[Chairman: Mr. Oldring] [2 p.m.]

MR. CHAIRMAN: I'll call the meeting to order, if I may. In light of the light attendance, Mr. Minister, you might want to move a little closer to the rest of the group, rather than sitting down there on your own.

While the minister is moving down, I might remind the members that when you're speaking, please make sure you are sitting at the table. At the last meeting I noticed that some of you were inclined to be a little way back, and it was difficult to pick up the recording at times.

MR. R. SPEAKER: Well, the laid-back approach is more acceptable today.

Are the Liberals and NDP snowbound somewhere, so they won't be here? Is that what you were saying, Mr. Chairman? Are the Liberals and NDP not in attendance today?

MR. CHAIRMAN: Gee, I didn't notice.

This afternoon we're going to be discussing Hospitals and Medical Care. I want to welcome the hon. Mr. Moore, Minister of Hospitals and Medical Care, and his executive assistant, Susan Green.

Mr. Minister, you'll be happy to know that one of the first projects the committee had an opportunity of touring was the Walter C. Mackenzie institute, at which time we had an opportunity to meet with the president, Donald Cramp, and also Mr. King, chairman of the board. Mr. Portlock arranged the tour through the facility. I think it's fair to say that the committee was most impressed with the facilities there, and we're very proud and pleased that we can offer that level of medical service to Albertans. As we went through the children's ward, it was interesting for me to note that there were a number of infants from the city of Red Deer being well taken care of.

Mr. Minister, you might want to open with a few brief remarks to the committee, and then we'll turn it over to them for questions. Members might want to turn to pages 19, 20, 22, and 23 of the annual report to refer to some of the areas we'll be covering this afternoon. On that note, Mr. Minister, I'll turn it over to you.

MR. M. MOORE: Thanks very much, Mr. Chairman and members of the committee. There are two specific programs under the Heritage Savings Trust Fund capital projects division that I'm responsible for as Minister of Hospitals and Medical Care. I'd just like to highlight each of them.

The first I'd like to speak to is the Alberta Heritage Savings Trust Fund applied cancer research program. Members may recall that earlier this year I distributed to most of you, I believe, a copy of the annual report of the applied cancer research work for the year ended March 31, 1986. I'd like to briefly highlight what is in that report, Mr. Chairman.

First of all, during the course of the fiscal year in question there were 10 new research projects approved and 53 renewed approvals for continuing research on projects that had been approved in previous years. In addition to that, there were funds for what's referred to as core support for the maintenance of research facilities and/or major research projects: the research scientists and major equipment.

This year's report deals with continuing research in such areas as cancer of the lung, colon, ovaries, prostate, breast, and the blood. Some of the major research initiatives that are presently under way are grants to study the application to cancer of magnetic resonance imaging. For those of you who may not be aware, the latest in X-ray equipment that is available for practical medical use and for research is called a magnetic resonance scanner, and it is a more advanced piece of equipment than the CAT scanners which are going into a number of hospitals at the present time. We have one of those machines at the University of Alberta hospital. It's actually under experimental use at the present time. In addition to that, there have been studies of leukemia cells from centres all over the world, studies on the use of radiation and immunology to detect breast and colon cancer, and many studies on cells and genetic development of cells and their immune reaction to various drugs and radiation, et cetera.

In total, the cancer research projects employ some 73 different investigators, and they were responsible for some 81 different grants over the period of this fiscal year. In addition to that, there are a number of laboratory personnel and research assistants, so there is quite a work force involved in this particular project. Of the $4.8 million that was approved

for actual projects, 42.5 percent went to University of Alberta researchers, 37.4 percent to the University of Calgary, and just over 20 percent to the Alberta Cancer Board. Grants were also awarded for specific research equipment required by principal researchers for particular projects.

Mr. Chairman, that's just an overview of the cancer research project. It's one that is obviously designed to pay dividends over the longer term, but we are already seeing the effects of this work over a short period of time. Literally hundreds of Albertans are alive today as a result of the work that's being done with these research dollars. While its major objective is longer term, certainly some short-term benefits in terms of improved methods of detecting and treating cancer are already being felt in the system.

The second major project your committee would be interested in, Mr. Chairman, is the Walter C. Mackenzie Health Sciences Centre complex, which opened just a couple of months ago its final phase in terms of health care. There is still some work to do. Again, you have available a report that outlines what was done there in 1986. The project is now almost complete. The total budget to completion as of April 1, 1986, is $415,573,499. As of March 31 three major activities remained to be undertaken to complete the project: demolition of the old hospital; landscaping of the grounds where the demolition will occur, for parking, lawn, open space, and so on; and renovation of the Clinical Sciences Building for research space.

I might add that while that was the status as of April 1, 1986, since that time there have been some changes with respect to the demolition of the Clinical Sciences Building and a communications corridor that was considered to be built. Since April 1 the University hospital board has come to us and suggested that within the same scope of dollars which had been previously approved, they could build some new research space at another location adjacent to the heritage medical research building, which is presently under design for construction. They could build some new research space, as opposed to renovating the Clinical Sciences Building for research space, and then renovate the Clinical Sciences Building for office and administration space, thereby providing a better operational plant than the previous proposal had considered and do it within the dollars that had been allocated. That has in fact been approved.

We also had another look at the proposed communications corridor, which would have connected the Cross cancer clinic with the University hospital buildings, and decided to defer any construction of that until such time as we were certain what direction we were going to go in terms of upgrading and new construction at the Cross cancer clinic.

Finally, and perhaps most important of all, the original plan had us demolishing the old sections of the University hospital, the first one being built in 1912, I believe, up to a 1957 wing. We recently became concerned about those plans in light of the shortage of auxiliary hospital beds in the city of Edmonton, and I asked the board of the University hospital to reconsider the demolition of the 1950 and 1957 wings, which contain about 400 active treatment beds. I've asked them to maintain the utilities to those two structures over the course of this winter, not to demolish them, and to undertake a short study which would indicate the capital costs of some refurbishing of those wings and determine what the operational costs would be if we made them into auxiliary beds, noting that we would have to free up some additional space for auxiliary hospital programming, like physiotherapy and that sort of thing. We believe it's possible to get 300 auxiliary hospital beds there at much less cost than constructing a new building.

It has been noted as well that the old '50 and '57 wings of the University hospital are probably in much better repair than some of the existing auxiliary hospitals, like St. Joseph's, half a dozen blocks away, which has fallen into disrepair. So that's a change, Mr. Chairman, from the status of the hospital at the end of March.

In summary, this project will leave Alberta with the finest facility of that kind anywhere in Canada. It's a showpiece for the world, for that matter, but more important than that, it's left us with recognition by the medical community throughout North America that Alberta is indeed the centre for medical research activity. We're now attracting a great many specialists and research scientists from other parts of North America and the world, which will continue to make us the leading researcher in Canada in terms of medical research. I'm very pleased about what we've been able to do

there. It's extremely costly in terms of its capital development, but we were able to do it at a time when the funds were available, and it will provide an opportunity for us to be a leading researcher in years to come.

Mr. Chairman, that's about all I need to say in opening remarks. I'd be pleased to answer any questions. I should have introduced Susan Green, who is my senior policy adviser in the Department of Hospitals and Medical Care.

MR. R. SPEAKER: Mr. Chairman, I was wondering if the minister would comment on the projected costs for this next fiscal year. What do programs under his responsibility look like in terms of needed dollars?

MR. M. MOORE: In the next fiscal year?

MR. R. SPEAKER: Right. The ones up to March 31, 1986, are listed here, but I was thinking of what you're looking at into '87 and '88 in terms of capital.

MR. M. MOORE: You're talking about the Mackenzie Health Sciences Centre?

MR. R. SPEAKER: Yes.

MR. M. MOORE: We're looking at renovations to the clinical sciences building and development of new research space. The renovations to the clinical sciences building to provide space for administrative and teaching functions were estimated in April '85 dollars at $6,094,900. We have also approved the hospital's altering the scope of the project without increasing the budget to construct 7,900 square metres of new research facilities in conjunction with the heritage medical research building project, which I talked about a moment ago. That's within existing approved dollars. I'm not sure exactly what that will cost. The renovations to the Clinical Sciences Building are just over $6 million, and the new research space . . . I'll have to provide that to you in a moment.

MR. R. SPEAKER: Will the amount requested be a reasonable amount? Six million is still reasonable. From all indications, are you going to be able to meet those commitments?

MR. M. MOORE: That's not yet been finally determined, but certainly the whole project is winding down, and the dollar costs associated with what's left to do are much less than any previous year. I can't answer the question.

MR. R. SPEAKER: Do you feel comfortable breaking it down to that amount?

MR. M. MOORE: I have no problem with that. The only thing I should say is that like any other hospital project, until the tender is actually awarded, there is always some chance, because of cost escalation or the government's decision to reduce expenditures, that it may not go ahead.

