[Chairman: Mr. Kowalski] [10 a.m.]

MR. CHAIRMAN: Good morning, ladies and gentlemen, and welcome to another meeting of the Standing Committee on the Alberta Heritage Savings Trust Fund Act. This morning we have the Hon. David Russell, Minister of Hospitals and Medical Care, appearing before us. In the annual report of the Heritage Savings Trust Fund, there are a number of portfolio responsibilities accruing to the minister that are identified on pages 14 and 15. They are identifiable items: the Alberta Children's Provincial General hospital, applied cancer research, Tom Baker Cancer Centre and Special Services Facility, and the Walter C. Mackenzie Health Sciences Centre. Mr. Russell has provided committee members with two documents, circulated yesterday, one titled the Alberta Heritage Savings Trust Fund Applied Research — Cancer Annual Report, and the other being A Review of Progress for the Year Ending March 31, 1984, with respect to the Walter C. Mackenzie Health Sciences Centre.

Mr. Russell, welcome again. You have a number of people with you that we would ask you to introduce to the committee. If you have an overview opening statement, we would ask that you proceed. Following that, we'll proceed to questions from committee members.

MR. RUSSELL: Thank you very much, Mr. Chairman. First of all to introduce the people with me, going down the row: George Beck, assistant deputy minister and chief financial officer for the department; next to Mr. Beck is Mr. Edge King, the newly appointed chairman of the board of the University of Alberta hospitals; next to Mr. King is the brand-new — he's been on the job just a few days — president and chief executive officer of the University of Alberta hospitals, back in Canada from his last posting in Ohio; Joan Nightingale, the right arm of my office, who administers the cancer research program; and next to Joan is Aziz Poonja, manager of capital construction budgets for the department.

By way of an overview, the two documents I gave you deal with the ongoing cancer applied research projects and the most recent annual report on the Mackenzie Health Sciences Centre, which of course is a major component of the University of Alberta hospitals. The other votes you're looking at in the annual report of the Heritage Savings Trust Fund — the southern Alberta children's hospital is complete, and there should be no more heritage fund money flowing to that project. It's been occupied and in service for some time. That is also the case of the southern Alberta cancer treatment centre and the Tom Baker complex at Foothills hospital. That complex is finished and has been operating for many months now. Again, there should be no more heritage funds required for that project.

We've discussed the Mackenzie Health Sciences Centre annually at all these meetings. It is a huge project, probably the biggest hospital project under way in Canada at the present time, and is going ahead in phases. Those of you who have been by the campus recently will have seen the huge size of the building itself. Those of you who have been in it know that occupancy is starting to occur and will have seen the phased-in commissioning of phase one of the building. Phase two has the exterior shell pretty well all up, and of course the board is now busy considering the tenders and contracts for the various things that have to be done inside.

I should conclude by reminding the members how this research money for cancer started. I think it was about 1975 or 1976. When the heritage dollars started to accumulate, we made a quick decision to put some money into applied heart and cancer research. This was several years before the medical research trust fund of $300 million was established. We simply set aside $50 million, to flow at $10 million a year — $3 million for cancer, $7 million for heart. It was a five-year program and was supposed to end at the end of five years.

In the case of the heart aspect of the program, it geared up very quickly. The different hospital boards and groups were able to get their specific projects approved and under way. It involved personnel, procedures, equipment, and some ongoing operating commitments. At the end of five years, those things had virtually become an integral part of several of our major hospitals in Calgary and Edmonton. The decision was then taken to merely roll that in with the ongoing operating budgets of those hospitals and not treat them as heritage projects any longer, because it meant simplified bookkeeping.

The case of cancer was quite different by the nature of the projects that were undertaken. Those of you who've had a chance to flip through the book have seen the kinds of projects that researchers are undertaking. I think it's fair to say that the majority of them occur at the laboratory bench rather than at the patient's bedside, and most of them extend over a period of several years. So it was very hard to cut that program off just bang at the end of five years. When the five years ended, we went into a two-year extension, and when that ended we went for a further two-year extension. So that has really become a nine-year program. What we're trying to do by giving these short extensions is find a way for the scientists and researchers to phase their activities and the funding requirements into the medical research trust if we can and still give them adequate lead time to do that, so we can end this program, which was not meant to be a permanent or ongoing thing.

The only other thing that's of interest is that Alberta's contribution toward the national breast-screening program now under way is being funded through this. I think that's a particularly important program. The majority of provinces across Canada have now undertaken a program whereby there will be regular and very carefully monitored breast screening on Canadian women to see if a program can be developed which will improve the treatment and identification of cancers in that aspect. So that's coming out of this budget this year.

I'll stop there for questions, Mr. Chairman.

MR. CHAIRMAN: Thank you very much, Mr. Russell. I hope that one thing you would avoid doing this morning is the annual tongue-lashing you want to direct to us who have an habitual concern with nicotine. I think I'm bringing forward that request on behalf of my colleagues Mr. Alger, Mr. Thompson, and Mr. Kroeger. We anticipate it happening, but we would ask that you avoid it as much as possible.

We'll now proceed to questions from committee members in this order: Mr. Musgreave, Mr. Hyland, Mr. Alger, Mr. Moore.

MR. MUSGREAVE: Mr. Chairman, I hate to disappoint you, but I have a question to the minister that's of a general nature. We are struggling here for direction as to recommendations on how heritage fund moneys should be spent. When you get all your buildings and equipment and everything else in place, it's wonderful. But I feel concern that we should be spending more money trying to somehow indicate to people that if they change their life-style, including eliminating smoking, the total cost of health services in our community would be lessened. I wonder if you could see, in co-operation with Dr. Webber, say, a large program going forward first of all to determine why we do the things we do, and how we could possibly redirect people into a way of life that would be more beneficial to them and particularly to the taxpayer's pocketbook.

MR. RUSSELL: Mr. Chairman, I believe there's been significant progress made in regard to that. I look at the incredible medical bill attached to Albertans by way of abuse of alcohol and other drugs. I think the work of AADAC is very significant there. You look at the preventative and safety programs carried out by our occupational health and safety division under Mr. Diachuk's direction, and certainly that's important in reducing medical and hospital bills. I find this very frustrating, because as I've said before annually — and the chairman knows what I'm going to say — it's just common sense.

