8:31 a.m. Wednesday, November 9, 1994

[Chairman: Mrs. Abdurahman]

MADAM CHAIRMAN: I'd like to call us to order and also indicate that you certainly feel free to get coffee or hot chocolate or whatever you would like the first thing this morning.

I'd like approval of the agenda, please, at this time. Moved by Mike Percy. Any discussion? If not, all in favour say aye. No nays. Thank you.

Approval of the minutes of the November 2, 1994, committee meeting. So moved by Carol. Are there any errors or omissions? Any discussion? If not, all in favour say aye. Any nays? Carried unanimously.

At this time I'd like to once again welcome Andrew Wingate, the Acting Auditor General, and also Nick Shandro from the Auditor General's department and extend a very warm welcome to the hon. Minister of Health, Shirley McClellan, and her staff. At this time I would ask if you could possibly introduce your staff, hon. minister.

MRS. McCLELLAN: Thank you, Madam Chairman. I will provide a few brief comments about the 1993-94 public accounts for Health, and I look forward to comments and questions and hope I will be able to address most of the issues that are raised. As is the practice in our department, if there are any questions for which we have to get further clarification or answers for members, we will follow up with that after the meeting.

The guests that are with me today – I'm going to start farther down the table. I think all of you know Bonnie Laing. She is the chairman of AADAC. Beside her is Len Blumenthal, executive director of AADAC. We have Stan Fisher, who is executive director of the Wild Rose Foundation. Those individuals are here to assist with questions you might have pertaining to those agencies. From the Department of Health, Don Philippon, my deputy minister. Beside Don is Peter Hegholz, director of the financial planning branch. And you may not have met Janet Davidson. She is new to our department, and she is the ADM of corporate services.

The Auditor General has reviewed our 1993-94 public accounts and has provided us with some recommendations. Certainly the Auditor General is the key accountability mechanism for the Legislature and for government. I find his comments very useful, and we take his directions and recommendations very seriously. We respond to the Auditor General in a timely fashion, and certainly if you have any questions on those responses, I'd be pleased to answer those as well. I was pleased that the Auditor General did recognize the efforts of the department in addressing many of the issues he has consistently raised with us. Better accountability is certainly a key direction of our government and is a main overriding theme of the restructuring of our health system. I would also welcome any suggestions from the hon. members as to how we might better present our financial information in the future. We are presently developing models for that presentation, and we certainly would welcome your suggestions.

The public accounts before us tell us where dollars went, but they don't tell us whether they were spent in the most efficient way or, indeed, whether they should have been spent at all, and certainly that is why we are moving in Health to focus on performance measures that measure outcomes. Three-year business plans are certainly a major part of that initiative. We estimated departmental net expenditures would be $3.447 billion. We spent $3.402 billion. This allowed us to surplus $45.3 million or 1.3 percent of the budget. I will give you some highlights in each program area.

Program 1. There was $25.43 million budgeted, $23.66 million expended. This is departmental administration. I am pleased we did achieve a surplus of $1.7 million in that area. Restraint in discretionary expenditures and the impact of the 5 percent reduction in compensation assisted us there.

Program 2. We were budgeted $666.22 million; we expended $649.3 million. This is the health care insurance fund. I must say that we've had very excellent co-operation from many health professionals in reducing expenditures in that area, and therefore we were able to surplus $16 million in this program. All of the professional groups voluntarily took a 5 percent compensation reduction, and certainly I applaud their efforts in that area. The implementation of the lowest cost alternative program in our Blue Cross drug plan and reduction in out-of-country rates also achieved savings.

In program 3 we were budgeted $1.894 billion; we expended $1.905 billion. This represents financial assistance to acute care. The deficit in this program was a result of two things: the preliminary estimates of the impact of the 5 percent compensation reduction had to be adjusted, and Alberta shared an increased cost of $1.8 million for blood product testing to ensure safety standards.

In program 4 we were budgeted $1.129 billion; we expended $1.061 billion. This represents financial assistance to long-term care. There was a surplus in this vote from two things: one, of course, again would be the impact of the 5 percent reduction, and the delayed opening of new long-term care beds at St. Joseph's in Edmonton and Strathcona centre in Sherwood Park.

In program 5 we budgeted $268.2 million; we expended $267.25 million. This represents financial assistance to community health services. The small surplus of about $1 million was due largely to the 5 percent compensation reduction. This was balanced against increased utilization of some AADL benefits, so the surplus there certainly is smaller than might be expected.

In program 6 we budgeted $47.4 million; we expended $45.9 million. This program provides financial assistance to mental health services. The small surplus of $1.5 million was due primarily to the 5 percent reduction.

In program 7 we budgeted $28.4 million; we expended $28.4 million. AADAC, which is that vote, was exactly on budget, and I congratulate the chair for her effective management of this organization.

There was an overall surplus of $17.2 million. I think that is accurate accountability on a budget of $3.5 billion. In the capital support area there was a surplus of $28.1 million. This was due to a freeze on capital equipment funding, which was announced as part of a number of restraint measures introduced in the middle of the year. As you remember, we as a government committed to stay on course with our budget, and during this year I adjusted programs on two occasions to ensure our budget stayed on track. One was on July 14 of 1993, when we had to reduce our expenditures by $67.5 million, and again on October 4 we were able to put into place a further reduction of $122 million as a result of recommendations from discussions at the roundtable in Red Deer. In those areas, departmental administration, there were savings of 1 and a half million dollars; a 5 percent reduction across the health sector of 37 and a half million dollars; a freeze on 27 capital projects, $31.8 million; a freeze on operational commissioning, $4.8 million; and reduced major grants and special programs of $18.6 million. In that reduction it was urban 1 percent, rural 3 percent, long-term care 1 percent, and health units 1 percent. Reductions in systems development were $.7 million.