MR. R. SPEAKER: Is there any market value to this point in terms of the research that has been done and the accomplishments made?

MR. M. MOORE: Are you talking about cancer research?

MR. R. SPEAKER: Applied cancer research. Or is it pretty well distributed to the common public market once discovered?

MR. M. MOORE: I am not aware that there is any market value to the research yet, but there certainly could be. As I understand it, both the university and the Cancer Board have the rights to anything they might develop. As far as I am aware, they have so far not reported any cash return from the work they've done. I'll check that, though, to make sure, but having read the report, I don't recall that there was any cash return.

MR. R. MOORE: Mr. Minister, I'm interested in research dollars and how they are utilized and what is given priority for research. I think we all understand that cancer research is a priority item right across the country and is taking a lot of dollars, time, and people. However, in your opening remarks, if I understood you, you said there was a certain split in research dollars, so much going to U of A, so much U of C, and 20 percent to the Alberta Cancer Board. Is that a true figure of what's going for cancer? Is cancer research involved at U of A and U of C? Are they getting more in their programs directed to cancer research, or is 20 percent of that money all that is going to cancer research?

MR. M. MOORE: In the fiscal year we're talking about we've only got $4.8 million approved for actual projects: 42.5 percent to the U of A and 37.4 to the University in Calgary. I have no idea how much more money might be channeled into cancer research, but there would obviously be a significant amount in various ways. There is a lot of research, as the hon. member knows, that is of a general nature and is of benefit to cancer research. I wouldn't know what that would be, but there would certainly be more.

MR. R. MOORE: I was glad to hear another thing in your opening remarks. You underlined the fact that you're taking a second look at the demolition of some of these older hospital buildings and seeing whether they can be utilized. Right across the province -- and my constituency is no different from others -- we've seen a new hospital built and the next step is to demolish the old hospital alongside and make it into a parking lot, then three years down the road say that we need more auxiliary and nursing home beds. If we look back, there is no reason the old hospital couldn't have served.

You've indicated that you're asking them to take a second look at some of that demolition over there at the U of A. Is this going to be policy across the province in this area, or are we going to try and encourage utilization of a lot of these older hospitals rather than demolish them?

MR. M. MOORE: It always has been policy that we look at whether or not we can utilize an existing building, but there are two problems associated with that. The first one is operational costs. Oftentimes in active treatment hospitals the operational costs of continuing with an old building are greater than the costs of building a new one, when you consider the refurbishing that's required and everything. So that's one criterion.

The second thing that's occurred most often is that when we've said, "Can we use the old active treatment hospital for an auxiliary facility?" the consultants have come in and said: "Yes, you can. All you have to do is tear down everything except the foundation and build a new building, put in new electrical, new mechanical, new plumbing, and new everything else." In my opinion, all that is not always necessary. We've already got a estimate of what it will cost to refurbish the '50 and '57 wings of the University hospital for an auxiliary hospital, and it's more than the cost of building a new auxiliary hospital. But the people who gave us the cost estimate gave us a Cadillac system. They recommended tearing out all the electrical, the mechanical, and the whole bit, and you simply don't have to do that. It isn't necessary that every building meet 1987 standards. I said to them, "Go back and tell us what it will cost to put on some wallpaper and some new tiles and paint the ceiling." So I'm hopeful of getting some better answers, recognizing that there are more difficult economic times. Hopefully we can get somebody to give us a cost estimate that will be reasonable.

MR. R. MOORE: When we're talking about hospital beds, Mr. Minister, we hear a lot about the need for active treatment, auxiliary, and nursing home, and then we hear we're opening and closing. What is the situation right here in Edmonton in relationship to hospital beds? There is a lot of misunderstanding out there as to what the demand is: what we have and the utilization.

MR. M. MOORE: With the hospital construction that's presently under way in Edmonton, which is mainly the Mill Woods hospital, with its completion, when it's opened, we'll have almost seven active treatment beds per thousand population in Edmonton. The provincial target now is four active treatment beds per thousand people in the province. Recognizing that Edmonton is a regional referral centre, you might get up to four and half or even five. So with the Mill Woods hospital, we have more active treatment beds than we require, probably by at least 700 or 800, maybe 1,000.

On the other hand, we have 750 people on a waiting list for auxiliary hospital beds, and the auxiliary hospital system is full. Three hundred and fifty of those people are in active treatment hospital beds in Edmonton right now. If we were able to move 300 of those out — and it would be reasonable to suggest we could — we'd free up another 300 active treatment beds. So the real need, in Edmonton in particular, is for auxiliary hospital beds, not active treatment beds.

I should say that the same situation exists in

Calgary, but not nearly so pronounced, in that here are only about 200 people waiting for auxiliary beds in Calgary as opposed to 750 here.

MR. HERON: Mr. Minister, for a moment I'd like to just stay on that topic of reusing the old university hospital. When this committee toured over there, some views were expressed by members of the committee as to what a shame it would be to demolish those, and certainly the little drawing inside the door and the model has it as a landscaped park. I'm just wondering what initiatives bring about something like that. Is that something that comes from your ministry as a recommendation to the board? What happens in a situation like that?

MR. M. MOORE: What happened in this situation is that I went to the finance and priorities committee of cabinet, which is chaired by the Premier, with the university's request for a change in the scope of their project to add a new research building and to change the configuration of the modifications to the Clinical Sciences Building and build this pedestrian corridor. During the course of that review of the whole project, which is what we do every time some request is made to alter a project, the Premier expressed the concern that we would be tearing down those '50 and '57 wings at the same time that I'm asking for funds for new auxiliary facilities. It was on his initiative that I then went to the hospital board and said, "What about keeping these two wings?" I was presented with a report that said it was not cost-effective to do so, but on analyzing that report, it wasn't very long before I discovered that we probably needed a better report. So that's how the initiative came about a couple of months ago.

MR. HERON: Certainly it's significant. If I heard your numbers correctly, you're saying that by utilizing the '50 and '57 wings, we could reduce the current waiting list of 750 by approximately 50 percent. Are those numbers correct?

MR. M. MOORE: It's just a guesstimate on my part, but I think probably we could accommodate 300 auxiliary patients in those two wings.

MR. HERON: Thank you, Mr. Chairman.

MR. KROEGER: On the process now, Mr. Chairman. We're talking auxiliary and about reuse and additional use. I wouldn't mind asking a question that relates to what we're into, and then you can strike me off the list. Or do you want to take it on the list?

MR. CHAIRMAN: I'll take it on the list, if that's . . .

MR. KROEGER: Sure. We'll go back to it.

MR. GOGO: Mr. Moore, I appreciate your comments on the auxiliary hospital question. I want to ask you two questions. One, do you have any concerns that there seems to be a variety of people doing medical research? For example, the cancer research is done in one place and then the medical foundation people are doing a lot of research. As minister responsible for a quarter of the budget, does it concern you at all that it's done in different places instead of under one overall authority?

MR. M. MOORE: It concerns me, but I have had nothing brought to my attention that would indicate we have a major problem in terms of duplication or overlap. In fact, quite the contrary; there appears to be a fairly good degree of co-ordination amongst the various research budgets. Bear in mind that a large component of the university's budget is always dedicated toward research. It appears to me that they have very good liaison with the dollars that go into cancer research and also with the Heritage Foundation for Medical Research. So I don't think there's any major problem. On the contrary, there are a lot of medical problems that simply wouldn't get the degree of research that is needed if everything had to come out of the general budget. What happens then is that whatever is the most dramatic at the time sort of gets the most research dollars, and you'd have dollars moving from one project to another a great deal more. I think it's beneficial to have specific dollars allocated for cancer research. It's a major cause of death in our population and in the world today, and to have major dollars dedicated to cancer research I think is useful.

I guess there are some limitations in terms of dedicating research to certain diseases. If you

went too far, you'd probably get into a lot of duplication, but on the major diseases like cancer, heart disease, and so on, I think there's no problem.

MR. GOGO: The reason I raise it, Minister, is -- a program out of Toronto that I watched on the weekend has caused me to ask the question, and that's this business of AIDS, acquired immune deficiency syndrome. For example, they say there are some 64 patients now in Alberta, with four in Edmonton; I don't know where the rest are. They say that the incubation period is five years. The message I get there is that there will be a dramatic impact down the road if what they say about a five-year incubation period is accurate. So although to me cancer is very important, I look at the implications of this problem of AIDS. It would be fine to say that Mr. Dinning has a responsibility for prevention, but we know it's your budget that's going to pay the average cost of $200,000 per hospital stay they talk about. So I raise the question: cancer research may be fine; to your knowledge, is anything going on in active research at this time in a way that can point out to you the implications to the health care system of the disease called AIDS?

MR. M. MOORE: You raise a difficult question. There are probably health care and medical researchers in every university in the world looking in some way or another at the AIDS virus and trying to figure out what they might do. That one is not a provincial, national, or North American problem; it's a worldwide one.

