MR. TAYLOR: [inaudible] with us this morning. I am going to ask the hon. Mr. Miniely to introduce the guests.

MR. MINIELY: Thank you, Mr. Chairman. I am pleased to have with me this morning for public accounts review of the Hospital Services Commission the chairman of the Hospital Services Commission, Dr. Bradley; on my immediate left, Mr. Larry Wilson, the Commissioner for Hospitals and the vice-chairman of the commission; of course, our MLA who is a member of the Hospital Services Commission just recently appointed, Henry Kroeger; on my right, Mr. Ronald Berglund, the Commissioner for Finance of the Hospital Services Commission; and on my far right, Mr. Brandell, who is the Director of Budgets for the Hospital Services Commission.

I believe the format would be, Mr. Chairman, with those introductions, to turn it back to you. We're prepared to take any approach that you would like to take.

MR. TAYLOR: Thank you very much, Mr. Miniely. Mr. Rogers has one or two comments to make to start with.

MR. ROGERS: Members. I'd like to refer to Volume 1 of Public Accounts, page 142. This reflects the monies appropriated for appropriation 2402, 2403, and 2404, which are the appropriations we're interested in this morning. The executive appropriation is shown on it, and the expended figures are also shown on the same statement.

If we turn to page 143, you will note that there is an amount under 2404 for grants and prizes. This represents a transfer of funds to the hospital commission for operating expenses.

2403 -- there is an amount under the code hospitalization, and 2404 an amount of $247,413,000, also under hospitalization. These are the amounts that are in effect transferred to the hospital commission, which acts in effect as a control agency and flows through funds from the general revenue fund to the hospitals.

If we turn the page to page 144, there is a statement headed Health Commission Revenue. You will see the appropriate figure under Alberta Hospital Services Commission. Now the point I should make here is these funds do not go back to the commissions but go directly to the Provincial Treasurer, are deposited into the general revenue fund, and, in effect, pertained to the hospital commission and aren't actually the revenue of the commission.

With those comments, I'd like to turn to Volume 2, where we have the financial statements of the Alberta Hospital Services Commission on page 59. On page 59, we have the auditor's report. Although the act under Section 24(1) of The Hospital Services Commission Act says there shall be an audited balance sheet included in the financial statement, because of the way in which we operate that the commission does not in effect have any assets or liabilities as such, then it's not possible to have a balance sheet, in effect. We have a statement of receipts and payments which is more suitable for this type of operation -- the flow-through type of operation.

Consequently, on page 59 we have the statement of receipts and payments, Statement A; and Statement B, there is a research trust fund, which is administered by the Alberta Hospital Services Commission. On page 61, we have the notes to the financial statement, and I would draw your attention to the method of operation whereby cheques are raised by the Alberta Hospital Services Commission but no transfer of funds takes place from the general revenue fund until those cheques are presented for payment. This is covered in note 2 and is referred to in note 4. At December 31, 1973, there was an amount of $6,336,567 which was held in the general revenue fund of the province on behalf of the commission. This represents the outstanding cheques at that date.

Notes 5 and 6 refer to the comment I made earlier that any refunds or revenue are not reflected in the accounts of the commission but are deposited directly to the Provincial Treasurer. Page 62 shows the schedule of administration expenses of the commission and in effect gives the detail of the item at the bottom of the statement of receipts and payments on page 59, which gives the total of administration expenses $1,346,715.

The only thing I would refer to other than that is that the fiscal years are different. There is no direct comparability between the figures in Volume 1 and Volume 2 because the commission itself has a fiscal year ended on December 31, 1973, whereas, of course, the Volume 1 shows the province's fiscal year, which ends at March 31, 1974.

Mr. Chairman, I think those are all my comments.

MR. TAYLOR: Thank you, Mr. Rogers. Are there any questions? If not, what is your pleasure? Would you like a short introductory statement by the hon. minister, and then we could start questioning? Would you like to do that, Mr. Miniely? All agreed? They were nodding their heads.

SOME HON. MEMBERS: Agreed.

MR. YOUNG: In the introductory statement, perhaps the minister would review the cost-sharing relationship. The dollars are in the annual report, but the formula is not.

MR. MINIELY: Mr. Chairman, I suppose, as the minister, I would make some general comments, and then I will ask Dr. Bradley to perhaps expand, if he would like to, on general

comments. I think that there are some basic things which it might be useful for me to point out to the members of Public Accounts.

The hospital services commission budget, the one you're looking at, although it's some $258 million for the fiscal year ending March 1974, has now grown to about $430 million in the period of -- well, that's in just one year. The reason, of course, for this substantial escalation -- it hasn't been experienced solely in Alberta, it's been a trend right across Canada -- of tremendous increase in salaries and wages paid to employees in the hospital system, which accounts for 75 and in some cases 80 per cent of all hospital spending. Many of you, I think all MLAs would know, that our hospital system in Alberta is organized in a way that individual hospitals, auxiliary hospitals, and nursing homes are not run on a day-to-day operating basis by the Province of Alberta but in fact are run by individual boards. Across Canada, certainly in the recent six to seven months, both at the federal level and other provinces, there has been a developing concern that we must get better control of the cost escalation side in hospitals when that represents one-fifth to one-quarter of all your provincial spending. That's not to say that that's accomplished with sacrifice of quality but accomplished in terms of getting value for the dollar where you're spending such a large amount of public funds in this area.

So I think I see the major challenge over the next 3 1/2 to 4 years in this very large expenditure area of developing assessing the organizational system of the delivery of hospital care, auxiliary hospital care, and nursing homes in the Province of Alberta. Looking at other hospital systems, I've been spending a great deal of my time travelling with Dr. Bradley and Mr. Wilson in particular. I have made five tours, rural tours to different parts of Alberta, meeting with boards, communicating the concern, asking their views as to how can we improve our decision-making process in a way that will result in this substantial amount of public dollars being utilized in the most effective and efficient manner possible. I think it represents a substantial challenge. We have, I think, in excess of some 150 individual boards that we have to work with in the hospital field, and we have, I think, at last count something like 260 individual institutions -- hospital, auxiliary, or nursing home care institutions. So somehow I hope that during the period that I'm the minister to be able to work with Dr. Bradley and the commission and with the individual boards in a very close way to try to pull that together and make it more effective so that we, number 1, have better control over the escalation of costs, and number 2, that we're using the dollars in the most efficient and effective way that we can.

I think that being such a large area and with so many people involved, the numbers of involved -- the numbers of citizens involved on a part-time basis on boards in Alberta, I don't have the figure at hand, but it must be well in the thousands, a thousand or couple thousand, citizens who are involved in sitting on boards and doing this they volunteer their time. They certainly aren't paid anything near what the responsibility is that they take, and in some of our larger hospitals, as Calgary MLAs will testify, some pretty thorny and difficult problems can arise. A board member and particularly a board chairman in these hospitals spends a great deal of time with very little compensation.