I know you're all aware of those changes, but it's good to refresh our memories as we're going into review. These were tough choices, but certainly we were given a mandate to eliminate the deficit and create a healthy future, and expending more than you have budgeted does not lead to that. The only way we're going to preserve the quality health system we have in this country is to make a committed effort to control costs. I make no apologies for taking tough action. We do have a plan for health services in this province. It's not a dictatorial one. It's one we're going to work on with Alberta communities. Do we set tough fiscal targets? Yes, we do. We need to do that. The problem in health is that you have to make decisions and choices between worthwhile initiatives.

8:41

Meeting the budget is not the only goal. That is an important measure, but it only tells us part of the larger accountability story, and at the patient encounter level we must look at the specific outcomes of various interventions. We need to ask questions. Was it necessary? Did it improve my health? Do I agree with my health provider? What is my opinion as a patient?

New knowledge through clinical research has challenged our present practices. Consumers are wanting more input into individual care decisions. Both of these things are going to create a more accountable system. Certainly at the system level we have to look at the health status of our population and ask the question: are we any healthier? Are we investing in the right things? Is our multibillion dollar investment worth it? We need to link our resource allocation to some outcomes, and we need information systems in place to assess the outcomes of what we do, let alone track them over time. We need better information systems, and this is a key priority as we restructure our system.

I think I could say I'm proud of what we have been able to accomplish over the past year, and I look forward to your comments and constructive suggestions as to how we might improve that and certainly to providing you with answers as to how we expended these dollars in 1993-94, which is the focus of our discussions this morning.

With that, Madam Chairman, thank you.

MADAM CHAIRMAN: Thank you very much, hon. minister.

Mike Percy.

DR. PERCY: Thank you, Madam Chairman, Madam Minister. My questions relate to program 1 in the public accounts, volume 2, for '93-94. I guess it would fall under policy development and planning services. It would be page 99. The issue really is: in light of the general restructuring of health care and the choice of specific health care budget targets, particularly the amount of the reduction, could you tell me what studies were undertaken under vote 1.1.3 that would confirm that for the level of expenditures chosen it's possible to provide the level of health care services we formerly had?

MRS. McCLELLAN: The vote you're looking at is policy development and planning services. There were a number of initiatives. It isn't any one study or any one document. I think I've read out in the Legislature a list of studies that have occurred over a period of time. I use the benchmark of The Rainbow Report. There was obviously some work done before that, but that's when major work was done in reviewing how we deliver health services in this province. We went from The Rainbow Report to implementation of a number of areas of that report and a number of areas that required more study.

One thing was the Mirosh report on long-term care, single point of entry that emerged from that. I should say the Watanabe report on utilization was another important one. I'd be happy to share with you all these reports because they are very interesting reading, and I do believe if you did take time to review even just the summaries or recommendations of some of these reports you would understand how we have come to where we are today.

We did a major consultation process last year to ensure that the Alberta public and the health providers in this province indeed were in agreement that the information in these studies was still valid. That began in Red Deer in August and went on in 10 communities. Over 5,000 people participating plus hundreds of written submissions led us to how we could better structure our system and utilize it. I could give a number of studies or papers written on the numbers of beds per thousand, the number of patient days per thousand, where we are in Alberta with that, where we are in Canada's scope. Not all of these studies have been done in Alberta. Many of them were done in Canada. The information we have used is primarily Canadian, although we can give you studies from the U.S. that also confirm that information.

DR. PERCY: Thank you, Madam Minister.

I'll rephrase the question. I have read a number of those studies, The Rainbow Report, et cetera, but none of them says that for this dollar value this is the level of health services we can provide. In the budget process, and I'm sure under this particular vote, there must have been studies that said: for this particular vote, this is the level of services we can provide by district that provides a justification or rationale for the budget figure.

MRS. McCLELLAN: Okay. We could get into some other work that was done in the acute care funding plan. That is the determinant for how we fund acute care. The case mix index is a funding mechanism for long-term care. I'm not too sure what more you want on that. These numbers are not picked out of the air. Acute care is funded on a formula. We introduced this year the funding formula for under 50-bed hospitals or under a thousand admissions in a year. That's how we determine dollars: on activity. In public health we do have population figures. We don't have in some of those areas information as good as we might have. One of our keys in the future is to have measures to ensure that how we spend those dollars is in the best way. But in acute care and in long-term care and in some areas of public health we can define quite precisely the dollars required to provide the services offered.

DR. PERCY: Were there studies undertaken to justify the choice of boundaries and distribution of hospitals within regional health?

DR. L. TAYLOR: We're looking at the expenditure previous, not looking at the future and what was done in this present year. We're supposed to be looking at the . . .

DR. PERCY: Madam Chairman, it's quite clear to me that the hon. member doesn't understand what the planning process is, that if you're going to undertake a particular set of restructuring, you actually would have done studies to demonstrate that those are taking place. My question dealt specifically with section 1.1.3, policy development and planning services. What the hon. member is asserting is that there would have been no planning undertaken to justify the restructuring that has occurred. I believe that's the assertion being made.

MADAM CHAIRMAN: I don't want to get into backwards and forwards between members. I believe the supplementary question

is in order, and I base that on the practice of previous Public Accounts meetings, questions from both sides of the House, and also tying it to 1.1.3, page 99.

I ask the minister if she would like to proceed.

MRS. McCLELLAN: I have absolutely no problem with the question. I would like to just supplement one more bit of information to your second question, Dr. Percy. Am I supposed to call you hon. member?

MADAM CHAIRMAN: Just call him Mike.

8:51

MRS. McCLELLAN: I don't know whether you had the opportunity to read the national study on Canadian hospitals that was released quite recently. It's on using Canada's hospitals more efficiently. I think it was quite recent. It was released within the last six weeks, two months, something like that, and I'd be happy to give you a copy of it. I would remind you that our reductions have been primarily in acute care, which I think you will find ties in nicely.

