Title: Wednesday, May 14, 2003 Public Accounts Committee

Date: 03/05/14

[Mr. MacDonald in the chair]

The Chair: Good morning, everyone. I would like to please call to order this morning's meeting. I would like on behalf of all the committee members to welcome the Hon. Gary Mar, QC, Minister of Health and Wellness, and his staff, also the Auditor General and his staff.

Before we get started this morning, perhaps we should go around and quickly introduce ourselves.

[The following members introduced themselves: Mr. Broda, Ms DeLong, Mr. MacDonald, Mr. Marz, and Dr. Taft]

Mrs. Dacyshyn: Corinne Dacyshyn, committee clerk.

Dr. Taft: I might say now that I suspect that Laurie Blakeman, the MLA for Edmonton-Centre, is sick, so I'm not sure that she'll be here this morning.

Thanks.

[The following staff of the Auditor General's office introduced themselves: Mr. Dunn, Mr. Shandro, and Mr. Wylie]

Mr. Mar: Gary Mar, Minister of Health and Wellness.

The Chair: Mr. Mar, would the other part of your delegation like to introduce themselves as well.

[The following departmental support staff introduced themselves: Ms Bowman, Mr. Kaushal, Ms Kolbuc, Dr. Palmer, Mr. Perry, Ms Powell, Mrs. Sandouga, Mr. Shields]

[The following staff of the Alberta Alcohol and Drug Abuse Commission introduced themselves: Mr. Finnerty and Mr. McCutcheon]

The Chair: If they would like to participate or add some information to a question, they'd be free to do so.

Mr. Mar, if you would like to give a brief overview, please, of your department for the fiscal year 2001-2002, we would be grateful. Thank you.

Mr. Mar: Thank you, Chairman. It would be my pleasure to do that and to present the public accounts for Alberta Health and Wellness for the year 2001-2002.

Now, the difficulty with public accounts is recreating what the health system looked like two years ago so that we have a context in which to evaluate the expenditures we are considering. This is a challenge because so much has happened so fast in the last two years. Most of fiscal 2001-2002 preceded the Premier's Advisory Council on Health report. It preceded regional restructuring. It preceded our current commitment to affordable, single-digit increases in health funding.

Certainly, the 12.7 percent increase in 2001-2002 was needed and welcome. Still, we realize that the public purse could not continue to support those types of increases in that magnitude. In fact, we could not sustain that level of funding even then. The economic aftermath of September 11 proved to us that health spending does not exist in isolation, and that is why our current business plan makes commitments of 4.3 percent in year 2 and 5.8 percent in year 3. Those efforts are to try and keep funding for health care in line with anticipated provincial revenues. Still, in 2001-2002 every dollar was needed, every dollar was used and used well, and today I am happy to account for those dollars being spent.

Back in May 2001 when I presented the estimates for that year, I talked about a maintenance budget. The Premier's Advisory Council on Health was still in consultation. Senator Kirby had just released his first report, and the Romanow commission was just a few days old. We needed to maintain the system as it was until we had recommendations for change that were based on the results of consultation, a review of literature and best practices of other jurisdictions, and also an evaluation of our own made-in-Alberta solutions.

We see how urgently health reform is needed when we consider that just maintaining the health system would cost more than 28 percent over three years. The budget in 2001-2002 was to cover the higher cost of paying our physicians and nurses, maintaining existing services to meet rising demand, underwriting prescription drugs, protecting the wellness of Albertans, and staying in the lead of health system management. For example, the impact of our settlements with physicians, nurses, and other health workers was $514 million in year 1 alone, yet that increase was necessary in order to recruit and retain needed and highly skilled health professionals that are highly sought across this country and around the world. Over $234 million was needed simply to maintain health services under the pressure of growing demand. With the addition of seven new MRI scanners in the public health system, just operating MRIs was expected to cost $13.4 million more.

As I turn to my budget overview for 2001-2002, I note that my ministry's annual report for 2001-2002 shows two sets of financial statements. The ministry started the 2001-2002 fiscal year with estimates of $6.271 billion. This is the amount announced as part of Budget 2002. The authorized budget was $6.389 billion, a difference of $119 million. The difference is the result of several major decisions. In July 2001 we made a onetime fiscal adjustment of $200 million to health authority budgets. Regions made a convincing argument that they needed the additional funds in order to meet the twin pressures of population growth and aging. Then September 11 came along, and the world changed, including the revenue world that we had predicted in Budget 2001 with at that time great confidence. Health and Wellness did its part and contributed $92 million to the provincial adjustment. The net of $200 million in onetime increase and the $92.2 million adjustment was a supplementary estimate of $107 million.

Another supplementary estimate of $10.9 million implemented a provincewide meningococcal immunization program for children 24 months or younger. That immunization program makes up the $119 million difference between my estimates and my approved budget. The year did end with actual expenditures of $6.325 billion, approximately $45 million less than the approved budget.

I've always said that it is not as important how much you spend as how you spend it. The test for how we spend public health care dollars lies in the performance measures. For the third year in a row 86 percent of patients rated the quality of care they received as good to excellent. An equal number said that they were satisfied with the way the services were provided. Even though only 62 percent of survey respondents said that they had easy or very easy access to services, more specific questions showed that 86 percent had easy or very easy access to family physicians, that 77 percent had similar access to specialists, and 73 percent to services in hospital. All those results are close to or exceed our 75 percent target.

Still on the subject of access, 93 percent of AADAC clients

reported no difficulty in accessing treatment, which exceeds our 91 percent target. An additional 222 physicians were serving Albertans through the public health system in 2001-2002. MRIs reached the target of 24 scans per thousand population, the highest scan rate in the country. By the end of the fiscal year telehealth linked rural and urban health care through 21 teleradiology sites and 147 videoconferencing sites, more than double the previous year. Since then, telehealth has continued to grow, improving rural physician and patient access to specialists in urban centres and offering continuing education to rural health professionals. As of December 2002 Alberta's telehealth network had expanded to 226 videoconferencing sites. Between October and December 2002 the system handled over 23,000 telehealth transactions. Those three months alone are almost double the 13,500 telehealth transactions in the last half of 2001-2002.

8:40

Knowing where we need to improve is just as important as knowing where we do well. The results from our 2001-2002 year identified areas where we need to do better: easier access to health services generally, higher childhood immunization rates, and shorter in-hospital waits for long-term care beds.