All the members have to do is decide whether they want to legislate common sense or leave it up to individual responsibility. If they make that decision, they pay whatever bills accrue as a result of their decision. The use of seat belts, nicotine and alcohol, nutritional habits, exercise — I could go on and on. I suppose the government could develop a very nice Bill which would tell people what to eat, to strap themselves in, to exercise daily, to quit smoking, and to cut down on drinking, but I don't think such a Bill would get through this Legislature.

MR. HYLAND: Mr. Chairman, my first question was answered. I had put my hand up before the minister covered in his opening remarks the five-year program on cancer research that's still going on nine years later.

My second question relates to the Mackenzie Health Sciences Centre. I know you covered it in your review, but how many more years do we have in the program? In the earlier years, before I was on this committee, I remember some of the costs on the centre were escalating rapidly. What's happened now with the construction has happened in almost every other industry. Has that changed as well with the Mackenzie Health Sciences Centre?

MR. RUSSELL: We should be finished construction of the main building by the third quarter of 1987. Three additional renovation projects to existing buildings there are presently before us, awaiting a decision: the existing clinical sciences building, the existing clinical services building, and the obsolete system of communication and utilities tunnels. We have to make a decision soon whether or not we're going to recommend that the work involved in those three add-ons or implied components of this should be funded. But the new construction, what we all think of as the heritage trust fund project over there, should be finished by 1987.

This is the first year I've been here that I've been able to say the final estimated cost has gone down since last year. [some applause] Yes. Of course this reflects what's happening out there in our economy. There were a few years when I appeared here, in those days of high annual inflation, when we were trying to project ahead and guess at what agreements might bring forward. That made it very difficult. You recall that at one time we were looking at a ballpark figure of $450 million to $600 million. I think that figure is down now to $407 million — $412 million is the latest final figure. So that's a bit of good news for you. It took me five years to be able to say it.

MR. HYLAND: My second question is related to the staffing of the complex. Are we being successful in attracting the personnel needed to operate that facility? My understanding is that it's unique in Canada. Will we have the personnel there to operate it? Whereas now we have some people going to the States for operations and to Toronto with children, and stuff like that, will we be able to do that here now?

MR. RUSSELL: My understanding is that the bulk of the ongoing operating staff — nurses, nursing assistants, technicians, and maintenance and administrative people — is no problem. They were in the old hospital, and they've expanded and transferred into the new one. The bulk of the medical staff is there. I think what you're referring to is the stories you've probably heard about very unique specialists. Cardiac surgeons in the field of pediatrics is one example that comes to mind. I know they lost the one they had and have succeeded in replacing that doctor. I'm going to ask Mr. King to perhaps add to what I'm saying, but I haven't heard that there's any particular problem other than the type of example I mentioned.

MR. KING: I think that's true, Mr. Russell. It is going to be a superb facility when it's finally in place. It already possesses an excellent medical staff. There are many skills there that are pre-eminent in the profession. It would be my personal ambition to see it become the pre-eminent tertiary hospital in Canada, and I think there's no reason that can't be accomplished. The facility itself, while it has cost a lot of money — and I'm sure this committee has agonized over the costs — is coming now, beginning to fall into place. I'm sure that those of you who have seen it will agree that it has great potential. Mr. Cramp is dedicated, as I am, to seeing that facility really fill a role Albertans can be proud of.

MR. HYLAND: Thank you. My third and last question is related to part of the work the committee needs to do; that is, look at making recommendations for future programs. In these future recommendations, does the minister see on the horizon a need for a northern Alberta children's hospital as part of the recommendations of the

committee?

MR. RUSSELL: We've dealt with that question before. When you say the "need", that basic need is not there insofar as beds are concerned. Virtually half the pediatric beds in the city of Edmonton hospitals are unoccupied at any given time; there's a surplus of bed capacity. The proponents of the hospital have made very good arguments that the centre they would like to see built involves more than just the issue of bed numbers, that they want a centre of excellent care, specifically designed for children, that would have a research component attached to it. This government is on record as saying that when the need for a children's hospital is identified, one will be built. So we're committed to making an improvement in that area.

This leads you into that very difficult situation of someone deciding the need is now or the need isn't here. I think it's known that the Royal Alex hospital, for example, has put forward a proposal with respect to enhancing very significantly the existing children's pavilion there, which would certainly result in an attached children's hospital to an existing major metropolitan hospital. That was one of the alternatives that was examined a few years ago. We'll know in a few months whether that will prove to be feasible or attractive. That work is presently under way in connection with other assessments we're doing for capital requests from the board of the Royal Alex. So it's not a dead issue by any means.

In the meantime we're able to assure Albertans throughout the province that there is certainly the bed capacity and the necessary medical professionals to care for children's needs. We're doing like any other province. In the case of very unique medical problems attached to children, if the service is not available in the province, we fly them to the nearest centre.

MR. ALGER: Mr. Chairman, I wonder if I could ask the minister to reintroduce the president and chief executive officer, the third man from your left. I don't think I grasped his name.

MR. RUSSELL: It's Donald Cramp. How many days have you been at work?

MR. CRAMP: Less than 30.

MR. RUSSELL: He's brand new, but he wanted to come to this meeting and meet you.

MR. ALGER: I'm sure he will be a great addition to your staff, Minister. Since your decision, a remarkable decision, to build a brand-new hospital in northeast Calgary, there has been an awful lot of controversy about the state of affairs at the Holy Cross. I think the public in general would like to know, even from this hearing, your argument with regard to the cardiovascular unit there, the possible movement of it and that sort of thing. I think it seems to the public a possible extravagance we could do without. I wonder if you could clarify that.

MR. CHAIRMAN: Mr. Alger, we're dealing with the funding under the Heritage Savings Trust Fund, and I'm having a little difficulty tying the Holy Cross into this conversation. Perhaps you'd like to rethink the motive of the question. We have the four portfolio items here. No disrespect — it's just that our committee deals with specific items contained in the report.

MR. ALGER: I appreciate that, Chairman, and I'll rephrase it after a while.

MR. R. MOORE: Mr. Chairman, the white paper deals with a future direction we may take. It mentions the Alberta Heritage Foundation for Medical Research and the Mackenzie Health Sciences Centre as examples of commitment to research. They focus on cancer and heart disease, Mr. Minister. I wonder, should we be broadening the base of that to other diseases? There are other diseases that are certainly crying for research. Should we broaden that base?