On the definition of boundaries, there was a decision to reduce the number of boards and agencies from some 200 to a smaller number. The steering committee we put in place – I think you are aware that the membership was 17 people from across Alberta including the chairman of the Alberta Association of Municipal Districts and Counties, including a mayor of a city, people from various backgrounds in health provision – was given the task of providing us with some advice as to how those boundaries should be. What direction they were given was that there should be a minimal number of regions, which I think left a fair amount of scope; that they should be based on patterns where delivery services could occur in an efficient manner respecting geography, respecting demographics and be of a size that would make an efficient delivery system. They did come back to us with a recommendation, and with some very minor changes to their recommendation the boundaries were drawn. That is the basis it was done on.

There was a lot of consultation by that committee with the communities and a review of how health services are delivered. And it's not just the pattern of delivering health services. You try as much as you can to keep people within the travel patterns of their own communities so that they're not going for school services in one direction and hospital services in another direction and perhaps groceries or other needs in another direction, and yet you have to look at the efficiencies of the system.

We put those boundaries out, and we did offer that if after the period of a year and through the planning process where 17 regions bring in their business plans it was seen that indeed changes should be made to operate the system better, we would look at those very carefully. I have not had that advice at this point. When I do I will review it, but it will be on the basis of a better delivery system of health services. So that's how it was done.

MADAM CHAIRMAN: Thank you, hon. minister.

Carol Haley.

MS HALEY: In the last two weeks we've had the Auditor General here, and I've questioned him on output performance measures with regard to the Department of Health. I'm wondering, Madam Minister, if you could tell the House where we're at in the Department of Health on setting output performance measures and defining those outputs or relating them back to costs.

MRS. McCLELLAN: Well, you've asked it fairly generally. We are committed, absolutely committed to providing performance measures as much as you can in health. The World Health Organization uses a number of status areas, you might call them, for measurement of outcomes. We're looking at those to see if indeed they would all be appropriate for us. In some ways it's fairly easy, but in some ways it is not as easy to be definitive.

We're looking at some work that's being done in the States on performance measures, because there really isn't a great deal of advanced work in Canada that we've found. We've looked at information from Minnesota and Oregon, and last week one of the leaders of a nationwide U.S. initiative being led by the Henry Ford health system that is looking at system performance indicators gave a presentation to our regional health authorities and our departmental staff.

MS HALEY: With the fact that we have 17 regional health authorities, are they working independently to set their own output measurements because of specific regions they're in, or will there in fact be one measurement for the province?

MRS. McCLELLAN: In some areas there can be one measurement for the province, but not all regions may offer the same programs. What we have told the regions is that it's important for them to assess the health needs of their communities and then come back and in their business plan show us how they're going to deliver services, but we have also asked them that when they put programs in place to address a specific health concern they provide performance measures or outcome measurements to ensure that that program indeed was effective.

I could give you an example. If an area considered that the incidence of teenagers starting to smoke was of major concern to them and they put some programs in place, it's not enough to put a program in place and leave it. They should do performance measures on that program and continue to review it to ensure that indeed it did work, there was a difference made, or if it didn't, how could it be changed. But on standards – low birth weight is one of the areas we look at often. You can do provincial programs in that area. But as I say, there may be some individual programs that are key. Fetal alcohol syndrome may be a key issue in some of our communities and not an issue in others, so they would not necessarily offer those programs.

MS HALEY: My final supplementary comes from a quote from the Auditor General on page 174 of Public Accounts. He says:

> If organizations could just agree on what their outputs are, what it is they're trying to influence, what it is they're trying to do, that would be tremendous progress, because once you've got that you can then build in the costing systems and start measuring effects.

My final supplementary is based on that. In the next year, possibly in that kind of time frame, do you see us being able to clearly identify those points prior to worrying about costing, just worrying about what it is we're trying to measure?

MADAM CHAIRMAN: Before we proceed, which page did you . . .

MS HALEY: It's 174, Public Accounts.

MADAM CHAIRMAN: Public Accounts?

MS HALEY: Yes, 174.

MADAM CHAIRMAN: Thank you. You had mentioned the Auditor General, Carol, so that's why . . .

MS HALEY: Well, he was here for two weeks. This quote comes from October 26, page 174, Mr. Wingate.

MADAM CHAIRMAN: What document are you referring to?

MS HALEY: *Hansard*, Public Accounts.

MADAM CHAIRMAN: Oh, *Hansard*. That's very different. Okay. She's referring to a quote in *Hansard*. That's why we couldn't find it in the Auditor General's report. Thank you. I had to clarify that for the record.

Hon. minister.

MRS. McCLELLAN: I think it's very important that the regional health authorities work together to reach definitions of what outputs are. As I said earlier, I think there are some provincial measurements we can put in place, but it's very important that the regional health authorities collectively, as a group, come to some agreement on definitions. If we achieve that, we will have a better measurement. We're certainly working with the regional health authorities to move to that end: the council of chairs. We're working with the AMA to develop practice guidelines – I think that's another very, very key area – to ensure that the practices we indeed are funding do have what we hope would be a positive effect on health. We have tended to zero in on health care, and I think you will see a much stronger focus through the regions on health, on keeping people healthy, giving them information and knowledge, and if we believe that, we have got to be able to show that those efforts have made a positive impact on the health of the people of a region. So the regional health authorities are working hard on this with our assistance now.

MADAM CHAIRMAN: Thank you, hon. minister.

Alice Hanson.

9:01

MS HANSON: Thank you, Madam Chairman. Good morning, minister. I have a question from the Auditor General's report. It's on page 78, recommendation 19:

> that the Department of Health establish procedures to report publicly on the cost of the services funded by the Province and delivered by . . .

It refers specifically to "the regional health authorities." I wonder if you have taken any action in this regard since the report was compiled.