The number of seniors who reported they were in good to excellent health jumped from 72 to 78 percent. However, the nonseniors who said that they were in good to excellent health remained steady at 63 percent, which is below our 70 percent target. I expect that our renewed commitment to wellness education, including the department's Healthy U campaign, will improve all Albertans' health status.

Health reforms, like a team approach to primary health care and a provincewide telephone health link, will help Albertans manage their use of the health system and reduce wait times. A wait list registry that comes on-line this summer will help physicians and their patients manage access to the procedures they need.

I believe that Albertans received value for the health care dollars that we spent on their behalf in 2001-2002, and I am confident that they will receive even better value in the future.

The Auditor General was critical of the ministry's financial statements in a number of areas, and I am pleased to assure the members of this committee that my ministry has taken steps to address these concerns.

Recently the Public Sector Accounting Board clarified its guidelines on consolidation of controlled entities. As a result, a governmentwide initiative is under way to consolidate all controlled entities including health authorities. This is a massive undertaking, and we expect it to be completed by 2006. However, health foundations are not among those organizations and will not be consolidated with health authorities as they are separate legal entities and most are not controlled by the regions. Consolidating their financial statements would not be appropriate.

The Auditor General was concerned about health authority fiscal accountability. New regulations prohibit health authorities from running annual operating deficits. Where such deficits lead to accumulated debts, regions must submit a satisfactory debt elimination plan. I do not rely solely on regulations to eliminate regional deficits. A more efficient regional structure and health reform measures like primary health care should help regions make more effective use of the money that they receive while still meeting people's needs.

The Premier's Advisory Council on Health recommended multiyear contracts between government and the regions. Those contracts are now under development. They will clearly specify expectations and regional performance targets and will be a significant tool in assuring health authority accountability.

The Auditor General also raised the issue of risk and benefit for the St. Michael's long-term care facility in Lethbridge. My department has reached an agreement with the Alberta Catholic Health Corporation on how the lease should be worded, and my expectation is that the situation will be resolved before the AG audits my next financial statements.

While my ministry works to resolve many of the Auditor General's concerns, the policy of expensing assets less than $15,000 is a standard accounting practice by Alberta Finance.

To conclude, when I presented the estimates to Committee of Supply in May of 2001, I said that health care in Alberta faced a herculean task to meet the full range of health needs of 3 million people and growing, take advantage of new medical, diagnostic, and information technologies, keep our health workforce in the province and attract more professionals, and keep the cost of all this within the ability of Albertans to pay. The task remains. It is still herculean, but it is achievable, and we are making progress. We will build on the foundations laid in 2001-2002. We will continue to implement the recommendations from the Premier's Advisory Council on Health. We are working to address the Auditor General's concerns, and the new multiyear contracts under development now will increase regional accountability.

I'd now invite the discussion of members of the committee. Thank you.

The Chair: Thank you very much, Mr. Mar.

Mr. Dunn, would you like to add a few comments in regard to your last AG's report?

Mr. Dunn: Thank you, Mr. Chairman. Our comments on this ministry are located on pages 125 to 145 of our 2002 annual report. In this section we've made four numbered recommendations, two of which were included in our top 15 recommendations, that we previously reviewed with this committee, and I'll review those briefly.

Recommendation 23, which is on page 128, is the most important recommendation to this ministry. It discusses developing a strategy to ensure that authorized business plans are in place at the start of the fiscal year. In other Public Accounts Committee meetings you have questioned how a ministry can exercise oversight control if business plans and budgets are not in place at the start of a fiscal year.

Recommendation 24 on page 135 is also a very important recommendation. It discusses controls over information technology, including controls over private-sector outsourcing service providers. On page 136 we have provided a summary list of where those controls need to improve over financial and administrative information.

We have tried to summarize other outstanding prior-year recommendations within tables in this year's annual report. Table 1, starting on page 130, summarizes nine prior-year outstanding system audit recommendations for which there was satisfactory progress towards implementation last year and which we'll be following up in this fiscal year. The last item in table 1, which is on page 133, may be the most important in this table, because health sector information system issues need to be addressed, and this matter has been included in numerous commission reports across Canada.

Table 2, starting on page 133, summarizes eight prior-year system audit recommendations that were substantially implemented in the fiscal 2002 year, and table 4, on pages 139 and 140, summarizes three prior-year recommendations pertaining to the Calgary and Capital health authorities for which there has been satisfactory progress towards implementation over the last year.

In addition, on pages 142 and 143 we also comment on nine other observations and recommendations for improved controls at various health authorities.

So, Mr. Chairman and committee members, those are my opening comments. Health and Wellness is the government's largest ministry, and I and my staff will be pleased to address any questions directed to us during this meeting. Thank you.

The Chair: Thank you very much. We'll get started quickly with questions from the members starting with Dr. Taft, followed by Mr. Marz.

Dr. Taft: Thanks, Mr. Chairman. I will start with something I've raised from time to time in the Assembly and something the Auditor General raised as the most important recommendation in his report for this department. On page 128 recommendation 23 has to do with ensuring that authorized business plans are implemented at the start of the fiscal year. I don't need to review this issue in much detail, I hope. It's pretty obvious that if you're undertaking a budget which is a plan or if you're undertaking a business plan more generally, if events for the time period covered by the plan have already occurred before the plan is brought in, then it's the cart, well, the horse – not to mix my metaphors too much here, but the horse is out of the barn before you close the doors; something like that. I need more coffee.

Anyway, last year the Auditor General said, "We made this recommendation in the past three Annual Reports." We're in the same kind of situation still. I recognize that this is not all the fault of the minister or the Department of Health and Wellness, but the simple fact is that yet again the business plans for the regional health authorities, which spend – what? – 15 percent or something of the total provincial budget or perhaps more than that, 20 percent, won't be in place until probably the second quarter of the year. What is going to be done to correct this problem? What are you doing to address this recommendation from the Auditor General? I'd appreciate, actually, comments from the deputy as well as from the minister if that's possible.

8:50

Mr. Mar: Of course. First of all, we agree with the recommendation. We accept the recommendations of the Auditor General and take them seriously. It's quite likely that this recommendation will be repeated for 2002-2003 due to business plan approvals that remain outstanding, but we are making every effort to try and rectify the situation by dealing with the delay in completing business plans that results largely because of the timing of the province's funding announcements. Also, the approach being taken with multiyear contracting between the province of Alberta and health authorities will help address this. This, as you've indicated, is not a matter simply within the control of the Department of Health and Wellness.

I don't know if Bruce Perry wanted to add anything to that.

