[Chairman: Mr. Pashak] [10:05 a.m.]

MR. CHAIRMAN: I'll call the meeting of the Public Accounts Committee to order. My first item of business would be to introduce to you the Hon. Marvin Moore, Minister of Hospitals and Medical Care. We will be back with him in a minute.

We have some business items to go through. We have to approve the minutes. Is there a motion to approve the minutes as circulated?

MR. R. MOORE: So moved.

MR. CHAIRMAN: Moved by Mr. Moore. Agreed?

HON. MEMBERS: Agreed.

MR. CHAIRMAN: Mr. Moore, I guess you are here to answer questions, if there are questions that members would like to put to you. Or you could make an overview statement first, if you want.

MR. M. MOORE: Thank you, Mr. Chairman. I wouldn't mind making a couple of opening comments on items that might be of interest to the committee when it comes to questions they wish to pose or comments they wish to make and will distribute a little bit of information.

First of all, I've brought with me in a couple of black binders all there is to know about the Department of Hospitals and Medical Care for the 1984-85 fiscal year. I've read it all, Mr. Chairman, but I don't remember what page it's on. So you may have to bear with me in terms of any details you ask about that I'm not able to respond to, in which case I would be delighted to come back another time or, if you're not able to have me back, to provide in writing whatever information I'm not able to provide to members of the committee today.

With that background, I'd just like to express to you, Mr. Chairman, two concerns I have with respect to the operations of the Department of Hospitals and Medical Care. They relate not specifically to the '84-85 public accounts but generally to what's been happening over the course of the last four or five years and what's projected for the coming years.

I have with me some copies of the expenditure and premium revenues with respect to the Alberta health care insurance plan for basic health services that I'd like to distribute to members. I brought those along because they show the rate of increase in the budgetary expenditures for the Alberta health care insurance plan from 1970 to what's forecast to the end of March 1987; in other words, the end of this fiscal year. I thought that would be of interest to the committee, because you can see the rather rapid escalation which has occurred in the total expenditures. The premium revenue of course is there as well.

Mr. Chairman, we have what we refer to as a demand-driven system. There are no lids whatsoever on the total cost of the health care insurance plan. The public takes whatever it wants from the plan in terms of services, and we provide the funding. We don't have any control over the increase in those expenditures except by way of inventing some means to reduce the overall demand, and that has not yet been done. That's a matter for serious consideration by this Legislature and the Public Accounts Committee in terms of our overall management of the province's fiscal plan and our resources.

The other comment I want to make relates to hospitals. Active treatment hospitals and mental hospitals in this province take a very large chunk of the budget, as members can see in looking at the public accounts for the year ended March 31, 1985. Again, we have a built-in escalation factor. It's a demand-driven system. No one says there are limits on the number of times you can visit a hospital, the number of days you stay there, or the kinds of operations or other procedures the doctor might perform. The result is that in our active treatment hospital system we have had a built-in increase over the last five years of about 15 percent a year without inflation. I'm not aware that anything will prevent that from occurring over the course of the next five years.

In 1987 we're dealing in total with a $2.4 billion operating budget, growing at the rate of 15 percent a year without inflation and literally no way to control that growth at the present time. That's something the committee may at some point in time want to focus on. I think it's an important aspect of our legislative work to consider the fiscal plan of the province and look to the future to make sure that we don't get ourselves into the same problem that exists in

Ottawa today.

Mr. Chairman, those are just a few remarks that are food for thought for the committee. There are certain recommendations and questions raised in the Auditor General's report, some of which I am prepared to respond to today if members wish me to and perhaps anything else that might be of interest to members. I hope we provided a copy of the annual report of the health care insurance plan to everyone — there is a lot of detail and information about the operation of that plan — and also the annual report of the Department of Hospitals and Medical Care for the same year, which again has a fair number of statistics about individual hospitals, the indicators in our health care system, and the operations for that particular fiscal year.

Mr. Chairman, those are some opening comments. I hope they are useful in getting the members to think about [inaudible].

MR. CHAIRMAN: I'm sure the members will find it useful. I have a list of speakers here. I wonder if you'd like to respond to his remarks before I . . . No? I'll just go with the list of speakers. Mr. Payne, you're first on the list.

MR. PAYNE: Thank you, Mr. Chairman. My first question has to do with the section on noncompliance with legislative authorities and specifically the question of capital funding for hospitals, which I believe the committee made brief reference to at one of our earlier meetings. The Auditor General's recommendation in his '83-84 annual report was that the department establish some kinds of consultative relationships to help the hospitals resolve this problem of funding commitments that lapse at fiscal year-ends. From the '84-85 Auditor's report, it appears that the department had at least triggered some discussions with Treasury but that no arrangements had been initiated with the hospitals to resolve this problem of lapsing funding commitments. I wonder if the minister could report on the progress of his department's response to that specific recommendation. It's recommendation 2 on page 32 of the '84-85 Auditor General's report.

MR. M. MOORE: Mr. Chairman, the notes I have indicate that following the '83-84 fiscal year in the annual report of the Auditor, the department contacted two hospitals where these situations existed and informed them of the need to follow existing regulations and procedures. Since that time, the department has taken steps to ensure that the occurrence doesn't repeat itself by amending the regulations to provide for advanced funding of approved capital expenditures when appropriate. We believe this will deal with the lapsing difficulties that were mentioned in that section of the report.

MR. PAYNE: I take it from the minister's answer, Mr. Chairman, that his department's response to this particular recommendation was to amend a departmental regulation to sort of regularize the practice. Is that correct?

MR. M. MOORE: No, I believe the situation would be one of our amending the regulations to be consistent with the recommendations that were made by the Auditor General. The Auditor General recommended that the department and the two hospitals comply more fully in future with legislative authorities and approved accounting policies. That's the objective we had, but in order to make it abundantly clear, some changes in regulations were accomplished. I would hope that the annual report of the Auditor General for the year ending March 31, 1986, would either not mention this item or suggest that we had taken steps to resolve the matter. I'm not sure that that's the case.

MR. PAYNE: I'm sure, Mr. Chairman, the members of the committee share the minister's hope.

MR. CHAIRMAN: Any further supplementary, Mr. Payne?

MR. PAYNE: No, that's fine.

MR. R. MOORE: Mr. Chairman, I kind of feel for the minister. He's a new minister looking at somebody else's operation two years ago. I had some questions I wanted to ask regarding the Auditor's report, but I have some questions on the sheet that was distributed when we got here. Would you put my name at the bottom of the list, Mr. Chairman, so I can come in with my other questions if I go to this one while it's fresh in my mind.