I'm not sure what is happening in terms of research in Alberta. Obviously, there is some. For us to embark upon a full-scale research project in that area would probably not be very effective at this time, unless we want to put a lot of resources into it and try to attract a lot of research scientists here who are not presently here. It isn't that I don't recognize the seriousness of the disease; it's just that we have some limitations in terms of the areas we branch out into. We're well equipped to do cancer research, and as far as I know, at the present time we're not well equipped to do research into AIDS. Perhaps nobody is.

MR. GOGO: The reason I raised it, Minister, is that as you know, the health sciences centre's budget is about $200 million, which is running at about 45 percent of its capital cost, I guess. Obviously, you must be concerned, based on your public comments about new hospitals coming on stream. I hope you would be well aware of the significance of the problem of AIDS that may come about as a result of research and the implications it's going to have on the operating budget in the hospital system. That's really why I raised it.

MR. PAYNE: Mr. Minister, our $300 million endowment for the Heritage Foundation for Medical Research and $58 million going to applied cancer research and applied heart disease research is a total heritage fund tab of, say, $358 million, which in any economy, and certainly Alberta's economy, is a very significant expenditure or investment. I suspect there is widespread support throughout the province for the kind of priorization accorded to medical research. However, I suspect that the primary objective or motivation for that research, whether it's in the Heritage Foundation for Medical Research or in the two applied research programs, is the eradication, or at least reduction, of pain and suffering associated with disease. I'm sure there would be unanimity around the province for that goal. But against the backdrop of a very troubling and worrisome deficit and an obvious need to diversify our economy away from the oil and gas and agricultural sectors, it seems to me that we need to be as aggressively and as imaginatively as possible seeking new avenues for diversification. With all that as a backdrop, I'm wondering if you as the minister have heretofore given any consideration to or would be prepared to consider in the future attaching a higher priority to the economic diversification possibility in medical research program selection.

Not too many days ago in this room we met with some of the officers of the Heritage Foundation for Medical Research, and they presented to us a very impressive array or catalogue of a wide variety of medical research projects that are being undertaken. Although I'm certainly a layman in this area, as I read that report carefully, it was obvious that a number of those projects were almost academic or esoteric, whereas some appeared to hold out the possibility of additional jobs, new technology, new equipment, or new skills, which

would bode well for our economy.

I guess my question is: have you been giving any thought or would you be prepared to give some thought to ascribing to the economic diversification objective a higher priority than may have been the case up to now in the selection of medical research projects?

MR. M. MOORE: First of all, Mr. Chairman, I don't make the decisions as to what they do with regard to research through the Heritage Foundation for Medical Research Endowment Fund. There is a committee of world-renowned experts who pass judgment on what they do. It's a very long-term project. I don't know how to try to move that research work into the area of job creation, nor do I think I would want to. That's a different thing, which needs to be done on a shorter term basis. The same comments would apply to cancer research, where I do approve the projects they submit. We're talking about research into disease, and in my view it would be wrong for me to take those capital project dollars and try to direct them in some way that might create more jobs. I think the first direction needs to be in the creation of treatments and cures for cancer rather than the number of jobs.

MR. PAYNE: Mr. Chairman, it certainly isn't appropriate for members of the committee to engage in debate with ministers, and that's certainly not my intent today.

MR. M. MOORE: That's no problem.

MR. PAYNE: I'm sure it's not. But I would like to perhaps recast the question with just the observation that we were told by the officers of the Heritage Foundation for Medical Research that there are a great number of projects they're unable to undertake because the endowment isn't large enough to enable them to take on more than they are presently doing. So it's obvious that there is a process whereby some projects are taken and some are not. It just seems to me that if we were picking and choosing between two research projects that were equally valuable in the hope they held out for the eradication of disease but one was more likely to create the kinds of things I made reference to in my opening comment, I would like to see some written or unwritten criterion whereby the latter project would be given preference. I appreciate that that's more of a statement than a question, but I did want to get it on the record.

MR. M. MOORE: Thanks. That presents it in a bit of a different light than your earlier comments. You're saying: all other things being equal in terms of the research value, would we then pick the project that creates the most economic activity? I think the obvious answer is yes. That's different from directing the researchers or the people who approve the actual research projects to look at economic activity as the major criterion.

MR. PAYNE: Thank you, Mr. Chairman.

MR. CHUMIR: Mr. Chairman, I'd like to congratulate the Premier for his astuteness in the question with respect to whether or not we should be using the old hospital facilities for auxiliary hospitals and also the minister for his astuteness in questioning the report at issue. It's very refreshing, and I hope we'll see more of that.

I'd like to direct several questions to the issue of children's hospitals in the province, first with respect to the Alberta Children's Provincial General hospital in Calgary, which is one of the assets of the capital projects division of the fund. There has been a great deal of emotion in Calgary with respect to the hospital: difficulty in getting medical staff, a number of medical staff recently signed a letter to the press in Calgary, and a tremendous amount of crisis in confidence with respect to the operation of the hospital. A number of the complaints I have been hearing relate to facilities of that hospital. One relates to the absence of a blood bank. The second relates to inadequate emergency room facilities, particularly the absence of a holding room, and finally, the absence of diagnostic equipment such as a CAT scanner. I understand that these matters are being addressed. Some of the problems relate to the size of the facility and perhaps an initial error in locating the hospital in that area.

In light of the fact that we are moving on to provide some world-class facilities such as the Walter Mackenzie unit, it raises the issue of whether or not the government plans to maintain the standards of the facilities in the existing hospital base. I wonder if the minister

would comment on what the plans are with respect to the children's hospital in Calgary, particularly relating to the matters I have just raised.

MR. M. MOORE: Mr. Chairman, I had an opportunity this fall to visit the children's hospital in Calgary to meet with the board and senior members of the medical staff. I wanted to view firsthand the hospital and their programs and get some feel for what the problem was there before making any major decisions about how it would be funded or what increase in the level of funding might be appropriate.

My observations are that it would in all likelihood have been more cost-effective if the Calgary children's hospital had been built in close proximity to one of the other major treatment hospitals, like the Foothills hospital, than to have built it to stand alone. The reason is that many of the facilities they need, such as a blood bank, or the equipment they need, such as a CAT scanner, aren't needed at the same level of intensity with a 125-bed hospital that the same equipment might work in Foothills hospital. So in terms of total utilization, you do wind up with the need to provide more expensive facilities at this rather small hospital. Nevertheless, it's built where it's built, and it certainly isn't going to be moved, so we have to put behind us the argument that it should have been put elsewhere or be moved and try to make the best of what we've got.

I was surprised to learn that the children's hospital has such a large component attached to outpatient facilities for day treatment. It's only a 125-bed hospital, but there is a great deal of outpatient treatment. The budget is about $39 million for 125 beds, which by any standards at all is a lot of money for a hospital that small, even with the large outpatient facility. They have in excess of 900 employees at that hospital, which also surprised me. In terms of the size of it, I thought there would be about half that number.

One of the things I observed as well is that there doesn't seem to be a very clearly defined role in terms of what the mission of the hospital really is. They seem to be doing everything they've done over the last 20 years and whatever else they decide to do that is new each year. The result, I believe, is that the hospital is trying to be all things to all people. For example, I was told that there were some 40 speech pathologists or speech therapists on staff going out into the community, the schools, and elsewhere to assist with speech training. I'm not exactly sure if in 1986 that's the mandate of a hospital which specializes in the treatment of sick children. So one of the things I think we need to do is assess whether or not there is a need to have a more clearly defined role for the hospital.

If I could comment on the matter of equipment, the hospital was considering the purchase of new imaging X-ray technology and for much of the last couple of years were debating amongst themselves whether they should have a CT scanner or a magnetic resonance scanner, which is the equipment I referred to a moment ago of which only one exists in Alberta on an experimental basis at U of A. They finally did decide this summer that a CT scanner would adequately serve their needs. I approved their purchasing a CT scanner with funds they had on hand, which will be repaid next year from the department of hospitals' budget for capital equipment. Then we will fund the operating costs in 1987-88. So they will have a CT scanner in operation probably very early in the new year.

I think, Mr. Chairman, that generally answers most of the questions, but if I've missed some . . .

MR. CHUMIR: The blood bank and the emergency room problems.

MR. M. MOORE: I'm not aware that we're able to make any early moves to resolve their problems with the blood bank. It wasn't pointed out to me by the board when I visited that the emergency room is a major problem. That's certainly something I'd be prepared to look into.

As members may know, attached to the hospital is a school which is operating at about a quarter to a third capacity. There is a great deal of excess space in some parts of the hospital because of program changes.

MR. CHUMIR: Thank you, Mr. Minister. As I mentioned, there is erosion of public confidence as well as confidence of the staff at the hospital. One of the problem areas that has been brought to my attention by constituents as well as members of the staff is the emergency facilities, so perhaps you might have that

looked into.

