8:30 a.m. **Wednesday, March 9, 1994**

[Chairman: Mrs. Abdurahman]

MADAM CHAIRMAN: I'd like to call us to order. I'd like firstly approval of the agenda, please, as circulated. That's being moved by Debby. All in favour, say aye.

HON. MEMBERS: Aye.

MADAM CHAIRMAN: Any nays?

Approval of the minutes of the March 2, 1994, committee meeting. A motion to accept them as circulated? Moved by Mike. Any discussion? If not, I'll call the question. All in favour, say aye.

HON. MEMBERS: Aye.

MADAM CHAIRMAN: Any nays? Carried.

At this time I'd like to extend a warm welcome to the Hon. Shirley McClellan, the Minister of Health – it's good to have you here with your staff – and once again to Mr. Salmon. Hon. minister, I'd like you to introduce your staff at this time. Mr. Shandro was introduced at the last meeting. If you'd just like to introduce your staff and go into opening remarks, please.

MRS. McCLELLAN: Thank you, Madam Chairman. I'm pleased to be here with my staff to present the public accounts for the Department of Health for the fiscal year 1992-1993. I'd like to introduce Don Philippon, our deputy minister; Aslam Bhatti, our finance guru; and Karen Porenchuk, who is really with Wild Rose Foundation. We were not sure by our invitation just what was included in the Department of Health public accounts, so rather than be unprepared, Madam Chairman, we decided to cover all bases and, if you don't mind, Karen will sit in.

MADAM CHAIRMAN: No. That's excellent. It's whatever is under your jurisdiction.

MRS. McCLELLAN: Okay.

I would like to provide a few opening comments and look forward to questions from the hon. members. As in the past, if there are questions we cannot give a fuller detailed answer for today, we would be pleased to provide a written follow-up following the review of *Hansard.*

When we look at the public accounts for 1992-1993 in the Department of Health, we see a system that is structured on the past. Funding is highlighted in particular votes which are reflective of particular sectors of health. Long-term care is separate from acute care which is separate from community health and so on. We had accountability linked in that way, and as you know, we are moving forward. The year 1992-1993 was important in the development of the change of consolidation of some of the services we offer, but it was also a year when our various sectors began to talk across barriers. Provincial and regional sessions were held across the province, and I think in 1992-1993 the various health sectors truly began to be partners in health.

The one significant partnership that produced very tangible results in 1992-93 was between the government and the Alberta Medical Association, and that was when we achieved the overall agreement on physician expenditures. That ended the open-ended way we were paying physicians and made our expenditures much more manageable and predictable. I think it was also a recognition by a key provider group that government is not just a place to send bills and that the cost-effective use of health resources is everyone's concern. Providers began talking to their neighbours about sharing services, different models, and those efforts are seen today.

I'm sure we will examine the specifics of public accounts, but you will notice that our actual expenditures were less than estimated. We'd estimated departmental net expenditures would be $3.549 billion, and we spent $3.516 billion. As you may recall, in the fall of 1992-93 a restraint program was introduced by the government to all departments. Any discretionary spending was to be curtailed and Alberta Health was part of that effort. We were able to save $33 million or expend $33 million less than predicted.

I would note that the Auditor General has reviewed the 1992-93 public accounts and provided some recommendations. The office of the Auditor General is a key accountability mechanism for the Legislature and for government. I find the Auditor General's comments very useful, and we take his directions and recommendations very seriously. We have responded to those recommendations, and I would welcome questions regarding Alberta Health's follow-up to that report. The public accounts that are before us today tell us where the dollars went. They do not tell us whether they were spent in the most efficient way or whether they should have been spent at all. I guess that is why we are certainly moving through some recommendations from the Auditor General and some key initiatives we have in own department to focus on performance measures that do focus on outcomes.

Meeting our budget is not our only goal. It's an important measure, but it only tells us one part of a much larger accountability story. We do need to look at specific outcomes of various interventions. We need to ask questions. Was it necessary? Did it improve health? New knowledge through clinical research has certainly challenged our present practices. Consumers are wanting more input on individual care decisions. Both of those things are going to create and introduce more accountability into our system.

At the system level, we are looking at the health status of our population and asking the questions: are we healthier; are we investing in the right things; is our multibillion dollar investment worth it? If you follow Statistics Canada you would notice in recent data comparing GNP spent on health and various health status indicators such as life expectancy and infant mortality that clearly from those results simply spending more money is not the answer. We have to link our resource allocation to some outcomes. We do not currently have information systems in place to assess the outcomes of what we do let alone track them over time. We do need better information systems, and this is a priority to us as we restructure our system.

We're talking about 1992-1993 today, and I think it is important that we get into that discussion and I have an opportunity to respond to the questions you might have about the expenditures of the Department of Health in those years. So, Madam Chairman, with those brief remarks about the Department of Health, I would be pleased to entertain questions from your members.

MADAM CHAIRMAN: Thank you very much, Madam Minister. Ty Lund, and then Mike Percy.

MR. LUND: Good morning, Madam Minister and staff.

Looking in volume 2 of public accounts, page 2.82, I would like some kind of explanation: what's the difference between corporate support services and centralized program delivery?

MRS. McCLELLAN: Do you want to give me just one and respond that way, or do you want to . . . Right after each one?

MR. LUND: Yes, please.

MADAM CHAIRMAN: The main question and then two supplementaries.

MRS. McCLELLAN: Okay. It's been a while since I've been to your committee, Madam Chairman.

The corporate services include the support services of the department – for example, finance, human resources, information services, et cetera – whereas centralized program delivery provides program funds which cannot be specifically identified with one program. So they are program funds and centralized program delivery that may be applied to a variety of programs, and corporate services are the support operations of the department.

MR. LUND: Thanks.

Under the health services innovation fund, some $967,000 was spent. What exactly did we do under that expenditure?

MRS. McCLELLAN: The health services innovation fund was set up to promote and provide funds for research activities that would enhance the delivery of health services. I could give you examples of some of the projects that were funded: one would be a study on pilot screening programs in Alberta for women with cancer of the cervix; a demonstration project to provide educational and support services to families of brain-injured survivors; and an evaluation of a fitness-to-drive assessment program for cognitively impaired elderly people. Those are some examples of some of the projects that were under health services innovation.