I think some of the things we have to look at on the policy side are, how do we have boards that are the most effective. Because they really have in our system the responsibility to operate the hospitals on a day-to-day basis, to select the staff, to decide who should have medical privileges, to hire and fire staff, to ensure that the overall health care facility, whichever one we may be talking about [inaudible] in that facility. That can be some difficult judgment or determination of priorities. So that's one major question: what kind of things can we do to strengthen the capacity of boards and the people who are involved on boards. Should we consider things like enlarge hospils over a certain size? It's really the board that protects the public. The rest are professional hospital management people or members of the medical profession. I'm very interested in those kinds of things.

The other thing is: what about our decision-making processes I referred to earlier? Can we look at communities working together more to rationalize facilities? We're trying to move in terms of a voluntary area planning councils, so that communities, instead of the situation which we've historically had, and I'm a great believer that even though it may be difficult that we as MLAs and members of this Legislature should be communicating to our citizens and trying to change that we see just aren't logical. On these tours, I've said to communities, you know, if community A wants everything and community B wants everything, unfortunately you put your government in a position where we have to say no to both. If community A and community B could start breaking down this attitude and start to work together and say: why don't you get this, and we won't try to duplicate everything you have. We'll try to do something different from what you're doing. If we could move toward that kind of a thing, then we could utilize the dollars that are available much more wisely and much more effectively for our high level of overall health care in Alberta. But it will take a lot of communication. I won't be able to do it alone; Dr. Bradley won't be able to do it alone. We'll need the MLAs; we'll need you talking and communicating to your constituents and to your board members in this way. But I'm confident if we keep doing it, that maybe we can reorganize in a more positive way the decision-making process in the health care system and thereby have really improved not only the quality of health care but in effect the use of public funds in this area. That's a very major question.

Please don't anyone use the term "regionalization" if you pursue this, because that's not really what it is. It's not regionalization. It's a matter of rationalizing the health care facilities within a natural area of Alberta and trying to develop a co-operative attitude of working together rather than one of just bopping each others heads.

So that's a major organizational question. We feel that sometime after this assessment process is through, that we'll probably be proposing some fairly substantial policy changes in The Alberta Hospitals Act in areas like ambulance service. In terms of

our priorities, we're assessing where the greatest need is between different levels of care in nursing home care, which is the lowest cost health care facility we have on a per patient-day basis. Second lowest is the auxiliary hospital, which is a medium level of care in the system in Alberta, and of course the highest cost is the active treatment hospital. There's another important policy question becomes: where should our priorities and our dollars be directed as between those different levels of care? We suspect that people are kept in active treatment hospitals much longer than they should be kept in active treatment hospitals. We're trying to develop ways now and we're seeing some breakthroughs of in fact even performing minor kinds of surgery with no admittance to the hospital -- day surgery kinds of things -- to provide people with the quality of medical service that's required.

What hospitals have, I must say, is an excellent peer review system. It's doubtful that you would have any kind of control of the medical care that's given that is superior to what you have in a hospital. All of you who have your own endeavors, whether you're a professional farmer, whether you're a professional lawyer as Mr. Ashton is, or a professional engineer like others are, or a professional businessman, know that the things you do can really only be judged by your fellow professionals or your professional peers. It's very difficult for me to judge Mr. Butler's capacity to farm. In a hospital system, there is this continuous check on what is being done in terms of medical procedures. So it is an excellent peer review system. Sometimes that system gives us problems. It gives us very difficult problems and difficult communicative problems.

Without going on, Mr. Chairman, there are many other questions -- ambulance service, I mentioned that -- very large questions that we have to look at, decide if we should propose some policy changes, and if we do then we propose to do that within a rewrite of The Alberta Hospitals Act. The whole area in Alberta now we have five provincial general hospitals which are still run by boards appointed by myself as the minister, being the University Hospital and the Glenrose, which is a longer term care facility, in Edmonton; also in Edmonton the W. W. Cross Cancer Institute; and in Calgary the Alberta Children's Hospital and the Foothills Hospital. The only area of health care in the hospital system that is treated as unique and separate from all other areas is the delivery of cancer service. Cancer service is choices and priorities and is really worked by the provincial cancer hospitals board. Other areas of medical treatment, at least to this point in the system, that we're responsible for are all incorporated as part of the service of an active treatment or general hospital. Cancer facilities in Alberta are built and managed separate from other hospitals, although there is liaison and co-operation there.

I've tried to without getting in details, Mr. Chairman, just give some of what I think are the challenges that I have as the minister and that we have as legislators and that Dr. Bradley and his staff have as administrators. I think it's really interesting to again note that here we're talking about an area that represents, while we have 22 or 23 departments in government, we have one area that represents one-fifth to one-quarter of all provincial spending in Alberta. That means, and I think all of us take that responsibility seriously, that we've got to find ways of spending that money in the most effective and efficient manner possible. I don't think in my words I could describe our challenge any better than that.

Dr. Bradley, would you like to just add a few comments?

DR. BRADLEY: [inaudible]

MR. MINIELY: I didn't give you your question . . .

MR. TAYLOR: Thank you, Mr. Miniely, I think . . .

MR. MINIELY: Why don't you . . . Mr. Young wanted the federal cost-sharing formula or an explanation.

MR. YOUNG: Well, I thought as part of your introduction it would be useful because it's pretty basic to the financial arrangements. It's on page 21 of the 1974 annual report but not with any statistics. It's just there in a general [inaudible].

DR. BRADLEY: Mr. Chairman, gentlemen, speaking specifically to the point of cost-sharing as it affects our area, we have cost-sharing for active hospitals and auxiliary hospitals with the federal government. This comes under the federal act, The Diagnostic Services and Treatment Act, which was the basis of the hospital plan across Canada. The contribution of the government of Canada for in-patient hospitalization is the aggregate of 25 per cent of the per capita cost in Canada and 25 per cent of the per capita cost in Alberta, less authorized charges. Now at this particular time that we're discussing, in 1973, the authorized charges were $5 admission fee -- that's still applicable -- and the $3 co-insurance charge after 120 days that still is being carried on in the auxiliary hospitals. Then, of course, you multiply it by the insured population of the province, and the insured population of the province is nowadays accepted as the -- it's actually greater than the census figure -- and it relates to the registration with the Alberta Health Care Insurance Commission. We use that as our calculator.

Capital outlays, interest on capital, borrowings, and certain other expenditures are included in the costs. The nursing home plan at that time was not included in the federal sharing agreement. Administrative costs are not shared.

That's a short summary. I have figures if you want them.

MR. YOUNG: I was wondering whether we could, Mr. Chairman, get specific enough to put some figures on to the formula for either of the year '73 or '74. I'm a little bit confused which year we're dealing with, which is the most recent year we can deal with.

MR. TAYLOR: [inaudible] the public accounts of '73-74.