The second question I have relates to funding problems in the hospital system in general and the Alberta children's hospital in Calgary in particular. It raises the question as to whether or not the government still has plans to proceed with the new children's hospital in Edmonton, particularly in light of the comments that the government is considering mothballing the two new hospitals that are presently under construction. I'd appreciate the minister's comments on that issue.

MR. M. MOORE: Mr. Chairman, in relation to the member's mention of funding problems at the children's hospital in Calgary, could I just say that having reviewed the total amount of funds available to that hospital, I have difficulty agreeing that there is a funding problem. There may well be a problem with allocation of funds within the hospital in terms of various programs. That's best solved by the board and the administration.

In terms of the Edmonton Northern Alberta Children's hospital, like any other project of that magnitude, the planning time frame from announcement until you lay the first brick is about four years. Before a tender is called for construction of the Northern Alberta Children's hospital, about another three years of planning is required. The planning involves analysis of the needs with respect to beds and programs and examination of the facilities that currently exist and their location and effectiveness. Much of that examination is going to be extremely useful to us. In Edmonton right now we have about 500 pediatric beds in half a dozen different hospitals, not very well co-ordinated and spread all over with less than effective use of resources. That's not the fault of individual hospitals; they do the best they can with whatever they've been allocated.

So a lot of good things could come out of the planning process that's going to go on for the Northern Alberta Children's hospital. It would be my determination to try to provide enough funding for that planning to continue, and then a decision with respect to whether or not construction proceeds will be made at the time it's ready to go to tender.

MR. CHUMIR: Mr. Chairman, my final question relates to the issue of organ transplants, which are being done in a number of Alberta hospitals, depending on the organ, I gather. It's heart transplants at the Walter Mackenzie and differing transplants at other different hospitals. The matter that I have written the minister on just recently — I don't know whether the letter has arrived -- is of concern to myself. In looking into it and noting the two-and-a-half-year wait of young Curtis Nadeau, having read the 1985 task force report commissioned by the department of hospitals and the resolution of the 1986 Canadian Medical Association annual meeting, and having spoken to a neurosurgeon friend in Calgary, all led to the same conclusion: a large number of potentially available organs were not being made available through needed donors because there was no system in place which ensured that next of kin were asked for donations of organs of those who were brain dead. The statement was that the doctors themselves were the main obstacle because many of them couldn't bring themselves to ask the next of kin. One can understand that, but that simply raises the issue of why we don't have a system in place for paramedical personnel, nurses, or social workers to do that. As I said, I've written the minister about that. It seems like such an obvious thing. Certainly there are costs involved, but on the other hand I gather that there are benefits. Dialysis costs about $30,000 a year and a kidney transplant costs $8,000 a year.

I wonder whether the minister might comment on what plans are in motion with respect to improving the system of obtaining organs for transplant and dealing with that situation generally. If there are no plans, would the minister perhaps undertake to have a look at that issue? It could be simply implemented and have benefit to the community.

MR. M. MOORE: I have had an opportunity to review the report the hon. member refers to and tabled a copy of it in the Legislature last summer, but we've come to no decision yet as to whether or not we can take any action outlined in the report, which, as I recall, did involve the establishment of organ banks and so on. We'll be looking at that over the course of the next year or so, but it's not likely that we would be spending any very large amounts of money to implement the recommendations of the report. On the other hand, I think general public knowledge of the requirement for organs is increasing each year and certainly has

increased substantially with the advent of the heart, heart/lung transplant program at the Mackenzie Health Sciences Centre. Those kinds of things increase public awareness. But we don't have any plans at the present time to implement the recommendations of the report, although it is still under review.

MR. CHUMIR: I'm not thinking so much of the broader implications of the report, because this is a very complex thing. What struck me, Mr. Minister, is that there is something that's so obvious and simple, and it merely requires a bit of will and a minor amount of organization -- the personnel are basically there -- to see that there is a system in place for requests. In Calgary now we have a man who was given a week to 10 days to live because they can't find a heart. It seems such a shame to be aware that we just don't have a system to ensure that the next of kin of potential donors are asked, particularly when we're aware from statistics that most people these days would wish to have their organs used and that next of kin find it a gratifying experience to be able to find some value coming out of an otherwise senseless death. So I would encourage you to focus on that narrow aspect of it, which I believe could be implemented simply and with minimal expense.

MR. M. MOORE: Mr. Chairman, I don't think I'm in a position to advocate, implement, or develop that sort of system.

MR. CHERRY: Mr. Minister, a couple of my questions have already been [asked] by people before me, but I guess the one question I have is: is there going to be a backing off on funds for medical research due to the economy, and if so, what do you feel might happen in that regard?

MR. M. MOORE: With respect to the Heritage Savings Trust Fund capital projects division, the $300 million endowment is already in place, so that particular project will continue. There's no question about that. In terms of applied cancer research, I would want to recommend that we continue at the level we are, but that depends upon the government's overall plan with respect to the Heritage Savings Trust Fund and what other calls there are on the capital projects division. In terms of the Mackenzie Health Sciences Centre, of course that was a capital project and it's almost complete. So that's done.

In my opinion, the economic situation will probably have very little impact on medical research under the capital projects division in that the funds are already in place or the projects are already completed, with the exception of the cancer project.

MR. CHERRY: Thank you.

MR. HAWKESWORTH: Mr. Chairman, I'd like to follow up with a couple of questions on what Sheldon asked earlier as far as the role of the Alberta children's hospital is concerned. I appreciate the minister's frankness about the fact that the Alberta children's hospital has tended to be all things to all people, and out of that, of the number of things that hospital could be, it's tried to be all of them. Perhaps one of the dilemmas is whether it should focus only on the long-term care of a particular group of sick kids who need that long-term care or whether it should be an acute care hospital; that is, like any other hospital except that the people using it are little instead of big.

My question then is: how is that kind of decision going to be made as far as the role of the Alberta children's hospital? Is it going to be something on which the Department of Hospitals and Medical Care will just make a statement: "This is what it's going to be"? Is it up to the board to do that? Will there be the use of the purse strings to encourage that to happen within a year or two years, as far as the department is concerned? If you're saying it can't continue being all things to all people, then the question is: how does it make that transition?

MR. M. MOORE: I don't have an answer to that, Mr. Chairman, at the present time. I was merely suggesting what my own personal observations were about the hospital, and I have yet to determine how we might develop some role statement or analyze its present operations. Certainly it would have to involve both my office and the board.

MR. HAWKESWORTH: When you mentioned that you thought the funding was adequate but it perhaps wasn't being used to its optimum or it needed to be reallocated within the global

budget of the Alberta children's hospital, does that mean you feel it can continue to be all things to all people or that they're misspending some money in less important areas and letting more important areas go without receiving proper funding? I guess your answer to the previous question raised some questions in my mind as to exactly the point you were trying to make. I didn't follow the point you were trying to make.

MR. M. MOORE: Mr. Chairman, I can only repeat exactly what I said before; that is, I believe the hospital does have adequate funding, considering the number of beds it has, the number of outpatients, and the kinds of things it is doing. By any standards it has a lot of money for that size of hospital with that patient load.

My observations were that there needs to be some study done with respect to what role the hospital should play, and that obviously has to look at the services provided by other hospitals in both Calgary and the region in deciding what things the children's hospital is and isn't going to do. I have not yet had an opportunity to discuss with the board what direction such a study should take, who should do it, or how it should be done. In many cases the administration and the board themselves undertake to do a role study and do have a mission statement and a defined objective. They may do it at the children's hospital in Calgary, but it's not something that has recently been reviewed.

MR. HAWKESWORTH: When all this money goes into various hospitals -- I see the Walter C. Mackenzie, the Alberta children's hospital, and the two hospitals under construction in Edmonton and Calgary -- are role statements not part of the planning before funds are committed to these various institutions? If an institution has grown to be all things to all people, wasn't that looked at at one time before funding was allocated to these hospitals? Isn't that review going on within the department all the time? If not, why not?

MR. M. MOORE: Firstly, with respect to the Calgary children's hospital, as the hon. member knows, the facility has been there for some length of time. I don't know when the board last undertook a role study. That's something that's the responsibility of the hospital board and the administration. I don't recall the hon. member or anyone else who has visited the hospital ever having raised with me the need for such a role study. I've raised it because of my personal observations of the hospital, and as Minister of Hospitals and Medical Care I would raise it with respect to any other hospital too.

The situation is substantially different with regard to an active treatment hospital like the new Peter Lougheed hospital or some other one that's not specializing, in that it's not difficult to determine what role they should play. On the other hand, it's much more difficult for a children's hospital to decide what it's going to be and how it relates to other health care facilities in the community. I don't know when the Calgary children's hospital last undertook a study of their mandate to try to identify what they should or should not be doing, but it's certainly something that's a responsibility of the hospital board.