8:40

MADAM CHAIRMAN: Thanks.

Ty.

MR. LUND: Thanks, Madam Chairman. My final supplemental. The rural physician action plan: I notice there was approximately $700,000 underexpended. Why was that? I thought we were having quite a problem getting physicians out, yet we're told that the number of physicians in the province exceeds the demand and we have a program like this that was underexpended.

MRS. McCLELLAN: Okay. The rural physician action plan was started in 1991-92. This program has 16 initiatives. I'm sure members have heard me speak of it in the House. The most visible of those are the rural rotation program and the rural locum program. In 1991-92 the rural rotation program co-ordinated by the University of Calgary and the University of Alberta was implemented later in the year, so the 1992-93 allocation was reduced by the amount of funds not expended by the universities. That is why there was a savings in that area.

MADAM CHAIRMAN: Thank you, Madam Minister.

Mike.

DR. PERCY: Thank you, Madam Chairman. Madam Minister, I'd like to turn to the Auditor General's report and recommendation 35 on page 125, where it states:

> It is recommended that the Department of Health improve the reporting of the full costs of health care programs and services in order to facilitate decision making.

My first question is: what is the department doing both at the systems level and at the level of the hospital board to implement this recommendation?

MRS. McCLELLAN: Well, I'll give an explanation, and Aslam or Don may want to expand on it. We do fully report our expenditures on funds appropriated. The Auditor General is recommending that all health-associated expenditures incurred by various government departments be consolidated. I think that's the issue you're discussing. Am I correct? Am I following you? We agree in principle with that recommendation. Aslam, you might refer to ways that we can . . .

MR. BHATTI: Yes. I believe the recommendation from the Auditor General asks that in the public accounts all health related expenditures in various departments – i.e., Education, social services, perhaps Justice, even agriculture and so forth on health-related activities – be consolidated in one area saying this is how much the whole province of Alberta spent on health. As the minister indicated, we agree in principle; it's just finding a mechanism to do that in the public accounts. We have started discussions with our colleagues in Treasury to do that.

DR. PERCY: Certainly on page 124 the key item the Auditor General focuses on is administration costs for each program in allocating those overheads. Could you just briefly review for us, then, where these administration costs arise, which departments, and in a little more detail what is the problem, then, in terms of being able to allocate them specifically to the Department of Health?

MR. BHATTI: The difficulty in administration costs is that multiple programs are delivered by various departments. You may have one person delivering social services programs and part of that may impinge on the health area. The same thing in education: while you give grants to primary schools, part of the education can be related to health like sexual health and so forth. How does one go about delineating those costs as to how much of a teacher's time is spent on sexual health versus the bulk of primary health and so forth. That's the question we're trying to answer with our colleagues in Treasury.

DR. PERCY: The supplementary public accounts that were just released by the Provincial Treasurer give a breakdown on a grant basis for each hospital or hospital board. Is it going to be the policy of the Health minister to disaggregate those and provide additional data on administration costs at the board level? It's clear these recommendations sort of represent the systems for the provincial government, but if we're to get a handle on the overall cost of administration, it's clear that we have to have a much tighter handle on administrative costs at the board level. So in pursuing this recommendation here, will the minister also then be providing far more detailed information on administrative costs at the board level?

MRS. McCLELLAN: Well, yes. In 1993-94 we are asking our hospitals to break down their financial statements in that way so we have more information in those areas. It will be the standard in '94-95, but we have asked for that information in 1993-94. Aslam rightly points out that for the seven provincial hospitals we do have that filed now.

DR. PERCY: But it's the others that we're waiting on.

MRS. McCLELLAN: Yes.

MADAM CHAIRMAN: Thank you.

Gary.

MR. FRIEDEL: Yes. My question refers to page 2.82, vote 1.1.2., and it regards the expenditures in the deputy . . .

MRS. McCLELLAN: Let me get the page. Page 2.82?

MR. FRIEDEL: Page 2.82. It's in regard to the expenditures in the deputy minister's office. I notice that the budget is overspent by some $54,000, and I was wondering if you would care to comment on that.

MRS. McCLELLAN: Seeing I have the deputy minister here – well, the expenditure amounts to a severance package for the previous deputy minister.

MR. FRIEDEL: Okay. Then moving to the minister's office, it is underexpended by $12,800 and change. Is this a sort of transfer, or is it not related at all?

MRS. McCLELLAN: No. There is no relationship of the underexpenditure in the minister's office to the overexpenditure in the deputy's office. I would like to tell you that it was frugal management by the minister, careful care of costs.

MR. FRIEDEL: If I could, I'd like to use my final supplemental on the topic that Ty raised on the rural physician action plan. It's a matter that is fairly dear to my heart. I was just wondering: with the underexpenditure in that budget, is there any assurance that the funds will be used for that program in the future, or is this an indication that the program may depreciate?

MRS. McCLELLAN: Well, we will ensure that the resources we allocate to the rural physician action plan are expended for that program. However, we will also ensure that they are spent in a very responsible way as well. So if indeed in a year expenditures were not required in a particular area, it would be the direction of this minister that those funds not be expended. However, that is not normally the problem in that program, because we do have some 16 initiatives in the program and we believe it is making a difference. In our discussions with both the physicians who are in training and institutions receiving physicians through some part of that plan, it would appear to be quite successful. I think probably the rural internship is a very major part of it as well as the locum program. So we will continue to give that program full attention and endeavour to have our physicians spread out in our province where they are needed. Certainly there are rural areas that do have that problem now.

8:50

MADAM CHAIRMAN: Anything further? Thank you.
Debby.

MS CARLSON: Thank you, Madam Chairman.
Madam Minister, I'd like to turn to page 130, recommendation 38. How is the department . . .

MRS. McCLELLAN: We don't know as well as you do which questions you're going to ask, so we have to find the pages. Sorry.

MS CARLSON: It's recommended there

> that the Department of Health determine whether the hospital performance information used to allocate funds to hospitals is reliable for that purpose.

Can you tell me how your department is changing to meet this recommendation?

MRS. McCLELLAN: We have a data quality improvement plan in place now to address the problem of data quality and reliability, and we think that will address that concern.