MR. MINIELY: Mr. Chairman, through you to Mr. Young. We have different analyses of the contribution of governments, both provincial and federal, as a result of the cost-sharing arrangement. We have on a document which I could give you now where the dollar comes from on a per capita basis from both our citizens and the two levels of government. As an example, in 1973, and the ratios have not changed substantially since this point, it gives you an idea or feel for . . . the patient was paying, out of a total per capita cost in 1973 of $153.14, the patient was paying $8.07 of that amount, or about 5 per cent was being borne by our citizens, if you like, directly. The owners were paying 30 cents, the owners being the hospital boards. I take it this would be their contribution. The provincial government was paying $76.99, which would be almost 50 per cent. The federal government was paying $67.78, which would be about 45 per cent. So, for summary, in 1973 the province would be paying about 50 per cent, the federal government would be paying about 45 per cent, and our citizens in Alberta would be paying about 5 per cent of the total cost.

MR. BATIUK: Mr. Chairman, my question would be directed more to the minister and his opening remarks. The former minister in charge of hospitals had announced a policy that wherever there are health care services as hospitals and so forth, that no way would the department ever decide to close that particular area. Should the hospital need to be replaced, it would be done so. Could the minister advise whether he is following the same pattern, or has there been some different change?

MR. MINIELY: Mr. Chairman, I don't know whether you can make that kind of statment without exceptions, even though, for instance, all the citizens would have moved out of the community and it became a ghost town. But there is no intent to withdraw in any general way health care service from communities that now have health care service. Now having said that, it is our hope, and I mentioned communication earlier, it is our hope to be able to communicate to citizens in communities that what's most desirable, even from their point of view, is the proper level of care for what their needs really are. As an example, we have in many smaller communities 50 to 60 per cent of the beds unoccupied on an average at any average time -- active treatment beds. In the meantime in the same community, they have a need for extended care beds, and they're not being utilized for extended care. So we're talking to the boards and saying, and we're trying to make it possible for them, and saying, actually, go ahead and use them for extended care beds. If the need down the road switches to active treatment beds, then they can go back into active treatment beds. But I think this is an area where all of us again have a challenge, because there's the fear that somehow if we use those active treatment beds even for the next two or three years for a lower cost level of care, that maybe we'll lose the active treatment beds. This is the fear in the community.

What's interesting is another thing that the average bed access that a city doctor may have is what . . .

UNIDENTIFIED: Ten is a lot.

MR. MINIELY: I think it was more like perhaps one or four at the most. The average -- if you took the population of doctors in the city, and you looked at the number of active treatment beds -- a doctor in the city may have access to four active treatment beds. The medical profession whom I've been talking to say that, basically, for a doctor to be able to function and make economically in a smaller community, he might need four active treatment beds to justify a doctor being able to function in a community. Most of our smaller-plan hospitals are built with a minimum of 20 beds, I believe, Mr. Wilson, would be around the figure 20 active treatment beds. Now I think we should give some serious thought to whether we should build 20 active treatment beds. Maybe we should build five or six active treatment beds and the rest should be extended care beds, longer term care beds, lower cost beds, and then utilized in that way, because many of them end up being utilized in that manner anyway.

I hope I've answered your question. Whereas we might try to reorient. We would not withdraw the health care available, but we might try through communication -- we won't impose it -- but we might try through communication to say, look, why don't you use your existing facility in a way that meets the needs of the community better, and a level of health care that meets the needs of the community better.

MR. BATIUK: Yes, Mr. Minister, you answered it more specifically than I really expected you to. But why I brought this question out was, being on the hospital visitors committee a year ago, and I went through a good number of them, and their occupancy in places was maybe 40-50 per cent, and yet right across there's a waiting list in the nursing home, in the auxiliary, and so forth, and here half the hospital beds are standing idle. That was my question. That's what I want to know.

MR. TAYLOR: Gentlemen, I'm wondering if we're getting into policy more than public accounts. It's entirely up to you, but the idea of the committee is to delve into public accounts, and this is your opportunity to delve into the inner workings of the hospital commission. Matters of policy can be discussed in a number of other ways in the Legislature. I'm just suggesting that we try to keep on the purpose for which the committee is set up, if at all possible.

Mr. Young has a question.

MR. YOUNG: Mr. Chairman, I'll do my best to frame this so that it's not policy and is . . . But I understand that 1973 fiscal year that we're dealing with is the first year in which the government removed all possibility of local requisitions. This raises some interesting questions about the perspective of local hospital boards and also questions about how are we able through the hospital services commission to control costs, control expenditures. I'd like the commission to respond (a) does it sense that the perspectives of boards have changed as a consequence of this policy, and (b) what method is followed to control hospital budgets?

DR. BRADLEY: Perhaps, Mr. Chairman, Mr. Young, I'll start and have Mr. Berglund give you more detail of the technical end of it. We started in 1972, which was the first time we asked hospitals to submit budgets. Before that, hospitals were not required to submit budgets to the government but instead they ran their own management, if you will, of their finance, and the government paid them so much per day. The balance of the amount not covered by the accounts was requisitioned from the rate payers. That was they way it happened.

With the turn in 1973, we had moved into budgeting as a management technique and a monitoring technique for the expenditure of public money and trying to increase sufficiency. This was what we were after when we first introduced it. The requisitioning gave the hospital boards a certain amount of flexibility in the introduction of programs and the expenditure of funds. When the whole funding system of the hospital system became public accounts, we introduced more monitoring and control of expenditures on the basis of an approved budget which each hospital submitted. I would say that generally over the system, that it has been generally successful; inotherwords, most hospital boards have attempted very strongly to stay within the amount of money allocated to them.

Now from the point of view of programs, the one problem we have is that we introduced regulations to require our approval for new programs, and then the dictum went that if the program were approved, the funds would flow with the program to support it. That is the way it has gone for the last two years. Most hospital boards do a very conscientous job on trying to control public funds, but there is, at the moment, I would have to say, I think, a feeling on behalf of some boards that if they overspend, the government will pay it anyway. We have not had to ask, until this year, for a special warrant above the appropriations that were passed by the Legislature. That goes from '71-73. This particular year is different because of the labor negotiations, so forth, that the appropriation was set up differently.

All new programs are introduced on what we call a B budget basis -- any significant expansion of the program is. The hospitals really have no other source of income except through the hospital commission from the appropriation. The significance of the remark then comes, how efficient is the commission in monitoring and controlling. Well, it's as efficient as you can do with the small staff which we have. We have introduced, naturally, computer techniques and so forth, to try to monitor the expenditure of funds through a reporting system. Beyond that, I have never felt that there was a great wastage by the boards in the system. I think that some of the actions that have been taken by boards that we didn't agree with were done in good faith by the board members, and usually it was a problem of communication. We've been trying to communicate with all the boards -- and the hospital association does, too, with all the boards.

Do you want to know a little more about the technical end of the monitoring and the budgeting?

MR. BERGLUND: Mr. Chairman, members, Mr. Minister. Dr. Bradley has indicated to you that at the time the hospitals commission was formed, a budgetary procedure was implemented whereby each hospital was expected to provide to the commission a budget which was reviewed very carefully by the budget section of the commission, and the support for the next coming year was determined.

Now it's interesting to note that we have to work a year behind or a year ahead of ourselves in the budgetary process because we make our submission for next year's budget. Now, it's been for a number of months in one form or another, and yet we do not have the review of the hospital budgets completed until the early part of the subsequent year. So we work, as I say, either ahead or behind ourselves; nevertheless, it does work reasonably well, and we have been able to project costs by careful review of the budget submissions.