It relates to the basic health services expenditures on the sheet you distributed, Mr. Minister. The premium revenue in 1970 was 57.6 percent; the individual paid that, and the government picked up the balance. In 1987 the individual is picking up 29.8 percent, and the government is picking up the balance. There's a trend down the road that we're moving to a more and more total payment by the government. Is there a reason for that? Have we added on services, or what have we done that has changed the proportion?

MR. M. MOORE: First of all, Mr. Chairman, with respect to the total expenditures in the health care plan, we have done a number of things since 1970. Inflation, of course, accounts for a substantial portion of the increases. Population increases account for another substantial portion. However, utilization increases in the coverage of additional items account for another very large portion of the total health care expenditure. Utilization has increased rapidly over the course of the period of time since we first joined the national health care plan. One has to wonder whether all of that utilization is necessary or whether some of it is driven by the fact that there is no direct financial cost to the individual.

At the present time we have no controls on utilization by either patients or doctors. We have recently done some spot checks on patient records coming into the health care insurance plan and have found that indeed there are a good number of patients who are seeing more than one doctor at the same time for the same ailment, and most often the doctors are not aware that the patient is doctoring. We've found some that are doctoring with as many as half a dozen different medical doctors at the same time; again, most of them probably not being aware that the others are involved as well. So we do have some considerable concern with utilization and how that has increased the total amount.

With reference to premium revenue, as I understand it, the amount that's raised has been an arbitrary decision of governments over the course of the years since 1970. We have simply said that health care insurance premiums will increase or will not increase, and it has never been related to the cost of the plan. It's simply been a question of deciding how many dollars per month an individual or a family should pay, and that situation is no different today. In that respect it's not a very traditional insurance package. Most people expect that when they buy insurance, their premium relates to the actual costs. Life insurance premiums go up or down because the statistics on how long you live change. Your automobile insurance, liability insurance, and fire insurance premiums move with the cost of the total plan. In that respect it's pretty difficult to continue to call it an insurance plan. It really isn't. It's a medical services plan. It's partly funded by premiums that have no relationship to the ongoing cost.

That's a debate I raised in this Legislature a short time ago, Mr. Chairman. I respect the differing views that relate there. Some provinces don't provide for any premium revenue at all. They take all of the funding out of the General Revenue Fund, which probably means higher income taxes or some other method of funding.

MR. R. MOORE: In this regard, Mr. Minister, I know that utilization and inflation are involved. To your knowledge, have we added further services that medicare covers in the last few years? I know we talk about utilization of services such as cosmetic surgery or face-lifts, which I think everybody agrees shouldn't even be there, but they are. Have we added other services that have contributed to this?

MR. M. MOORE: Mr. Chairman, we've added a number of services over the years. I can't be too specific on it, but certainly there are services that are not covered in other provinces that are covered by our plan or services which are not required to be covered by the Canada Health Act, a great number of them that are covered by our plan. For example, your annual medical checkup is not a required medical service according to the Canada Health Act, and we could quite easily delete that from the health care insurance plan coverage and not be in contravention of the Canada Health Act. There are a good number of similar items that are not considered to be medically required.

There's also the whole question of the coverage provided for people who choose to go to chiropractors, physiotherapists, or optometrists: all very necessary services, none of which are required by the Canada Health Act to be covered by the Alberta health care insurance plan. Many of those services have

been added since 1970. They've been added on the basis of our paying a relatively modest standard amount with respect to physiotherapy, chiropractic work, or optometrists and the individual doctor billing an extra amount to the patient. That won't change with the agreement we just reached with the Alberta Medical Association. The optometrists, for example, are now lobbying many of you with respect to having their fees increased so they are equal to the ophthalmologists, who are considered medical practitioners under the Canada Health Act, an item that would cost some $9 million if they were brought up to the same level as ophthalmologists in all the coverages provided for all the services they perform.

Indeed, Mr. Chairman, a lot has been added over the years. There are still more requests to add more services to the Alberta health care insurance plan.

MR. HERON: Mr. Chairman, I would like to focus for a moment on two tables: pages 38 and 39 of the annual report of the Alberta health care insurance plan. I think these two tables attract a lot of negative press to the plan, to the medical practitioner, to administration, and to our government. These tables focus on the amount of money paid to general practitioners or medical specialists broken down by category of payment. I look at the table and immediately see that there are four general practitioners who earned between $400,000 and $0.5 million, that on average they billed $450,000.

My question to you, Mr. Minister, is: are these data meaningful given that doctors have different input costs? Are we comparing homogeneous data, or are we comparing, for example, apples and oranges when we look at the amount of money paid one doctor vis-a-vis another?

MR. M. MOORE: Mr. Chairman, what page is the hon. member referring to?

MR. HERON: Pages 38 and 39 of the Alberta health care insurance plan annual.

MR. M. MOORE: The question is interesting. These statistics in themselves don't really give you much idea whether or not some medical practitioner is billing the plan fraudulently. I don't think they give any idea at all of that. For example, I believe the highest billing doctor in this particular year was a doctor by the name of Dr. Gimbel in Calgary, who is a specialist in cataract removal. He has an outpatient clinic that replaces what otherwise would be hospitalization. He has a staff of some considerable number of people. There's no question that his overhead is well above that of the average doctor, and the million-plus dollars that he might have billed to the plan covers all of that. There are some extra billings done for his facility as well. It's almost impossible to look at his total billings and say that there's something wrong with a system that allows one medical practitioner to collect that much, because you have to consider all of his expenses.

You also should consider a medical practitioner's ability to treat patients in his own clinic as opposed to hospitalizing them, and this is an area where I think we've fallen down over the years. As soon as he puts them in the hospital system it costs us $400 or $500 a day. In my view, one of the things we have not done over the course of the last several years in terms of dealing with medical practitioners is provide them with any opportunity to recover funds for the use of their own facilities, which are oftentimes much less expensive than an active treatment hospital. One of the things I'd like to do over the next two or three years is see if we can develop ways to compensate medical practitioners who develop their own clinics and treat patients there as opposed to simply admitting them to the hospital and treating them there. If there's a saving to be found in outpatient treatment, we surely should be looking for it.

Mr. Chairman, I'd like to make one other comment, though, about the average payment to practitioners and the numbers we see above certain levels. In the Alberta health care insurance plan offices we have a pretty complex system of checking doctors' billings. Oftentimes you will hear doctors complaining because the system is slow and there's a lot of red tape and rejections. We actually have an automatic machine that analyzes a doctor's statement and, if everything appears to be perfectly okay, approves it without any human being having to look at it. About 15 percent of all the bills that come in are automatically approved. The other 85 percent are scrutinized in some way or another. So there's a pretty

careful check on doctors' billings.