MS CARLSON: Then is the department moving away from HPI, the hospital performance index, as the primary funding method?

MRS. McCLELLAN: No, I wouldn't say we are moving away from it, but the hospital performance index program is a relatively new one and we are improving it, I think, each year. We have had some recommendations from the Auditor General that would improve that program, so we have changed it in subsequent years, but the principles of the program are there.

MS CARLSON: Many of the concerns about using that index have been that it's been unfair and it's not a reasonable basis for allocating funds and, in fact, may specifically discriminate against hospitals that handle very difficult cases. Can you comment on what changes you're actually implementing there?

MRS. McCLELLAN: Well, it's interesting, because the hospital performance index program was put together not simply by the Department of Health but by a group of people from hospitals. So really it is their program. Certainly some hospitals do lose some dollars in the reallocation and are more likely to not agree with the program. However, in speaking with the groups involved in the various hospitals, I think it was not so much a disagreement on the principles of the program; it was the application of them. One of the difficulties in the program in the early years was the lapse from the time there was a problem identified or an inefficiency to the time when the hospital would address that. The time that was reflected in their next funding allocation was quite a long time. They found it difficult to adjust. We have now put in place what we call prospective funding, so that brings that forward. Indeed, they do not have that longer lag time.

In fact, the hospital performance index program is to indeed measure the severity, the acuity of cases and to fund hospitals dealing with those in a fair way. That was the difficulty that was expressed to us before we introduced HPI: we tended to fund on beds rather than severity or acuity or type of service provided by that hospital. So I think in principle that HPI is much better. Obviously, when you do introduce a new program, you are going to have some challenges as you go through it, but I think we are working through those. We have the acute care funding plan group which is made up of people from the hospitals, reflective of the size and diversity of the hospitals as well as the province, and they work through these issues that are raised as the program continues. So I think we have introduced some things that will improve the program, and we will continue to do that. That is one measure, and I think an important measure, of how we fund hospitals.

MADAM CHAIRMAN: Thank you, Madam Minister.
Yvonne.

MRS. FRITZ: Thank you, Madam Chairman. I just have a question on the health care insurance fund statements, and my question is . . .

MADAM CHAIRMAN: Could you tell us the page, Yvonne, please?

MRS. FRITZ: I'm on page 2.82, and I read it under Blue Cross nongroup benefits, 2.2.3. I notice the expenditures have increased.

I thought it was very significant over the past year, and I wondered why this would be and how you're anticipating handling that.

MRS. McCLELLAN: The Blue Cross benefit program expenditure of $165 million is largely for a drug program. Of the $145 million in drug expenditures, $120 million is for seniors, for which there is no premium charged.

We have introduced two strategies that I think are important in addressing the concern we have in rising drug costs. One is the least cost alternative program which was introduced last October: where there is an interchangeable drug of a lesser cost, that is the drug prescribed. If there is a personal preference for another drug that is of a higher cost, then the person would pay the difference. That was expected. I believe the Auditor General did recommend to us that we consider that program very strongly, and we did and have.

The drug benefit list also is another vehicle, and this year for the first time we have included beside the drug names the price of various drugs. We think that will be helpful in making people a bit more conscious of drug costs.

I should say that on the least cost alternative program, we do have an expert panel that list the drugs and the interchangeability of them, and that is with pharmacists involved in that expert panel.

MRS. FRITZ: Madam Minister, thank you.

I'm still surprised, I guess. Because of the use of generic drugs, I had expected that would be down. I really appreciate your answer. That's clarified that for me.

I'm also interested in why the out-of-province hospitalization costs are approximately 15 to 18 percent higher.

MRS. McCLELLAN: I should indicate to the hon. member, Madam Chairman, on the first question that because the public accounts we're dealing with today are 1992-1993, the savings we anticipate from the least cost alternative program will show up in later years after implementation, such as this year. This year, the current year we're in, we would have experienced about six months of that program.

On the out-of-province hospitalization costs, it's very difficult for us to estimate what number of Albertans will travel outside the province and require hospital services. We do have a reciprocal agreement with provinces to pay for other residents' health costs when they travel to other provinces, and that reciprocal agreement is with all provinces, with the exception of Quebec. Some of these costs are reimbursed for expenses incurred out of country. As you know, we have implemented a maximum of $100 per day reimbursement per inpatient day for out-of-country services. The previous rate was significantly higher than that, between $270 and $540 per inpatient day. So it is an area of concern for us, and it is an area having difficulty on control unless you do put some qualifiers on it. But within Canada we have portability.

9:00

MRS. FRITZ: Will that be in the same way, then, as you mentioned with Blue Cross for the budget year: that next year with these changes to the $100 that will change? Thank you.

My final supplemental, Madam Chairman. In reading this, the extended health benefit program, I simply wondered why the expenditures were dropping what I thought was fairly significantly. They seem to have decreased.

MRS. McCLELLAN: We did make some program adjustments in 1991. Some of those reduced the coverage of services by about 20 percent. We did decrease the maximum annual dental benefit from $1,200 to $960. We did make a decrease in the maximum annual benefit for eyeglass frames from $57.60 to $46.10. The impact of those changes was realized in 1992-1993 by lower utilization as well as the savings in the reductions in the amount.

MADAM CHAIRMAN: Thank you.

Alice.

MS HANSON: Thank you, Madam Chairman. Good morning, Madam Minister. I'd like to ask some questions about community health services. That's on page 2.78, and it's vote 5. I want to ask about the overall budget for '92-93. About $12 million wasn't spent. Given our shift towards prevention and promotion in community health, I wondered what happened there.

MRS. McCLELLAN: I'm going to get Aslam to elaborate a bit on it, but it was in the AADL program that there were expenditures not as high. Aslam, would you give me more details on that?

MR. BHATTI: Certainly. In the '92-93 fiscal year we had reduced the numerous smaller items that were benefits in that category; i.e., cane tips and so forth. In listening to various people, we found that it cost more to administer than the benefit that was being provided to them for those items. So a lot of the smaller items were deleted from the benefit list. In reverse, certain items were added which were very, very expensive and were not included in earlier benefits; i.e., wheelchairs, for example, that cost thousands of dollars. Numerous small items were deleted. As well, a cost-sharing component was put in at that time for the seniors that was applicable to nonseniors, and due to those changes, the net result was that our expenditures were $10 million less. A large part of it is due to the reduction in the benefits provided, but also we found that there was lower utilization by people as well. People were much more conservative in their utilization.