MRS. McCLELLAN: We're definitely working with the regional health authorities on the reporting, and you would know that Bill 20 requires that the regional health authorities' audited statements are presented in the Legislature, which is new. Previous to that we had not had individual institutions or agencies doing that. So they will be presenting that information.

I think what's important is that we develop a reporting methodology for information that's consistent across the 17 regions so that that information is easily digested by the people who read it, otherwise why would we do it? We are working with the council of chairs. I think you could well imagine a group of 17, the council of chairs, has a lot of work on their plate and a lot of things before them, but I met with them about a month ago and they're making very good progress on a number of these items.

All of the regional health authorities presented their business plans to us in September. We have asked for an update about the 1st of December, and we will continue to do that. As you know, the final date for assumption of full operation is April 1, so it's important we have all these things in place as much as possible by then.

MS HANSON: Thank you for your comprehensive answer. You answered my first two questions.

I have another question in regard to the nongrant funds. There's been some discussion about that. I understand that the hospitals or health care institutions are required to budget for the generation of nongrant funds. How do you respond to the call for hospitals and other institutions to plan? You know, how are they going to use those funds?

MRS. McCLELLAN: Well, I agree with the recommendation from the Auditor General, and the regional health authorities will be encouraged to account for nongrant funds. We have requested information on nongrant funds as a part of the regional health authorities' business plans as a first step in encouraging them to include this in their budget. So we've begun the process.

MADAM CHAIRMAN: Final supplementary?

MS HANSON: Can I just get a clarification on this one without losing my third question?

MADAM CHAIRMAN: Certainly.

MS HANSON: I imagine they'll have to budget them in specific ways, because they won't be consistent every year. I mean, they won't have the same amount every year, so you can't say you'll put them toward predictable costs like salaries or something. Is that assumption . . .

MRS. McCLELLAN: One of the areas we're working on with the regional health authorities in getting them into full force is the financial regulations they must adhere to. That will be part of it.

MS HANSON: What about the surpluses that have been accumulated in the past? Has there been any direction?

MRS. McCLELLAN: There hasn't been a final decision on that. We've been reviewing it. Because there are two types of funds and because of the way we have had those reported in the past, it's not as easy an issue to deal with. Some of the funds have been generated in a specific institution or area with absolutely no government dollars. Some of the funds that are discretionary are dollars that have been generated from either interest or fees, out-of-country treatments and so on, so I believe they have to be dealt with in a fair way. The biggest difficulty in some cases is sorting those out, but we are working with the institutions, and the regional health authorities are working with the institutions within their areas, too, on a discussion of that. I think it's important to understand that some of those dollars are not government dollars, and we cannot be as directional or arbitrary in those.

MADAM CHAIRMAN: Thank you.

Pearl Calahasen.

MS CALAHASEN: Thank you very much. Good morning, Madam Minister.

MRS. McCLELLAN: Good morning.

MS CALAHASEN: It's good to see you here this morning, especially after such a late night or early morning, I guess we should say.

My question was related to the nongrant funds, but I also have a question relative to: is there other nongovernmental revenue that hospitals could pursue further at present relative to nongrant funding? There's quite an underutilized source of revenue presently for hospitals.

MRS. McCLELLAN: Certainly there are a number of nongrant revenues used by facilities to provide services they think are important that are not funded in another way. I think this would continue, including the use of volunteer resources and charitable donations. There is nothing that would preclude that from occurring with the changes we've made.

MADAM CHAIRMAN: Supplementary, Pearl.

MS CALAHASEN: Thank you. I'm on page 79 of the Auditor General's report. Even though there's argument that these funds are not provided by the province, that there's no need to prepare fiscal plans, do you have anything in place that would look at the fiscal planning?

MRS. McCLELLAN: I'm sorry?

MS CALAHASEN: On page 79.

MRS. McCLELLAN: I've got the page, but I didn't understand.

MADAM CHAIRMAN: Would you like to repeat it?

MS CALAHASEN: Yes. On page 79, where the recommendation came forward on the nongrant funds, in the third paragraph: "Some may argue that as these funds are not provided by the Province, there is no need to prepare fiscal plans." I'm talking about the nongrant funds that are generated and used or not used. Are you as the minister preparing fiscal plans relative to nongrant funding and encouraging the institutions to do so?

MRS. McCLELLAN: What we are doing is preparing the financial regulations for the regional health authorities, and we are including how they will report the use of nongrant funds. We agree that that's important, that those funds should be accountable. Probably the people who donate, or however those funds are given, would expect that too. So we are working on that.

MS CALAHASEN: The last question, Madam Chairman, has to do with the development of health care insurance. That's on page 102, public accounts, volume 2.

MRS. McCLELLAN: I haven't found it yet. I'm a little slow this morning.

MS CALAHASEN: That's okay. So am I.

MRS. McCLELLAN: Yes. Okay.

MS CALAHASEN: In the capital investment under health care insurance, information technology, there's an overexpended amount. Could you tell me why that was?

MRS. McCLELLAN: Yes. Some of you will remember this. We put in a new system for physician billing during the year. It's called the claims redevelopment system; you may have had the odd call on it. That is really where that expenditure occurred. I could tell you that the system is working much better now. I think the glitches are smoothed out. The system we had was about 20 years old. It needed to be changed, and that has been accomplished. That's where those dollars were.

I should just add that our new system is state of the art, and it's the envy of many other areas. So I guess the pain we went through was perhaps worth it.

9:11

MADAM CHAIRMAN: Thank you, hon. minister.

Debby Carlson.

MS CARLSON: Thank you, Madam Chairman. Good morning, everyone. My questions relate to the Alberta Cancer Board, which is in public accounts, volume 4, pages 210, 211, 212, and 213.

MADAM CHAIRMAN: Could you just give them a second to find it, please.