MR. RUSSELL: That's the exact thrust of the medical research foundation. The income from the $300 million is intended to do that. Of course by the nature of the way that was organized, it is kept at arm's length from government, so no future elected body can turn the financial tap off or on, which has been a weakness of a great many trust accounts for research in other parts of the world. The legislation also calls for triennial reports to the Legislature, and the first of those is due this year. My understanding from your chairman is that the officers of the trust will be here early in September to answer your questions. If you recall my tabling the report in the spring session, I think you'll be very much encouraged by what you're reading and seeing. It does go way beyond just the fields of heart and cancer research. Those two programs which I mentioned were only limited programs which were started, put in place very quickly, and certainly never intended to be the government's full scope of medical research. So you will be dealing with that other aspect in detail early in September.

MR. R. MOORE: Mr. Chairman, if I may. As this committee has to look not only at the past use of heritage trust fund money but to the future with our recommendations, I wonder, considering the waiting list for palliative care facilities, if there's any possible chance that heritage trust fund money could be used in this area in the future.

MR. RUSSELL: There could be, and there's certainly increasing interest in such a program. Some groups and organizations are proceeding on their own. Whether or not it's made an integral part of the Alberta hospital system is a very major policy and financial decision for us to take. But I'm sure that if the committee decided that there would be good use made of heritage fund dollars for palliative care programs . . .

MR. R. MOORE: Mr. Chairman, on another issue. Our research has basically been addressed to the treatment of disease. One area I'd like to know is: what direction will we take, or should we take, in preventative treatment? The other one that bothers me in this area is: what is the co-ordination between our research projects and other jurisdictions? Have we got 10 provinces going their separate ways, or is there co-ordination of all these activities and an

exchange of ideas?

MR. RUSSELL: My understanding of the research community is that there are incredible communications among the people in the field throughout the world. The constant publication of papers, the ongoing seminars and conventions, the daily phone calls, the competitions that are going on, and the various trust funds that are available throughout the world encourage us to believe that there's pretty good co-ordination. Maybe Miss Nightingale will speak specifically on cancer. But I suspect that you could turn to the book and look at some very technical and detailed study carried out by a researcher, and she'd be able to tell you that he's perhaps working in co-ordination or with the knowledge of an allied project perhaps in London, England, or someplace in the United States. This is constant and ongoing.

Joan, do you want to add to that?

MISS NIGHTINGALE: Yes. As Mr. Russell indicated, there is a constant network of communication with other researchers. At the back of your book you will notice that in this past year alone, 246 publications which emanated from the research in Alberta were accepted and published. That is a phenomenal achievement, and these journals are circulated throughout the world.

There are a number of studies, particularly related to pediatric leukemia, in which researchers here collaborate with researchers in other centres, to study particular disease entities or the effects of certain treatment modalities on pediatric leukemia. That is just one example. There are other examples which involve human interferon, which is research that is in fact being produced in laboratories in Alberta. So there are many examples of instances where it's essential that researchers here communicate closely with researchers in other fields and in other jurisdictions.

MR. ALEXANDER: Mr. Chairman, a couple of comments and then a couple of questions. First off, I was interested in the minister's comments that we could do a great deal to help ourselves with the application of some common sense. I share the minister's frustration. We both know that common sense has absolutely no place in the mentality of Canadians, particularly in the matter of health care and especially in the matter of costs of health care. With that as our unfortunate but basic ground, I wonder if I could ask a couple of questions about the management philosophy and operating elements of the hospital.

As a second comment, I might say I'm very pleased to see Mr. King as the new chairman of the board, and although I don't know Mr. Cramp, I hope he can bring a similar kind of private-sector business experience to bear on the policy management level of the hospital. Could either of those gentlemen or the minister give me some kind of indication as to what management philosophy, what control of operational expenses, may be put in place in the new hospital? I know we can't say anything quite as sinful as managing it as though it were going to be profitable, but let's say managing it on a cost-effective basis.

I note that in the document we've been provided with here, on pages 23 and 24 of the review of progress, comments are made that financial reports for operations have

> become increasingly important in the planning for the level of service to be provided at the Mackenzie Centre and the corresponding level of government funding to support the service.

On page 24 I find the very last sentence to be the source of my worry.

> At the same time, if the University Hospitals is to proceed with the full implementation of services in the ... Centre as programmed and designed, then funding must be provided in a timely fashion to coordinate this with the Hospitals' occupancy plans.

This has a distinctly supply-driven sound to it rather than a demand-driven sound, and I'm interested in the comments of both Mr. King and the new president as to their philosophy in terms of operations. After all, if we have the $412 million in capital costs behind us, that's just the beginning. Now the real costs start, because in operations on an ongoing basis those will be substantial. I'd be interested in hearing what the plan is to operate it on an operational control basis.

MR. KING: Mr. Chairman, first of all I don't want to hide behind my newness as well because I've only been on the job there a couple of months. I can assure you that when I was asked to take the position, it was with the suggestion that this was the most expensive hospital per bed in the province and it was desired that a businessman's point of view would be brought to its operation. It's certainly my intention to do that. I cannot give you specifics of what we propose to do or hope to accomplish. I can assure you that every element of cost is going to be carefully examined and the cost-effectiveness of what we do will be examined. The length of patient stay and things of that kind bear very strongly on costs of operating a hospital. That's being looked at.

So I can only give you the general assurance that I'm bringing a business point of view to it, and I'm sure that with his background, Mr. Cramp can support the same position.

MR. CRAMP: Mr. Russell, with your blessing I'll make a comment. I'm complimented to be here and thank you for the kind words of welcome. I too cannot be specific, but if I may comment on attitude, it seems a demonstration of courage to bring a business-oriented person and a University of Western Ontario business school graduate into this position, in dramatic contrast to the credentials that might have been brought. I believe that if I can instill an attitude that costs are a worthy matter — it's a very delicate balance for us to instill in a scientific mind the awareness of costs related to quality of care. I think we also have the aura of coming from a dominant financial environment that exists across the border. I hope all that symbolism is already being seen, that we do approach things in quite a businesslike, statistical, financial orientation, while recognizing, as Miss Nightingale commented, the need for research. It is my opinion that research must be supported as we move toward cost control. It's a symbolism I hope I can represent to instill an attitude, and I hope in a year's time we can be very specific on what we've done against that attitude set

I hope to instill.