MRS. McCLELLAN: Maybe because of the cost-sharing.

MR. BHATTI: Largely because of the cost-sharing.

MS HANSON: Thank you very much.

My second question has to do with environmental health. I noticed that there was about an $180,000 surplus, which over the province isn't all that much, but the restraint in those programs, particularly in the urban areas, in regard to restaurant inspections, day care inspections, all those things – for a number of years now they have been restricted in that way, partly because so much of their budget is going toward looking at waste management. I wonder if you have any plans to look at those environmental protection departments and bring them up to date in terms of funding.

MRS. McCLELLAN: Well, in that particular year dollars were not expended because hiring didn't occur. People were not available. Also, as you know, in the later half of that year we were saying: be very careful with the dollars you spend; don't spend them unnecessarily.

You have raised an area that I think is of significant interest to a number of municipalities: the waste program. I have been working with my colleague the minister responsible for the environment, and we have a team looking at this area to ensure that we are not duplicating what each of us is doing, that public

health's role in regulating or monitoring waste – mainly dumps, really – is not repeating the work that has already been done by the department of the environment. So that is ongoing, and I do believe we are going to put some efficiencies in that so we have lesser costs to our municipalities but maintain the integrity of the control and monitoring of those facilities. So that's an area of concern that has been raised with us.

MS HANSON: Thank you.
My third question. I first have to ask you: is speech therapy included in one of these lines? I couldn't find it.

MRS. McCLELLAN: Speech therapy is under family health services.

MS HANSON: Okay. Thank you. It was about five or six years ago that speech therapy was moved into public health. The funding was evened out across the province so that all health units – before it hadn't been available to some health units. I am still hearing from people with children with speech problems that the waiting lists are terribly long, and the treatment available under the budget is so minimal that some people feel their kids are getting behind in school because of this. I just wonder if that's an issue for you.

MRS. McCLELLAN: We do expend a fairly significant number of dollars in speech therapy, and it is a priority for us. Just to give you an example of the importance we feel for this program, when we had to ask for a reduction in expenditures by health units, we did say that speech therapy was not an area to be reduced. I believe we are managing as best we can. I think we have to do more work in that area of training people to supplement the experts' work, whether it be family members or others, because having that dealt with is a very important program particularly in the early years in school or even in preschool. Our health units understand the importance of it. It's a matter of priorizing and allocating resources, but more importantly in that area, I think, ensuring that we're getting the most value out of those resources that we can.

MADAM CHAIRMAN: Thank you, Madam Minister.
Barry.

MR. McFARLAND: Thank you, and good morning, Madam Minister. My question has to do with the health care premiums. I want to know if you can give me some indication of what percentage health care premiums contribute towards our total health care expenditures.

MRS. McCLELLAN: The revenue of some $434 million from health care premiums offsets approximately 10.6 percent of the health expenditures of $4.1 billion in that year.

MR. McFARLAND: How much would the government of Canada through the EPF program contribute towards total health expenditures?

9:10

MRS. McCLELLAN: If we get into EPF and so on, I might have to call Aslam back, but I can tell you that $1.39 billion in federal contributions amounts to about 34 percent of the total.

MADAM CHAIRMAN: Final supplementary.

MR. McFARLAND: My last one, Madam Chairman. I guess I'm trying to get an idea of the cost between seniors and nonseniors. Would the minister be able to tell me how much revenue is forgone through the subsidy program for nonseniors and full exemption for seniors and perhaps the few of them that do have dependants?

MRS. McCLELLAN: For nonseniors, approximately $55 million was provided under the subsidy program. When you understand that there is a staged subsidy program for lower income people, it's in three stages. From seniors, if the same subsidy program were applied to seniors as is applied to nonseniors, we would have collected about $60 million in that year.

MADAM CHAIRMAN: Thank you, Madam Minister.
Sorry, Barry.

MR. McFARLAND: I just want in. I've got a couple of related questions. Could I get my name back on the list, please?

MADAM CHAIRMAN: You certainly can.
Sine.

MR. CHADI: Thank you, Madam Chairman, and good morning, Madam Minister. My questions are related to page 132 of the Auditor General's report. In particular, around the middle of the page, it's quite clear that the Auditor General had some concerns as to surplus equipment in hospitals and the fact that certain hospitals are not identifying and disposing of them to maximize value to the province. The Auditor General goes on to say that his concerns have not yet been resolved. My question to you is: are we dealing with this concern?

MRS. McCLELLAN: This is on the capital equipment surplus?

MR. CHADI: That's correct. Capital assets.

MRS. McCLELLAN: On capital assets. I'm sorry. I'm having trouble . . .

MR. CHADI: Yes, 132, in the middle of the page. It's clear. It says that he's

> reported that capital assets that are surplus to a hospital's needs are not being identified and disposed of in a manner that would yield the maximum value to the Province.

He goes on to say: "My concern has not yet been resolved."

MRS. McCLELLAN: We accepted that recommendation from the Auditor General, and we've been working very closely with the Department of Public Works, Supply and Services regarding the disposal of surplus equipment. We are making interfacility transfers of equipment wherever appropriate, and I should say that department staff are visiting hospitals and identifying assets for transfer. So I believe we have improved greatly in the identification of surplus equipment and also in the movement or transfer of it. An equipment acquisition and disbursement policy has been developed, and we think that will address that issue. Certainly we're able to transfer equipment from facility to facility much easier now, and if we have a new facility, a new wing, or something where they require equipment, we can much more quickly identify where there might be surplus equipment to supply that. So it's coming.

MR. CHADI: Thank you.

Madam Minister, further on again, just in the next paragraph it says clearly:

> there is no incentive for hospitals to identify equipment surplus to Provincial needs which could have disposal value.

Have we a mechanism in place that would rectify this problem?

MRS. McCLELLAN: Well, I think it's a valid point. You know, if you don't have any benefit in giving it up, you hold it. I think in some cases equipment was held thinking they may need it and then would not have the dollars to get it. I believe through this policy we've introduced now there is a feeling of assurance with hospitals that this equipment will be moved – I don't know whether "credited to them" is exactly the right term, but certainly a recognition of the equipment moving from their institution to another one.