As in any other group of people, there are some who abuse the system. We refer that abuse to the College of Physicians and Surgeons, who are the policemen of the medical profession and protectors of the public's funds and medical care. The college then makes appropriate reprimands with respect to the members of the profession. There have been from time to time, including this year and last, medical doctors suspended from practice for having fraudulently billed the Alberta health care insurance plan. Those names are not published by the college. Obviously, our health care plan is aware of who they are and so is the minister. I have some considerable doubt as to whether or not it's appropriate to keep that information confidential.

I think that someone who sets out deliberately to abuse a system and collects money fraudulently ought to be dealt with in the professions the same as they are anywhere else. Again, I'm undertaking to consider the manner in which those kinds of abuses might be made public. It's a delicate matter, but I think it's one that you can't sort of sweep under the rug if there are people out there in the system who are bad. After all, the vast majority, the large percentage, are very good people, very dedicated hardworking doctors who bill appropriately, and they too probably have more concerns than I do about the reputation generated by some in the profession. That applies to other groups like the Law Society and so on that are having problems.

I don't know if that answers the member's question.

MR. HERON: Mr. Minister, that certainly cleared up a lot about the information here. I believe your response has indicated that in looking at these charts alone, one can say that Doctor 1 could make a lot less and take home more than, say, some of the highest billing ones, given the difference in the practices and the number of employees. In other words, we're not looking at anything that represents the bottom line.

Given that, Mr. Minister, may I suggest with respect that we not show this kind of information for it may in fact discourage efficient practices, the family clinics or the practice that you mentioned in the case of the Calgary doctor who has a very efficient, large staff probably providing better health care than the practitioner standing by himself. Would you give consideration to not showing this kind of information if it can be deemed misleading?

MR. M. MOORE: Mr. Chairman, I'm not sure that I would want to do that. I think it's important to get some indicator, some averages. Perhaps what needs to be done is to provide more information relative to the average overhead or operating cost, group some clinics and say that these are medical practitioners who provide a clinical service facility cost, not just simply a nurse or an office receptionist. It's something we could give some consideration to, but I think it's important that the public know what the health care insurance plan costs and who bills it and how much in terms of at least the broad general categories. The member is right; the indicators here are far from accurate when you consider the operating costs of each individual medical practice.

MR. HERON: I have one further supplementary. It is revealed in the data here that when you look at the general practitioners and the medical specialists, well over 50 percent of the number have practised in Alberta for less than 10 years. Given that we have probably the best health care system and the broadest range of coverage perhaps in North America, do you see an alarming influx of doctors to Alberta represented in these statistics?

MR. M. MOORE: So far, Mr. Chairman, we have not had the problem of an alarming influx of doctors. One would have to look carefully at the number of medical practitioners in Canada and what's coming out of our medical schools before you could really determine whether or not there's going to be a problem in the future. The government of British Columbia, as members would know, decided to reverse the trend of the increasing number of doctors coming particularly to the Vancouver Island area by saying they would issue every doctor a number to bill the health care insurance plan. If some doctor doesn't leave the province, they can't issue a new number. So they've controlled the number of medical doctors. Obviously in some rural, outlying areas where there's been a shortage of practitioners willing to go and

practise, it would be easy to get a number.

The same situation exists here in Alberta. We have difficulty attracting doctors to some rural locations. In the two major cities of Edmonton and Calgary we have adequate numbers of general practitioners, but there are some specialities — pediatric and geriatric care specialists — who are in short numbers and high demand right across the country. It's pretty hard to generalize. You've got to look at locations, whether we're talking about our two metropolitan areas or the rest of the province, and whether you're talking about specialists or general practitioners. I would say, though, that we may at some point in time when we're looking at utilization have to place some controls on the number of medical practitioners who move to the two major metropolitan areas and begin to practise. I don't know that that's around the corner.

The only other thing I should comment on is the number of doctors coming from countries other than the United States, particularly some from countries where the education system is at a standard far below ours. There are a lot of doctors in this country coming from overseas countries who aren't able to practise because they have not met Canadian medical standards and have not been able to pass the medical examinations here. I think it's entirely appropriate that those standards should be fully met. There should be no circumstances where we accept less than a hundred percent of the Canadian medical standards. I mention that, Mr. Chairman, because there's quite a lot of pressure from time to time on me and others, the College of Physicians and Surgeons and so on, to do something about allowing people who have been educated elsewhere and don't meet the Canadian standards to practise.

MRS. MIROSH: Mr. Chairman, to the minister. You mentioned the built-in costs. Knowing nurses as I do, they'll soon be striking for more money, and many other costs continue to escalate with the demands placed on hospitals and health care. I'm wondering how you plan to put a cap on these costs without reducing the quality of care we provide in this province.

MR. M. MOORE: Haven't you got an easy question?

First of all, nurses in my opinion earn every nickle we pay them and more besides. I love them all. I might be sick some day too. In terms of nurses' salaries and salaries in the whole hospital system, we need to be competitive with other provinces. I don't believe we're necessarily leading the way now. We were for a while, but we're not now.

I think the real key to the question of controlling costs lies in utilization. We have a system of compulsory binding arbitration to establish salaries for nurses that we put in place after the last nurses' strike in this province. Nurses' services are now considered an essential service, so I am certain that there will not be any nurses' strike. There will obviously be some discussions that may lead to compulsory binding arbitration. It's interesting to note that the Alberta Hospital Association, which does the bargaining with the United Nurses on behalf of all Alberta hospitals, has recently made a two-year settlement so that nurses will know what to expect over the course of the next two years in terms of their salaries.

The real problem is utilization. I don't know how to control that. I know that this province has by far more active treatment hospital beds per capita than any other province in Canada. I know that our total health care costs are some $1,100 per capita for the Alberta health care insurance plan on our hospital cost, which is far above any other province in Canada. I believe that if you build a hospital bed and open it, it will be filled.

Perhaps a great deal of the problem, Mrs. Mirosh, involves our own government's building of additional new hospitals right across the province. We presently have under construction a new 500-bed hospital here in Edmonton called the Mill Woods hospital and a new 500-bed hospital in Calgary called the Peter Lougheed hospital. In my opinion, given today's economic circumstances and the population of the Edmonton and Calgary regions, neither of those hospitals is needed. There is some misallocation, if you like, of beds in terms of certain areas of the city not being covered. The new suburbs, where all the families are, are located some distance from the hospitals. That's what gave rise to the development of those. We were also looking at a dramatic increase in population when we made the early decisions — we are still looking at some increase in population — and a stable economic climate when we started building both of

them. I don't fault the decisions, but we're going to have to make some pretty hard decisions in the years to come about the increasing number of hospital beds.