MR. KROEGER: Mr. Chairman, I was listening with a great deal of interest to the minister's comments on the conversion of active treatment to auxiliary as it relates to the health sciences centre. We hear a good deal today about the role of rural hospitals and the money that's been invested in them. We may be straying, Mr. Chairman, but in the context of what we're into, I think you'll let me go with this one. You can choose your route here now.

Given the fluctuating people count in a lot of areas in rural Alberta, if on one side you take a specific general hospital that isn't full and on the other side there's enough activity to warrant an auxiliary hospital, what sort of position should we be taking? I know of a number that are supposed to be on the cost of an active treatment as opposed to an auxiliary, but you have an existing hospital that is not being fully utilized at the same time that you have people who are in need of auxiliary care. Isn't there some way we can use without attaching those high-cost active treatment numbers to part of that hospital as an auxiliary without a designation? It really doesn't change the cost of the operation very much if you put a person in there who needs auxiliary care for, say, a relatively short term. That doesn't substantially increase the cost of that to the relative cost of an active treatment scene, for example. So you have an active treatment hospital with 60 percent occupancy. You've got

a demand for auxiliary, but you can't get them in anywhere. Those two things don't seem to be consistent.

MR. M. MOORE: Mr. Chairman, the hon. member raises a very good question. I asked staff of my department the same thing: why can't we simply allocate auxiliary beds in active treatment hospitals in an area where we have a surplus of active beds and a shortage of auxiliary beds, particularly in small rural hospitals? Quite frankly, it's not something that had ever been discussed at any length. I believe that what we should be doing is creating a situation where a community with, say, a 50-bed hospital that believes they need 10 or 15 auxiliary beds can have them within the existing hospital. The way you have to do that is to recognize a different cost factor attached to auxiliary beds.

What happens now is that my staff go out and say to a hospital board, "Yes, you have 75 percent occupancy in this hospital, but we found five auxiliary patients." The hospital board argues that they're not auxiliary patients. They don't want them identified, because they get accused of keeping long-term care patients in an active treatment facility. We'll say that on average it costs $300 a day for an active treatment bed and $100 a day for an auxiliary bed. What happens is that the hospital board finally says, "We need auxiliary beds." They make an application for 15 or 20 auxiliary beds, and if we have the funds, we go and build them. Then we pay $100 a day for them, and the active treatment beds stay empty. We also probably pay $250 a day for the empty bed because the costs are still there.

What needs to be done, Mr. Chairman, is to look at active treatment hospitals with surplus capacity and say, "Move five or 10 of those beds into auxiliary care, and we'll provide you with funding that's equal to something more than normal auxiliary but less than active treatment and make it work." That can be done.

Incidentally, we are just now building some facilities. About two months ago I helped to open one in Grande Prairie called Mackenzie Place. It's a 200-bed nursing home/auxiliary hospital facility. Every bed is interchangeable. You go in as a nursing home patient, stay in the same bed, and two years later you may become an auxiliary patient, with a higher dollar assistance to the hospital because of greater nursing care. I think we could do exactly the same thing with auxiliary patients in smaller active treatment hospitals when you move from being an active treatment patient to an auxiliary patient. We have to work on the dollars so we're not penalizing the hospital for doing that, and that's certainly something I'm following up on now.

MR. KROEGER: I think that's extremely important, Mr. Chairman. In a bookkeeping way I suppose you could say that we can't afford to do conversions, because we have this locked-in view of an active treatment hospital's cost. But in actual fact, if you were to say, "Sure, you need a small auxiliary, so we'll build it," the end result is that it's even higher than conversion would be.

I've had conversations on that with hospital boards as recently as this weekend, and the hospital board isn't very sure how to proceed. Here they have half a dozen auxiliary patients sitting there with no place to go. They're beyond what the senior citizens' lodge can do for them. At the same time, there's room at the hospital, and they can't bring the two together. I'd like some direction on how to tackle that.

MR. M. MOORE: Perhaps you could let me know directly what hospital it is and we could consult with them. That might be a good way to get the process started.

MR. KROEGER: Thanks, Mr. Chairman. I appreciate your leniency.

MR. McEACHERN: Mr. Chairman, my first question is related to the Northern Alberta Children's hospital. You'll recall that in the election the Premier suggested that Alberta would probably be going ahead with one. Now that it's looking like we're overexpanded in hospital beds and also from your comments about the children's hospital in Calgary, it makes me wonder if any thought has been given to perhaps using some of the overexpanded facilities, if one could use that word, for a children's hospital. Alternately, would it just make more sense, again from your comments on the Calgary situation, to expand a children's ward in an existing hospital? I'd just ask you for some comments on that.

MR. M. MOORE: Mr. Chairman, I guess the member was not here when I spoke to that issue a few minutes ago.

MR. McEACHERN: I'm sorry. I did miss your preamble. Perhaps you would be extra brief then so we don't bore other people.

MR. M. MOORE: I can repeat what I said if you wish, or if there's a verbatim transcript, perhaps the member can read it.

MR. McEACHERN: I'll read Hansard.

MR. CHAIRMAN: Perhaps it would be appropriate for the member to read the Hansard.

MR. McEACHERN: That question has pretty well been taken up then?

MR. R. MOORE: I did cover where we're at with the Northern Alberta Children's hospital in terms of planning and everything.

MR. McEACHERN: Thank you. I'll look at the record on that then.

MR. GOGO: It wasn't a preamble; it was an answer to a question.

MR. McEACHERN: Thank you.

I want to ask a second question. I heard a comment the other day -- and I can't really remember who it was from -- something to the effect that if beds are available, doctors will fill them.

MR. M. MOORE: It was from me.

MR. McEACHERN: Is was from you, was it?

MR. M. MOORE: I made it yesterday, the day before, and this morning.

MR. McEACHERN: If there's a certain truth in that, it means doctors are basically the ones to decide who will be in a hospital bed and who won't. In view of that, I wonder if you would recall some of the government's ideas about having user fees in order to deter patients from seeking hospital beds, so to speak, or some other ideas you've been musing about lately about having patients sign the bill so they know what it's costing them and they won't sort of overuse or misuse the hospital system. It would seem to me that that comment clearly puts the onus on the doctors and how you administer the system at that end of it rather than worrying too much about patients overusing it. Is that a fair observation?

MR. M. MOORE: I made those comments in relation to discussions about the number of active treatment beds we have in Alberta or in any given area of Alberta, like Edmonton city. The facts of the matter are that the number of active treatment hospital beds you require in any given province, country, or jurisdiction relates more to what you can afford than what you need. Nobody knows what the need is. When medicare is free -- you walk in, walk out, and pay nothing -- it's very difficult for even doctors to control the use of hospital beds. The only thing that controls them is the number you build.

British Columbia and Ontario have a target of 3.5 active treatment beds per 1,000 population, and they're now down to about four in both provinces. We have a target of four, a new one that I just announced a week ago. With the opening of the Mill Woods hospital, we'd be up to seven in Edmonton city. The only way I know of to control the use of active treatment hospital beds is by their numbers, unless you revert to the situation they have in the United States and some other countries where people have to pay to go to a hospital. There are lots of surplus hospital beds in the United States . . .

MR. McEACHERN: But some people are not getting . . .

MR. M. MOORE: . . . but there are far fewer people occupying beds per 1,000 than in Alberta. That's the difference between the product of people having to pay and its being free.

I made those comments in relation to how we control the costs of health care in terms of active treatment beds by figuring out how many beds we need and then stopping at that amount. What happens then is that -- I think a good part of the product of the utilization of hospital beds is length of stay. If you expand a four-day stay into a five-day stay because there's room in the hospital and the doctor says, "Well, it just might be a bit better if this person

stayed for one more day," you increase bed utilization by 20 percent. It doesn't take very long for that to occur. I don't think you can say the doctor did the wrong thing; if the bed is available, it didn't cost the patient anything. That's a natural thing for the medical practitioner to do.

MR. McEACHERN: I was wondering if you'd sort of specifically looked at how you might administer some of the ideas you had about putting the responsibility on the doctors or on the patient in a technical sort of way. I guess that's something you'll have to look at in the future.

MR. M. MOORE: All my comments there for the most part have been related to the health care insurance plan and patients' visits to doctors' offices as opposed to the hospital system. The only way I know of to control hospital costs within the Canada Health Act is by the number of beds. Obviously, you could put some user charge on and you would effect some control, but we've just removed the user charges from hospitals.

MR. McEACHERN: My last question then has to do with research on cancer. I think it was indicated at last year's heritage trust fund hearings that the funding for cancer was committed till 1987, which is now only a year away. Do you know what the plans are beyond that?

MR. M. MOORE: No decision has been made beyond that.

MR. CHAIRMAN: The Member for Lacombe.

MR. R. MOORE: I've been listening here, and I had some questions. I just have to gather in my mind what my questions are, Mr. Chairman.

MR. CHAIRMAN: Maybe we could go to the Member for Calgary Fish Creek, who's next on the program.