In conjunction with the actual budgets, we require the hospitals to provide us with monthly statements of their operations, both financial and statistical. These are forms referred to as Forms 160 and 161, which is simply the operating side of the hospital activity. It does not include a balance sheet or any balance sheet items of any particular note. These monthly submissions of the hospital are matched against their budgets, their projected costs, a program which we have set up first of all on a manual basis, and are now converting to a computer program with the expectation that this will give us faster results.

I think perhaps I should say a word about hospitals operations, and that is the fact that you can't compare hospitals to each other. They're all different. They have different physical facilities, they have different medical practice, they have different modes of operation, they have different boards and different administrators, with the result that we have to develop in the hospital system a method of comparing hospitals to themselves. So we do build up a month-by-month and year-by-year historical operation of the hospital to see how they are doing this year compared with last year and the year before, how they're going to do in November compared with October, and so on for a period of time.

As we monitor these monthly returns submitted by the hospitals, we come across occasionally items which are cause for concern. When this happens, we get in touch with the hospital, endeavor to determine what has gone wrong, why their operations are coming

in at a figure higher than we had anticipated and to which the hospital had agreed in the budget review. We try to impress upon the hospitals that if they exceed their allocated global budget, they should immediately get in touch with us. If it's a minor matter, one of the budget officers will visit the hospital and endeavor to see what the situation is, where the cost excesses have occurred, and see if there is a solution. Sometimes we'll get a real serious problem which requires some review by the executive committee if I'm not able to deal with it myself.

I think your question really was, or at least the final part of it, would be: what happens when a hospital does get out of control under this last dollar support. I have a feeling that there have been some hospital boards who have adopted a rather indifferent attitude, and they say: well even if we spend it, there's nothing to worry about -- I heard the Premier say that we're going to look after the last dollar expenditure. Perhaps on occasion they don't exercise the financial responsibility and accountability that they should. In fact, we decided in 1974 [inaudible] that they would take a very, very close look at those which had exceeded their approved budget amounts as agreed to by the hospital board. Quite deliberately, we left with a number of hospitals some of the 1974 costs, not in any substantial amount but enough to indicate to the hospitals that it was a matter of concern to the commission.

We recognize that the hospital board cannot now go to the municipality for these excess funds, be they $20,000, $50,000, or $100,000, that they have no source of funds available to them to pick up this shortfall. Our thinking at the time was that they would recognize the fact that they were operating beyond their means and would cut back in the subsequent year, 1976, to make up the shortfall that did exist. Now 1976, of course, is going to be a very difficult year for any hospital to find funds out of its '76 budget to pick up a '75 deficit. I don't know what the final solution will be here. Nevertheless, the purpose of it was to impress upon the hospital boards that the commission was concerned with overruns on budgets and wanted to bring it firmly to the attention of the various boards. There has been a bit of static on this policy, and we did have one appeal yesterday on the '74 boards, which was of considerable interest to members of the executive committee.

I think perhaps, Mr. Chairman, Mr. Minister, I've covered the technical points.

MR. TAYLOR: Thank you, Mr. Berglund. Any further questions? Mr. Young.

MR. YOUNG: Pursuing the point, just once more, in a very gentle way, that is, reading your very gentle response, I get the impression that attitudes may have changed -- that you may have detected a slight change -- on the part of some boards. Is that what you're saying?

MR. BERGLUND: I think that's true, yes.

MR. YOUNG: If I may then interpret Mr. Berglund's remarks a little bit further, I take it that the only control that we have is a sort of after the fact control where we leave a deficit standing there, but they know and we know who's going to pay it under the existing situation. Is that correct?

MR. BERGLUND: Partly, Mr. Chairman. I indicated that we do have this monthly monitoring operation, and when the hospital appears to be in trouble, we immediately get in touch with them to try to rectify the matter. There is, of course, the matter which the matter which you referred to, that the post facto control also exists. I think one of the other problems we have with boards is that they change. A new board can move in, and they want to revitalize the hospital, and they don't really understand what they're getting into.

MR. STROMBERG: Mr. Chairman, just one comment. I think that Dr. Bradley and Mr. Berglund have given a very good overview of the, if you like, the control of the existing system, not that there aren't some areas that we hope to achieve some improvement in, both in terms of the hospital services commission financial system and in terms of looking at the internal operation of a hospital in finding out whether in fact they're operating in the most efficient manner. Both the chairman of the commission and Mr. Berglund indicated that we do have some concern whether financial responsibilities altered since we went to last-dollar financing.

But I want to make a couple of points based on my first six or seven months' look at the financial control area of hospitals that I think are perhaps the key to controlling, or one of the keys to controlling, costs.

The first thing I would say is that 10 of our larger hospitals in Alberta would account for 50 to 60 per cent of our total hospital budget. So if you think about that one for a while . . .

The health care system probably, more so than any other public policy area, when you start a new service, the demand and growth in cost of delivering that service is almost endless. I think we have to have a much better assessment of as best we can the health care priorities when we make a decision to implement a new service. I've met with Dr. Bradley and the finance commissioner, Mr. Berglund, and Mr. Brandell, the Director of Budgets, in connection with our existing budget that we're presenting in the next fiscal year. Although it may be difficult, one of the things that I hope we can do is take a new program at a cost of $1 million today placed in the hospital system and look historically at the average experience of that program four years down the road -- what it's costing. I think this is going to be critical information if we're going to know in fact what we're building in in terms of future cost everytime we place a new program in a hospital. Our experience, I think, generally, Dr. Bradley, is that once the new program is in the hospital, the demand for it and the growth for it just explodes. A good example is the

neo-natal program which we started two years ago. The demand, growth, and cost of that program is very substantial. That's one side of the question.

The other side of the question is then: how do we make a good, valid judgment. Maybe it's impossible, but it's a question that interests me, as to what is the health care priority in terms of the overall health of our citizens. Should we be choosing this new program or this new program? Which one has the most validity in terms of overall level of health of citizens of Alberta? Yet it's a question we should be trying to address ourselves to.

I think, Mr. Chairman, those two things, along with some of the other organizational factors, are perhaps the areas that we have to improve our information in. When we make our decisions, we have to have a clear assessment of priorities, knowing not just the cost today, but the cost four and five years down the road, which will give us an idea what it might be ten years down the road.

MR. TAYLOR: Thank you, Mr. Stromberg. MR. STROMBERG: Mr. Chairman, to the minister. How many hospitals presently in Alberta have overruns on their budget? Is St. Mary's in Camrose one of them?

UNIDENTIFIED: I would say that for 1974, the final situation was 16 hospitals had an overrun. The current figure for 1975, I'm afraid I don't have the information to date. We're still adjusting budgets, as a matter of fact.