The other thing we're going to have to do that's perhaps more important than that is find ways to treat people outside the hospital system, in terms of staying in the hospital day after day. I believe very strongly that the advent of day hospitals, particularly for elderly people, where you come in from 9 o'clock in the morning till four in the afternoon or come in for two or three hours or whatever it takes every day, twice a week, or three times a week, is going to be a new concept in medical care that will probably be a big improvement for the patient. They'll be able to keep involved in their own home and community life at much less cost to the system.

It's entirely possible, for example, that we may have in Alberta today all the nursing home beds that we will ever require. With adequate home care programs and day hospital programs, it's entirely possible that we may have all the active treatment hospital beds we will require for the next 15 or 20 years if we can move to more outpatient facilities, day hospitals as I referred to, for people who come in for some length of time. I think we're right on the edge, Mr. Chairman, of a major breakthrough, if you like, in the thinking of people about medical care when it comes to being put in a hospital and staying there day after day.

The hon. member who sits in this chair was asking the other day about patients who are required to take intravenous medication and are relegated to hospital because that's where it has always been done. There are a lot of suggestions that you don't need to be in the hospital just because you're on intravenous. You can be at home and check in once a day or somebody can check on you once a day. Those sorts of things are going to start happening more and more. Certainly our department, this Legislature, and our government have to encourage that kind of thing if we want to get control of health care costs. So it's utilization, a change in the utilization of hospitals from overnight stay to more day hospitals, more outpatients. I think those are the kinds of things that will help us get some control over the system.

That doesn't answer your question, but it gives you an idea of some of my thinking at least.

MRS. MIROSH: It was a very general question.

I've been reviewing this '84-85 annual report, and the Walter Mackenzie sciences centre budget now indicates $156 million soaring to $200 million. That's on page 33, the University hospital; I presume that's the same as the Walter Mackenzie. Comparing that to the Foothills hospital in Calgary — I believe the same number of beds — I'm wondering why there's such a high operational cost at the University hospital. Can you explain?

MR. M. MOORE: You're talking about the operating cost of $121,604,000?

MRS. MIROSH: One hundred and fifty-six million.

MR. M. MOORE: That includes capital construction and so on. If you look in the lefthand column, the Edmonton University of Alberta hospital has $121 million in operating costs, while the Foothills has $86 million. I really can't answer that question except to say that the University of Alberta hospital is more than just the Mackenzie Health Sciences Centre; that's the entire hospital which includes the Mackenzie Health Sciences Centre. The differences this year will be even greater than they are now.

The Mackenzie Health Sciences Centre is a high-cost per bed hospital to operate, in part of course because of the nature of the work that's done there. The five heart/lung transplants performed in the last month or so are an indication of the level of nursing care and so on that's required for one patient in one ward. So there are very definitely some higher cost operations going on. There are some 700 open-heart surgery operations a year at the University hospital at the present time; they would cost more.

About the only thing I can say, Mr. Chairman, is that our department does a very careful monitoring of all operating costs in terms of ensuring to the best of our ability that there are not a lot of frills attached to the operating costs. With the large metropolitan hospitals particularly we bargain or debate or discuss operating budgets a great deal. As members know, from time to time I'm told that a certain hospital doesn't have enough funds and

may have to close beds and those sorts of things, so we try to keep a pretty close rein on expenditures. Perhaps I could get a little more detail about the comparison between the U of A hospital and the Foothills in Calgary.

MRS. MIROSH: One final supplementary, Mr. Chairman. It is my experience from sitting on a hospital board that boards operate on a zero-based budget. At the end of the year the province picks up all their costs. It is also my understanding that the province has built in some incentive for the boards to try to keep these costs down, and if they do have a revenue or money left over, they would be able to keep this in their operating budget. Is this practice going to continue, and do you know if it has been effective?

MR. M. MOORE: Mr. Chairman, perhaps one of the problems that we have with regard to hospital funding in this province dates back to our decision, which I was a part of in 1972, to finance 100 percent of hospital operating costs from the provincial General Revenue Fund as opposed to allowing hospitals to requisition local municipalities. We took that decision with regard to hospital costs while we left the matter of education to be a local requisitioning responsibility. Prior to 1972 a hospital could requisition the taxpayers for additional funds, and many of them did. We took that decision, and ever since then we've been saddled with the problem of one level of government paying 100 percent of the costs of something and another level of government — i.e., hospital boards — deciding what the expenses are going to be.

We've wrestled with it over the years in a variety of ways, and we've said: "If you run a deficit, we have to pick up the deficit. There's no other way you can get paid for it." So we appealed to hospital boards to run a good ship. If on the other hand they ran a surplus, it would be returned to us because we couldn't pick up deficits and let them retain surpluses. The result was that there was no incentive. My predecessor, David Russell, said two or three years ago that there had to be some incentive. So he said that we would allow hospitals to retain 1 percent of their operating budget and a minimum of $25,000, I believe it was, in surplus revenue, which they could then use for whatever purposes; it would be discretionary funding. I think there's room to review that decision again. Maybe they need to retain a greater amount if they can show better operating cost responsibilities and then use it for discretionary funding for their own programming needs. In other words, maybe 1 percent is not enough of an incentive.

Mr. Chairman, the answer to the question is, yes, I think the existing system has been somewhat helpful compared to what we did before, but there may be room for some improvements. If the members have any thoughts about how we might better encourage hospital boards to utilize their funding and have some left over, it would be worth while considering.

MR. MUSGROVE: Mr. Chairman, the March 31, 1987, figure for basic health services expenditure, $682 million: is that just doctors' fees?

MR. M. MOORE: Yes, that is all fees that are paid to medical practitioners, but it does cover what is paid out of the health care insurance plan to physiotherapists, chiropractors, optometrists, and denturists, who are not under the Canada Health Act. I should add again that the doctor's fee includes all his overhead costs which, depending on whose number you look at, average from 40 to 50 percent of the total fee. So it covers his or her office, nurses, clinic, and whatever else.

MR. MUSGROVE: When this figure was taken into consideration, did it include the elimination of extra billing?