We looked very seriously at a way we could provide an incentive. That's difficult to do short of paying an institution for equipment that was already paid for by the taxpayers of Alberta. I felt what you had to do was have a better understanding with the hospitals about the mobility and the transfer of this equipment and that they wouldn't be negatively impacted by this. I think that is being achieved now.

MADAM CHAIRMAN: Final supplementary.

MR. CHADI: Yes, Madam Chairman. My final supplementary relates to the current situation in health care; i.e., the shutdown of certain wings of hospitals and bed closures and the like. Are we therefore looking at the liquidation of certain equipment, or have we got big warehouses somewhere and are just storing it for future use? What do we do? Because I would suspect . . .

MADAM CHAIRMAN: How are you tying that back, Sine?

MR. CHADI: I'm sorry. It's back in . . .

MADAM CHAIRMAN: You have to identify how you tie it back, because it sounds like a question that's related to today.

MR. CHADI: Again, there is no incentive for hospitals to identify an equipment surplus, Madam Chairman. It's a concern dating to the 1992-93 Auditor General's report. So I'm just wondering: do we have mechanisms in place that would deal with situations? Back then, did we have mechanisms in place that will look after our current needs?

MADAM CHAIRMAN: I'll allow the question then.

MRS. McCLELLAN: We have a number of things that can occur. Obviously, there are shifts in our acute care facilities in particular – that indeed were occurring in 1992-93 and perhaps have accelerated since then – where we do not have a need for the number of acute care beds that we have available in this province, so in many instances wings have been closed. One of the things we are doing to address this is to ensure that equipment is appropriate to the institution and the function of that institution, because that is changing. We are not doing surgeries of certain kinds in all hospitals; they are being done in certain areas. If you tie the equipment you have in your institution to the role of your institution, you won't, for example, have equipment to do heart surgery in an institution where you wouldn't be doing it. As I said, we have developed an inventory of equipment, and we are looking at that very closely. Much of the equipment – when you close an area or a section of a hospital, the beds are transferable and are able to be utilized in a long-term care facility or another facility where they simply need to upgrade their equipment. It's an area that certainly was of concern to me, that perhaps we were buying new equipment when we had equipment that was appropriate and could be utilized. So I think development of a policy, development of an inventory tying the equipment needed to the role statements of the institutions, will go a long way to address those concerns in that area.

9:20

MADAM CHAIRMAN: Thank you, Madam Minister.
Harry.

MR. SOHAL: Madam Chairman, my question to the minister is in reference to hospitals' nongrant revenues on page 135. This nongrant revenue in some cases is a considerable amount of money ranging between $65 million to $100 million. The question is regarding recommendation 42.

MADAM CHAIRMAN: Page 135 in the Auditor General's report.

MR. SOHAL: Yes. The Auditor General's report, recommendation 42. The recommendation requires

> hospitals to account for the use of non-grant revenues as a means of reporting how such funds are used to further health care.

What is the department doing to address that question?

MRS. McCLELLAN: We reviewed that recommendation and continue to. Traditionally discretionary revenue has not been viewed as public funds, because those dollars are under the control of the hospital boards subject to the Hospitals Act and regulations. However, we are reviewing the sources of hospital discretionary revenue, and we are making recommendations on components which should be most appropriately considered as public funds as we move into the area of planning. Discretionary funds can come from activities such as gift shops, parking revenues if you have an associated parking lot. They can indeed be private donations to an institution. In those ways they are not truly public funds, although they are given to an institution or gained by an institution for the furthering of health. Other funds that institutions have that are gained from provincial dollars or tax dollars could be dollars gained in interest, and we feel there is some separation in those two types of surpluses.

MADAM CHAIRMAN: Supplementary?

MR. SOHAL: Supplementary. It's page 140, recommendation 43. The Auditor General states:

> It is recommended that in future physician service agreements the Department of Health include provisions to deal with payments to physicians when service volumes do not match forecasted volumes.

What is the department doing to address this concern?

MRS. McCLELLAN: The Department of Health and the Alberta Medical Association have agreed to discuss ways in which expenditures can be reduced by 20 percent by 1996-1997. The issues of appropriate payments for anticipated volumes and adjustments to payments as volumes change are included in those discussions. We expect there would be some recommendations, some decisions coming forward from those discussions with the AMA on that area.

MADAM CHAIRMAN: Final supplementary?

MR. SOHAL: No. Thanks.

MADAM CHAIRMAN: Leo.

MR. VASSEUR: Thank you, Madam Chairman. Madam Minister, in regards to financial assistance for acute care, could we have a breakdown of exactly how much money went to each acute care facility in the province?

MRS. McCLELLAN: Well, I was asked in the Legislature by motion to provide for – I'm trying to think of what the year was. I agreed to table the provincial dollars, all of the grants, that went to institutions in the province. So I have agreed to do that. I believe that question was asked for the 1992-1993 year. Is that what you would like?

MR. VASSEUR: Yes, the question is for '92-93.

MRS. McCLELLAN: So that will be coming.

MR. VASSEUR: In addition to that, Madam Minister, could we get financial statements for each and every acute care hospital?

MRS. McCLELLAN: That was part of the discussion. The seven provincial hospitals' financial statements are tabled in this Legislature. I believe you can receive those if you wish to contact any other hospital. It would be their prerogative to give them to you. I know of no reason you couldn't do that. I do not duplicate them and provide them. I think if a member is interested in a particular hospital or hospitals, you certainly can get them from them. They are not tabled in the Legislature. It is not a requirement that they be.

MR. VASSEUR: So if we want access to them, we have to take the initiative to contact these boards on our own.

MRS. McCLELLAN: Yes, I think that would be appropriate. I am quite happy to give you the information on all the provincial dollars that go to those individual institutions, and I will be tabling that in the Legislature very soon. When you receive that, that may be what you want. So when that's tabled, perhaps you could . . .

MR. VASSEUR: Just one additional question on volume 2, vote 3, again on financial assistance for acute care hospitals. In 3.1 we had an estimated expenditure of $81.2 million, and the actual expenditure was $88 million, a difference of almost $7 million. Could we have an explanation on that?