MR. STROMBERG: Second question, Mr. Chairman. In regards to the hospital beds at a cost of $60 upwards and different times that patients are in hospitals at this high rate of per bed per day, if there were nursing home or auxiliary home facilities available, they would be over there -- I know this is getting into policy -- but is the planning of your department to get into the nursing hospital and the auxiliary hospital end of it an emphasis on that?

MR. MINIELY: I suppose, generally speaking, although we haven't completed our assessment of where the priorities should be for the next three and a half to four years. I think, though, that our preliminary information would indicate that in terms of the construction of beds that there appears to be no doubt that our priorities should be in the longer term care area -- the auxiliary hospital area and the nursing home care area.

We already are starting with a situation in Alberta where we have by far the highest number of active treatment beds per thousand population of any province in Canada. I think I was using the figure seven and a half, but I looked at a figure of nine not too recently. Maybe that was with auxiliary hospital beds. Say seven to seven and a half beds, whereas I think the national desirable standard in Canada that the federal government has indicated is four. So we're pretty heavily built in active treatment beds, and we should be looking at our priority of capital dollars in this auxiliary longer term care beds and the nursing home.

It is sometimes difficult, Mr. Chairman, through you to Mr. Stromberg, because we're going by information we gather from all the different boards and all the different districts on waiting lists, nursing home bed waiting lists, auxiliary hospital waiting lists. Sometimes that information is good from an individual community or area; sometimes it is overstated, if I could use the term. We have to try to determine what the actual situation is. Well, the commission can go out, send a staff member out, to talk to people in the community and make an assessment on an individual basis. We're trying to improve this area of our information system, too, in arriving at planning and where our priorities and dollar commitments should be.

One more point I'd like to make -- one of the things we frequently run into, though, in a smaller community, is that the existing hospital is occupied on an average basis 40 or 50 per cent, which is a very low occupancy rate. If it's a 20-bed hospital, it means that we've got on average 10 beds available on average in that hospital. Many times, the highest occupancy rate is 60 per cent. In other words, it's never in the whole year been more than 60 per cent. So there's a minimum at all times of about 30 to 40 per cent of the active treatment beds that would be available for another purpose. Frequently, in response to the member's question, Mr. Chairman, the board will say, we need nursing home or extended care beds. We're saying, why don't you use some of those beds for that. If you have a need for nursing home and extended care beds beyond that -- let's use what we have first -- then we'll assess it and determine whether in fact we should build some extended care beds. But let's not build -- one of the mistakes we make is that we build beds of one level care, sometimes, where if you were strictly on a straight assessment of need, what the actual need was, you wouldn't build them, because the need can't be demonstrated.

MR. STROMBERG: Mr. Chairman, to the minister for clarification. I wasn't thinking of the smaller hospitals in my constituency. I was thinking of the problem in a large hospital, at St. Mary's. Monthly they tell me, we have four patients that we've had here now for three months, if we just could get them over in a nursing home.

MR. MINIELY: Well, I think that's, you know, if those figures are accurate, that's the kind of thing we would be assessing. If, in fact, the Camrose hospital -- one of the things you have to look at is, what is the occupancy rate of the Camrose hospital on an average basis. If you find for instance, that it's 60 or 65 per cent -- it's fairly high, Mr. Berglund tells me -- if it's a high occupancy rate anyway, and there's a demand for extended care beds like nursing home or auxiliary, then we should be looking and assessing that. If we agree with the demand, then we're prepared to build the extended care beds,

either nursing home or auxiliary beds. But if there's not a high occupancy rate in the hospital, then that argument doesn't wash.

MR. McCRAE: Mr. Chairman, just a point of clarification arising out of the minister's opening remarks. During your tribute to the hundreds of volunteers that serve on the hospital boards, Mr. Miniely, you said that they receive very little compensation for their efforts. It was my understanding that they worked without any gratuity or per diem payment at all. I wonder if you could just clarify that for the record.

MR. MINIELY: They all vary, and this, I think, includes the chairmen of boards, from anywhere from nothing -- many boards, I think, it's nothing, no remuneration at all for the time that is involved -- up to the high would be $40 to $50 per day. But then you're talking about a very large metropolitan hospital with substantial problems. A lot of times your board chairman is a professional person or a very high-standing business person, and at $40 to $50 a day. So the general statement I was making, Mr. Chairman, was that my view is that you can almost say that it's voluntary time, with that kind of a . . . Now I'm not saying that that's right, because I think we have to look at, you know, how do we ensure that good-quality persons, not just board chairmen but all members of board, that we maximize the quality of people that are in there.

Some of these, the University Hospital, is a $30 million operation -- one hospital. It has the largest single budget of any hospital in Alberta. What interests me is that it's not the administrator that has to answer directly to the public for what the University Hospital does. It's the board and the board chairman -- the board through the board chairman that has to answer to our citizens for the day-to-day operation of the hospital and the efficient and effective use of the budget that I and the Hospital Services Commission grant that hospital. Here you've got a $30 million some operation, and you've got strictly a part-time board chairman and part-time board members who are receiving next to nothing for their effort. That's a question . . .

UNIDENTIFIED: Clarification, Mr. Chairman. I appreciate the fine work the volunteers do and certainly wouldn't quarrel with anything [inaudible] paid, and I'm sure they're underpaid if paid -- whatever they're paid.

Is it set out in statute what they will be paid? We all from time to time receive recommendations for [inaudible] to hospital boards, and of course some of us from time to time make recommendations, and it is helpful to know which of them are paid and which are not. Is it prescribed by statute or is it a determination of yourself or the Hospital Services Commission?

MR. MINIELY: No, we don't set out remuneration. Do we in the provincial hospitals?

DR. BRADLEY: It's in the act.

MR. MINIELY: In the provincial hospitals, I think there's some. But in other hospitals it's done by board by-law, Dr. Bradley advises me. In other words, the province doesn't because they're municipally appointed board members, and it's done by by-law of the hospital board. Those are the ranges they're in at the present time.

MR. DCAN: Mr. Chairman, Mr. Minister, and gentlemen. I had occasion recently to meet with our administrator in the Red Deer hospital for about an hour to talk over the problems there, and one impression I got, sir, was the number of beds that were held available. He tried to explain to me why they have to hold this number of beds. It seemed to me there was excessive number in lieu of the fact we have between 800 and 1,000 people there on the waiting list. Can you explain this a little?

MR. MINIELY: There are two comments that I'll make. There's generally an unwritten understanding, if you like, that about 10 per cent or about 90 per cent occupancy -- if a hospital gets over 90 per cent occupancy, they're not leaving enough room for disaster -- even a small disaster or an emergency situation and that type of thing. So hospitals are operated on the basis that you don't occupy them 100 per cent in the event that you have this kind of a -- you know, you've always got to have so many beds for an emergency type of situation.

But having said that, there are very few hospitals in the other than perhaps your very large metropolitan centres that are up to 90 per cent or over the 90 per cent occupancy rate.

Now one other comment that I would make is I think it's important for MLAs to know and realize this, is that administrators will frequently overstate the case. The chief administrator of a hospital will talk about a big, long waiting list in a hospital. All I say is, do some of your own checking before you just accept that for the gospel truth, because it's a natural tendency to do so. I'm not being critical of it -- I'm just saying it's a natural tendency for the administrator to say, we've got a big, long waiting list in the hospital.