MR. M. MOORE: No, it didn't, because the figures here have no relationship to extra billing. I haven't shown the revenue from the federal government; I've shown the premium revenue. If I had put in another column that showed revenue from the federal government, the decision to eliminate extra billing would have shown an increase on an annual basis of about $12 million on revenue from the federal government and a corresponding decrease in revenue from the provincial government. What we did was simply make up that loss in revenue from the provincial General Revenue Fund.

MR. MUSGROVE: Mr. Chairman, I wonder if the minister has considered another method of billing for medicare to make people aware of

what their medical costs are.

MR. M. MOORE: Mr. Chairman, the answer is yes; it's on the record. I have considered a variety of things: increasing the premium and tying it to a percentage of health care costs so it would rise or fall with utilization and the increase of fees, eliminating it altogether, or leaving it as it is. No decision was made with respect to doing anything in the current fiscal year, and the matter of what we do in future years will be subject to budgetary considerations by the Treasury Board and the cabinet as time goes along. Again, Mr. Chairman, I'm open to any positive suggestions that might be made by members in that regard.

MR. ALGER: My question is almost supplemental to Mr. Musgrove's. I, too, feel that in a demand-driven system, surely there is a certain loyalty among the residents of our province to not overdo the system if they don't have to, yet we seem to see cases of exaggeration. I wonder why we couldn't at least let them know right on the spot what the visit actually costs. It wouldn't take a minute. Why couldn't a little bill be written out to let them know what happens to them for, say, a hangnail, a broken leg, or a bent elbow — you name it? When we visit the doctor, why can't we know what it costs when we walk out of his office? We should know whether we left him $75 or $350. It seems to me that people would then catch on that they're blowing a lot of money, and possibly they'd try to do something about it.

MR. M. MOORE: Mr. Chairman, two comments. First of all, we had a pilot project in Red Deer, I believe, and another in Fort McMurray where we let people know about hospital and medical care costs. I believe there was one out of the Grande Prairie hospital too. Early in my term of office as Minister of Hospitals and Medical Care I got a letter from a citizen who sent a copy of a bill that had been sent to show how much it cost for his stay in the hospital. It was an irate letter telling me how badly the individual felt. First of all, he was sick; that was bad enough. Then he got a letter from the hospital saying that on his behalf the province or somebody had paid $2,000. He thought that was a terrible thing; what an insult to write and suggest that this cost had been paid on his behalf. Needless to say, I didn't answer the letter; it didn't need an answer. But it shows you what happens: people become so accustomed to having medical services absolutely free that they're now insulted if you even tell them what it costs. Frankly, I don't have very much time for people who are insulted by that information.

I agree with the hon. member: people ought to know what it costs. If I have any influence on the system, they will know what it costs both in the hospital and when they visit the doctor's office. Unfortunately, the people who run my health care insurance plan aren't too delighted with the idea of the mechanics of implementing such a system. Obviously, the medical practitioners and those who work for them aren't very delighted with it either, for what reason I don't know. I'm hoping over the course of the next few months to turn around the opinions of those who are working in the system to recognizing that people need to know what it costs. I'm sorry, but there isn't anybody who can convince me that the need for people to know is not an important aspect of the control over health care costs. There isn't any question in my view that it is.

The hon. member who is now sitting on your right has on the Order Paper a motion that we debated a while ago suggesting that when they leave their doctor's office, every patient should sign a bill that says what it cost for that visit. In my opinion, that's exactly what should happen. It's a matter of getting the medical profession to agree and working out the mechanics of how it happens.

MR. CHAIRMAN: I'd just like to point out that the hon. Mr. Moore is proving to be such an informative guest that I've got nine people on the list who would like to ask questions, and we've got 25 minutes.

MR. ALGER: Mr. Chairman, it seems to me that in actuality we do eventually learn what we've spent for medical care by the list they send us every six months or so. I scrutinize mine very carefully because I like to know what things cost. I would recommend that that continue, but I would also like to know right on the spot what this fellow took off me for whatever aid he might have given.

Following on no control of expenditure, I have one more little point that I'd like to have come up in debate at some point or other. It

seems to me that hospital administration costs are extreme, particularly in the nature of salaries. I would say, Mr. Minister, that we should debate that at some time and determine whether there isn't a scale of wages that would be comparable to, say, a bank manager or an oil company superintendent or someone like that who doesn't get away with murder. Consequently, there's a possibility of cutting down on administration costs and improving on our nursing staff.

MR. M. MOORE: Mr. Chairman, I'd like to respond to that. First of all, in terms of administration costs, I have some sympathy for the hon. member's comments. But remember this: we're into a pretty competitive situation here. I had a meeting this morning with the chairman and one of the board members of the Northern Alberta Children's hospital, which we are now planning for. They've been looking at hiring a first-class administrator to build and operate this new hospital. When we look at these figures, in 1985 it cost $120 million just to operate the University of Alberta hospital. Bearing that in mind, you don't want to be cheap in the area of the top man or woman who is going to run the place; you have to find the best you possibly can.

The chairman of the Northern Alberta Children's hospital was telling me that they were looking across Canada and that they thought they'd also do a little looking to our neighbour to the south, the United States, to see if there might be somebody down there who would be interested. They told me that salaries in the U.S. run from $100,000 to $150,000 U.S. per year for anybody of the calibre they would want, which is well above the salaries in Canada. In other provinces, no matter where you go, there is a level of salary for hospital administrators that is very high. It's a lot better than being Premier or minister of hospitals or something like that; it's a very well paid position. I would encourage young people to get into hospital administration, because it's a field where there are not a lot of people; they pretty nearly call their own shots.

We can't run a good system without good people. It's a business proposition, Mr. Alger, and you've been in lots of them. Whatever the market is, you've got to meet it. It may be that we could look at ways to control administration costs in the number of people involved in administration, but I like to think that most of them are doing a reasonably good job in that regard.

MR. ALGER: I have several more supplementals, but I'll defer to the next questioner.

REV. ROBERTS: Thank you. If I could, I'd like to move into an area that hasn't been touched on yet. I'm kind of concerned that it hasn't, because wherever I go, whoever I speak to seems to think that long-term chronic care is one of the biggest unmet needs and one of the biggest problem areas in our whole health system. As you know, the most recent edition of Hospital is devoted to the issues of long-term care and how we're going to meet the chronic shortage of auxiliary beds that somehow developed in this province.