MS CARLSON: Yeah.

MRS. McCLELLAN: We don't have quite the advantage you do in knowing in advance what you're going to ask.

MS CARLSON: No problem.

MRS. McCLELLAN: Page 210; got it.

MADAM CHAIRMAN: Just indicate to the chair.

MS CARLSON: Okay. The first question is with regard to equipment. How does your department ensure that one facility is used to its greatest potential? This specifically refers to the W.W. Cross cancer hospital's MRI, which I understand is used only two days a week but there are waiting lists at other facilities. Is there some sort of intertransfer agreement between facilities where these pieces of equipment can be utilized?

MRS. McCLELLAN: Well, one, I don't think the equipment dollars are in this document. If you could give me the . . .

MS CARLSON: Okay. Note 5, capital assets, page 213. I would think that kind of equipment would be listed in furniture and equipment there. Right?

MRS. McCLELLAN: Well, it isn't.

MS CARLSON: Where would we find it?

MRS. McCLELLAN: In the public works budget.

MS CARLSON: Okay.

MRS. McCLELLAN: Public Works, Supply and Services.

MS CARLSON: Can I have a point of clarification on that?

MRS. McCLELLAN: Unless there's something in furniture and equipment. But I would not think the MRI would be in there. Anyway, ask the question. Maybe I can help you. Madam Chairman, I'm quite willing to try. I was just trying to find out where the specific item is in this book.

MADAM CHAIRMAN: Mr. Wingate, just for clarification, could the Auditor General's department assist us here? Would it be in this document under Health or not?

MR. WINGATE: Yes, as indicated, I think note 5, capital assets should contain the equipment that's being referred to.

MRS. McCLELLAN: If it was purchased by someone else it would still show up in there, wouldn't it?

MR. WINGATE: I think so. Yes.

MRS. McCLELLAN: Okay.

MADAM CHAIRMAN: Would you like to repeat your question?

MS CARLSON: Sure. The question is specifically with regard to utilization of the MRI. I understand that at the W.W. Cross Institute it's underutilized. I'm wondering why that would be and why you wouldn't have any sort of transfer agreements between institutes to better utilize such a costly piece of equipment.

MRS. McCLELLAN: I don't think the answer to this lies in public accounts. There is an MRI planning group made up of experts, physicians, professionals that actually allocates the use of MRI. We do not fund MRI specifically, but when MRI was introduced in this province there were additional funds placed in hospital budgets that had MRI and they fund the use of MRI through their global budgets. But there is a planning process, and it is not directed by the Department of Health. It is directed by the hospitals and the physicians on that group, and they priorize the use of MRI. As far as I know, there is nothing that precludes the use of the MRI at the Cross or at the University or anywhere else. I guess the question has to be taken up with the group if there's a feeling that it's underutilized. I would say that Alberta has more MRI per capita in the publicly funded system than any other province in Canada. That's really all I can help you with on that one.

MADAM CHAIRMAN: Thank you, hon. minister.
Supplementary?

MS CARLSON: Yes. On page 211, under the statement of changes in financial position, acquisition of portfolio investments, a simple question: what kind of investments would the hospitals be investing in, not only in terms of type but in terms of short term, long term?

MADAM CHAIRMAN: Hon. minister.

MRS. McCLELLAN: I'm just finding it.

MS CARLSON: Page 211.

MRS. McCLELLAN: And you want to know what those investments are?

MS CARLSON: Yes, and what kind of mix they are in terms of short term or long term, and how liquid they are.

MRS. McCLELLAN: I would have to give you the detail. That's a withdrawal of an investment. You want to know where they withdrew it from?

MS CARLSON: Well, that's really my next question. I would like to know what they were and, again, what the mix of the investment portfolio was.

MRS. McCLELLAN: I'm sorry, I don't have that kind of detail.

MS CARLSON: Would you be prepared to provide that at some later date?

MRS. McCLELLAN: Okay.

MS CARLSON: That would be great.

MADAM CHAIRMAN: Thank you very much, hon. minister. Thank you, Debby.
Moving to Barry McFarland.

MR. McFARLAND: Thank you, Madam Chairman. Good morning, minister. It's eight hours since we saw each other, and I'll bet your constituents at home wouldn't believe that.

A special hello to corporate services ADM, Janet Davidson. It's been about eight years since she helped a pilot project in the conversion of a small rural active hospital to auxiliary, something that took a long time and I see we're doing now. I think it was worth while and will be a worthwhile endeavour. Congratulations to you, Janet.

My question is on page 99 of volume 2, public accounts, vote 2.1. Under vote 2.1, administration support services, I see a total overexpenditure of slightly in excess of $2 million, and it seems to be opposite from the numbers you see under vote 1. Would the minister explain why this particular area of administration was overspent?

MRS. McCLELLAN: Again this comes into the area of claims development and the new system we did put in place. The actual overspending occurred, I believe, mainly in the implementation phase. There was a testing of the new system to ensure that all the bugs were worked out. That included operating both the old system and the new system in parallel, so we were actually operating two systems at once. Also, introducing the new system resulted in a reassessment of a large number of claims that were rejected because of new assessment rules. This did result in increased operating costs. At the same time, you might recall that we also produced the new health care cards. So there were a number of things that occurred in that time frame.

MADAM CHAIRMAN: A supplementary, Barry?

MR. McFARLAND: Thank you, Madam Chairman. There's been quite a bit of discussion about the claims development project over the past couple of years that's funded from this budget. Will the minister explain what this program is about or how much money has been spent on it and when you expect the savings to be achieved?

9:21

MRS. McCLELLAN: The system that was used was about 20 years old. When we looked at it, it would have been very, very costly to upgrade or enhance it, and it would have been very limited in what it could do in the future. So it was important that we develop a new system. The work on development of this system actually began in 1988, and it became fully operational in November of 1993. We spent about $9 million on development and implementation. The expenditures will be offset within 28 months of implementation by reductions in administrative costs and savings of program benefits such as a reduction for inappropriate payments for medical and nonmedical services.