We also must remember that our hospital system is built for many elective kinds of things -- elective surgery, things that don't have to be done today, things that can be done just as well two months from now or three months from now. So you can't really look at a 100-person waiting list and say that that's a valid waiting list in public policy terms, because maybe 100 per cent of that waiting list is elective surgery, things that don't have to be done today but can be done later. We experienced in Edmonton, I think all of you know, a shut-down of 600 beds, a partial shut-down for 3 weeks and a total shut-down for 3 weeks. All it did during the whole period was drag the elective surgery. Anyone who needed emergency treatment, who needed to get in the hospital right away, got

in the hospital right away. So the judgment gets to become, how far do you drag optional or elective things rather than, you know, is there an immediate need today to get in a hospital.

MR. HYLAND: Mr. Chairman, just as a comment. It appears different for me to be looking across to Dr. Bradley and Mr. Berglund. Six, eight months ago I used to be on the other end, looking up.

I just want to clarify something Mr. McCrae said, and I think the minister covered it. On the hospital board I used to be on, we got $10 a meeting and $20 a day if we spent all day on hospital business. It was in the by-laws of the board, and the board controlled your pay there.

MR. SCHMIDT: Mr. Chairman, I would like to address my question to Mr. Berglund. In view of the fact that we have the opportunity at the present time to monitor basically monthly the expenditures of local boards and the hospitals that they're responsible for, is there any indication that those public nursing homes are exceeding the actual financial daily allowance? In other words, are their budgets being balanced as to those that are opposed to the private? I'm not talking about level of service. I'm speaking dollars and cents, the money that's received by the board to operate the nursing home -- are their costs exceeding the actual amounts received?

MR. BERGLUND: Mr. Chairman, the nursing home system is funded in a different manner than the hospital system, which is funded on a budget basis. The nursing home program is funded on a subsidy basis. At the present time, government provides $15 a patient-day, and the patient provides $3 for a total revenue per patient-day of $18. The mix may change next year, but that's the present situation.

As to the difference in operating a district home or a private or voluntary, we have to go back a few years when before the days of the Alberta tax reduction act, when as a matter of community policy, many nursing homes decided to provide their guests with additional facilities, perhaps additional recreational activities, perhaps in those days, air conditioning, and other amenities not generally necessary for the operation of a specific nursing home. At that time, they could go back to the municipalities for additional funds, and in most cases this was done with the blessing of the municipalities. In addition, many of the smaller nursing homes -- 20, 30, 40 beds -- are uneconomic units, and they cannot be operated at a break-even point. We have found that the minimum beds should be 75 and then multiplied by multiples of that 75 in order to be an efficient economic unit.

It is true that at the present time there are still nursing homes that exceed their subsidy for these two reasons -- because they could do it before and because of their size. Last year, the hospitals commission made up the deficits, both in operations and/or long-term debt retirement.

MR. DOAN: Mr. Chairman, I hope I'm not pressing the questions more in a policy angle, but could I ask, what's the question between the ASH Deerhome hospital in Red Deer and our general hospital? I have two questions on that.

DR. BRADLEY: Deerhome, Mr. Chairman, is an institution under the homes and institutions branch of the Department of Social Services and Community Health and actually participates through services to the handicapped. It has nothing to do with the hospital system, nor does the school for the children have anything to do with the hospital system. Whereas, of course, the institutions in Red Deer that we fund are the Red Deer General Hospital, the auxiliary hospital, and the three nursing homes.

MR. DOAN: My second question, then, sir, and this was brought to my attention by a constituent who objected to the situation. Do they not have the facilities at the ASH Deerhome to look after their own patients? They seem to be crowding an over-crowded situation we already have in our general hospital.

DR. BRADLEY: No, because Deerhome is not a health institution. It's a residential place and a place where they give personal care for the handicapped -- the mentally handicapped. When they require medical services or the services of a health care institution, then they are considered citizens of the community and are admitted to any of the community ity ... You know, that's traditional in Red Deer for years and years. I've heard from time to time people that have complained about being in a room where there was a mentally retarded adult. At that time, it really is left to the board and the administration of the hospital to make an equitable distribution of the patients. There are many people in that area that employ these people and are used to having them, whereas another area they might object. It's a personal thing, but there's no discrimination from the point of view of a physician admitting a patient to a hospital. It doesn't matter whether they're retarded or not, if they need the care of the hospital.

MR. MINIELY: Mr. Chairman, Dr. Bradley has done an excellent job of answering the question, but it leads to something that I personally feel very strongly about, and that's where the responsibility for determination of priority in any public policy area is. I think one of the real questions in terms of health care -- we have examples I'm not going to mention specifically -- well, no I will mention a specific which concerns me.

The Workmen's Compensation Board is now delivering rehabilitation programs for injured workers. My view is that you create a real distortion of overall public priority unless you clearly define the responsibility for where a particular public service and the priority of a particular public service should be determined. If we create a situation

throughout the government generally where different departments or different program areas are in fact delivering health care, an element of health care, then how can we control through the Hospital Services Commission or through, if it was a former Department of Health and Social Development, the total cost of health care? Surely, in the case of the Workmen's Compensation Board, they're moving into the delivery of an element of health care for the injured workman. It is either a testimony to the fact that the priority of our health care delivery system is out of wack or an oversimplified solution to what seemed to them to be a problem.

Now, it's not exclusive. I've used that as an example. I think it's extremely important, if we're going to have a clear assessment of overall government priorities, that those areas that are responsible for delivery of health care are the only areas that can really determine the priorities of the dollars for the delivery of health care. If we have other departments delivering health care, well, what you end up with, Mr. Chairman, is simply a distortion of public priorities.

I think it ties in with -- although here is an element this is even a finer line that Mr. Doan has raised, Mr. Chairman -- the point is this: is that our responsibility in the Hospital Services Commission and in the Health Care Insurance Commission is to deliver a general level and quality of health care service to citizens on a broad basis, available to all citizens. We can determine priorities within that overall objective, and it's important we do clearly define priorities in that overall objective. But if a certain other part of government starts to deliver a general health care service even on a specific basis to a particular group of citizens, then I think you can see how that distorts the overall determination of public priorities.

MR. STROMBERG: Mr. Chairman, I forgot what I was going to ask. I'm sorry.

MR. FLUKER: Mr. Chairman, I'd just like to ask Mr. Miniely . . . these private nursing homes, such as [inaudible] nursing homes, do they answer back to the Health Services Commission? Do you have control of them?

I guess what I'm talking about is the [inaudible] nursing home in St. Paul and also in Bonnyville and many of the problems we've had there over the past years. In the administration of this, and they have their own administration, and these people that are in there, sometimes they have a fair-sized amount of money built up, is there anyway that you have control over the administration for them not to be dipping their fingers into the pork barrel, as we might say, a bit? There are a few people coming to me often who complain that they have patients in this hospital, and a fair-sized bit of money builds up in their account there, which they keep. But then there comes a time when they check out, and the money is not there. I sometimes question the administration of some of these privately-run places, such as [inaudible]. There are lots and lots of problems there.