MRS. McCLELLAN: Aslam's going to help me find the page.

MR. BHATTI: The budget itself, I believe you've just indicated, was $81.2 million. This is in public accounts, page 2.78. Subsequently, we had transferred in about $5.9 million additional from within that same program, acute care. We had taken some funds for liver transplants and, I believe, renal and put them into the program support area because we wanted to monitor how much money we were actually spending in those areas. We had taken it from the global support and put it into specific programs so we could monitor it. That's why the authorized budget went up from $81.2 million to $87.1 million. What we actually ended up spending was $88 million, which was about $900,000 more. That overexpenditure was covered within the acute care program.

MADAM CHAIRMAN: Thank you.
Debby.

MS CARLSON: Madam Minister, recommendation 22 of the Guidelines for Public Accounts Committees in Canada states:

> The Public Accounts Committee shall have the right of access to all financial information and other documents as it determines necessary.

In light of that, if this committee were to ask you to provide the financial statements of the acute care hospitals in the province, would you do so?

MRS. McCLELLAN: Well, I have already said to the House that I will table all the public dollars that have been provided to the hospitals. I have already said that.

MS CARLSON: But that is not the financial statements. When commercial enterprises who are affiliated with the government and other provincial agencies are required to table financial statements, I don't think it's outside the realm of expectation to have the financial statements for those hospitals provided for this committee.

MRS. McCLELLAN: I don't know whether the Auditor General wants to help me on this one. All the hospitals in the province are not included in the public accounts. The seven provincial hospitals are and they are there, and all the public dollars that are given to those hospitals I have agreed by a motion in the Assembly to table. I do believe I am complying with the public accounts.

MS CARLSON: Would you be prepared to provide to this committee the management letters for your department

9:30

MR. SALMON: Well, Madam Chairman, I've been here all the time, so I've already answered the question. It's in the transcript, my concern about management letters.

MADAM CHAIRMAN: I believe the question was directed to the minister, and she's referred it to you.

MR. SALMON: But maybe she doesn't know that the working papers, et cetera, are not tabled to the committee or to the Legislature under section 27 of the Auditor General Act.

MADAM CHAIRMAN: Thank you.
Moving on. Jocelyn.

MRS. BURGENER: Thank you, Madam Chairman. I am referring to 2.78. In the financial assistance for acute care, the program support budget was $87.1 million. This is vote . . .

MADAM CHAIRMAN: I'm sorry, Jocelyn.
Could I have some attention, please? The minister didn't actually hear because of some talking.

MRS. BURGENER: I'm sorry.

MADAM CHAIRMAN: If you'd identify the page and number.

MRS. BURGENER: Reference 2.78, and it's vote 3.1, the acute care. In the financial assistance for acute care, the program support budget was approximately $87.1 million, but the actual expenditures were 88 million plus dollars. I'm just questioning it. This is a large expenditure on administration. Could you provide some background on that?

MRS. McCLELLAN: This is a similar area that Aslam just replied on. To maybe clarify it a little but further, the program support budget contains many program budgets that can't be directly associated with specific hospitals. Examples could be ambulance services, medical education allowances, equity interest programs, and so on. That appears to be a very large expenditure, but it's also a very large and very complex area.

Aslam.

MR. BHATTI: Yes, an additional clarification. You were saying that seems like a large expenditure for administration. The actual amount of money spent for administration in acute care is about $4.3 million of the $88 million. The remainder of the $88 million, about $84 million, is direct program grants to hospitals that we monitor on a specific basis.

MRS. BURGENER: Thank you. I guess just for somebody following it, the clarification is really important.

My supplementary question is referring to the operational commissioning program, vote 3.1.10. There is an overexpenditure of about $2 million on that.

MRS. McCLELLAN: The operational commissioning program provides funds to facilities where major capital renovations have occurred or additions to those facilities or new facilities. The additional funds in that year were provided to the Royal Alex hospital and the Alberta Cancer Board. The overexpenditure really was due to their capital projects being completed well ahead of schedule. It was to put them on stream.

MRS. BURGENER: Okay. Thank you for that clarification.

My final one would be vote 3.1.5, the equity interest program. Again, that budget is identified as being overexpended.

MRS. McCLELLAN: The equity interest program provides payment for interest on owners' equity, and it's really to religious and lay corporations in recognition of the equity they have contributed to the facilities. The reason for overexpenditure in 1992-1993 is that when the Caritas organization came into existence, the Edmonton General and Misericordia hospitals' equity was paid out. That is an agreement that occurs when a change in ownership . . .

MRS. BURGENER: It was a change in ownership.

MRS. McCLELLAN: Yes.

MRS. BURGENER: Thank you, Madam Minister.

MADAM CHAIRMAN: Thank you.

Mike.

DR. PERCY: Yes. Madam Minister, I'd like to return to recommendation 40 in the Auditor General's report, page 133, about "underutilized capital assets." In 1992-93 one of the things that occurred within the private sector was the emergence of private MRI. At the same time we have an MRI at the University hospital, we have one at the Cross Cancer clinic, and they're not being fully utilized 24 hours a day because of financial constraints. How then, when you look at a recommendation like this, which is to ensure that we fully utilize very expensive capital equipment, does that tie in? I mean, you would have the emergence, then, of a fee-for-service aspect. At the same time, there is capacity that's not being fully used in the publicly owned MRIs.

MRS. McCLELLAN: The publicly owned MRIs are in a hospital program, and they are there to support medical diagnostics. We will have a fourth MRI on stream in this province very shortly, and I believe when that MRI comes on stream we will have a higher per capita availability of MRI than anywhere in Canada. The utilization, of course, of MRI is as a diagnostic tool. They are only available in the major cities, so they are in both cities. Hospitals are expected to operate those within their global budgets, so a part of their decisions is fiscal. Certainly they have a team that decides the urgency and the use of those MRIs. I am satisfied that people who require MRIs are receiving them very promptly and that the waiting lists are for nonemergent reasons.