Mr. Perry: Essentially that's correct, Minister. The issue, of course, is always around the funding of three-year targets, and in fact health authorities are in the position of receiving a three-year target. They know the provincial portion of the target, and they plan accordingly.

The other issue is that health authorities do start their process much earlier. They start in January planning for their service plan, other elements of the business plan. What remains is their fiscal plan, and they have to wait for the provincial announcement for that. So, in fact, they do have most of the elements, which they are sharing with the ministry, well before the commencement of the year, just not completely.

Dr. Taft: My supplemental. You can appreciate the frustration when this has come up for three years, and it will now be a fourth year – I'm sure you're right – if the Auditor General stays with this as a priority. So when you say that we're making best efforts, it just sounds, after that many years, like placating the critic or placating the Auditor General. I don't know if the Auditor General wants to jump in here or not, but give me some more detail. Convince me that actually this is on the road to improvement with something more specific than: we're making best efforts.

Dr. Palmer: Well, I think the most important thing is that we're fundamentally changing the approach to business planning; that is, we are moving into the multiyear contracts as recommended by the Mazankowski report. We were working, in fact, with the RHAs yesterday on designing the structure around priorities so that they would be very clear: service delivery plans in place before the beginning of each fiscal period.

Bruce has pointed out one outstanding difficulty which, even with the completely revised structure for putting together the plan, will have to wait till there is a provincial budget in place before the final statements and the final lines of the fiscal plan are incorporated within that service delivery plan. But we're absolutely convinced that we can get to a point where just about every detail is ready to roll given the expectations of the final announcement of the government's fiscal plan in accordance with the targets that we've set out within our three-year goals. We expect that to be a consistent, stable funding structure, and that's the commitment we're making to the RHAs, to live within those targets, within the forward plans, and insofar as the Legislature agrees, we will be able to meet this target, this goal.

Mr. Dunn: Do you want me to comment on this?

The Chair: Certainly.

Mr. Dunn: Indeed, the important point is that in order to measure yourself against the budget, you have to have the budget approved prior to the start of the year, or else you're actually working for a point in time without that control exercised. So what I guess we're hearing here is that we have to have the province bring down its fiscal plan earlier. That seems to be the driver. That is the message I'm receiving. We must have the province bring down its fiscal plan earlier in order that that fiscal plan can then make its way into the regional health authorities' plans.

Mr. Mar: The alternative, if I may, Mr. Chairman, to the Auditor General, is that perhaps we should change the fiscal year of the regional health authorities.

Dr. Taft: Is that being considered?

Mr. Mar: Well, only by reason of my experience in the department of what is now Learning. My recollection is that their fiscal year begins in September. We can give consideration to that possibility.

The Chair: Mr. Marz, followed again by Dr. Taft.

Mr. Marz: Thank you, Chair. Mr. Minister, my questions relate to the annual report, section 1, pages 31 to 37. Starting with page 31, it shows that the number of physicians since '97 has increased from 1.52 to 1.67 per thousand in the province. If my memory serves me correctly, in that same time frame we've gone from roughly $11 million a day in health care to I believe around $20 million a day

now. Reading over those pages and seeing how the number of people on waiting lists is actually increasing and that the waiting times in most cases are increasing, this paints a fairly bleak scenario, especially from a personal perspective when I'm faced with accessing increased health services myself as I become a senior sometime within the next 20 years and for other people in the same scenario that are sitting in a waiting room or sitting at home waiting for months and months to get service. What has been the impact of the increased health professionals on the waiting lists? It appears that we're going the wrong way.

Mr. Mar: Well, as I indicated, in surveying Albertans with respect to the issue of access, most are reporting that access has been good, but that doesn't mean that we're satisfied with that. We have a number of different factors that impact on the health needs of the population, not the least of which is what you've identified yourself: that, generally speaking, as people age, they tend to access more services. So even if the population were to remain fixed in terms of its size, there would still be growth of demand within a fixed population because all of that population would be growing older.

I think that we've done a good job in terms of recruiting health professionals from other jurisdictions. We've increased the number of people that we train in our medical schools. We've increased the number of people that we train in health professions including nursing. Let me suggest this. If our system were to remain unchanged, then we don't have enough physicians and we don't have enough health professionals, but on the assumption that we can change our system to move towards more of a multidisciplinary approach to health care delivery, then we will have enough of those health resources, and that should help improve access.

Doing things in a different way is also an important part of it. The Health Link line is a good example, which of course will be up and running this summer provincewide. That has demonstrably reduced the number of unnecessary visits to emergency rooms, thereby improving access in emergency rooms. But there is still much more that we need to do in this whole area of primary health care reform which helps answer the questions: who provides the service to the patient, and where is that service provided? By answering those questions and doing things differently, we think that we can improve access notwithstanding the increasing demand associated with a growing and aging population.

Mr. Marz: Thanks. Now, you talked about change. I realize how difficult it is to get a system such as a health care system to change. A lot of communication with the public is involved, and the public isn't always willing to change. Has your department done any calculations on what it would cost, without any changes, to meet your targets for waiting times under the current system? How many more health professionals would we need to hire? What would the extra cost be to actually meet the targets that you've got listed down here? We're a long way from meeting those targets.

Dr. Palmer: No, we haven't. We haven't done complete costing of all the targets on the current model because we don't think we can get there. The minister made the point, I think, a few moments ago – and certainly the department completely agrees with the position – that it is not possible to reach these targets in the current structure. We've got to actually change the structure, and changing the structure means doing a whole series of major acts over the course of the next two or three years to change the relationship with the health professionals, the organization of primary health care, and the delivery structure.

There's one other uncertainty which all of us in health administration find extremely frustrating, and that is actually predicting demand given the nature of service. The classic for us is MRIs. Almost every time we do an analysis, it's including the number of machines and the number of professionals required to meet the wait lists for MRIs, which one would think was one of the simpler ones to analyze. We add a machine; the wait list actually gets worse. We haven't quite found another way of dealing with this issue yet. I've talked to my colleagues across the country, and nearly all of them feel that they're in exactly the same position.

9:00

Mr. Marz: I don't have another question but just a comment on that if I may. Perhaps if that type of information was out to the public, it would be easier for them to understand and to buy into necessary changes, if they knew how much it was going to cost to meet those targets.