I thought we were actually talking about the public accounts of the department, and when I look at page 13.8 of the public accounts of hospitals for 1984-85 under votes 6.8.2, 6.8.4, and 6.8.13, particularly in capital spending, capital construction program support, and look under long-term chronic care, for some reason unknown to me — and you're all going to call me a nasty socialist — we're not spending the money that's allocated. On the other hand, there's a glaring decrease in the amount allocated that was in fact spent. Here we find that Calgary Auxiliary hospital, number 7, Good Samaritan in Edmonton, and even rural long-term chronic care facilities all drastically underspent what was allocated to them in the estimates for that year, this in a situation where there is already a critical shortage of auxiliary beds, as I said. I'm wondering if we're now paying the penalty for the sins of our fathers just a year or two ago. I know the government has now moved to correct the situation and provide better diagnosis and treatment rehab for the elderly so that we don't have to institutionalize them, but as the minister knows and as most of the people in our constituency are telling us, there are often long waiting lists for auxiliary beds.

What happened in '84-85 that it was so underspent, particularly in terms of capital construction in long-term chronic care?

MR. M. MOORE: What page in the public accounts are you referring to? Volume 2?

REV. ROBERTS: Volume 2, page 13.8.

MR. M. MOORE: Where it shows $62 million unexpended? Is that what you're referring to?

REV. ROBERTS: That's right; 6.8.2, 6.8.4, and 6.8.13 show that moneys allocated for auxiliary care were drastically underspent.

MR. M. MOORE: The only comment I can make is that the situation hasn't changed at all. Right now we are involved, for example, in trying to develop both operating and capital budgets for the department for the 1987-88 fiscal year. We have to project now, and then we keep refining until we get to about February, when the budget has to be finalized, how much progress is going to be made on each of the capital projects. We don't always know whether the thing is going to get tendered or planned or what stage it's going to be at 12 or 14 months from now. So any underexpenditure is not by reason of the department saying that we're not going to build this; it's simply by reason of the hospital board having told us in, say, September of 1984 that they expected to make this much progress on an approved project in the next fiscal year and then for some reason they didn't. It may even be that the project is completed but that there's a holdback in paying the contractor because of certain deficiencies and those sorts of things. These numbers do not reflect in any way any decisions by the department not to expend funds but only the progress that's made.

The only exception to that, with some funding that might have been placed in this particular budget, was a decision we made to build two urban hospitals in Edmonton and two in Calgary — put some funds in the budget and then put them on hold. Those are the only two projects I know of that might have touched on this fiscal year where we actually made a decision to retrack, but those had nothing to do with long-term care. As a matter of fact, 100-plus beds in the Mill Woods hospital have now been converted to long-term care.

Mr. Chairman, the hon. member wanted to talk a bit about extended care and long-term care. There's no question that one of my major concerns over the course of the next couple of years has to be looking at what we can do additionally with respect to long-term care for elderly people. I said earlier that we may well have enough nursing homes in Alberta if we do a better job of home care and day hospitals and that sort of thing. That's not a large expenditure area as much as it is planning for what kind of action needs to be taken.

I'm really excited about the prospects that lie ahead for us to improve care of the elderly without a lot of expense. I don't think we need to be looking at $500-a-day beds — something far less expensive than that. There are lot of long-term care boards that I've met with who are involved in care of elderly people and who are really excited as well about the prospects that exist for improving the care of elderly people. So that's going to be a high priority in the future.

REV. ROBERTS: A supplementary, if I could. You're saying that it has been a high priority in the past as well and the urgency hasn't been seen?

I notice also that the operating budgets for some long-term auxiliary care in '84-85 were also underspent. I see the whole area was underspent by about $7 million. The Youville was underspent, and again rural auxiliary care hospitals were underspent in terms of their operating for the years '84-85. What I'm told and what you're saying is that the need is there, the demand is there, and we're trying to move in that direction to improve things, yet the moneys allocated for this particular year were not . . .

MR. M. MOORE: The operating funds would have fallen in the same category as the delay in capital projects. We may have projected that a new auxiliary hospital would come on stream in the middle of the fiscal year and that we'd have to pay for operating for six months. The construction was delayed, it didn't open, so you've got that money left over. Practically all the funds that are unspent there would fall in that category of facilities that were new or refurbished or expanded or something of that nature.

I hope I didn't leave the impression that in this year or years past we always had a high priority on care of the elderly. While we've done a reasonably good job in this province of providing facilities, I don't think that in years past we — "we" being the medical profession, the community, the government, and the Legislature — spent very much time thinking

about new ways to care for the elderly, thinking about anything more than just putting them in nursing homes or auxiliary hospitals. I think we still have not done the kind of job we should be doing. We're just beginning to get a feel for the possibilities that exist for a dramatic improvement in the way we care for elderly people.

I know very little about it. I've only been exposed to it, to be honest about it, for the last few months, but I'm excited by the prospects that exist. I'd be the last one to say that our record in that area is good. I think we need to improve, Mr. Chairman, and I'm looking forward to contributions about how we can do that from all members of the Assembly, particularly the hon. member who just asked the question.

REV. ROBERTS: Perhaps one of the ways that — I'm discovering this in terms of how hospitals and care facilities talk to one another in terms of co-ordinating and planning together, whether it's for active treatment or auxiliary or whatever. Just a small side supplementary, Mr. Chairman, if I can ask the minister. In terms of provincial committees, on pages 6.11 and 6.12 of the public accounts, volume 1, the whole area of the Edmonton Area Hospital Planning Council: it's not a big-ticket item; in fact, I believe it's only about $14,000. But I'm wondering what is the status of various regional planning councils that can together talk about the demographic situation in their area, whether it's the care of the elderly or pediatrics or whatever, so they can plan in a rational way what needs to be done. Is it all being done by the department? There is only a mere $14,000 set aside for the council here. I have heard from various members of hospital administration boards that the whole thing is a bit of a joke anyway and that it's just up to the hospital boards to play politics with the department to get what they want or need and that a rationalization of services and meeting the real needs is not looked at as well as it might be. Is that money being well spent? What are your comments about regional planning councils?

MR. M. MOORE: It's not very much money, and I think that what's there has been well spent. The facts of the matter are that we've got a hospital planning council in both Edmonton and Calgary. They were formed for the purpose of trying to co-ordinate the services of different hospitals and trying to make sure there wasn't duplication: a forum for discussion of things like how many neonatal beds there ought to be in the city of Calgary and those sorts of things. I don't think they have worked very well, because what happens is that they deal with the easy problems and the tough ones simply get dealt with in the public arena. Hospital boards go their own way and don't worry about what the planning council said.

The idea was that every hospital board would be represented on the planning council and that they would all get together and come to a rational decision as to what to do. I don't think it has worked very well. Some things they've done quite well, though. But that's not the fault of the members of the committee; the problem is probably associated with how they are structured, their terms of reference, and their mandate. I intend to meet with both the Edmonton and Calgary area advisory councils very shortly to review with them their existence, if you like, and their mandate and to try to determine whether there is something better that can be done.