MR. ALEXANDER: That didn't burn up my two questions. The first one was very long, and I'll make the second one a lot shorter. I'm sorry. Actually I appreciate those answers, and I wasn't really looking for specifics. I was looking for a management philosophy. I think you've both given it to me, and I must say I appreciate that.

However, I think there's one more element added to that, and it was touched on just a moment ago by Mr. Cramp. I suspect that the question of costs related to quality of care is going to emerge to impede the progress you speak of. I'm wondering if we could ask the minister to say to us, insofar as he's able, whether he will do whatever he can to provide a mandate to operate on a cost-effective basis. While I don't for a moment doubt the desire of many of the board members of the hospital and people who are already there as qualified businesspeople with experience in controlling costs and making things work sensibly, there is no mandate to do that in this country. So in a sense your hands are tied. As I say, you have a supply-driven business, not a demand-driven business.

I wonder if we could ask the minister whether he would support the management philosophy that's just been expressed, and with the help of the rest of us, try his very best to give this hospital and this board a mandate to operate on a cost-effective basis while we all sit here and know that there's going to be criticism because of this so-called quality of care. The quality of care may or may not be in the eyes of the beholder, but nonetheless we know it's coming.

Unless we are able to actually capitalize on the experience of people like Mr. King and Mr. Cramp — and I'm delighted to hear that he's a Western Ontario graduate in business; I couldn't hear better news — they're going to need a support level. They're going to need a mandate from the minister. They're going to need the support of the people in this Legislature to be able to keep those costs under control, because there's going to be a great outcry and a great demand for so-called quality of service and extension of services. Those two things are going to clash. You need support to do that, and I'd like the minister to say whether he would be prepared, if he can, to supply that kind of support.

MR. RUSSELL: Yes — that's the short answer to the question — not only support but I think pretty strong direction. We've been undergoing some pretty significant changes in the system since 1972, when the provincial government said they would pick up 100 percent of the costs of operating the hospital system and did away with local requisitioning, as it was known at that time. Over the years, I think we're developing a more sophisticated means of approaching what ought to be a reasonable budget for each hospital in the province. The old system, when you looked at last year's figure and tacked some percentage on and that was next year's budget, was not certainly not fair, not logical, and not effective. We've been turning that around now, and very significant progress has been made in examining the approved programs of a hospital, the number of full-time staffing equivalents that are needed to run those programs, and the extent of the programs as they respond to the community needs. That's really the essence of what our budgeting approach is all about now.

The department people have had some pretty heated discussions with hospital boards throughout the province, saying to them: you should be able to run your hospital for a year with 635 full-time staff, or whatever it is, and then the money flows. I have emphasized the staffing aspect because that's about 80 percent of the cost of the hospital. Some of those decisions are not completely within the control of the boards. They result from decisions coming from binding arbitration, et cetera. But to the extent that they are, I think it's coming under pretty good control.

A couple of years ago, we indicated to the hospitals that the days of automatically picking up your deficits are over, that there is a limit to the amount of funds, and that if you don't live within your budget, you can either reduce services or start charging your customers, and that's called the user fee. It has been an incredible success — and I underline the word "incredible" — because the boards have responded very well. Of course there was no special warrant for deficits at all this year; a year ago it was something like $140 million. I'm frustrated now that all parties in the Canadian Parliament have seen fit to penalize provinces that use that cost-control effect. I can't believe the stupidity of that approach. But it's there, and we have to work our way around it.

The last move we're taking, which will come into effect within weeks, is the carrot that if a board is able to generate a surplus, they are going to be able to keep it and not have to return it. The regulations that will permit us to do that are working their way through the administrative and committee system at the present time, and should be in place within a few short weeks. Again, I'm very much encouraged by the surpluses that were shown at the end of the last fiscal year. I think your board had a significant surplus for the first time in many years. So I am encouraged. I think we're starting to turn it around.

MR. THOMPSON: Mr. Chairman, I really support the proximity of the health sciences centre to the university. I think it is of real value. There can be a lot of co-operation and hopefully work together. But I have one concern to do with research. I think the proximity of the science centre to the university — I'm afraid that there's a dominance of the university when it comes to things like grants for research and that. The University of Alberta is in what I would call a dominant position when it comes to those kinds of things. I wonder if the minister feels that's a valid concern.

MR. RUSSELL: I am told that it is. I know this is one of the major problems the hospital board is looking at. Perhaps Mr. King will want to expand on what I'm going to say. When we were looking at the establishment of the heritage medical research trust, we were under the impression, I think naively, that this would sort of respond to the needs of medical research per se, and that's not the case. As you mentioned, the university has its own schedule and demands of research funding for all faculties. The Faculty of Medicine certainly has a large shopping list, and the hospital has its own specific programs. Then again we go into the specifics of heart and

cancer. It's also my understanding that the medical research trustees have decided to invest some funds in capital facilities for research space, which will be allied pretty closely to the hospital, in both Calgary and Edmonton. But your comment is quite right. I think the people in the medical part of it are making significant progress in getting their message across.

Mr. King?

MR. KING: I'm sorry, Mr. Minister, I really can't contribute anything useful to this point at this time. There have been other things occupying my mind there. The relationship of the university and the hospital on research hasn't got to me yet.

MR. RUSSELL: For those of you who might be interested in medical trivia, we were talking earlier about the communications among researchers in the world. I just happened to flip the report open to page 91, and you will see the brother of our Member for Red Deer, who has published three papers, from Edmonton — a local boy, if I can put it that way. That's money we voted. Dr. McPherson of course is the medical director at the Cross cancer hospital and has published three papers on the use of interferon. I think it's kind of neat that heritage trust funds are supporting the endeavours of a local fellow on a project of worldwide interest.

MR. ALGER: Mr. Chairman, to the minister. I can't help but think of the horrendous amounts of money that are required to run the total hospital system. Obviously you don't come to the heritage fund for all of those funds. Certainly through your budget in the spring, it almost baffles us to realize how much it really costs. I wonder, do people not contribute to the hospital system anymore like we used to? Are there no foundations of sorts that people can contribute their money to, say through wills and bequests, in appreciation or even to take the strain off the whole provincial system? For instance, you're going to go through some extra costs in a program I mentioned earlier. Will we have to go to the heritage fund for all these funds, or is there some other system of receiving moneys?