Mr. Mar: I think that there is an increasing public appetite for more information, and one example of how we're going to address that this summer is having wait lists posted on-line. Many people will express their frustration in waiting for a year to see a specific type of specialist, and they say, "I'm waiting a year to see an orthopod," when in fact they're waiting a year to see a specific person, Dr. Brown. Now, by placing wait lists on the Internet, people will then have the ability to see that Dr. Brown is not the only orthopod that provides this particular type of service, and they may choose to go to some other specialist in order to get the procedure that they need done to them.

There's an increasing need to provide information to the public about the nature of wait lists, about the costs associated with procedures. These are important parts that will fall into place as we continue in the use of information technology and producing electronic health records, and that will help improve our ability to, for example, put out statements of what a person's utilization of the health care system actually costs.

The Chair: Thank you.

Dr. Taft, followed by Mr. Broda.

Dr. Taft: Thanks, Mr. Chairman. My question relates directly to the one before me, and then I'll focus on MRIs, which are mentioned in the annual report of the department on pages 33 and 34 and were mentioned in the minister's opening comments. It's pretty obvious that while the number of MRIs increased, the waiting lists increased even more quickly. When I see that occurring, it makes me think that the fundamental organization of that service delivery hasn't been sorted out properly.

I suppose my first question on that. The business plan refers to a comprehensive provincial magnetic resonance imaging strategy on page 33. The simple way to put that is that presumably this is not the outcome that the strategy anticipated – and again this can be, through the minister, to others in the room – so why did the strategy fail? I'll just put it that bluntly, and you may debate with me whether it failed or not. But why, although you've increased the number of MRIs, do you as a department think that the waiting list has gone up even more quickly?

Mr. Mar: Well, if I might quote from *Field of Dreams*, "If you build it, they will come." I think that there are probably a number of different reasons why this has happened, one of which is the demand by the public, by patients, to their physicians to have this important diagnostic test done to them. I think it would be fair to say that

MRIs are a very important diagnostic test and that they may be necessary but not necessarily beneficial in all cases. I think that as people pick up the newspaper, the *Edmonton Journal* or the *Calgary Herald* or the *National Post*, they may see that famous celebrities are getting MRIs done, that sports athletes are getting MRIs done, and if it's good enough for Doug Gilmour, it's good enough for them as well. So that's part of what's driving demand.

Another part of what's driving demand, I think it would be fair to conclude, is that many physicians practise defensive medicine and that MRIs are prescribed not because they will provide any additional diagnostic information to allow the physician to perform a procedure differently but because they could find themselves in the middle of a medical malpractice action if they don't provide an MRI.

There are probably a number of other reasons, but I think that what it suggests to us in the end result is that we really need to examine not only our scan rate but the purposes for which MRIs are being used and that we should do our best to try and separate useful MRIs, which of course should be our priority, from those which are not particularly useful and that we continue our commitment that if an MRI is needed on an urgent basis, there be no wait time at all. But we need to be able to evaluate the priorities for which MRIs can be used and to share that information with the public and indicate to them again that when it comes to urgent or emergent needs for MRIs, your wait time is zero but that things that are less urgent will take some time, and some things that are presently covered perhaps should not be covered at all.

Dr. Taft: Well, I'm skeptical that we've got the fundamentals right here. When you say, "If you build it, they will come," it's not as simple as that. You know, it's not as simple as that. Frankly, people don't go out for an MRI for their pleasure. This is not like people going home and saying: will I go to the Trappers game tonight, or will I go for an MRI? That's to misunderstand the nature of the service. Have you examined the role of market forces in driving up demand for unnecessary MRIs? In other words, the effect of the very substantial marketing that the for-profit MRI clinics do to physicians and even to the public: have you examined that as a factor in increasing the wait lists? Again, any official in the department.

Dr. Palmer: Not specifically, because it's very difficult to separate the various impacts, as you're aware, but if you look at the different patterns across North America, you can see that this is a common feature. Whether the MRIs are entirely within public systems or in mixed systems or entirely in private systems, there is a dramatic increase in the demand for MRIs. Your points are well made in terms of that you don't do it just for fun, but there is, as you all know, in areas which are entirely in a commercial MRI system a very high demand now being created within the public for whole-body MRIs in areas where there is no obvious medical benefit for such processes. So I suspect that you're right that within the entire context of the North American culture there is an issue here in terms of a particular procedure being used more than it needs to be, as are many medical procedures, may I add.

There is one point I want to add to the overall issue of demand that the minister didn't mention which I think is important because it applies to so much of what we do, and that is that in my brief time within this ministry I have become very much aware of the pace of change and the pace of technological change within this field, faster than in any other that I know. MRIs are now being used for things they were not used for even 12 months ago. Their impact on analysis of soft tissue injuries in ways which were not dreamed of two years ago steadily increases, exponentially in some cases, the potential value of this diagnostic tool in ways that are entirely unpredictable at the beginning of any fiscal period. So I think that while it's certainly not a main one – the minister mentioned, I think, the main drivers – that is another one which must be taken into account.

9:10

The Chair: Thank you.

Mr. Shandro: I'd like to make a comment here. I think that in the United States they're predicting health care to rise to 20 percent of their GDP, and one of the reasons they believe that is happening is because consumers are not looking just at the medical model in terms of what they want in the way of services. I know personally that there's a person here who's traveling to the United States because what he wants isn't permitted under the medical model. His doctor is not recommending it, so he's going down to the U.S. and he's getting what he wants. Now, in fact, he's not doing it for fun but because he's got cancer, and he wants to do something. He's desperate, and he found somebody who's going to do that for him. So he's disagreeing with the physicians here and traveling somewhere else.

We're seeing a lot of evidence that there are practices outside of the medical model, alternative forms of treatment, those kinds of things, where people are prepared to pay for it, and they're also prepared to pay for expensive diagnostic exploratory voyages that are not recommended by physicians. That pressure is going to, I think, continue, and there's going to be a lot of debate about: I want it, I have the money to pay for it, and if we're in a democracy, why can't I have it if I'm prepared to pay for it? Unless the state steps in and says that you're doing something very dangerous to your life, these guys are going to push very hard for this, and it's going to be very difficult to prove that a lot of what they want is dangerous to their life.

The Chair: Thank you.

Mr. Broda, followed by Dr. Taft.

Mr. Broda: Thank you, Chair. Before I begin, as we all know, Minister, your department is probably one of the most complex departments within government, with a lot of pressures, and I've got to commend you and your staff for a really good job that is tough to handle but is progressing very well. I think that has to be recognized.

Also, people expect a lot and want new programs. My question is on value for money. When you develop new programs, do you analyze the costs and the benefits, and can you provide some examples of that?