MR. R. MOORE: I was so interested in the minister's answers.

MR. PAYNE: Perhaps, Mr. Chairman, I could ask the minister to return just one more time to the Alberta children's hospital in Calgary. I appreciate, Mr. Minister, that you've dealt with the Alberta children's hospital on two or three occasions today, and in each instance you've made reference to the need for perhaps a revised role statement or mandate at the Alberta children's. I obviously agree with your comment that that's really the responsibility of the Alberta children's hospital board and administration.

I would draw the minister's attention to page 23 of the current annual report of the heritage fund in which the role of the hospital is summarized as follows:

> The facility provides for the diagnostic assessment and treatment of children on both an in-patient and out-patient basis.

I wonder if the minister would be prepared to make a general comment of his own views with respect to the role or mandate of that hospital.

MR. M. MOORE: Mr. Chairman, the answer is that at this time I wouldn't want to do that. I think it's a very complex problem in terms of determining what the role of the hospital is. My observation of the existing operation of the hospital is that in recent years there hasn't been that sort of defined study of what it ought to be doing. I think that needs to be done. It may be that a role statement would decide that the hospital's present operations are entirely appropriate and that we ought do be doing even more, sort of all things to everybody. With my limited experience in terms of knowing what medical attention should be provided to sick children, I don't think I should comment at this time on what its role should be. I think, though, that I have fairly good judgment in terms of analyzing the situation as to whether or not anybody has looked at the role in recent years. In that particular case, I don't think they have.

MR. PAYNE: Mr. Chairman, I think the minister is far too modest when he refers to his own limited experience. Whether he's been in the saddle a decade or two days, I think he's on top of the department, and I have every confidence in his ability to assess the institutional needs of the province.

AN HON. MEMBER: Hear, hear.

MR. PAYNE: I would further agree with the minister that developing a role statement is a very complex matter. I would like to humbly

submit that some general parameters by the minister would make the matter a little bit more simple for those charged with that complex matter.

MR. M. MOORE: Mr. Chairman, I will consider that as one of the statements I make sometime in the new year.

MR. R. MOORE: We've touched on research time and again this afternoon, Mr. Minister. However, I'd like to get an overall look from you on where we're going with it. When we started out, the goal was to establish Alberta as a world centre for medical research. We've heard all this as we went along. We know we've come a long way down that trail. Are we near that area now where we're recognized as one of the leading areas in medical research, or is this still further ahead of us? How far along are we toward obtaining that goal?

MR. M. MOORE: I'm not sure I can answer that. I talked with a number of medical people from outside Canada at the heart symposium, 30 years of open-heart surgery, that was sponsored by the University hospital and chaired by Dr. John Callaghan. It brought here people from all over the world who are experts in cardiac surgery, for instance, and others. I talked with a number of people at the opening of the Mackenzie Health Sciences Centre as well. I got the feeling that we're sort of on the verge of being recognized in North America as a leading centre for medical research. People who come here say, "We never expected to see the facilities, the equipment, the brains that are here." Nobody told them in New York to go to Edmonton, but once they came and saw what was here, they recognized the superiority of what we're doing. I think it will take a little while yet for our medical research programs in Edmonton to be on the same recognition level as Wayne Gretzky and West Edmonton Mall, but we're getting close.

MR. R. MOORE: That's good.

We talk a lot about cancer and heart research, Mr. Minister, and that's very important, but do you think we should be concentrating our research on the preventative end of it, a change in life-style, the smoking area and so on, that our research should be directed more toward changing life-styles and probably preventing a lot of these diseases? We would all like to see the Member for Lethbridge West around. We know he's a good-looking fellow, but we don't think he'd look so good as a corpse.

MR. M. MOORE: Maybe flying nonstop on Time Air from Lethbridge to Edmonton will convince people that they no longer need to smoke, if they can make it that long.

MR. GOGO: There's going to be a prohibition against preaching too.

MR. M. MOORE: It's a sort of motherhood thing to say, "Let's concentrate more on preventive health care than we are, and we'll save some dollars down the road." There's no question that that's true. If everybody quit drinking and smoking and started wearing seat belts and all these sorts of things, our costs would be lower.

MR. GOGO: They'd live so long they'd bust you.

MR. R. MOORE: We'd have a bigger demand for auxiliary and nursing homes.

MR. M. MOORE: I think we've made very, very significant steps in recent years in terms of preventive health care. Pretty near anybody around this table — a lot of us; not all of us, I guess — can remember when nobody said anything about tobacco being a hazard to health. It was just a thing kids weren't supposed to do. We know so much more now about what's harmful to our health than we used to, in terms of alcohol, tobacco, and drug use. The great majority of people have quit smoking. I think we're making some progress. The biggest concern is amongst younger people who still like to experiment with various life-styles that don't lend themselves to good health. Even there, I think the Alcohol and Drug Abuse Commission has some pretty innovative programs going that are certainly helpful.

It's difficult to judge the balance between dollars to preventive health and dollars to the hospitals and medical care system. It's like the chicken and the egg: which comes first? You can't ignore sick people and take dollars from that budget to put into preventive health care, so you've got a difficult problem with funding. But I think the balance is not all that bad right

now.

MR. CHUMIR: Here I am again. As a member of the opposition who believes that my role is not merely to criticize but to make constructive comments whenever appropriate, I don't often get the minister ensconced in a position where he has to listen. I can't resist. Well, he doesn't . . . He could probably cover his ears.

I can't resist stating that insofar as preventive health care is concerned, it's my belief and my representation to the minister, in a constructive attempt to turn his attention to these things, that the government has been very lax in contributing to the focus on that end, by way of antismoking programs within its own home, its own departments, impaired driving initiatives and, of course, the seat belt initiative. So I would encourage more focus. I would say that the community is running well ahead of the government in that regard.

However, I wish to direct my first question as a follow-up to an excellent question asked by the Member for Chinook relating to rural hospitals. I would appreciate hearing the minister's comments with respect to his plans for those hospitals in light of what has become a general commentary and observation with respect to our health care system: many, although certainly not all, hospitals in rural areas have been overbuilt, many unstaffed, many with more beds then are needed. One possibility suggested by the Member for Chinook, an excellent thought, is to use some beds for auxiliary purposes. I wonder if the minister might comment more globally on the situation: the number of beds in rural areas, what their plans are in the future with respect to new hospitals, closures, consolidations, and how the minister sees any reassessment of the role of those hospitals fitting into current attempts to get the budget under control.

MR. M. MOORE: First of all, Mr. Chairman, the hon. member's observations about rural hospitals indicate that he hasn't been there. What the member suggested with regard to overbuilding and so on is not at all accurate. It's the same kind of junk I've heard from other urban members, and I'm frankly tired of hearing it. There are 128 active treatment hospitals in this province. Twenty-eight of the largest ones take 80 percent of the budget. The other 100 take 20 percent. In rural Alberta we have a lot of active treatment hospitals that have 95 percent occupancy. They are bursting at the seams. We have others where occupancy isn't as high, and there is a critical need for auxiliary beds or nursing home beds. We've got those patients in the active treatment hospitals. What we're talking about is trying to find some way to accommodate that because we haven't been able to build auxiliary hospitals in rural Alberta.

I just finished saying that with the opening of the Mill Woods hospital, Edmonton will have seven active treatment beds per 1,000 people. Tell me any rural area in this province that has anywhere near that. There's one only, and that's Fort McMurray, and they're shelled-in beds; some of them aren't open. I'd be happy to take the hon. member on a 100-hospital tour of rural Alberta to see what's happening. I might have to get somebody to help me.

MR. CHUMIR: I accept; I give in.

MR. M. MOORE: It just isn't so.

MR. CHUMIR: Another question I have Mr. Chairman -- obviously, we have differing information bases, and this is not the place to pursue or debate that issue.

MR. M. MOORE: Go ahead. I'm perfectly prepared for the debate. I enjoy it.

MR. CHUMIR: What about the hospital in Carmangay that has been built and apparently doesn't have a doctor there? It has to have a doctor come in.

MR. M. MOORE: That's a problem of trying to get medical staff to go outside of Edmonton and Calgary. If you heard me the other day, talking about . . .

MR. CHUMIR: I understand, but that's part of the global problem. Once the . . .

MR. CHAIRMAN: Maybe we can try to get back to the . . . [interjections] The chairman is trying to be lenient with the discussion this afternoon, but perhaps we can start focussing on the trust fund.

MR. CHUMIR: Another question I'd like to

address to the minister, Mr. Chairman, relates to the question of in vitro fertilization and whether or not there are any plans to utilize heritage trust fund moneys to support that type of program. The issue has arisen with respect to the program at the Foothills hospital in Calgary. I understand there are budgetary problems. One suggestion has been that if funding cannot be forthcoming — and perhaps that's not an unreasonable position. The question has arisen as to whether or not the minister will sanction a fee for service to be utilized or levied in that circumstance in order to keep the program alive. I would appreciate the minister's comments on that issue.