The private MRIs, I should point out for the committee's knowledge, have absolutely no government dollars in them, and we do not pay for services that are provided at a private MRI clinic. It is my understanding that the private MRI clinics are dealing with what you might call nonmedical, but Workers' Compensation Board claims or third party insurance claims – which indeed, with the introduction of the private MRI, has taken some of the stress off the hospital-based system. But whatever, we do not provide funding to them. We are satisfied that the provision of MRI services to the people in this province is quite sufficient. The physicians, people who control the MRI lists, I believe also feel they are able to handle the needs of that program within the budgets they have.

DR. PERCY: Madam Minister, so there are absolutely no charges by these privately owned MRIs that are paid for by the government in terms of procedure fees or nothing insurable under Alberta health care?

MRS. McCLELLAN: No. The only case if that were to vary: if a hospital did have a waiting list it could not handle and if it wished to enter into an agreement for usage of that, they would have to pay for that out of their global budget. That is not occurring, but it is the only way it would be done.

DR. PERCY: A final supplemental, Madam Minister, is with regard to some of the accumulated cash surpluses hospitals have on hand. In some instances that has arisen from funds earmarked for specific projects. In other instances it has arisen from things as mundane as parking fees and the like. In evaluating these cash surpluses and in light of recommendation 40, is the minister going to try and get a better handle on, say, the nonearmarked cash reserves that have arisen, such as from parking services, and ensure they are specifically used for the delivery of health care services?

9:40

MRS. McCLELLAN: Well, as I pointed out earlier in my comments, in my view there are two types of surpluses. There are what we call offset revenues, which could be generated from the use of provincial dollars, and there are discretionary funds, which can come from private donations and any number of fundraisers, et cetera. As I understand it, and Don can correct me if I'm wrong, within the Act the hospitals operate under, they have discretion as to how they spend those funds, except if they have a deficit they must expend those funds toward the deficit of their operation first. Now, if you are suggesting we should change that, or if you're just suggesting you would like to see a better accounting of that, which I believe was the Auditor General's recommendation, not in directing them how to spend it but a better accounting system of how they are expended, we need to clarify. Madam Chairman, if you would allow us a little flexibility?

MADAM CHAIRMAN: Yes, I will.

DR. PERCY: Well, issues such as UniCare at the University of Alberta hospital are clearly not an appropriate use of funds by an institution when health care delivery is the object. And generating software or some of the other businesses hospitals are entering into in a period of restraint does not appear to be appropriate.

MRS. McCLELLAN: Well, in that case they were completely within their right under the Act in what they did. You're saying that you don't consider it appropriate. I am saying that they acted appropriately within the Act they are governed by. So you come back to the question: should it be more directive? Again, I would have to come back to: I think the discussion has to be over which are public funds and which are not, because not all surpluses are public funds. They may be raised for specific activities the community considers enhance the use of that facility for that community. That's a debate, I believe.

MADAM CHAIRMAN: Yes. I'll cut you off now. Thank you. Barry.

MR. McFARLAND: Thank you, Madam Chairman. Madam Minister, I just want you to know that I was an elected board member for over 11 years, and our board never ran a deficit. We were also never asked for financial statements, even from the people that elected us, and I think we would have been happy to provide them to any of the ratepayers at the time. Maybe that's because we spent our money conservatively and didn't liberally spend the dollars we had. It leads me to the question I had. Having said that – and I can't pinpoint it in public accounts here – one of the things I've always felt is that accreditation is a dandy thing but it costs an awful lot of money. Is there any indication in public accounts here on the amount of money – I guess what I'm leading to is: what is the cost/benefit ratio of accreditation to the benefits of the small hospitals in particular?

MRS. McCLELLAN: Well, I'm sorry. I apologize. I cannot give you that, and I'm not sure if that is available. Accreditation is not mandatory. It is not directed by Alberta Health or by the Minister of Health. I believe a number of institutions feel it is a very useful process to them in ensuring they are meeting certain standards, but it is voluntary and hospitals undertake that.

I want to just comment on your preamble. I have the utmost confidence in the elected and/or appointed boards that are responsible at a local level for the fiscal management of their hospitals, and I believe they are directly accountable at that source as well as accountable for the public funds we give them. I do not want to leave any impression that I have a concern with the fiscal management our boards maintain, and certainly if we do have a concern, we have the opportunity to review issues with them and assist them in straightening out any problems. I do believe the board members are very accountable to people they serve.

MR. McFARLAND: Thank you, Madam Chairman. The supplementary I have goes back to my previous question in relation to the revenues that have been forgone for nonseniors and the exemption for seniors and their dependants. Is there a breakdown available on the number of claimants or the number of people involved; in other words, the $55 million you alluded to under the nonseniors and the $60 million you allude to for the seniors program? I guess what I am looking for is a cost for those who are classified as seniors as opposed to those who are not in terms of numbers.

MRS. McCLELLAN: Well, we have over 250,000 people who pay either no premium or a partial premium, and it varies because it's an income level. It could be 230,000 in one year and 240,000 in the second half of the year, but it is in that range of numbers. Oh, Aslam has got them right down pat here for nonseniors: 207,985 nonseniors that are in this subsidized program. Okay?

MR. BHATTI: At the various levels, either fully subsidized, partial, and so forth.

MRS. McCLELLAN: There are three steps in that. There are 277,858 seniors aged 65 or over who do not pay a premium. We also have 157,952 who do not pay premiums, who are on social assistance allowances.

MR. BHATTI: That's for '91.

MRS. McCLELLAN: Yeah.

MADAM CHAIRMAN: Final supplementary.

MRS. McCLELLAN: Have you got all those numbers?

MR. McFARLAND: Yeah; 277,858.

MRS. McCLELLAN: I think you could find those in the supplement to the health care insurance plan.

MR. McFARLAND: Thank you very much. I'll forego the final supplementary.

MADAM CHAIRMAN: Gary.

MR. FRIEDEL: Yes. It would be a shame to have someone come all the way over here and not get to share the hot seat, so I'm going to move, if you don't mind, to the Wild Rose Foundation. On page 1.180 in volume 3 I noticed there's a transfer to the endowment fund of $2 million. Then if you move back a page, the endowment fund sits with a balance of $6.5 million. What is that fund for?

MS PORENCHUK: The endowment fund of the Wild Rose Foundation serves the purpose of providing interest to offset the administration costs of the Wild Rose Foundation. The foundation was created in November 1984 and . . .