I mentioned earlier that this system is state of the art and the envy of many others. It is being used by Blue Cross of Atlantic Canada to build their medical claims system, and other organizations have indicated an interest in this system as well.

MADAM CHAIRMAN: Final supplementary, Barry?

MR. McFARLAND: Yes, Madam Chairman. This is an unrelated subject. I understand that government did in fact enter into an agreement with physicians on their fee schedules, but I'd like to know just where it's reflected in here or what sort of financial numbers changed as a result of this agreement.

MRS. McCLELLAN: Yes, we did enter into an agreement with physicians resulting in the changes in the fee schedules. The dollar impact of those changes has been built into our budget for 1993-94 and for '94-95, as well as in our three-year business plan. In '93-94 the reductions were 1 percent to the fee schedule effective August 31, 1993, and it also reflects an additional reduction of 5 percent to the total budget for medical services. I think we should be very aware of the fact that initial reductions made in physicians' fees were done voluntarily by the physicians, certainly the first 1 percent reduction, and as minister I appreciate the very positive role the AMA and the physicians in this province have played in assisting us in getting our costs under control.

MADAM CHAIRMAN: Thank you. Thank you, Barry.
Moving to Peter Sekulic.

MR. SEKULIC: Thank you, Madam Chairman, and good morning, all. Madam Minister, my questions pertain to the Auditor General's report, specifically pages 82 through 85 and as it pertains to the Alberta Hospital Edmonton, which is in my constituency. The Auditor General indicates that with regard to allegations of conflict of interest involving a hospital employee, there wasn't any evidence to indicate there was significant influence on the bidding of the contract or on the getting of the contract. However, he did cite that the process used to acquire contracted services and the hospital's conflict of interest policies need improvement. My question is: what direction has your department given Alberta Hospital to meet the recommendations regarding conflict of interest as set out by the Auditor General?

MRS. McCLELLAN: I'm sorry, Peter. Are you asking me what we are going to do in the future – what future work with them – or on the specific incident?

MR. SEKULIC: On the specific incident and as a result of the recommendation, has your department discussed this and advised the department as to the recommendation or how they expect to meet it in the future or change their policies?

MRS. McCLELLAN: My understanding is that the Auditor General did not find any incidence of wrongdoing or irregularity in that case, and certainly we are working with the Provincial Mental Health Board who, as you know, will assume authority for operating our mental health hospitals as well as our mental health system in the very near future. We are working with them to ensure that proper procedures are in place to eliminate chances of those concerns being raised again. The Provincial Mental Health Board report or three-year business plan is due now, and we'll be reviewing it and moving forward with the ability for them to resume the role. So I think it's appropriate that we work with them, who will be the new operators, to ensure we don't have concerns like this raised.

MR. WINGATE: Madam Chairman, I think I can help here in that Alberta Hospital Edmonton has agreed to review their conduct and ethics policy. We have that specific agreement from them already.

MR. SEKULIC: My second question, Madam Minister, is found on page 84 of the same report. It's the second paragraph from the bottom, where the Auditor General indicated that

> there was inadequate evidence that the additional benefits offered by the selected contractor exceeded the benefits that could have been realized from accepting a lower bidder. For example, a lower bid received by the Hospital may have resulted in additional savings of $365,000 over two years.

My question there – and maybe Mr. Wingate would be able to advise me on this – is whether the hospital has been given direction or has in fact agreed to any changes in the method by which they acquire contracted services?

MADAM CHAIRMAN: I'll allow the minister to proceed first, if you'd like, before Mr. Wingate.

MRS. McCLELLAN: I guess I'm not absolutely clear, Peter, on your question. The Auditor General may be better able to help you. As I understand it, the Auditor General did not say that further savings could have been achieved. His comments were related to the inadequacies of the information document, and had inadequacies not been there, further savings might have been achieved. I think the information as to how to prepare those documents and the type of information that should be requested or included has been passed on, and I expect that would be followed in the future.

MADAM CHAIRMAN: Do you wish to comment, Mr. Wingate?

MR. WINGATE: Madam Chairman, we're still in the process of discussing this question with Alberta Hospital Edmonton. I think we'll have to discuss it further before we can say we have agreement from the hospital. There is at the moment some disagreement as to our finding, and I think it would be helpful for us to continue discussions with the hospital.

MADAM CHAIRMAN: A final supplementary, Peter?

MR. SEKULIC: Yes. My final supplemental, Madam Minister, is: did Alberta Health sanction or were they required to sanction the decision of Alberta Hospital to contract out those housekeeping services?

MRS. McCLELLAN: It's not necessary to sanction those. Institutions are given a budget to provide services. It is our responsibility to ensure that provincial standards and guidelines are followed. We expect institutions to develop the services they are there to provide in the most cost-effective and efficient manner, and we leave the decision-making on how to do those things – as long as they meet Alberta guidelines, regulation standards, that is their decision.

MADAM CHAIRMAN: Thank you, hon. minister.
Gary Friedel.

9:31

MR. FRIEDEL: In volume 2, page 99, vote 1.2.3 deals with the rural physician action plan. I noticed $1.5 million is spent on the administration of this program, and I'm wondering if the minister could comment on what the nature of this administration was and

also why the department cut the program a quarter million dollars short of its budget.

MRS. McCLELLAN: Of the $1.5 million, only $117,000 or 8 percent of it was spent on the administration. The balance was program funding to address issues really affecting the recruitment and retention of physicians. Some of those initiatives were additional medical training for rural physicians, rural rotation for medical students, continuing medical education for rural physicians, and – I have to check with Don – the local program would be a part of that as well.