I just wondered if -- I suppose you're aware of it, and I suppose you're aware of the problems we've had there. My suggestion would be that you try to get rid of them, buy them out, and be one part of the whole system.

MR. MINIELY: We receive, I think it's fair to say, a lot of complaints about private nursing homes, but I don't know that it would be fair to say that we receive to that degree more complaints about private nursing homes than we do publicly-operated nursing homes. It's a matter of degree, I guess. We receive complaints about publicly-operated nursing homes.

In answer to the specific questions, Mr. Berglund indicated to you that in the nursing home plan we are really purchasing a service. That's the province's role -- we are purchasing a service. We're not funding the whole budget. We're paying on a per patient-day. We're paying, now as an example, commencing January 1, or at the present time we're paying $15 per patient-day for standard accommodation in a nursing home. Whether it's a private operation or whether it's a public operation, we're paying $15 per patient-day. We have actual ways of checking the residents of the nursing home and that type of thing.

It can be, depending on when the nursing home was built, because our $15 per patient-day does include an element of capital cost, that a nursing home that was built 10, 15, 20, or 25 years ago can be a much more profitable operation than a private nursing home that was constructed 5 years ago, because of the difference in capital cost and we're paying them both the same rate. We do require an audited financial statement by independent auditors of every private nursing home operation in Alberta.

The existence of private nursing home operators is a historical situation that we have. I think that many MLAs believe, and many citizens believe, that we should try to retain the capacity for privately-operated nursing homes as opposed to the other extreme of all nursing homes being publicly operated.

That's really a policy question, Mr. Chairman, and one which to the present time I have not found a unanimous support or agreement that all nursing homes should be publicly operated. That may happen -- I'm not saying that may not happen. But to try to retain an element of the private sector delivery of nursing home care, I think most of us, if the level of care and the standard of care, could be maintained as equal with public, we would at least like to try to retain that historical situation in our nursing home care system.

Now having said that, I think one of, and Dr. Bradley would probably agree, one of our more difficult things to do under the nursing home plan is, whereas we're limiting our contribution on a per patient-day basis and we're actually purchasing a service from all nursing home operators, and we also have standards of quality of care and service that the nursing home operator is supposed to adhere to, our capacity to shut down the facility, if you like, to force the maintenance of that level of quality of care, I think most of you can appreciate in thinking about it, can be difficult. Particularly when you've got residents of a nursing home -- can you shut it down? Obviously, it's difficult to shut it down when you've got residents of a nursing home. We do in fact say, when we get

complaints, we go to the operator and say, now, you've got to shape this up, you've got to improve this. But I think it's fair to say we have a lot of difficulty with some that we think are probably not maintaining the level and quality that they should be. One of them, perhaps is the one that Mr. Fluker raises.

UNIDENTIFIED: It's the most frequent.

MR. MINIELY: We're trying to do the best we can in that area, but the other area is one that I'm not sure I'm prepared yet to say that we should give up on private sector involvement in nursing homes.

MR. FLUKER: What I was getting Mr. Minister, was, many of these patients in these places have a fair-sized amount of money. These nursing homes keep this money in the nursing home. It should be put in the bank or somewhere, and I'm not always sure that the same amount is there when they leave or when they die as when . . . there's something going on there somewhere. This is a complaint I get from my constituents and people who have people in there, that maybe some of this money is being meddled with a little bit. You see what I mean here?

MR. BERGLUND: Mr. Chairman, on occasion, murmurings of this nature do come to the ears of the commission as well, and when they do, we immediately investigate to see if the affairs of the nursing home are being conducted in a proper manner. The requirement of the nursing home operator is that he segregate these funds belonging to the patient and maintain them in a trust account, against which the patient can draw. In addition to the trust account maintained in the local bank, he maintains a sort of a petty cash fund at the nursing home, against which the patient can go down and get $20 or $30 if he's going shopping or out for dinner or whatever. This is merely a cash convenience for the patient, and to my knowledge, operates very successfully.

Bear in mind as well, of course, that the accounts, including the trust account of the nursing home, is subject to external audit and report.

MR. YOUNG: Mr. Chairman, back to a topic that I was on earlier. The minister has stated that the University Hospital budget is about $30 million. Mr. Berglund has stated you get these monthly reports and that we don't introduce new programs unless they're approved. It has been stated that the neo-natal program came into being about two years ago and is rather expensive.

Is it realistic, and this question I guess to Mr. Berglund, with a $30 million budget, which means there is an expenditure of $2.5 million a month, to expect it on a report form you're going to be able to detect an expenditure which may start out with as little money as, say, $20,000 a month?

MR. BERGLUND: Well, Mr. Chairman, the detection of small amounts of over-expenditure is, of course, extremely difficult, and particularly so when we operate really on a quase-global budget nature. Anything substantial would certainly throw out the accounts, and we are adding to our monitoring program, which is just the monthly financial statements, a sub-program which will monitor B budget operations, whereby we will be able to control of them from a year to year basis rather than lose control of them after the first year of operation. I think this will be a great improvement in our ability to determine if the hospital is staying within the funds provided for its use.

MR. YOUNG: I guess to express it another way, it may not be an over-expenditure. It may just be a different expenditure. It seems to me, if I were an administrator, and I had $2.5 million a month, and within that I have a staff established, it shouldn't be impossible to redirect one or two nurses, one or two beds, if I want to establish a program, and to have that established and running for a year -- I mean, large oak trees from little acorns sometimes flourish. It seems to me that's possible. I'm sorry, I have some doubt about whether it's possible under this system you have, when the first control, as I understand it, in the sense of a check on the administration or the medical staff assessment of what is the objective or what they would like to do, when the first check is your office and not local. I just wonder whether it's possible to really detect some of these things in those large situations. Smaller hospitals may be different.

UNIDENTIFIED:Mr. Minister, Mr. Chairman, I think that there are two or three things here about hospitals that have to be brought out. I have an old -- a new or an old -- cliche that says, we don't run hospitals, we fund them and that the boards own and operate them. Now that is true.

In the development of hospital plans all over the world, the problem that has been associated with the control of funding by central authorities is common. In every developing country, they're raising the same questions that you are, Mr. Young, and that is, how does a government that fully funds a decentralized system where the authority is in the field, how does it control expenditure of the money when it passes it out. It was thought about four or five years ago that if you determine on the basis of a budget the amount of money that a hospital needed and you gave it to them and you gave them certain rules about how to spend it, that the boards are responsible people, are citizens in a community, and they would do it. I would say at the University Hospital, the Misericordia Hospital, Calgary General Hospital -- hospitals of that nature -- the board does control the expenditure and flow of funds in a reasonable, responsible way.

Now then, as far as the administration or running of a hospital and the introduction of a new program -- how would we know? The answer is, we would not. The answer is, from the board's point of view of the hospital, the University Hospital, that administration

would not introduce anything, it wouldn't change its funding in any sector without having the approval of that board. The board knows the rules about the introduction of new programs that can encourage expenditures.