AN HON. MEMBER: I'm sorry; I can't hear.

MS PORENCHUK: The foundation was created in 1984 by the Crown, and an endowment fund was established for this specific purpose, to offset the cost of its administration.

MR. FRIEDEL: Between pages 1.180 and 1.183 there's quite a bit of advertising involved. Why would an operation that gives out money need to spend that much money on advertising?

MS PORENCHUK: Part of that advertising is the production of the annual report that is tabled in the Legislature. Another portion of that would be production of our newsletter that we send out to past grant recipients, libraries, municipalities. It's basically to inform them as to what the foundation is doing presently and what we have accomplished. It's also an advertising tool for our volunteer conference which we host annually, providing . . .

9:50

MRS. McCLELLAN: Can you tell us where it's being hosted this year?

MS PORENCHUK: Yes. It is being hosted in Grande Prairie, Alberta, this year in June. We've hosted this conference for five years now, and we believe part of the success of this is through our advertising and promotion of the conference itself.

MR. FRIEDEL: It's more conferences and publication than it is actual advertising.

MS PORENCHUK: It's not specifically advertising for the conference, but it includes advertising pertaining to all our initiatives, including the quarterly granting program.

MRS. McCLELLAN: If I could just supplement. It may seem high, but I think when you consider there is an annual report produced that is tabled in the Legislature and there is a quarterly newsletter which is circulated to ensure that people are aware of the functions and the activities of the Wild Rose Foundation, perhaps in view of what costs can be in advertising and publications, it is very conservative. I think the Wild Rose Foundation has managed to display their activities and make people aware of them using those dollars quite frugally.

MR. FRIEDEL: Going back to page 1.180, in the expenditure section it talks about minus grant recoveries of $66,000. Is that exactly what it sounds like, that grants are returned, or can you explain that?

MS PORENCHUK: Yes. We don't have a contingency in our budget. We don't know what to expect as far as grant recoveries. These are funds that are unspent by organizations, funds that were previously awarded. Changes in budgets perhaps obtain a lower price for a capital item than what they forecasted and, as such, they've returned funds. So it's accumulation or otherwise a change in plans and a grant was returned.

MADAM CHAIRMAN: Thank you.
Sine.

MR. CHADI: Thank you, Madam Chairman. Madam Minister, I think Ty touched on this previously: page 2.82 of volume 2, in particular reference 1.2.3, the rural physician action plan. I realize that an area that I understand is northern Alberta, particularly northeastern Alberta – there doesn't seem to be a lot of activity going on in terms of trying to attract physicians to the northern parts of the province. At least we don't see the results of it. It's been that way for a long time. I speak in particular of an area called Fort Chipewyan. I understand there is no local physician there. There's a nursing unit. Can you tell us what has been done to try to recruit a physician to, say, Fort Chipewyan, an isolated area? There's a great number of people living in that community.

MRS. McCLELLAN: The recruitment of physicians to any area in this province is not done by the minister or by the department, but we are there in a supportive role to assist. I think that most appropriately, through some studies and work done with communities in Alberta, the rural physician action plan was initiated, designed to assist those communities. Communities themselves would recruit physicians. What we want to ensure is that the physicians available have the support or the information required or the training to practise in remote or rural areas. One of those very important initiatives was the rural rotation. Until a physician actually spends some time in a rural practice, they would not know what to expect there. It would be quite a change to be trained in a facility such as one of our medical schools in Edmonton, where you have support at your fingertips, and then go to a rural community as remote as, for example, Fort Chipewyan where you don't perhaps have that support. So it was important that they have the knowledge of the rural practice. That was one thing.

The other difficulty identified was that many times those are single practitioner practices, and they are virtually on call 24 hours a day seven days a week. There are very few opportunities for getting away and upgrading your educational opportunities. The rural locum program addressed a great deal of that. I think the other area that we should refer to that maybe is not identified much in this action plan is a pilot project that is occurring between Foothills hospital and Drumheller, where there is a technological linkage between physicians and physicians of higher skills. So there are a number of things we have done.

I think that when you consider we're only in the third year of this program, the results have been quite significant. The interesting thing is that when I've talked to hospitals who are receiving the rural internship program, they say the benefits of that program are to them as well because they have the opportunity to have newly trained physicians in their hospitals that keep them updated and so on. It's quite positive for the receiving hospitals. We're going to continue to monitor that program and work with communities to see if there are other things that could be initiated in the program.

I think one of the important areas is that in the training of our physicians, they are trained indeed to work in rural practices where they don't have the support. A number of communities, too, have come together where they can share a physician and they can go on call one weekend. It's a very serious problem for placement. However, I do not think it is the role of the Minister of Health to tell physicians where they should practise in this province.

MADAM CHAIRMAN: Thank you, Madam Minister. Because of the hour . . .

MR. CHADI: Madam Chairman, a quick supplementary. We've still got two minutes.

MADAM CHAIRMAN: We'd have to be very quick, and probably the answer will have to be in writing. If you put your question in quickly, I'll allow it.

MR. CHADI: It seems to me that an extremely significant amount of money is being spent – and I can't seem to locate it in the public accounts – on medevac services, particularly coming out of places like Fort Chipewyan and remote areas. I'd like to know the amount of money that is being spent in terms of medevac. Perhaps a great number of those dollars could be saved by the minister's intervention. I understand you don't want to get involved in seeing a doctor move to places like that or insist that they go, but we have to encourage them in order to mitigate . . .

MADAM CHAIRMAN: Sine, because of the hour, I'll have to cut you off. I would ask the minister if you could possibly address the question in a written form.

MRS. McCLELLAN: Yes. It's referring to the air ambulance program, and I'd be happy to provide some detail. I would just quickly say to the member that when somebody is airlifted out, in

many cases it is for a higher level of care that would be available in any case. But I'd be happy to give that.

MADAM CHAIRMAN: Thank you, Madam Minister.

Because of the hour, I would remind you that the next meeting is March 16, and we will be having the Hon. Peter Trynchy, Transportation and Utilities, appearing before us.

I'd also like to thank the hon. minister and her staff, and also once again Mr. Salmon and Mr. Shandro, for making themselves available. Thank you. We stand adjourned.

[The committee adjourned at 10:01 a.m.]