Unfortunately, the buck stops at the Minister of Hospitals and Medical Care's door. If the Edmonton area hospital advisory committee were to say to me that when we build the new children's hospital in Edmonton, we ought to phase out all 550 pediatric beds that exist in the other six hospitals, I would be very surprised, because the majority of them are from those other hospitals. But if they do say that, then the only way it will happen is if the government decides to quit funding those beds and close them. It probably won't happen voluntarily.

MR. MITCHELL: Mr. Chairman, this point was alluded to earlier by Mr. Payne. I would like to pursue it further. It concerns the question of the Foothills Provincial General hospital and the provincial cancer hospitals, which issued falsified financial reports to obtain capital funding before such funding was due under the prevailing legislative authorities. What they did was falsify invoices so they could claim the expenditure this year and therefore not lose that money. I'm looking at pages 32 and 33 of the Auditor General's report, Mr. Moore. The Department of Hospitals and Medical Care indulged in the same kind of activity in '83-84 by attempting to charge the cost of acquiring

the Lethbridge St. Michael's hospital against funds appropriated by the Legislative Assembly for a preceding year. The Auditor General's recommendation is that the Department of Hospitals and Medical Care — this is recommendation 2 -- should help the two hospitals resolve these problems so that this kind of fiscal year-end problem won't occur. I believe it goes beyond a question of administrative procedures to a question of how people would be making those kinds of what I believe to be fraudulent financial decisions. Has your department reviewed those two cases specifically? Have people been reprimanded? Have steps been taken to ensure that kind of decision-making attitude can't prevail in that department?

MR. M. MOORE: Could the hon. member just review again which two specific cases he's referring to?

MR. MITCHELL: Item 3.3.2 on page 32 and item 3.3.4 on page 33. Item 3.3.2 is two provincial hospitals which falsified financial reports by year-end. They went to companies and said, "Give us an invoice so we can claim this is this year's expenditure so our funding won't lapse." The department itself tried to do a similar thing by charging the cost of acquiring the Lethbridge St. Michael's hospital against funds appropriated for 1983-84 even though the hospital wasn't acquired in that year and hadn't been acquired at that time. It seems to me that that goes beyond fiscal mismanagement to things that are fraudulent. If you have financial managers in the department or in hospitals who are prepared to do that, what steps have been taken to review their activities? What steps have been taken to reprimand or remove them? What steps have been taken to ensure that that kind of thinking and activity categorically is not acceptable in any of our government departments, specifically in this government department?

It always concerns me that if they're prepared to do it once, ethical misjudgments can frequently be repeated.

MR. M. MOORE: Mr. Chairman, I think I already dealt with the first question of item 3.3.2 on page 32 and the two hospitals in question. We took steps to ensure that the hospitals were aware that such actions were not appropriate, and then we made certain changes in the regulations. I think that has been dealt with.

With respect to item 3.3.4, again I regard that as substantially different than 3.3.2. It was a question of department money managers, if you like, trying to utilize funding in a particular year for a purchase that technically was not completed until the following year. For all practical purposes the hospital was certainly purchased in the year that the funding was trying to be used for, but from a technical point of view it was not. I accept that the Auditor certainly has the responsibility to point out what occurred there. But there was certainly no misuse of funds, nor could there have been any intention to misuse funds or defraud anybody in that particular case. It was simply a department official wanting to utilize funds that were in the budget that fiscal year. I'm not unaware either of the fact that the department had originally intended that the purchase be completed that fiscal year. I don't find that particular one very alarming. I would hope that more careful attention is paid to such details as that by the department in the future.

MR. MITCHELL: A supplementary to the Auditor General. Mr. Salmon, could you please comment on whether it was just a question of a technical definition of purchase or whether it more properly could be construed as a department attempting to make sure it spends all the money it has this year so it can get the same amount or more next year and doesn't somehow miss the opportunity to spend more money the following year?

MR. SALMON: Mr. Chairman, I believe it was the one particular hospital where all the actual documentation relative to the agreement had not been settled at the end of the year. The money was in that particular year. I believe the intent was to complete it in that year, but the agreement was not finalized until the following year and that was the reason for the lapse problem at the end of that fiscal year.

MR. MITCHELL: I hate to waste a question if I keep going. I'll go onto something else. Thank you.

Could the minister please comment on the suggestion that hospitals are being built in rural areas at considerable expense that we are

unable to staff, where we can't find the proper staff? Is there an effort to reduce the need for those kinds of hospitals by improving air ambulance service in the province?

MR. M. MOORE: Any suggestions that we built unnecessary hospitals in rural Alberta is absolute garbage, whether it comes from the opposition, the Auditor, or whoever.

MR. CHAIRMAN: I think you finished your supplemental, but the minister might care to expand a little bit on this question.

MR. M. MOORE: I'd like to expand. We take a lot of pride in the fact that we provided hospital and medical services in this province in other than Edmonton and Calgary. We're going to continue to do that. I for one get pretty upset when people say it wasn't necessary to build that hospital; you can provide an ambulance. Hell, people want to live all over this province. It's a big province. One might take a look at the public accounts too and see that 80 percent of this entire budget is spent on 20 of the largest hospitals. They don't exist in rural Alberta; they're in the major urban centres. The so-called 10-bed hospitals that were built by this government take less than 1 percent of this total budget. I don't have any trouble at all defending those or the ones that exist in my rural constituency or any of the others around here. We might even build one in Stony Plain.

MR. CHAIRMAN: In the minister's first response, though, he did mention the Auditor General. To my knowledge the Auditor General has not made any comment with respect to rural hospitals.

MR. M. MOORE: I was giving him fair warning in my answer.

MR. R. MOORE: Mr. Chairman, to the minister. I am referring to page 43 of the Auditor General's report, section 3.4.5.

MR. DOWNEY: On a point of order, Mr. Chairman. Doesn't everybody get a chance to ask a question before the second one comes on?

MR. CHAIRMAN: No, as I understand it, the way this committee functioned last year was that you were recognized at the time you put up your hand, and the list developed that way.

MR. DOWNEY: If we look back at the arrangements we made when we set up this committee, everyone is allowed a question and two supplementaries before we start the rotation again.

MR. CHAIRMAN: We never really decided that. If that's what the committee members would like, I could rule Mr. Moore out of order. Maybe I could just get a show of hands. Would you prefer that everyone should have an opportunity to at least ask one question before we add new ones? Agreed?

HON. MEMBERS: Agreed.