Mr. Perry: The question of value for money. First of all, for Health and Wellness the majority of the dollars are delivered through the health authorities, and they're the primary agent. For the programs that are administered in the ministry such as provincewide services, ADL, one of the primary concepts is to have costing of what is being done. To build a measure of value for money, you need to actually know more than just the inputs that go into that. So for those core programs that are remaining within the ministry, there is an ongoing goal to have better costing and to be able to measure. For services such as ADL, the consumption of inventory, and the recycling I think there is by their program design a value benefit both to Albertans and in the use of the service. So, yes, we are cognizant of it, but that would be limited to the programs that the ministry administers. With the health authorities their value for money is essentially delivering such things as acute care, and they would be more interested, I think, in efficiencies and those aspects.

Mr. Broda: So in order to meet some of these expectations, do you know whether the programs that are delivered are economical and efficient? Again, like I say, there's a lot of public expectation and "Why can't I get it?" So when we do this, are they economical, and are they efficient in a lot of cases? I'm going to use examples. From some programs that were delivered in some of the regional health authorities, in speaking to the constituents, the community has really benefited. But when the regional health authority may at some point in time say that it's only a pilot project and pull it off, to the community it's a negative. I guess what I'm asking is: who determines these efficiencies?

Mr. Perry: A hospital could be inefficient but still deliver critical services. In fact, some of the regional health delivery systems, such as the northern part, may not be as efficient as an urban hospital, for example, but you still need the basic hospital structure, so one has to take care in terms of measuring just on efficiency. The effectiveness of those hospitals is very high, the satisfaction rate. With the health authority how they measure and balance off is their judgment because, in fairness, they're the ones in the best position to make choices.

Pilot programs usually are to enhance or to replace. I presume that at some point in time they determine whether it is a replacement or it needs to be replaced with something else.

There was an earlier comment about the pace of change in health. To do this, you need it over a consistent time frame. It's very difficult to measure based on a one- or two-year time frame. You actually need 10 years to measure some of these efficiencies. Again, we're certainly aware of what they're doing in their new programming.

The Chair: Thank you.

Mr. Mar: Mr. Chairman, I was just going to have Murray Finnerty say a few words with respect to AADAC programs.

Mr. Finnerty: Well, I think, Mr. Broda, we're still in the direct delivery business, and certainly any requests that come to us require a business case analysis. I guess that a good example of a new initiative with an extensive cost-benefit analysis that was performed is the Alberta tobacco reduction strategy, which has extensive numbers in terms of the benefit of a program. Like a lot of things in prevention, particularly, it's difficult to measure what your effect would be down the road, but we definitely have procedures in place.

Mr. Broda: Thank you. I might have another question later, time permitting. Thanks.

The Chair: Thank you, Mr. Broda.

Dr. Taft, followed by Alana DeLong.

Dr. Taft: Thanks, Mr. Chairman. I could go on with questions all day on this department.

Mr. Mason: It's your job.

Dr. Taft: It's my job; that's right.

I would appreciate the reflection of the Auditor General on this question. It's a fairly broad one. The mission of the department as laid out on page 16 is "to maintain and improve the health of Albertans by leading and working collaboratively with citizens and stakeholders." My question is around an issue that's been debated for a few decades now, which is the tension between treating illness and maintaining health and wellness. The title of the department itself is Health and Wellness. The mission relates to maintaining and improving health. We've talked about sustainability and demand. If I were to borrow, perhaps reluctantly right now, from the electricity side of the world, we really need to focus more on demand-side management than just endlessly trying to meet demand. How do we reduce demand? The way we reduce demand for health care services is to maintain a healthier population. My question really reflects a concern I have that a huge majority of the department's efforts go to treating illness and a small, small minority go to preventing illness, for understandable reasons. But in the long run we can't just endlessly treat illness; we have to get better at preventing it. Can you tell me what proportion of the department's budget goes to health promotion and prevention of illness?

Mr. Mar: Depending on your definition of it, it would be in the magnitude of about $250 million, but that would also include programs like immunization, as an example, which I think would be fairly characterized as a wellness promotion initiative. I might have Bruce correct me if I'm incorrect about the numbers.

Let me say that we recognize the importance of, as you say, trying to manage demand or reduce demand upon an acute care system. There are a number of things that we've done. The tobacco reduction strategy, which Murray Finnerty has already talked about, has been an important part of this. It has measurably reduced the number of people who are smoking, and that is clear from the surveys, not just from the tobacco sales but from surveys of Albertans with respect to their smoking habits, and Murray can talk about that.

9:20

The Healthy U campaign. I'll be happy to give the hon. Member for Edmonton-Riverview my own pedometer. The Healthy U campaign has been an important part and an initiative that our own department is all participating in. The pedometers you reset at the beginning of each day, and your goal is to try and reach 10,000 steps in a day, or theoretically 10 kilometres. We've been very aggressive in our advertising campaigns to the public on the importance of this. It's particularly important when you see alarming numbers about rates of overweight kids and obesity in this country. I'm pleased to report that Alberta has among the lowest rates, I think in fact the lowest rate, of overweight children from ages two to 17. I think it was something in the range of 23 percent. We're of course still not satisfied with that. It needs to be improved. We've put in a health curriculum, starting last September, from kindergarten through grade 9. An important aspect of health promotion is for kids to understand the importance of making healthy choices, whether it be about what you eat or your physical activity.

I've already mentioned immunization. I don't have any statistical evidence to back this up, but my own intuition is that if there were two things that have contributed most to increased longevity in this country in the last 100 years, I would suggest that it would be immunization and access to clean water. That leads us to also talk about the importance of working collaboratively with departments like the Department of Environment.

We do recognize the importance of initiatives to improve overall population health. There are inextricable links between levels of education and personal health status. It's the reason why we've supported in the past the student health initiative in schools, some moneys that have been put towards dealing with health issues among students while in the K to 12 system. I can say that it is difficult to find moneys to do this because of course heart surgeries trump phys ed programs every time. But we are making every effort to maintain

the system that we have for the treatment of illness now while still setting aside money for these important initiatives that, in your words, help control the demand upon the acute care system.

Murray might want to talk about tobacco reduction in particular.