MADAM CHAIRMAN: Supplementary, Gary?

MR. FRIEDEL: Okay. Further down on the same page, 2.2.4, out-of-province health care services. We spent $24.5 million on out-of-province services, and I'm curious why such a large amount is spent out of the province. Looking at the unexpended portion, $6.5 million, which is a fifth of its budget, is this an indication that more of these services are being done or will be done in the province, or is it relative to the type of services we deliver in or out of province?

MRS. McCLELLAN: The program really reflects the expenditures, I believe, for out of province as well as out of country, but the surplus in the out of province is related to changes we implemented on August 1 where we reduced to a maximum flat rate of $100 per day. This policy is consistent with other provinces. So that's primarily where the savings were achieved there.

MR. FRIEDEL: Moving to page 103, the Department of Health received $60 million in supplementary estimate funding, and I'm wondering if the minister can tell us why we then proceeded to a surplus of $45.36 million in capital expenditures.

MADAM CHAIRMAN: Which page and line are you on, Gary?

MR. FRIEDEL: Page 103, if you look at the total surplus.

MRS. McCLELLAN: I covered that a little bit in my opening comments, but we included a line in Budget '93 that said savings through stakeholder consultations of $121.9 million. In October of '93 we announced the various measures that would be implemented to arrive at those. Two of the items that were identified for reduction were capital expenditures. One was a capital construction projects area of $31.8 million, and the second was capital grants to hospitals for equipment. Bringing that all together, it was $60 million. The budget tabled in September of '93 removed the entire $121.9 million from the operating budget and nothing from the capital budget. Because the Financial Administration Act prohibits movement of budgets between operating and capital, we were going to be short $60 million, hence we had to ask for a supplementary estimate to have those dollars moved. As for the surplus, $28.1 million is capital equipment grants, and the balance was primarily savings in the health care insurance fund as a result of cost-saving measures that were put in place.

MADAM CHAIRMAN: Thank you, hon. minister.
Leo Vasseur.

MR. VASSEUR: Thank you, Madam Chairman. Good morning. We're referring to page 80 of the Auditor General's report. As you indicated earlier this morning, Madam Minister, the regional health authorities will be providing to the Legislature their annual reports. Now, if you take this one step further, taking a look at some of the regions – for example, the Edmonton regional authority which will be spending approximately $650 million on an annual basis – will you ensure for Albertans that those expenditures are subject to the Auditor General's scrutiny?

MRS. McCLELLAN: I said in my opening comments that I take the Auditor General's recommendations very seriously and I value them. As you would note by his report, he has made some recommendations to us as to accountability for the regional health authorities. I also believe that I indicated in an earlier answer to a question that we are developing the financial regulations for regional health authorities now. I can assure you that the recommendations the Auditor General has given us will be fully considered in those, and indeed we may ask for his advice to ensure that we do have the accountability factors covered. And we will be working very closely with our regional health authorities to ensure that they understand those reporting mechanisms.

MR. VASSEUR: The Auditor General also addressed the problem involved in transferring assets and liabilities from the present hospitals to the regional authorities. How is this being addressed?

MRS. McCLELLAN: Well, we're working on that right now. That obviously is a major part of transition, and we don't have all those things completed. But each regional health authority is discussing with various institutions in their area – and I guess you would realize it varies widely from area to area – as to how those transitional moves can be made. That would be part of the update I would be receiving by December 1 from all regional health authorities and indeed perhaps sooner from some who are more ready to move ahead with assuming responsibility for operation.

MADAM CHAIRMAN: Final supplementary?

MR. VASSEUR: Yes. In the report there's another comment made by the Auditor General.

> The Department needs to ensure that assets previously funded through government grants are not paid for again with public funds provided to the regions.

Is this also going to be addressed to make sure the regions don't pay for this thing twice?

MRS. McCLELLAN: I think it would be easy to give you a very short answer. Yes.

MADAM CHAIRMAN: Thank you, hon. minister. Thank you, Leo.
Jocelyn Burgener.

MRS. BURGENER: Thank you, Madam Chairman. Good morning. I'd like to focus my questions this morning on page 100, volume 2 of public accounts. Specifically, I want to address two questions to the votes in 3.1.6 and 3.1.9, and then I have my third supplementary question for AADAC.

In vote 3.1.6, the numbers indicate that the human tissue and blood services element was overspent by $1.4 million, and I think it would be appropriate to get some clarification on that expenditure.

9:41

MADAM CHAIRMAN: Thank you, Jocelyn.
Hon. minister.

MRS. McCLELLAN: The overexpenditure represents additional funds that were provided to the Canadian Blood Agency as

Alberta's share of the increased costs for safety testing and screening of blood and blood products. I'm sure you're aware that the Canadian Blood Agency receives its funding from provinces. So that is our share.

MRS. BURGENER: If we look at vote 3.1.9, other program support, I think some clarification should be given on what is included in that other program.

MRS. McCLELLAN: This program includes things like waste management, support for various health related organizations such as the Canadian Standards Association, the Vital Organ Transplant Registry, the Canadian Reference Centre for Cancer Pathology. Those are some examples where some of those dollars go. I should say that about $2 million of that is in waste management.

MADAM CHAIRMAN: Final supplementary, Jocelyn?

MRS. BURGENER: Yes. The question on AADAC is a social concern with respect to teenage alcoholism. I wonder, Bonnie, if you could indicate: are there specific numbers that would tell us whether or not teenage alcoholism is up or down in the province relative to the number of dollars put into AADAC? Could you maybe give us some indication of that?

MADAM CHAIRMAN: Hon. member Bonnie.

MRS. LAING: I'm going to ask the executive director to answer that question.