MR. M. MOORE: Mr. Chairman, the in vitro fertilization program at the Foothills hospital in Calgary was started utilizing funds that had been collected on a volunteer basis and the volunteer services of some professionals involved in the program. It has not been provided with any funds from the Department of Hospitals and Medical Care. I was asked recently whether or not we would fund a program from global funds of the department next year, and my answer was: no, we do not have any funding for any new programs in 1987 beyond what's already been approved.

The board of the Foothills hospital expressed concern that the program may have to close -- I am not aware of what might happen to the existing funding — and met with officials of my department just last Thursday to review the program. My understanding is that the board will be forwarding to me a letter requesting that they be allowed to continue the program, because our department has to approve all new programs, and do it on the basis of charging the patients for the cost of the service. When I receive that letter, if I do, I will be judging it on the basis of whether or not their approval of that program would deter from any other medically required services the hospital might now be providing. In other words, if it takes beds from some other program, I would want to carefully consider it. But if it doesn't interfere with any other medically required services, then I would be inclined to approve the program based upon patients' paying the costs themselves.

I would add, Mr. Chairman, for the benefit of other members of the committee, that while in vitro fertilization may be very helpful to some couples in being able to have children, it certainly does not fall within the scope of a medically required service, and in times of very limited budgets, I simply could not approve something of that nature to be funded while at the same time we are reducing hospital budgets elsewhere.

MR. CHUMIR: Thank you, Mr. Minister.

A final question, Mr. Chairman. A matter that's been puzzling me relates to the manner in which our hospitals are administered and the way our hospital boards are set up. In Calgary we have the Calgary district hospital board, which is responsible for four hospitals. We have the General hospital board, which I understand is responsible for only one; the Foothills hospital for one; and the children's hospital for one. I'm wondering whether there is any philosophy which the government follows in terms of organizing the administration of our hospitals which relates to the efficiency and any other types of questions which arise, depending on how these boards are set up. I find that one hospital board is running four hospitals, and I understand they have a central laundry and miscellaneous other economies of scale. Why are some of the other hospitals operated separately? Is one system better, more efficient? I'd appreciate some commentary on that.

MR. M. MOORE: Mr. Chairman, I'm not able to shed much light on the question of how we got where we're at in terms of the system of operating hospitals. Perhaps if one had Mr. Aberhart, Mr. Manning, Mr. Strom, and Mr. Lougheed here -- I only say that because there's a historical development. We have Crown hospitals, which are the Foothills, university, cancer, and children's hospitals. They're operated by boards appointed by the provincial government; no problem. We then have some municipally owned hospitals, like the Calgary General and the Edmonton Royal Alex. As I understand it, they were built largely at a municipal initiative, relied on municipal funds, and operated municipally many, many years ago. Over the ensuing years the province has assumed almost 100 percent of the cost of not only the capital but the operating, yet the city council still appoints the board.

Then we have district hospitals, which used to be funded on a percentage basis for operating

by the province with the balance on the property tax, and we did away with that in 1972. So they're funded 100 percent by the province for operating. At one time they were funded substantially for capital by the municipality as well. The most common form is a district board, which is either elected or appointed by the municipality, with the municipality having almost no responsibility for its funding anymore.

In the case of Calgary you've got three kinds. You've got the Foothills, children's hospital, and Tom Baker Cancer Centre board. Crown hospitals have boards appointed by our cabinet. You've got the Calgary General, which is a city-owned hospital with a board appointed by the city. You've then got district 93, which operates four hospitals: the Rockyview, the Colonel Belcher, the Holy Cross, and may operate the Peter Lougheed. They have board members drawn by appointment from both the city and the surrounding rural municipalities that are part of the hospital district. They could be elected as well, if the city chose to have them elected.

I missed some. You've got the religious organizations that operate hospitals, like the Grace hospital, which is operated by the Salvation Army, and the board is appointed by them. In the case of Edmonton, you have the Edmonton General, operated by the Grey Nuns, and the board is appointed by them.

You have to be a historian to figure out how we got where we are. On balance, the system is not all that bad when you consider how it occurs, except for this: there is very little co-ordination in the two major cities. The biggest problem with hospitals in this province is Edmonton and Calgary. When I go to Medicine Hat, there's one hospital and one hospital board, and they're not all fighting to get a program in every hospital because there is only one. But in Calgary and Edmonton, almost every hospital wants to be a full-service hospital with an emergency department, a maternity ward, the whole bit, and it's very expensive for us to maintain those facilities, full service everywhere.

MR. GOGO: Eighty percent of the budget.

MR. M. MOORE: So we've got things like district 93 in Calgary, which is going to wind up running four hospitals. That was all predicated on the thought that now we will have some co-ordination; we'll be able to have one program in one, one in another, and another in another. It doesn't work that way. They want the same programs in all four hospitals. What's going to have to happen in the hospital system in both Edmonton and Calgary is that somebody — and it may have to be the Minister of Hospitals and Medical Care — is going to have to say, "Here's what's going to happen," and spell it out and resist any efforts to change it. That's going to have to happen in the interests of medical care and costs. We're going to have to disregard community wishes to have everything handy and close by and full service. Besides, we're probably doing a medical disservice by spreading our numbers so thin. Pediatric service in Edmonton is a very good example, with five or six hospitals. We should have had a northern Alberta children's hospital and a children's hospital in Calgary that specialized in pediatric care 20 years ago. We shouldn't have had pediatric wards in every other hospital. But somebody has to be brave enough to make those decisions and not alter them. That job may fall upon me in the next two or three years. Hopefully I'll have the support of members of the Legislature when we do it.

MR. R. MOORE: The opposition would support that.

MR. CHUMIR: My question doesn't preconceive an answer or any particular direction of thought, but the question is so obvious as one looks at the problems. The manner of administration may be an avenue for review to see whether or not restructuring might not be beneficial to the whole system.

MR. HAWKESWORTH: Mr. Chairman, I guess Mr. Moore is now talking about across-the-board cuts, as are many of the other members of cabinet in each of their departments. I suspect one of the reactions you're going to get when these things start becoming reality, if they become reality, is that there'll be tremendous pressure, political reaction, saying: "Why don't you dip into the Heritage Savings Trust Fund? After all, it was supposed to be for a rainy day, to prevent this kind of slashing and cutting of government budgets." When the people find out there's not that much money in the Heritage Savings Trust Fund that

you could easily dip into, I suspect they're going to ask a few questions. One of them might be, "Why did we pay for hospitals out of the Heritage Savings Trust Fund?" We pay for them out of general revenues, and there are some out of the Heritage Savings Trust Fund. Why would the Heritage Savings Trust Fund have been used for that kind of expenditure instead of sort of salting it away to generate a savings account for a rainy day?

MR. M. MOORE: That's an excellent question, and I recall very well the various discussions we had in developing the capital projects division of the Heritage Savings Trust Fund. We said, "What that fund should do is capital projects that we wouldn't otherwise do, that we can't get from the regular budget because they'd never get a high enough priority." That's the exact reason the Mackenzie Health Sciences Centre was built under the capital projects division of the Heritage Savings Trust Fund. If it hadn't gone under there, it wouldn't have happened. You couldn't put that ahead of a new hospital in Cold Lake, for instance, which we're now just building, because the old one is made out of trailers. You couldn't build the kind of facility the Mackenzie Health Sciences Centre is without saying that it's well beyond anything we would normally do. If you look in Hansard at the debates we had in the years when we set up the Heritage Savings Trust Fund, it will show that the criteria of the capital projects division was to do things we wouldn't otherwise normally do.

MR. HAWKESWORTH: That's fair enough. I guess hindsight is always much better than foresight, but at the same time you're also looking at perhaps not opening two hospitals, one in this city and one in Calgary. Would it have been better to have simply kept all the capital budget spending under the regular budgeting procedures and left the heritage trust fund alone so that you wouldn't have the Mackenzie Health Sciences Centre opening in Edmonton and not be opening two hospitals, one in Edmonton and one in Calgary?

MR. M. MOORE: The only way that could have been altered is if you didn't build the Mackenzie Health Sciences Centre and used those operational or capital dollars to operate the other two hospitals. But to just move the Mackenzie Health Sciences Centre from the capital projects division of the heritage fund to general revenues wouldn't ultimately have made any difference. It's still the same amount of dollars.

MR. HAWKESWORTH: Okay, but your point was that you did it out of the Heritage Savings Trust Fund because if you had done it through the regular budgeting procedures, it might not have gotten a high enough priority to be built. It was built. Also, there are these other urban hospitals that are in the process of construction, and they may not even be opened. It seems to me that bypassing the regular budgeting and priority setting of the government may have ended up in overspending and overbuilding if, as you said recently, those two hospitals in Calgary and Edmonton aren't going to be opened.

