals, as the minister knows, have experimented I think in this particular year with what's called the volume driven funding approach to how these moneys come to hospitals. It's a whole area that's not for a lot of us laymen, but it is a crucial one to determine that the moneys are indeed going to the people who are sick and in appropriate ways. So what moneys are being spent to ensure that hospitals are delivering the services they should be?

MR. M. MOORE: We provide, Mr. Chairman, grants to individual hospital boards in a global way and do not allocate parts of their budgets for the purpose the hon. member is talking about. So I wouldn't have any way of knowing how much time is spent by each individual hospital in discharge planning. I do know that after we had the reductions in the hospital budgets last year, a good many hospitals have worked very hard since then to reduce the length of patients' stay and ensure that the patients are discharged appropriately.

In the long-term care system we do have some pretty extensive assessment systems, particularly in district 24 in Edmonton and the Carewest in Calgary, where they assess patients for admission to auxiliary hospitals and nursing homes. Again it's a budget that's provided to those two hospital districts, and indeed other auxiliary hospital and nursing home districts, that we provide on a global basis. So I wouldn't have figures about how each one has expended their dollars.

MR. CHAIRMAN: Mr. Nelson.

REV. ROBERTS: I'm asking for clarification on that one.

MR. CHAIRMAN: Go ahead.

REV. ROBERTS: So is the minister saying that he is not envisioning a plan whereby all hospitals in the province would come under a volume driven funding program or use a DRG or case mix index or something, instead of this rather loose global budgeting approach?

MR. M. MOORE: We're always trying to develop more effective ways of providing funding to hospitals, but when there are no patient charges and almost 100 percent of the funding provided to hospitals is provided by the provincial government from public dollars, it's extremely difficult to develop incentives for cost control. They do a good job on balance, I think, but it's tough to develop any new systems. I'm certainly open, as is the Alberta Hospital Association, to looking at ways in which we can provide funding to hospitals on a better basis than we do. In the meantime, I think our system is as good as any in Canada, if not better.

MR. CHAIRMAN: Mr. Nelson, followed by Mr. Jonson, if there's time.

MR. NELSON: Mr. Chairman, just a question to the minister with regards to the manner of fiscal restraint. As we know, there's a considerable drain on the health care system with regards to people in traffic accidents and accidents of this nature where there is an insurance plan for those people. To allow for the fact that this is a great expense to the taxpayer, and generally because of somebody's stupidity on the highway, why is it that we would not, as a government or even through the health care plan, try to recover moneys from those people responsible for the carnage that they create on our highways at a great expense to the taxpayer of the province?

MR. M. MOORE: Well, as I understand it, there are general provisions across Canada in motor vehicle insurance that the health care insurance plans that exist in various provinces do come in and pay the bills relating to accident victims from automobile insurance. I guess if we didn't do that, the same cost would be reflected back to the public in terms of higher automobile insurance rates.

We could probably move in a lot of different ways, Mr. Chairman, in terms of trying to collect from insurance or individuals or whatever, but I believe it's better on balance to have a system that pays and then try to use our best efforts to reduce the cost of those accidents rather than to try to move the cost onto some other individual or insurance company.

MR. NELSON: A supplemental, Mr. Chairman. Just a little follow-up on that. In making those people purchase insurance because they have created that carnage in some cases, would it not make them more responsible and maybe cost the health care system less money in total by making the person who created the problem pay for the problem, that being the user of the highways, for example? And there are other certain examples to be given.

MR. M. MOORE: Mr. Chairman, that's a good thought. It would have to be something that would be done right across the country. I'm not sure what the end result would be in terms of the costs of settling insurance claims and so on. One would have to do some study to see whether in fact the end cost would be less or greater than the present system. I would suspect it would wind up being greater because right now we don't have to have too many lawyers involved to figure out who pays the bill. But if you got insurance companies battling all the time over who has to pay the hospital bill and the doctor bill, it could be pretty extensive.

MR. CHAIRMAN: A further supplementary, Mr. Nelson?

MR. NELSON: Yeah, Mr. Chairman, I'd like to follow up on a supplementary of the previous questioner, who has left the premises, where we have doctors who are determined to fraudulently make a claim against the system. I've asked this question previously, and I still wonder why we don't criminally charge these people with criminal fraud rather than let the college vent their frustration by giving them a little slap on the wrists, and then the courts determine that they can reduce that because there's no criminal fraud on there. I'm just wondering why we don't pursue that more actively and maybe stop some of this nonsense.

MR. CHAIRMAN: Well, we'll leave that up to the minister's discretion as to whether he wants to answer that question or not. It's . . .

MR. M. MOORE: Well, the facts are that if you're earning $200,000 a year as a medical doctor and the College of Physicians and Surgeons pulls your licence to practise for six months, that's a $100,000 fine. It's a pretty big one, but the short answer is that when in the judgment of our Attorney General's department we can be successful in the courts, we do charge. There was a very recent example where one physician in Calgary was charged and found guilty, and that will occur again.