MR. CHAIRMAN: Is there anyone who disagrees? Mr. Moore, obviously.

MR. R. MOORE: My disagreement is on the point of order. I think everybody has the same opportunity to get in at any given time. That is the way it should be.

MR. CHAIRMAN: At this point we're going to have to deal with this by way of a motion. Would you care to present a motion in that respect, Mr. Downey?

MR. DOWNEY: Mr. Chairman, I don't know whether we passed a motion on that. However, I did have my hand up before the rotation started again. If you would like to have a motion, I would do that, but I don't know if it's necessary. I think we covered it in our initial discussions.

I don't want to make a big deal of this, but I have a question I want to get out here today.

MR. R. MOORE: I'll trade my position with him, and we can have a motion another day.

MR. CHAIRMAN: That might resolve this. We'll deal with the issue later. Mr. Downey, Mr. Moore has switched with you.

MR. DOWNEY: Thank you, Mr. Chairman and Mr. Moore.

My questions deal with the payments under basic health services for optometric services. My first question is: do you have an agreement

with the optometrists similar to the one you have with the AMA with regard to elimination of extra billing?

MR. M. MOORE: The answer is no, because optometrists, physiotherapists, chiropractors, and some other health care professionals fall outside the Canada Health Act. They are not defined in the Canada Health Act as medical practitioners, and it's not required that we eliminate extra billing. Most other provinces have not eliminated extra billing for those health care professionals either. Optometrists are paid something like $23 for a basic eye examination, and they extra bill another amount on top of that that averages about 40 percent. They will continue to do that.

Incidentally, I'll be mailing a brochure to all holders of an Alberta health care insurance card about mid-September to try and explain all of the changes that have occurred through the elimination of extra billing plus the differences between an optometrist and an ophthamologist and other medical practitioners. It's going to be a bit confusing for the public for a while, because there are some people who can continue to extra bill and some who can't.

MR. DOWNEY: Thank you, Mr. Minister. My major concern with optometric services is that there is no payment for eyeglasses. I express that concern because if we're going to make essential health services universal, eyeglasses are certainly part of that. I go again to the schedule of basic health services and see that in podiatric services appliances are provided. Certainly eyeglasses are an appliance for optometric services. I wonder if your department is giving any consideration to covering the cost of eyeglasses, perhaps even on the basis that you do under extended health benefits, once every three years.

MR. M. MOORE: Mr. Chairman, the answer is that senior citizens are provided with eyeglasses under extended health benefits over certain periods of time. With respect to the rest of the population, no consideration whatever is being given to extending the provision of eyeglasses. I simply don't believe we can afford to add that to the health care system at this time.

MR. DOWNEY: A final supplementary and further clarification from the minister, if I could. It does seem inconsistent to me that you would provide podiatric appliances and not eyeglasses. I speak, I guess, from a personal point of view. Three members of my family require eyeglasses. It's a substantial expense. I go back to my argument that we have a policy that essential health services will be universally available.

MR. M. MOORE: We may have that policy, but as reflected by the Canada Health Act, that does not include eyeglasses. I have to say to the hon. member that at some point in time the bank goes dry. I don't know how we can add services to this health care insurance plan when our biggest concern is how to keep it from growing.

MR. CHAIRMAN: I've recognized Mr. Ady, but the time is rapidly drawing to a close. Would you forgo your questions, Mr. Ady?

MR. ADY: I just have one and it's very short, if I can have it.

MR. CHAIRMAN: Fair enough.

MR. ADY: I just have one concern, and it has to do with the perceived health haven we have created in Alberta for people who don't normally live in this country. There are people, especially senior citizens, who are moving back or even moving to Alberta initially in order to take part in the health care services. In fact, I've come across some who are in Alberta on a visitor's pass, aren't residents, have no landed immigrant status, and pay no premium, yet have a health care card and can participate in our health care. They take part in that and then move into the health unit provisions of extended services at the hospitals and nursing homes and so on. Do we have anything that precludes that, or are we going to continue to make this available to whoever sees it as a very great financial benefit to move into our province and use it? I have to be frank; I'm speaking primarily of people coming from the United States.

MR. M. MOORE: Mr. Chairman, I think that's probably a greater problem in the hon. member's constituency at border points than it would be in some other parts of the province.

Nevertheless, there is a real challenge to the health care insurance plan system to ensure that people aren't on the system who shouldn't be entitled to be. There are some very specific rules with regards to residency, landed immigrant status, et cetera, that have to be lived up to. I don't think they're attracting that many people here, but it has been possible in the past for people to get a health care card, as the member said, without proving residency. We're looking at ways to improve upon that, and I think we've improved a lot in the last couple of years. I definitely concede that when you're dealing with literally every person within the borders of Alberta in the health care insurance plan, it is a major challenge to us to try to say that this person is not eligible and this person is. There are some who get through the system that shouldn't.

MR. CHAIRMAN: Before I recognize Mr. Heron's motion to adjourn, we have to clear up the business of the date of the next meeting. I believe Mr. Moore has a motion with respect to that.

MR. R. MOORE: Mr. Chairman, because our next meeting is scheduled for September 3 and there will be people travelling here from their constituencies, I make a motion that we cancel the September 3 regular meeting of this committee and that our next meeting be held September 10 at 10 a.m.

MR. CHAIRMAN: Are the members agreed?

HON. MEMBERS: Agreed.

MR. CHAIRMAN: Those opposed? The motion is carried.

I would just like to say we had scheduled the ministers of agriculture for next week and the hon. Mr. Weiss the week after that. I will try to roll those meeting dates back so that we will have the ministers of agriculture two weeks from today.

MR. MITCHELL: Mr. Chairman, have you made any progress on your thinking of having this committee meet when the House isn't sitting?

MR. CHAIRMAN: I will introduce that as an item of business at the next meeting. We cannot do anything for this term, but we could build in a budgetary request for the subsequent year.

MR. MITCHELL: Just to clarify. If the House stops sitting shortly after the 10th, does that mean we might have reviewed only three departments for the 1984-85 public accounts?

MR. CHAIRMAN: That's correct.

MR. MITCHELL: Therefore, in the spring we'd be starting to talk about 1985-86 public accounts, and we would not have reviewed 27 departments?

MR. CHAIRMAN: That's correct.

MR. MITCHELL: Is that possible in a democratic system?

MR. CHAIRMAN: I think we'll deal with this item at our next meeting.

Mr. Heron, your motion is in order. Did you want to move adjournment? Moved by Mr. Heron. Agreed?

HON. MEMBERS: Agreed.

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