MR. RUSSELL: You may recall that last fall and again this spring we passed some pieces of legislation dealing with the standardized organization of hospital foundations. Some hospital boards had them and others didn't. But because of the growing interest in the very thing you mentioned, we did work out a system whereby I think there's a pretty good legislative package that deals with the formation and appointment of boards of trustees, auditing techniques, the use of the funds, et cetera.

Hospital board chairmen who have urged us to do this tell me they believe there's a very significant level of community interest out there just waiting to be tapped. I can very quickly think of recent examples of that. You and I were at a hospital opening in your constituency a couple of months ago, a small hospital in a small community. I saw three cheques in the four-figure range contributed from individuals that day. We know of a recent half-million-dollar bequest to the Holy Cross hospital two weeks ago. The General hospital was given their CAT scanner by a grateful patient several years ago. Those are the kinds of things that are out there which we hope to encourage.

MR. ALGER: I appreciate that it's still going on, Minister. Hopefully we could encourage those programs to be exaggerated far more than they are. I think it's a system that actually makes people feel better for their own sake and, as I say, takes the strain off the provincial taxpayer and indeed the fund. Thank you.

MRS. CRIPPS: Mr. Chairman, my question is a follow-up to Mr. Moore's. I was glad to hear there are mechanisms in place for communications between the various research projects so we're not duplicating identical research. Number one, I'd like to know what kind of library is being developed. I understand libraries are very, very crucial to the maintenance and distribution of information. Are we developing some sort of library at the Walter C. Mackenzie or through the cancer research that will ensure that permanent records of this kind of research and material are kept?

MR. CRAMP: On August 14 a remarkable new library opened in the Walter Mackenzie centre. The volumes are available to all staff members and physicians, and I believe the budget is generous in the fact that suitable publications, all current, are available. The sharing of information, be it research or on the side of education, is available without qualification in this province. It opened to resounding applause.

MRS. CRIPPS: Joan, could you expand on what's happening with the cancer research specifically?

MISS NIGHTINGALE: Yes. They maintain excellent files in terms of their publications. They have access to computerized sources which indicate what publications there are. They can connect to New York or anywhere where there's a computerized system to do literature searches, and they establish a significant library through the Faculty of Medicine and have access to interlibrary loans. An essential part of their work is to be extremely well informed on all aspects of their research. It's essential they maintain it.

MRS. CRIPPS: What balance is there between applied research and pure research in, say, the cancer and heart research?

MR. RUSSELL: That's a question I'm not able to answer for two reasons. First of all, I think the definitions in each field, applied and pure, have been open to different kinds of interpretation. Certainly insofar as the heritage fund for applied research programs, that was one criticism that came to us in an early stage of the program. For example, if we were expanding a room in a certain hospital to make way for some kind of new equipment that was being funded under applied research, there was criticism that the acquisition of equipment really couldn't be regarded as research. On the other hand, you can argue that if the doctors need that to do new things, then of course it is. So it's pretty hard to break it down.

I think your question on the pure research part of it should be saved for September 6 when the trustees

will be present. They have some pretty stringent rules about the allocation of their funds. I think these two programs, the basic heart and cancer research programs, have been pretty loosely interpreted.

Joan, do you want to comment on the cancer thing?

MISS NIGHTINGALE: Yes. With respect to the treatment of cancer, it's essential that they do so in a research environment. Many of the treatment modalities are research. They simply have to try the drug or radiation on patients. As new developments come on stream, this treatment modality is used clinically on patients. There is a very stringent network of ethic committees that would make representation to the researchers about the ethics of doing certain procedures, so they are guided by some pretty stringent guidelines. However, with respect to cancer, it's essential that much of what they do is of a research nature.

MR. NELSON: Mr. Chairman, I guess what I'd like to do is basically follow up on the questions in the research area, especially those that relate to cancer research at the various locations in the two major cities. There seems to be an exceptional number of — I don't know what you'd call this — smaller funded type programs at these locations. I'm just wondering, is the information that's being gained from this research bearing fruits to the extent that it can be used to suppress cancer? What other breakthroughs are we seeing in conjunction with other researchers throughout the world that are beneficial to the moneys expended in this program?

MR. RUSSELL: I'm going to ask Joan to expand on my brief comments. The program requires and has built into it annual evaluations by juries from the two universities, the University of Calgary and the University of Alberta. Those evaluations come directly to me and take a pretty hard look at the effectiveness of the programs. It's like anything else. Some of them are very successful and some aren't very significant. But if you don't try them, you'll never know.

I think it's fair to say that there's been incredible success in the treatment of cancer in recent years. In treatment I include the aspect of identification, because certainly citizens' knowledge seems to be greatly expanded. Our identification is occurring earlier, and our treatment techniques are gradually improving. With earlier detection and the ongoing improvement in techniques, we are having a success rate in the treatment. Of course the world is waiting for the headline that says, Cure for Cancer Found. When that may occur, I don't know. But in the meantime I think it's fair to say that because of programs like this and others around the world, the situation is improving dramatically. Joan?

MISS NIGHTINGALE: We are aware of significant achievements in the treatment of certain types of cancer. Much of that work has been done by the physicians who are practising here at the Cross Cancer Institute and the University of Alberta. Of particular interest is some unique work being done in the treatment of lung cancer and the use of laser surgery and laser instrumentation by Dr. Garner King and other physicians at the Cross Cancer Institute. There is unique and significant progress with respect to the survival rate of those patients with prostatic carcinoma. They've been able to decrease the first-year and five-year mortality rates of these people. There's significant work being done in the treatment of leukemia for children, in that they are able to prolong their lives and practically decrease the five- or 10-year mortality rates to very, very reasonable figures. They do significant work in the use of radionuclides and pharmaceutical agents that are able to, if not completely cure the cancer, arrest the disease for a significant period of time.

The fact that these researchers' publications and the work they're doing are able to be accepted in the scientific journals to the extent they have been is a tribute to their recognition worldwide, because the competition is phenomenal. The researchers here have gained an international reputation in a very short time.