MR. NELSON: Mr. Chairman, just . . .

MR. CHAIRMAN: I think you've used up your supplementaries. Mr. Jonson has said that he doesn't want to complete his series, right?

MR. JONSON: No, I do. Mr. Chairman, on page 51 of the Auditor General's report there's a reference here to the handling of moneys where money is advanced . . .

MR. M. MOORE: On which page?

MR. JONSON: Page 51. . . . to a hospital board for capital construction and not in fact used. I would like to ask a question on the reverse sort of situation. When, let us say, there are some unforeseen construction problems and so forth so that the hospital board incurs a deficit after the normal funding of the project has been completed, how does the Department of Hospitals and Medical Care handle that kind of situation?

MR. M. MOORE: The hospital board phones me or writes me a letter and tells me they've run into a deficit, and I tell them I don't have any more money.

AN HON. MEMBER: And then they phone the MLA.

MR. JONSON: And they phone the MLA, Mr. Chairman. Nevertheless, this is part of that initial capital project. Is any consideration being given to perhaps dealing with those?

MR. M. MOORE: Throughout a capital project, obviously, we have to negotiate from time to time some increases or some decreases. One of the things we do is set a target. Then we don't necessarily flow all the money if the costs come in less for equipment and furnishings and so on.

When a capital project goes ahead, a tender is called in every case unless there are some rare exceptions, and it goes to the low bidder. I have to, as minister of hospitals, approve the tender, so we know exactly what that figure is. But we do a fair bit of negotiating with them. But the bottom line this last year since I've been responsible is that I want them to know, the boards and their architects, that there are not the kinds of exceptions we used to make in terms of cost overruns.

MR. CHAIRMAN: I'm very conscious of the time. We have one more person on our list, and that's Mr. Ewasiuk. Could I turn to him, Mr. Jonson, or did you have a further . . .

MR. JONSON: No, I'm finished, Mr. Chairman.

MR. CHAIRMAN: Would the members agree to permitting Mr. Ewasiuk to put a question?

HON. MEMBERS: Agreed.

MR. EWASIUK: Thank you, Mr. Chairman. My question is also on page 51, and it's with the Health Care Insurance Fund. The question is relative to the Blue Cross Plan, senior citizens, and the ambulance services. Could the minister advise us who is the registrant with the Blue Cross relative to seniors and city ambulances? Who is the registrant?

MR. M. MOORE: Who are the registrants? Well, in the case of senior citizens, all the senior citizens in Alberta are covered.

MR. EWASIUK: It wouldn't be the ambulance services, for example?

MR. M. MOORE: It wouldn't be which?

MR. EWASIUK: It wouldn't be the Ambulance Authority, for

example?

MR. M. MOORE: No. I think the meaning of the word "registrants" there means the individuals who are covered by Blue Cross.

MR. EWASIUK: If I could just supplement that, Mr. Chairman. The difficulty you're experiencing with the Edmonton Ambulance Authority and the seniors relative to the $4 discrepancy: is that being resolved?

MR. M. MOORE: No, it has been. The situation there is simply this: this year we negotiated with Alberta Blue Cross to provide coverage at the rate of $131 for an ambulance trip, which was no increase from the previous year. That's what they're providing. The city of Edmonton -- I think it's the only jurisdiction in Alberta -- said, "We can't go along with that; we need $135." So there's $4 difference.

It's a municipal responsibility to provide ambulance services within your boundary. Provincially we are providing an insurance service, and we're providing a level of coverage that's $131. So the $4 is really a dispute between the city of Edmonton and the individuals who are being provided with service, in my opinion.

Recently, within the last couple of weeks, Blue Cross offered to allow the Edmonton Ambulance Authority to bill directly the $131 and just charge the senior $4, and the Edmonton Ambulance Authority rejected that. For whatever reasons, I don't know. So it's still a difficult situation. My understanding is that in the two previous fiscal years to this one, the city of Edmonton's budget for ambulance services was in surplus and in fact not all spent. I can't understand why the city doesn't simply add a little more to the Edmonton Ambulance Authority's operating budget and do away with the problem.

MR. CHAIRMAN: Well, I'd like to draw everyone's attention to the fact that our time for adjournment has arrived. I'd like to thank the hon. minister for taking time out of a busy schedule and being with us this morning.

We do not have a meeting scheduled for next Wednesday morning for, I suppose, obvious reasons. With that, I'd like to recognize Mr. Moore.

MR. R. MOORE: I move that we adjourn.

MR. CHAIRMAN: Motion to adjourn. Are you agreed?

HON. MEMBERS: Agreed.

[The committee adjourned at 11:32 a.m.]