Mr. Finnerty: Well, perhaps in general. The comment on prevention I think is extremely important, Dr. Taft, as you know. About 20 percent of the mortality rate in this province is due to addictions of some kind, which is a fairly substantive number, and I think the government has been fairly strong in this budget year in particular. The AADAC budget was $47 million; $31 million was for treatment services and $16 million for prevention and information, which is one-third of our budget. That's been a fairly consistent direction by the government, to emphasize prevention and treatment, particularly in the addictions field. I think you'll find an addiction story in the paper every day unfortunately.

Dr. Taft: Okay. Well, that's an interesting lead-in to my supplemental, then, because my quick calculations would be that the $250 million, while a lot of money, is less than 5 percent of the total department budget in comparison to AADAC spending about a third of its budget on prevention programs. Again, the Auditor General is welcome to jump in here. But if we're in the business of health and wellness, what steps are occurring in the year we're talking about and subsequently to expand the percentage of our resources committed to preventing illness, to health promotion, to wellness from, say, 3 or 4 percent of the total budget to some higher number? Is there a target you're aiming at to discipline the system to start putting more than 3 or 4 percent of its resources into the long-term health of the population?

Mr. Mar: Well, first I'm going to have Bruce outline the exact figure that's contained in our report, and then I'll address your question thereafter.

Mr. Perry: Thank you, Minister. The actual reference on the split between the two core businesses is on page 58 of the annual report, and the numbers are essentially $6 billion for the delivery of quality health services and $234 million for the promotion to encourage and support health living. That's for the record.

Mr. Mar: Now, with respect to your question there are things that can be done even within the current budget that is allocated, the 6 billion and some dollars that we're talking about, for what we broadly characterize as illness treatment. Certainly, in looking at the importance, for example, of initiatives like Health Link, there may come a time when we'll be able to take Health Link to not simply be an in-call service, but it may at some point be considered for an out-call service so that people with chronic conditions like diabetes or heart conditions and so on might get follow-up care in a preventative mode. Our diabetes strategy that was announced the other day is an important part of that as well. Again, while it may be characterized within the bigger illness treatment thing, the illness treatment rubric, it might actually be also characterized as a wellness promotion initiative.

We can also look at primary health care teams, multidisciplinary teams where instead of being simply treated by a physician in his or her clinic, you might see somebody else, say a dietician, working within a multidisciplinary primary health care team who might be able to give you some assistance in trying to get your cholesterol level or your lipid counts down. So we are making efforts, even within what is broadly categorized as the illness treatment side, to change the model of delivery so that there is a greater health promotion aspect of it, although that is not exactly how it is reported in our books.

The Chair: Thank you very much.

Ms DeLong, followed by Mr. Mason.

Ms DeLong: Thank you very much. My questions have to do with risk management, which is one of the things that the Auditor General suggests that we ask questions about. I guess I'm most concerned about risk tolerance. In the purchasing area, for example, supposing people found out that with, you know, the usual Q-Tips that we buy, one in 10 million people if they use those Q-Tips will have an allergic reaction and immediately die. One in 10 million people dies because of this, so somebody comes up with a Q-Tip that costs 10 or 20 times as much. It adds maybe, say, $30,000 to our bottom line, but it saves one in 10 million people.

I guess my concern is that unless there's some sort of an analysis that's going on in terms of purchasing, on the difference between product A and product B and the effects of it, unless an actual statistical analysis is done, if we just say the words "risk analysis" without actually doing the analysis, this can put tremendous pressure on how much we spend on health without actually increasing our life expectancy in Alberta. Unfortunately, when it comes to the health department, that is our actual risk, life and death. I guess the question that comes in is: what risk tolerance have you established? We can always spend, you know, another half a million here and save one life, but that half million could have been spent somewhere else and saved 100 lives. How do you deal with that?

Dr. Palmer: In the area that you're speaking about, in terms of specific health risk and health impact nearly every medical facility has an analysis done by physicians of the sorts of issues you're talking about. Do they do a statistical one? Very rarely. But they do do an analysis in terms of what sort of impact it's going to have. I'll give you an example. The example is latex elastic straps on masks. In most hospitals in the Toronto area, which is where I know the analysis was done, with a similar one done here, they excluded those types of face masks from the hospital because of the allergic reaction to the latex in the elastic strapping against the face. This was an irritant. It wasn't life or death except in a very, very rare circumstance. You know, latex emergency allergic reactions, severe ones, are relatively rare, but they do occur. So they were excluded from the hospital system, and the replacement brought in was, I believe, slightly more expensive, although the difference was small.

9:30

Much more important, the second that SARS came along, that risk was completely reanalyzed, and the fact is that it was completely ignored for all purchasing during the SARS epidemic because you had changed the risk dynamic enormously. It was obviously much more risky to go around without a mask than to worry about latex reaction. That's occurring all the time in our health system. It's not a matter of a static risk analysis. It's a matter of: is it a reasonable risk to take given the current circumstance? I think every physician you talk to will say that that's their daily job. Is this procedure, is this set of drugs, which has risk – they all do – of value given the circumstances for this patient and the services we're trying to provide?

Ms DeLong: I guess my question is: does money come into the analysis?

Dr. Palmer: In most of those cases, rarely. It's usually to do with:

is this an issue which is going to be risky to this patient given these circumstances? The place where it does come in, of course, is when we're looking at new drugs and new procedures, and we're starting to say: is this something that we're going to introduce into the system? We do attempt to look at the overall impact on the system. My experience in my brief time here, though, is that if there is a patient who can genuinely benefit, we do everything in our power to make that procedure available for that group of patients but not for ones where we know the benefit is small, because then the risk factor, the risk analysis says: don't do this.

The Chair: Thank you.

Mr. Mar: Let me, if I may, Mr. Chairman, just make one suggestion. I like the idea of doing statistical analyses to develop policy, but sometimes the amount of time and resources that you would devote to it would not pass a cost-benefit analysis either. I sometimes use the analogy of asking people: how many raindrops does it take before you pull out your umbrella? It might take 15 or 20 raindrops for you to conclude that it's raining, but if you were to do a full analysis as to whether it was raining or not, you might be wet to the skin before you opened up your umbrella. So sometimes we make decisions based on imperfect information, and we use our best estimates of risk and do that analysis without going through a full analysis. But as Roger said, when it comes to pharmaceuticals in particular, we pay a great deal of attention to risk and cost-benefit analysis in approving new drugs or replacing existing drugs.

Ms DeLong: Thank you.

The Chair: Thank you very much.
Mr. Mason, followed by Mr. Hutton, please.

Mr. Mason: Thank you very much, Mr. Chairman. I hope the minister won't throw anything at me.