MR. NELSON: Thank you. Mr. Chairman, to the minister. I guess I got onto this yesterday with Mr. Diachuk with regard to all the different research projects he was involved with. Certainly they weren't of the same standard as this. Mind you, looking through some of these projects, I couldn't tell you what they are because I can't even pronounce some of the words they use, let alone understand them. I just wonder why we don't put considerable moneys into a smaller number of major projects to possibly come up with a more significant advancement into the cure of cancer, let alone some other diseases such as heart disease and what have you. I'm focussing at the moment mainly on the area of the cancer situation. Would we not bear more fruit by spending more dollars on larger research programs than expending them on all these little ones?

MR. RUSSELL: I don't believe so. I have the same problem as you do in reading the report and trying to understand what these things are. But I think one thing comes through, and that is the complexity of it. There's not going to be one cure for something. As these scientists and doctors make their applications for research projects, they're going down a path where they're looking for something and saying, if there was a way to identify this, then maybe it would make it easier to open the door I'm trying to get through down here. So you get into all kinds of very, as you say, small or seemingly very specific things, but they're all very important to the total picture. It's like a jigsaw puzzle. It would be nice to have the total painting or picture immediately, but it's made up of many, many small pieces.

The advice we get comes from the jury and the scientific review committee of course, and not all applications for research are approved. If you go to the front of the book, you'll see the names of the people that sit on the committees and how the program is administered. In the earlier years we had many applications and very few approvals. Now we're getting fewer applications and a higher percentage of approvals. I think the medical community has learned what the guidelines and parameters are, and we're getting far better applications. That's a layperson's explanation.

Joan, again you may want to supplement something I've missed.

MISS NIGHTINGALE: I can't add a great deal to what you've said, because you've been right on. It is an immensely complex area. In cancer research the main focus, or a good deal of the focus, is concentrated now on immune response, molecular changes in antibodies and antigens, and all those things we're now beginning to understand about the genetic structure of cells. But it's an immense problem. Different tumours or cancer cells grow in different organs of the body, and they all have to be studied separately. They are all affected by different hormonal reactions within the body. It's mind-boggling. It is an extremely complex science assisted by the number of people who are working in the area. I believe the only hope we have of eventually reaching any cure is by continuing to make more and more moneys available for the scientific endeavours of a wide range of specialists.

MR. NELSON: Thank you very much. Mr. Chairman, to the minister again. I guess your reply has opened up the door for a subsequent question. I really don't disagree that you need to take it step by step. But as you're taking it step by step, and if the researcher has an end goal in going through these steps, why would you or the researcher not put a total package project together with what he wishes to achieve in that end result by going through these various steps, and make one major project out of it rather than bits and pieces? It seems to me that you would have a continuing thing rather than a reapplication for something to go from that first step to the next step in the future.

MR. RUSSELL: I don't know how to answer that question. I don't even know if such a thing is possible. If you go through the three sections of the report that the funds are supporting — the research projects themselves, the paying of research personnel, and the acquisition of research equipment — on any given page you'll see the title of each project that was approved. They're pretty specific and pretty complex. However, it's interesting. You can sort of flip to any page, and you'll see that there is probably a relationship in many cases between or among the projects listed on that page or between projects that have been approved and equipment that's being purchased. I have the impression as a layperson that there's a pretty good assessment being made of these projects as parts of the total picture. But again, when the average person looks at it, they think: well, that's pretty specific.

I just happened to flip open to page 51, and there's Dr. Paterson at the bottom doing something very, very specific that deals only with the liver. You'll see other parts of the body mentioned on other pages. Other than the academics, who knows what those other things on that page are. I certainly don't, but they do tie together.

MR. MARTIN: Mr. Chairman, I just want to come back to the Walter C. Mackenzie Health Sciences Centre. We've been talking about common sense, budgeting, and costs — all things that are important in every area. I'm sure it was good news that it's down to $412 [million]. I recall its being up to $600 million at one time. But Mr. Minister, the original was a hundred and some million when it was first announced. I know we've gone through this. It was the inflation factor at the time. I guess what most people don't understand is that if they build a house or something and they tender it out, the inflation factor is taken into consideration on the final project. Maybe this isn't possible. Because $412 million is a lot of money, especially when it was originally budgeted at a hundred and some, my question to the minister is, have we learned anything if we go into another major project like this? Would we have some more control over the inflation factor? It seems to me that with this project, we were strictly on the whims of what was happening with the economy. It could have skyrocketed even more. I think the minister would admit that. But have we learned anything in terms of any other projects we may get into in the future?

MR. RUSSELL: We've learned a great deal. As I said before, I tried to be very frank with this project. It wasn't all inflation. Because of the nature of the thing and the procedures that had been developed, I think there were some aspects of bad project control in the early years, even getting down to the way individuals were able to have direct access to the architectural consortium, the way their directions went forward, and the way tenders were handled. We've certainly made very, very significant progress and learned a lot from that.

The other thing of course was inflation. Hospital boards throughout the province, in fact any developers of any major capital project, had quite a time when that was taking place. You build a house in six months, so you're probably building it within the time constraint of any particular union agreement that might be in place. But when you have a project that's going six or eight years, it's pretty tough to guess at what those figures are going to be. Of course when inflation was soaring and the economy had that overheating, it was very difficult to manage projects of this nature. So there are two aspects.

If we go back a decade ago to the original time when they said phase one ought to cost $130 million and phase two ought to cost so much, that certainly didn't recognize any of the new factors that would arise when they got into detailed programming and development. It certainly didn't recognize the looseness of the project management and its effects in the early years, and of course it had the challenge of wrestling with ongoing inflation. It's coming back down now. We've got tighter management, and I think the loopholes have been closed. The management is good now and they're on track. There's a good, tight system there, and that's been combined with a decrease in the inflation factor in the construction industry. All these things have helped bring it down. But literally a year or two ago, I had no way of knowing what figure to compound for the remaining four or five years of the project. That's why we had that very broad range of final estimates, $450 million to $600 million. If the rate holds where it is, I'm sure they'll come in close to the $412 million mark, because they're marching toward completion. So yes, we have learned a lot.

At that time the construction industry and the design professionals were advising us not to put out

big projects in lump-sum tenders, because we were paying through the nose for it and it was better to get the smaller tenders out under construction management. Of course you don't hear about the ones that have done that very well. The Grande Prairie hospital and the Rockyview hospital are success stories in that field. The new Medicine Hat hospital was supposed to cost $80 million. It's going to be finished for $61 million, and it's construction management. So those are the examples of where the system worked well.