In light of these economic circumstances in this particular year and perhaps even into next year, let's assume that we're in effect going to put a cap on the Heritage Savings Trust Fund, I suspect within a matter of months. If that were to happen, would there be a particular impact on any projects affecting your department; that is, have all these commitments been fulfilled? If a cap were placed on the Heritage Savings Trust Fund, would some problems be created for any of these?

MR. M. MOORE: The only impact on the Department of Hospitals and Medical Care if a cap were placed on the Heritage Savings Trust Fund would be on applied cancer research. The other programs are all capital programs. The endowment fund, the $300 million, is in the heritage medical research. It isn't going to come out; it's in there. The Mackenzie Health Sciences Centre will be finished this coming year, and we pay the operating out of our regular budget. So the only thing that would be affected by any cap on the heritage fund would be the applied cancer research, $4.5 million or $5 million a year.

MR. PIQUETTE: Mr. Chairman, I'd like to apologize for being a bit late today. You probably know that the funeral for Mr. Ron Tesolin, the former MLA for Lac La Biche-McMurray, was this morning, so I just came rushing back.

I'd like to start out by making the general

comment — and I guess you did touch on the seat belt legislation -- that estimates indicate that if we had the same amount of usage in the province of Alberta, we would save about $40 million a year. In terms of the cost savings, I would hope the minister of health would apply a lot of pressure on the Minister of Transportation to make sure seat belt legislation is introduced in the spring. That would be a great preventive type of thing we could do here in terms of trying to save some money provincially.

The other aspect I want to know is: does the minister have any direction in terms of where research goes in terms of the medical research grant funded by the heritage fund? For example, in Lac La Biche a satellite cancer clinic has been instituted in the hospital to try to centralize some of the distance patients have to travel for treatment. The other thing I've discovered is that the area has a very high cancer rate. I believe it's around four to five times higher than the rest of the province in the last five or six years. I'm wondering if there is any medical research that looks at some of the environmental problems that might be causing some of these problems. Would the minister have any type of influence in terms of how the medical research is focussed in the province?

MR. HERON: On a point of privilege, Mr. Chairman. It is regrettable that the members of Her Majesty's Loyal Opposition weren't here for the full 25 percent of this meeting at the beginning. However, I wonder if I could appeal to your Chair and position to prevent us -- and I use the hideous analogy of a dog chasing his tail -- from a duplication of questions that have already been asked and answered.

MR. PIQUETTE: Has that question been answered?

MR. CHAIRMAN: At the outset of the meeting the minister did make reference to the applied cancer research annual report, which all members have received a copy of.

MR. McEACHERN: There is an aspect to this question that must surely be unique to his area, and perhaps a quick comment would not be out of order.

MR. M. MOORE: Mr. Chairman, I don't mind making some brief comments. The member indicated that he would have been here except for the funeral of one of our previous colleagues that he attended, so in that case perhaps we could let him continue shortly and I will try to answer shortly.

MR. GOGO: Is that high incidence of cancer you're talking about in Lac La Biche, Leo?

MR. PIQUETTE: Yes, in the area of Lac La Biche.

The question I have is: are we focussing in? Perhaps some of the causes for the high cancer rate could be part of the investigation done by medical research. Is that one of the responsibilities of the Alberta trust fund's medical research?

MR. M. MOORE: Perhaps what I could do, Mr. Chairman, is indicate that the involvement I have in cancer research is in approving the projects, not telling them what to do but authorizing them to proceed. They are so technical that quite frankly I get advice from my department staff and my chief medical adviser, and on the one occasion when I have approved them, I haven't questioned them too much. If members have specific areas of concern, I think it would be useful for me to say to the committee that is working on the approval of research grants, "Here's an area we'd like you to look more at."

The member should have a look at the annual report for the period ending March 31, 1986. In the back it mentions 235 different projects that have been worked on over the last several years that this has been going on. It says: publications, papers, and presentations. There are a lot of things going on that may be of interest to him in the area that he's talking about. I haven't reviewed it closely enough to know whether it affects what the member is . . .

If any member has any specific ideas or concerns with regard to cancer research, probably the best thing to do would be to put them in writing to me and I will pass them on to the committee and say, "Have you had an opportunity to look at this?" Both in this area, though, and in the $300 million endowment, I think it's important to know that we try to allocate the research dollars to the medical community and let them make most of the

decisions as to where it goes and keep it out of the political sphere. You can't get researchers to come and stay in this province if they have any doubts about whether the funds are going to be there or whether their project is going to be able to continue, if some researcher comes here for a five- or six-year project and we cut off the funding in year two because we have another project. So I prefer to let the medical community believe, as I think they should, that we allocate the global amounts but interfere very little in terms of what they actually do.

MR. PIQUETTE: Again, perhaps I'm repeating a question, but I hope not. Maybe you can correct me. Has anything been done to implement this committee's recommendation from last year that all medical research funded by the trust fund be consolidated under the Alberta Heritage Foundation for Medical Research?

MR. CHAIRMAN: It was discussed earlier. Certainly the issue of consolidation was touched on in earlier remarks, and I think you will find an answer in the Hansard.

MR. PIQUETTE: Okay. Those are questions I had.

MR. R. SPEAKER: A very quick question. Much of our discussion today has been about the rationalization of health care facilities, in terms of either location or alternate uses. My question relates to the use of the heritage fund in thinking how we could better deliver health care services in the province of Alberta in the future. We all recognize that because of the political system as it is, we try to respond to local needs, rural and urban, and political pressure often determines the location of a hospital. We have had the funding capability in the last 25 years to meet most of those needs. But what I note is that technology has certainly changed the ability to communicate between a mobile unit of health care in a rural community and centralized facilities, the regional facility in Lethbridge. I've noted some television summaries of the kind of capability where you have a patient out in a mobile unit with the doctor and the team of experts at the regional working with the mobile person. I see that as something that we really haven't dealt with in the province of Alberta. I look at the capability of just a simple helicopter, which MASH did a lot of work with in the '50s, bringing the soldiers from the front to the tent hospital. But I see that we are developing a better regional system, a centralized system, in the province of Alberta, in which we'll have a higher level of capability.

My question to the minister is: is there a role for the Heritage Savings Trust Fund in funding some of this future planning in terms of health care in the province of Alberta? Would that be something you'd like to see the committee look at, or would that still be the role of the minister's department? Have you that capability of looking further into it within the department? It's going to take some strong political leadership to bring about some of these things, because if you take the little hospital out of a certain rural constituency, you get a certain amount of political backlash out of that, some worse than others.

I see some rural plans on the drawing board at the present time. If we had other capabilities, we might be able to give the community an alternative. At present, there isn't another alternative. It's a matter of building a rural hospital to meet certain needs because we don't have these other options for the people. I've cited two examples. My specific question is: in futuristic sort of planning, if you saw that capability here, would funds from the heritage fund be of value and assistance to the minister and the government in facility planning? Has the minister given any thought to that?

MR. M. MOORE: Mr. Chairman, I'm not sure there's a role for the Heritage Savings Trust Fund to play. I think you would have to get into fairly specific programs before you would want to bring Heritage Savings Trust Fund dollars into play. But on the issue of whether or not there's something our department can do to rationalize health care facilities and systems, I think there's always more we can do.

Let me say this about the rural hospital facilities. We've done a lot in recent years to rebuild that whole system, in both rural and urban Alberta, and it's in pretty good shape now. One of the things that's happening more and more all the time with new technology is that we're able to transfer technology, specialists, and medical opinions from the major urban hospitals to the smaller rural hospitals without moving the patient. For example, a

short time ago I was in a major hospital in Calgary, and they showed me a project where a number of smaller rural hospitals within a 100-mile radius of the city of Calgary had hooked up to a machine that monitored pregnant women giving birth in terms of a variety of things, including the baby's heartbeat and so on. Medical specialists at the Foothills hospital were able to tell general practitioners on the scene what they had to do and were able by telephone hookup to give them all kinds of advice and information that they wouldn't otherwise have previously done.

The alternative to that is to have the patient come to Calgary, which burdens the patient and his family with an extra degree of cost, plus puts them in a $500-a-day bed instead of a $300-a-day bed, with a specialist full-time instead of part-time. The cheapest hospital facilities in Alberta are in rural Alberta, not in urban areas. Admittedly, the urban hospitals have a great deal more expertise and can look after the clinically more difficult cases, but the other people still have to be in hospital.

In my view, helicopter ambulance service isn't any solution at all. The better thing for us to be doing is trying to find out how we can keep patients at small local hospitals as long as we can, instead of sending them to the more expensive hospitals where there are a lot of specialists. I realize that has to be done sometimes and often is.

MR. R. MOORE: I move we adjourn.

MR. CHAIRMAN: Thank you very much, Mr. Minister. We appreciate your frank answers this afternoon. We stand adjourned until tomorrow at 10 a.m.

[The committee adjourned at 4 p.m.]