Mr. Mar: Just solid policy answers.

Mr. Mason: That would be welcome, Mr. Minister.
You mentioned in your last answer the use of cost-benefit analyses when looking at things, and I would like to know if the ministry requires health authorities to apply a systematic approach to cost and benefit when considering the method of delivery of a particular service. I'm specifically referring to decisions as to whether or not a service will be delivered privately, through contract or otherwise, or as a direct part of the publicly operated system.

Mr. Mar: Well, the contracts which have been approved, some 35 contracts that have been approved pursuant to what you've often referred to as Bill 11, have gone through a very rigorous process of analysis, and it's not simply cost benefit. It may also be better utilization of existing facilities or resources. At all times we are obviously concerned about whether or not such procedures can be done safely within facilities outside of public facilities, notably hospitals, so it's for that reason that we have our College of Physicians and Surgeons advise us on what may safely be done in a private surgical facility and that which should only be done within a publicly owned hospital. There's also the analysis in terms of dollars, and you may find that dollarwise for a procedure perhaps there's no difference between doing it within a public facility or a private surgical facility, but if doing it within the latter facility allows you to open up a surgical suite in a public hospital for use in conducting a more serious type of surgery, then that should have some value to it as well.
With respect to the criteria, you know, we worked very hard with folks from outside of the province, with the Auditor General's office, with the College of Physicians and Surgeons, and there is a complete and full summary of the criteria that were considered that's available for anybody to see on any particular contract that they wish.

[Mr. Marz in the chair]

Mr. Mason: Maybe I can put the same question to the Auditor General. Have you looked at this ministry's approach to making decisions about the best way and the most effective way to deliver services, and are you satisfied that they have a process in place which correctly allows them to evaluate the advantages, the costs, the disadvantages, including exercising that control over health authorities?

Mr. Dunn: I'm going to turn the microphone over to Nick Shandro, who's been involved in this ministry for many years. Indeed, you're hitting on an area which is very, very important and something which our office has been working on and trying to work with the ministry on, to look at cost-benefit analysis between the authorities, especially the two large authorities, Calgary and Capital, because obviously they're delivering similar services to albeit dissimilar populations, some might argue, but quite similar populations. It's through that that we want to see a good comparison of costs of service and delivery.
So over to you, Nick. You're working in that area.

Mr. Shandro: I think it was about two years ago – I can't remember when Bill 11 came to be; two years ago? – that we did look at the processes.

Dr. Taft: Three.

Mr. Shandro: Three years ago. Okay. Thank you.

Mr. Mason: How times flies.

Mr. Shandro: It goes quickly.
We did look at the processes. There was an extensive amount of work done by the ministry to set up the processes in conjunction with the health authorities, and we looked at those processes and procedures and reported on them in the year that we completed the work. In table 4 are the residuals remaining from that work. The process itself, I think, is fairly sound. The issues we saw at the time that we reviewed were more to measure the performance at the back end of those contracts, because the health sector to date hadn't had, I think, sufficient criteria, standards to measure the performance of such contractors. We know that the RHAs in Calgary and Edmonton have been working on developing those indicators of performance, and where they are at the moment is going to be a subject for our follow-up work. So that was some of it.

9:40

In terms of the other items, there was an item that we talked about, fixing the conflict of interest policy. It think that's in the works to complete, in terms of having the Ethics Commissioner deal with the issue of where it is necessary for him to get involved. As I understand it, that's in process as well. There's legislation that is required to permit the Ethics Commissioner to be part of that process.
So on the focus of your question on the system that they put in

place in terms of the processes and procedures on the contracting side – examining the contract, examining the proposals, and evaluating the proposals – we basically think that's sound. There were some other items, however, that needed to be fixed.

Mr. Mason: I take that as a no, Mr. Chairman. Certainly, I don't normally have a hard time following the answers from the Auditor General, but I think the question was fairly simple: can you assure the committee that the criteria used by the ministry ensures that when they make a decision between providing a service in-house through the existing public system or contracting it out to a private provider, they get the best value for money and it is the most efficient and effective way to deliver the service? That's the question.

Mr. Shandro: Probably I talked about our project to give you a flavour of the entire project, and you're only interested in the process that they have, which I reported was sound. I said that there were some other areas that needed fixing, but I did not say that the process for the contracting was lacking.

Mr. Mar: If I may, just to put in context your question on the value of the services that are being contracted for the year that we are considering, 2001-2002, there were three regional health authorities that had contracts with private surgical facilities: Capital, Calgary, and Headwaters. The total was $8.4 million, or .2 percent of the health authorities' total expenses. The contracts were for services relating to ophthalmology, oral surgery, dermatology, plastic surgery, and reproductive health.

The Acting Chair: We have Mr. Hutton, followed by Dr. Taft. I'd just like to remind everyone, our guests here, that you don't have to turn your microphones on. *Hansard* will do it for you.

[Mr. MacDonald in the chair]

Mr. Hutton: Thank you, Mr. Chairman. I'm a bit of a traditionalist, and this may be the last time this committee convenes this spring, and there's been something lacking this morning. I feel that it's appropriate that I make the comment on this beautiful Alberta spring day – and this is for the benefit of the committee and in particular the chairman and the hon. Member for Edmonton-Riverview – that I'd like to thank the Auditor General and the minister's staff and all the thrill seekers in the back for coming to the wonderful constituency of Edmonton-Centre.

I'm quite familiar with this department. Prior to my being elected, I had the privilege to work with the ministry and the minister's staff. I, too, have to commend the staff and the minister for their dedication. We do have a very, very good system that is sometimes excellent, as the minister says, and I truly appreciate, with the little knowledge I have of how tough it is to run a $7 billion business, as we'll call it today, that goes 24 hours a day, seven days a week. We have the best system in the country, and I'm very proud of it.

My questions this morning are related to not just the ministry. For those who don't know, I'm particularly interested in the area of addictions as it relates to fetal alcohol spectrum disorder. It is something that I would like to see eradicated, eliminated from this province. I want to know about the impact that the cross-ministry initiatives have had on your programs and resources and allocations, Mr. Minister.

Mr. Mar: The issue of fetal alcohol syndrome is a serious one, and although I can't purport to speak confidently on the numbers that have been expressed to many of us by the minister responsible for Children's Services, to the best of my recollection the cost associated with a child with fetal alcohol syndrome from birth to age 18 would be in the range of $1.3 million. So it's for this reason that we take seriously the notion that we need to work together better to ensure that those costs are not accrued by Children's Services and, more importantly, that a child would not have lifelong disabilities associated with that condition.