This was an incredibly complex project and was built on the site of several existing buildings that had to be kept going and torn down as the new structure proceeded, under the conditions I mentioned earlier. So we have learned a lot, and hopefully our experience will benefit future governments.

MR. MARTIN: Just to follow up on that with the obvious. If there's bad management you deal with that. The tendering was the other aspect. If I understand the minister, one of the things we've perhaps learned is that if you have a long-term project over four or five or six years, you have more specific goals within the year on the tendering process. Am I correct in that assessment? If they're trying to estimate a project over four or five years — and we can debate whether it was cost-plus in terms of the bidding and that — is that the major problem in terms of the tendering and why it got out of control?

MR. RUSSELL: No. I don't think the tendering got out of control. I think the design of the building got out of control. It got out of control by way of the loose organization of the user groups. The idea was out there that the government wanted to fund a superb project with the best standards. Of course that was interpreted by a number of people. Because the organization wasn't there to funnel everybody's shopping list in a very disciplined way, the thing did get out of hand in the early stages. There's no question about that. We've had long debates in this Legislature about what happened. That's been stopped. The process is now tight and it's working well.

As far as tendering is concerned, there's a great deal of opinion that in days of increasing and rapid inflation, it's to the owner's advantage to get tenders out quickly and keep them going while you're designing the building. They could have spent another three or four years finishing the construction drawings for the buildings and put it out as one lump-sum tender, but you miss the lower inflation rates of those early years. So the theory is, get as much tendered and signed up by way of contracts as you can while prices are good. Of course we're hearing that argument today: build now because prices are low and very competitive.

I mentioned the projects that had been successful using the construction management technique. With respect to the two new urban hospitals for Calgary and Edmonton this year, when we prepared the drawings we did them both ways. They were designed in such a way that they could go out as eight sequential packages or one lump-sum package. When the day finally came when it was time to go, the advice was to go with one package, which we did. Aside from some preliminary site preparation work, the construction of the building will be one package. We have the tender in for the Calgary hospital, and it's a fixed lump-sum tender several million dollars below our estimate. There again that was the right decision, but two years ago there was no way of knowing whether or not that would be the right decision.

In fairness to the University of Alberta's hospital board, I think they were launched on a project that was ill-defined — by "ill" I mean very loosely defined — in a day when oil royalties were pouring into the provincial coffers. They were encouraged to do the best and design a centre of medical excellence, and in the early years the system was simply not there to cope well under the conditions I've mentioned.

MR. MARTIN: Just to go into one other aspect. I'm a little vague on this, but if you recall, there was on the books a possible phase three of the Walter C. Mackenzie Health Sciences Centre at some point. Could the minister update if that's still on the books? Is there any possibility of that going ahead? What are the plans with phase three?

MR. RUSSELL: I mentioned that there are those three specific add-on projects, if I can call them that, although it's not really the right term because they were always there, as I identified, as something that would have to be considered at some decision day. They're there. It's possible that I will be coming back to the Legislature for an extension of more money. Insofar as phase three is concerned, I think that's on the back burner for now.

MR. KROEGER: Mr. Chairman, if I can divorce myself from the first half of the comments Mr. Alexander made, which had to do with the lack of common sense on my part for smoking, the point I was going to make was the one he was on, so I won't repeat it.

I'll confine myself to congratulating George Beck for having survived the system this long and welcoming Edge King on board. You and I have had some conversations in the past. Mr. King hails from the same general area I come from and has been around. I'm sure your expertise will be appreciated. I can't comment on the other new people. So with that, I'll just sign off, Mr. Chairman.

MR. CHAIRMAN: That's the east-central Alberta connection coming through here. Mr. Musgreave, to be followed by Mrs. Cripps and then Mr. Zip.

MR. MUSGREAVE: I have one quick question that really doesn't relate to the heritage trust fund, but the minister raised it. Having sat on a major hospital board for seven years, when every budget was larger than the last, I'm glad we are now finally getting to the point where we have surpluses. My concern, though, is that if you have a surplus, maybe you're giving them too much in the first place. I wonder, are they able to hold all the surplus or just a portion of it?

MR. RUSSELL: It will have reasonable caps on it, and those will be included in the regulations that are going to be made public within a few weeks. I can't imagine a hospital board managing to accumulate something beyond the cap we're proposing, but I

suppose it's possible.

MR. MUSGREAVE: Mr. Chairman, the other question. I noticed in the reports that there were two studies done, by the University of Alberta and the University of Calgary, wherein they were evaluating the programs and were then to report to the minister. Have you received these evaluations, or are they . . .

MR. RUSSELL: I haven't received the ones for last year yet, but those juries report annually.

MR. MUSGREAVE: Does this determine how the jury makes further awards? What is the purpose of this evaluation?

MR. RUSSELL: I think an outside evaluation when the projects are finished or as they're nearing completion is a very essential part of any research program. It's like a third party sitting in judgment saying: yes, that was a good decision; this has been very effective; or, in this case we didn't learn very much, and the thing should probably not be proceeded with because somebody else is finding similar results in another part of the world. There are all those kinds of comments.

MR. MUSGREAVE: The last question, Mr. Chairman. In effect this does control the jury's future granting. Is this correct?

MR. RUSSELL: I don't know if I'd use the word "control". It probably has an effect on it. Joan, how does the jury use those evaluation reports?

MISS NIGHTINGALE: They're used as an objective review by a scientist who's working in the same field to determine the worthiness of that project: did the scientist achieve his objective, and if so is it worth while to continue in that field of inquiry? It's of a very rigorous and confidential nature as well, because a research scientist from outside of Alberta who's commenting on the work of another research scientist would only do so candidly if it remained confidential. That report and the evaluation of that researcher is used as feedback to the researcher, and it may guide the research panel as well in the selection of projects for future grants.

MRS. CRIPPS: Mr. Chairman, I have a particular interest in the cardiac unit in the new Walter C. Mackenzie hospital. Maybe the minister could give me an evaluation on where the development, as I understand, or completion of the rest of the projected cardiac unit will be done.

MR. RUSSELL: I'm unable to answer that question. I'll ask Mr. King if he can.

MR. KING: I was afraid you were going to ask me, Mr. Chairman. I'm afraid I haven't got the specific detail on that.