I don't suppose we really care if they shift a nurse or accentuate a program and de-emphasize something else, provided that they don't want three things. One is renovations, second is capital equipment, and the third is people. Under the global budget system, if they keep the same number of people, they run it in the plant, and the board thinks it would be better to emphasize it this way than that -- we don't care.

But you take the introduction of the neo-natal unit at the Royal Alexandra Hospital, which was B budget commission, and at the University Hospital, that implied that we would fund medical people, a whole raft of nurses. How many was it they wanted? Thirty-five staff they wanted just for the high-risk obstetrical area. Thirty-five of those were nurses -- that's $35,000 . . .

MR. MINIELY: No, it can't be. It's more than that.

UNIDENTIFIED:The average pay now is about $12,000 or $14,000 for a nurse. Say they were $10,000 people. Right away you've got that on your budget. You've got the new space that's got to be held. You've got the utilities cost, and you've got to equip the thing. So you can't just have somebody say -- and I know hospitals that are trying to do it right now -- you can't have a hospital say, we're going to have a neo-natal unitt. •This particular unit at the Royal Alex and at the Foothills University Hospital, these units are needed in Alberta and they are doing what the government policy on that accepted. They're doing the job. They're costing a tremendous amount of money. It's growing, and of course this is the point the minister was making, is that we have found and discovered that under the old system, we lost the growth of the new items, but under the new system, we will carry them through at least for three or four years and longer if the things aren't stable so you know how much they cost.

No, you don't really have that control in a hospital. We have to do it from post fact. We do an awful lot of public education and monitoring, and we have field reps. But we only have about four men travelling around Alberta, and most of the time they're either putting out little fires or investigating complaints. The possibility of us inspecting hospitals on a regular basis -- well, first of all it's not necessary, it would be too expensive, and thirdly, it isn't possible. As a result, the commission more and more has to be seen as being an agency that advised government about the amount of money it requires for a system according to the government policy; it has to distribute it; and it has to feel that the people are spending it responsibly in the field.

We set standards. This is new in Alberta -- the setting of standards centrally. But that also goes with state plans where you are providing the money centrally.

I think I answered your question. The short answer would be, we can't control it.

MR. STROMBERG: Mr. Chairman, to the minister or to Dr. Bradley. Is there a saving to hospital boards in the use of day nurses and home care?

MR. MINIELY: I don't think anything is proven in that area yet, Mr. Chairman. These are both relatively new developments. We're monitoring them, both home care and day care. There are different forms of day care, and of course all kinds of home care as well. I think it may be another couple of years before we really have any experience. On the other hand, we might be able to in about a year.

One of the things we do have to be careful about, though, Mr. Chairman, in the development of home care and day care, is that we're not tacking on top of our existing system; in other words, it has to be done in a way that if we're actually extending home care or actually extending day care, that we are doing it to the same individuals who would otherwise be hospitalized or in a nursing home or an auxiliary hospital. If we build up a whole new area of public program to a group of citizens in any substantial way we're not presently not utilizing, you can see what will happen to costs. So it has to be controlled in a way that's cost effective in the overall health care delivery system.

MR. HYLAND: Mr. Chairman, this question may not be associated with the council. I'll let you make up your mind. A couple of years ago, at the hospital convention, when I was involved with the hospital board at home and the regional hospital association, there was talking going around about cutting the size of hospitals off at about 500 beds or less so that they didn't get large and unwieldy and of constructing more hospitals to take up the slack of this equivalent size and the possibility of one of these being an additional teaching hospital.

Is this a fact, or was it just a rumor as of then?

UNIDENTIFIED: Mr. Chairman, I don't quite know how to answer that one. We recognize that in the 19 large hospitals in this province -- you have some 7 teaching hospitals or affiliated hospitals with teaching -- that there has to be a critical base, a number of beds, a number of services, which support not only your teaching but your referral service to the community or to the region. So, you expect to find throughout the province about the number we have now, 5 to 7 hospitals, of over 700 -- some are between 700 and 1,000 beds. There is a feeling that as you pass the 1,000 beds, you tend to lose your contact, you tend to lose the atmosphere and the element within the hospital and that there may be an advantage or a benefit in restricting your size to somewhere around 1,000 to 1,100 beds.

Now in the other area, I think it's the minimum that we're looking at, and there was a recommendation, and there have been recommendations made by various groups throughout the country that there are minimums which you could designate as a hospital. Can you really

say that an 11 or 12-bed unit is a hospital in true fact? In that, you have to take into account what you mean by a hospital. Can it provide emergency service? Can it maintain support for 24-hour periods?

So there are minimums rather than maximums. The maximums tend to be dictated by the effectiveness of that unit. I think our own failing in the commission and the things that are reflected to us by the associations, both AHA and the medical association, are that the hospitals around the 500 to 700 beds are probably the most effective from their point of view, from an operational point of view.

MR. SCHMIDT: Mr. Chairman, just a general question. Is there any indication financially at the present time that would show up that amalgamated boards, in other words, one board that is operating all three levels of service, and the opportunity of the shared type service, is there any financial indication that this cost to the individual or to the district is less than the system that operates, of which we have both [inaudible]?

MR. MINIELY: I don't think we have yet, because this is another area that's moving now fairly rapidly, is the amalgamation of boards for different levels of care. We don't have any indication financially at the present time, because you could compare maybe on a historical basis, but there might be a lot of other factors involved as well.

I think, though, we're pretty intuitive on that particular matter. In other words, that if you think that in the system we have no question about administrative efficiency. We have no question about the capacity of amalgamated boards to be able to deal more effectively with the priority of need, because at least you're eliminating the rivalry between different levels of care. I guess the short answer would be, whereas we don't have definite results in yet, and even if we do have definite results, there may be other -- for instance, if costs go down on those particular facilities, the reasons may be more than just the amalgamated board -- and it may be difficult to judge. But I think all of us could, in thinking about it, come to the intuitive conclusion that amalgamated boards make a lot more sense because they're able to deal more effectively with both the needs for different levels of care and in fact eliminate the competition between different boards to expand their particular level of care of service in the community.

MR. TAYLOR: Gentlemen, we've reached adjournment time. Before we adjourn, however, what are your wishes for the next meeting?

MR. BUTLER: Mr. Chairman, I'd like to move that we take a look at telephones and utilities and the rural gas program in particular.

MR. TAYLOR: The rural gas program? It has been moved by Mr. Butler that we look into the rural gas program at the next meeting; seconded by Mr. Doan. Any questions? Ready for the question?

We'll invite the hon. Dr. Warrack and the rural gas people for our next meeting, which will be next Wednesday at 10 a.m.

I'd like to thank the hon. Mr. Miniely, Dr. Bradley, Mr. Wilson, Mr. Berglund, Mr. Brandell, and Mr. Kroeger for their attendance here today.

A motion now to adjourn would be in order. Moved by Mr. Stromberg, seconded by Mr. Thompson. All in favor? Opposed if any? Thank you very much, gentlemen.