I'll speak candidly that while we are doing much in cross-governmental initiatives, there's more that we should be doing. I'm going to have Murray Finnerty talk about the issues associated with addictions specifically and the kind of work that he's doing with other departments.

Mr. Finnerty: That's a very good question. Thank you very much, Mr. Hutton. We sit on the partnering deputy's committee for the Alberta children and youth initiative, and we are co-chairing with Children's Services the particular initiatives for fetal alcohol syndrome disorder. I would agree that we would like to see more done in the area. It's so preventable and so tragic. In one of the latest initiatives, using some funding from the federal government under the early childhood development program, AADAC started a program last year, which has been enhanced this year, for enhanced services for women. We have an outreach project that goes out particularly in the inner cities and tries to contact women who we think are users, either alcohol or drugs, who are pregnant or could become pregnant to make sure they are aware of the risks involved to their unborn child should they be using while they're pregnant. It's definitely a high-priority area for us. Internally we are relooking at our approach to fetal alcohol syndrome and perhaps looking at a request for enhanced funding in the area.

Mr. Hutton: I do have one supplemental, and I realize that this is budget 2001-2002. It's my understanding that the lead department with regard to fetal alcohol spectrum disorder is Children's Services, but there is a segment of our population that is impacted more so percentagewise than another. I'm wondering: have you worked in conjunction with the federal department of aboriginal affairs or our provincial department of aboriginal affairs with your allocations?

Mr. Finnerty: Yes. We have with Aboriginal Affairs and Northern Development had a major meeting with the federal government in terms of their services on reserve and indeed for the population off reserve with regard to the area of fetal alcohol syndrome. They are very interested in doing something, so we're trying to co-ordinate enhanced services with them. The meeting took place late last fall, but we haven't had a formal response from them yet.

Mr. Hutton: Thank you.

The Chair: Thank you very much.

There are a number of members who are still on the list to ask questions, and it has been the tradition of the committee that these questions get on the record and the ministry respond in writing through the committee clerk. Now, Dr. Taft, would you like to get in a written question?

Dr. Taft: How do you want to proceed? Do you want me to read the question into the record?

The Chair: Read the question for the record, please, and the ministry will respond through the clerk in writing. There is yourself, Mr. Masyk, Mr. Mason, Mr. Cao. Richard Marz also has a question.

9:50

Dr. Taft: You mean that I only have 10 minutes to read all my questions into the record?

The Chair: Yes.

Dr. Taft: Okay. Well, first of all, I'll join the others in thanking the minister and his staff for being here, and I will use the pedometer if he can tell me how to turn it on. [interjections] Thank you very much.

Well, then, I'll cut to my one question, which stems from the Auditor General's report on page 139, a page on which the Auditor General raises concerns about conflict of interest and ethics procedures. My question would be: specifically what actions has the department taken to address these concerns? I know that the Calgary health region had proposed new conflict of interest policies stemming from I think the Auditor General's report, and there was some back-and-forth between the region and the minister on those. Are those policies now signed off? What are the policies? Beyond the Calgary health region, what are the conflict of interest policies affecting the other RHAs and the department itself?

The Chair: Thank you.
Mr. Masyk.

Mr. Masyk: Thank you. Roger, you had mentioned earlier about the MRIs, and it actually struck quite some interest with me how even six months ago we were looking at tissue and different things that weren't heard of. My question is a multilateral question on jurisdiction but under the umbrella of the citizen, if you will, regarding WCB claimants. After they go through the system, through rehab, they're healed, yet the claimant says that they're not. I find that a lot in my constituency. However, could an MRI actually tell the tale, and could the health authority work with WCB using MRIs to tell whether that injury is actually healed or is not?

Dr. Palmer: A good question.

The Chair: Thank you very much.
Mr. Mason, followed by Mr. Cao, please.

Mr. Mason: Thank you very much, Mr. Chairman. My question is to the Auditor General. What criteria does the Department of Health and Wellness use to determine the effectiveness and the cost benefit of decisions on delivery between public health care and private delivery? Are these criteria adequate to ensure that citizens receive the best quality care and the best value for money?

The Chair: Thank you very much.
Mr. Cao, followed by Mr. Marz.

Mr. Cao: Thank you, Mr. Chair. I believe in the four Es, which are effective, efficient, economical, and ethical, so those are my four Es. My colleagues already talked a bit about the ethical conflict of interest and some on economical. Within the department there are always new initiatives proposed by various sectors or authorities or the staff of the department. Is there any procedure so that you could evaluate that? The budget is quite high, and if we have to do all of that, then it just keeps growing. My question is: do you have a process or operation where you can evaluate those things and then take the one that has sort of the best return to do those?

The Chair: Thank you.
Mr. Marz.

Mr. Marz: Thank you, Mr. Chair. Mr. Minister, on page 141 of your section 1 report are the expenses of AADAC, an increase of about 18 percent, from $37.4 million to $44.4 million. Relative to the client access and satisfaction with treatment and prevention on pages 64 to 67 of the same report, it appears that an 18 percent increase in our expenses hasn't resulted in any significant change at all in either access or client satisfaction in any of those areas. Are we to expect further increases of that nature in years to come without basically any improvement in results?

The Chair: Thank you.

Again I would remind the hon. minister that if those questions could be in written form through the clerk, we would be very grateful.

At this time I would like to conclude this portion of the meeting and express my gratitude on behalf of the entire committee to the minister and his staff for appearing this morning and also to the Auditor General. Thank you.

Mr. Mar: Thank you, Mr. Chairman. I'll only say thank you to all of you as well for the time you take to prepare yourself for this meeting. I'd like to thank also the Auditor General and his staff. Most importantly, I'd like to thank the Deputy Minister of Health and Wellness and all of our staff in the department for the hard work that they do not only in preparation for this but in dealing with important issues relating to health care and wellness throughout Alberta.

Thank you.

The Chair: At this time the chair apologizes for the error this morning. I forgot to seek approval of the agenda earlier, when we started. If I could have approval of the agenda as circulated, I would be grateful.

Mr. Hutton: So moved.

The Chair: If there is a meeting next Wednesday, it will be with the Hon. David Hancock. Also, before adjournment I would like to please advise you that the Legislature Library now has two copies of *The Overseers* for members to borrow if they so wish.

If I could now have a motion to adjourn. Thank you.

[The committee adjourned at 9:57 a.m.]