MISS NIGHTINGALE: I could probably answer that in a very general way, because on behalf of the Department of Hospitals and Medical Care, I review and recommend on the projects related to critical care. The cardiac unit, specifically the pediatric cardiology unit, is designed for phase two of the health sciences centre, and it's on stream. In the meantime they are able to occupy the diagnostic cardiology area in phase one of the health sciences centre. I believe you may have seen an announcement in the newspapers a few weeks ago that they are now occupying the pediatric cardiology diagnostic area. In the meantime those children are being accommodated in other areas of the hospital.

MRS. CRIPPS: Everyone recognizes that certain specialized operations can only be feasible in high-population centres. Is there a danger of fracturing the capability of cardiac specialization in Alberta by developing two or three centres in the province, or are they compatible and complementary?

MR. KING: I would like to answer that. It's my understanding they are compatible and complementary. I've discussed it with my opposite numbers in the Foothills hospital, and it seems to be agreed that there is an adequate need for the work in both centres, Calgary and Edmonton.

MRS. CRIPPS: I guess the third question relates to Mr. Russell's earlier answer on the development of the facility. How many doctors have been attracted to the province in both heart research and applied cancer because of the special support we have in Alberta in funding the excellent facilities and the research component?

MR. RUSSELL: Joan Nightingale may have the answer to that, specifically with heart and cancer; I don't know if the number is significant there.

You're going to get a very, very encouraging story in September when the board of trustees of the medical research trust appears in front of you. The number of people that have been attracted here, particularly to the University of Calgary, has been quite startling. They're building up an excellent nucleus of brainpower there. Joan, do you want to supplement what I'm saying?

MISS NIGHTINGALE: That's entirely correct. I don't have the exact numbers, but in cancer research alone it's in three digits. Just in the last few years, since the Alberta Heritage Savings Trust Fund applied research for heart, a cardiac catheterization laboratory has been established at Foothills hospital. They have attracted probably six world-renowned researchers in cardiology. That is just one facility. There are a significant number of researchers coming into Alberta because of the heritage fund.

MRS. CRIPPS: Thank you. I'll ask the question again. I guess Mr. Kroeger shows much more sense in his assessment of the high qualifications of you gentlemen than he does of his smoking habits, and I welcome you.

MR. CHAIRMAN: Mr. Russell, perhaps you might undertake to obtain the information Mrs. Cripps requested with respect to the number of doctors and medical people involved in research as a result of these programs. Send it to me, and I'll circulate it to committee members.

MR. RUSSELL: I'll do that.

MR. ZIP: Mr. Chairman, I'm very happy to see the serious and very courageous efforts our hon. Minister of Hospitals and Medical Care is making toward introducing accountability into the horrendously costly area of taxpayer involvement in health care. Of course part of this taxpayer involvement is in the funding of medical research, which is what we are discussing here today. I guess my question was answered in large part but not entirely. With the very lucrative financial rewards that are available in private practice for people who are highly skilled in the medical field, I wonder how difficult it is to obtain the best researchers for our medical research programs.

MR. RUSSELL: I don't really know how to answer that question. We went into that in a fair amount of detail when the heritage medical trust was established and when the legislation was written. There were some obvious principles that came through by way of advice that the Premier got by really searching for it on his world travels. Certainly one thing that came through in making programs attractive was that the financial tap had to be secured. Of course many of these trusts are organized in such a way that when times are tough for government, they turn off the research funds. That's tough on people in the research field, so our Act is written in such a way that it prohibits that. The capital pool is at arm's length from government, and the income from it can't be turned off and on by government. So that was a significant thing.

Secondly, of course, is the establishment of a critical brain mass and medical and science community, because these people are unique and don't work in isolation. They come to places where their colleagues are. It's a kind of ripple or snowball effect in a way, because if a jurisdiction is fortunate enough to acquire a person of international prestige, then he or she automatically attracts others who want to come and work with him or her.

The third thing we were told or advised is that we shouldn't attempt to go out with our money and buy somebody else's Nobel prize winner but that we should establish a system whereby in a few years we would have developed our own Nobel prize winners. Again, that's a policy that's underlying the program.

MR. ZIP: Thank you. I gather from this that the remuneration isn't really the prime consideration of these people who go into research, and that's substantially lower than what they could make in private practice.

MR. RUSSELL: I would guess that's probably true in the majority of cases.

MR. ZIP: What is being done to make the financial rewards to these researchers more attractive, or is that not a main parameter?

MR. RUSSELL: It's not a problem that's ever been presented to me. You look again in the cancer annual report and get an idea of the scale of funds in gross amounts that researchers are being paid. To my knowledge there has not been any unhappiness expressed with those ranges.

Mr. Chairman, Mr. Martin is back now. But for all members, in the report that deals with the Mackenzie Health Sciences Centre, probably the best dollar summary is Schedule 1 on page 52, because it goes back to 1975. You will see what the people estimated then. It deals with budget changes that had nothing to do with inflation but dealt with project management and control. Column 3 gives the effects of inflation. Column 6 of course gives the final figures. Down at the bottom, you will see that a year ago we were estimating roughly $420 million, and this year it could come in at $408 million. But that's a good capsulized financial summary.

MR. CHAIRMAN: Would there be additional questions from committee members?

There being none, Mr. Russell, we thank you again for your annual visit with this committee. We wish to thank the people that were with you as well and to wish particular good luck to the two new gentlemen on board. Mr. Russell, if all goes well, we will look forward to seeing you again one year hence. In the meantime, may we wish you and your officials the very best. Thank you.

Members of the committee, just to bring you up to date, next week, Tuesday, August 28 — no committee meeting. On Wednesday, August 29, we have the Hon. Dick Johnston here in the afternoon. On Thursday, August 30, we have two meetings, one at 10 o'clock in the morning with the Hon. Fred Bradley and then at 2 p.m. with the Hon. Hugh Planche. On Wednesday, September 5, the morning meeting is no longer, but in the afternoon we have the Auditor General with us. On Thursday, September 6, we have the Alberta Heritage Foundation for Medical Research.

Miss Conroy will be putting out an addendum to this schedule as a result of the changes I've just announced, which all committee members agreed to. There will also be one or two other minor adjustments. The meetings will remain the same. It's just a shuffling of people because of commitments they have.

I thank you very much. If there's no further business, we'll declare the meeting closed and meet again next Wednesday.

[The meeting adjourned at 11:35 a.m.]

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