MR. BLUMENTHAL: Actually, from what our surveys have shown, it hasn't changed. It's been the same for many years. Insofar as teenage drug addiction or drug use goes, it hasn't changed that much either, with the exception of . . . If you take tobacco as a drug, there are more young people, particularly young girls, who are smoking and they're now outnumbering the boys about 60 to 40. But as far as alcohol is concerned, it really hasn't changed a whole lot within probably the last 10 years.

MRS. BURGENER: Are those numbers available? I think it's a very big concern for Albertans – you know, the public support for AADAC and the budget allocated to it. That might be some more information that would be helpful.

MR. BLUMENTHAL: Okay. We'll get back and send you some stuff on it.

MRS. BURGENER: Thank you. Thank you, Madam Chairman.

MADAM CHAIRMAN: Hon. minister.

MRS. McCLELLAN: One of the things I'd like to add to Len's response is that it is really our sincere hope that through the regional health authorities doing the health needs assessment in their communities – in areas like this where there are problems in specific areas, those regions can work with AADAC to perhaps more effectively meet some of the challenges in some of those areas. By following performance measures at a community level, they can assist AADAC in bringing some of those numbers down. Although I guess if it's flat, it's perhaps achieving something; at least it is not increasing. But I do believe that through regional health authorities zeroing in on issues such as teenage smoking and really concentrating at a local level to work with AADAC on an extended basis, we will see some more positive results, and it will give us an opportunity to utilize our resources, scarce as they are, more efficiently.

MADAM CHAIRMAN: Thank you, hon. minister.
Alice Hanson.

MS HANSON: I got interested in that question and lost track.
Madam Minister, this is in regard to the Auditor General's report. It's page 86 and recommendation 21. I found that a very interesting recommendation.

MADAM CHAIRMAN: Could you just let them get to the spot, Alice, please? Page 86.
Okay, if you'd like to proceed.

MS HANSON: Okay. There are two interesting things about that, one of them being that I know trying to assess the cost of treatment is really complex. I think I would like to ask you a question about that, but my first question would be: the Auditor General recommends that the University Hospitals Board, specifying one hospital, continue to improve their systems in reporting the cost of health services. He mentions farther down that it is done by the cost of the illness rather than the cost of treatment. By just naming one hospital, does that mean there's not consistency across the board about how hospitals try to measure the cost of treatment?

MRS. McCLELLAN: I think you'd have to ask the Auditor General that question. I believe there is consistency in the way they do their reporting, but he might want to . . .

MADAM CHAIRMAN: Andrew Wingate.

MR. WINGATE: Thank you, Madam Chairman. We just thought that the University Hospitals Board system could be improved by expanding what they're currently doing to capturing this cost of treatments individually. Now, we make this recommendation as a result of doing some audit work specifically at this hospital. Whether or not our recommendation would apply at other hospitals is another question. We didn't audit other hospitals with this specific objective in mind, so it would be inappropriate for us to make a general comment out of a specific observation.

MRS. McCLELLAN: Just to add to that – and I may ask Don to supplement a little bit more on this because I think it's a very important area – one of the things regionalization will do is take the individuality away and we will have in, for example, region 10, which is the capital region, a number of hospitals that will be reporting similarly. We will have one hospital on a number of sites or one institution. But there are some initiatives. I think Don should just give you a quick briefing on the global MSI, if you want to do that.

MADAM CHAIRMAN: Don Philippon.

MR. PHILIPPON: Yes. Certainly, as the minister indicated before, we're developing regulations around reporting requirements so all hospitals will be expected to report in a similar way. We're being guided in that process by work that has been done on a national basis. It's called the MIS guidelines for hospitals, management information system guidelines. Those guidelines, which have been adopted across Canada, basically look at hospital costs at three levels. They look at costs at the chart of accounts, at a departmental level, and the most advanced level is the patient's specific costing. We in Alberta have a project going on

with about 10 of the larger hospitals to implement that. Alberta is further than any province in Canada in getting a patient's specific costing in place. You may hear from time to time that other provinces have that, but if you don't have standard definitions, then the patient's specific costs from one institution to another don't mean a lot. So we're trying to get those standard definitions in place, and we use the MIS guidelines to assist us in that regard. Those will be built into the reporting requirements we're developing for the new regional health authorities.

9:51

MADAM CHAIRMAN: Thank you, Don.
Supplementary, Alice?

MS HANSON: Yeah. You know, when you read further on page 87, the highest and lowest cost, the spread, in the current system is about a hundred percent. So given that, it seems you couldn't draw any accurate conclusions from that. Are you considering going into the per treatment system, or have you got that far along in your planning?

MRS. McCLELLAN: Well, I would say this is really not just part of it; this will to a great degree eliminate those variances. Obviously, one of the goals of putting in an acute care funding plan was to ensure that we did have some consistency in funding, and the same really with the long-term care case mix index where you were looking at the severity, the acuity, the type of service, and you were measuring it. But you are still paying on reporting, so it's important that the reporting and the definitions be consistent. I think perhaps we will have less chance of that occurring with one reporting system in each of 17 regions rather than some 150 or 200 different reporting systems. So we will work on getting that consistency in place.

MS HANSON: This is in regard to physician practices. There are implications in here that it would be possible for you to monitor or assess the variation in physician practices, which I assume is one reason why you have this broad hundred percent difference. Because there is such a difference, do you intend to try to use that to get a handle on practices and costs?

MRS. McCLELLAN: I think there are a couple of things. As Don just pointed out, hospitals are using that a lot internally to get a handle on it. I think the AMA, the Alberta Medical Association, has a strong role to play with us in that. One of the areas we are working with them on – and I believe they're as anxious to have practice guidelines in place as we are – is to ensure that we do have some consistency.

I suppose there will always be some variance. There's a great deal of variance between methods of treatment across Canada let alone between the U.S. and Canada. One of the things we're trying to get stability in is our inpatient days, which is a great deal of hospital costs. One hospital may have a much higher inpatient day for the same treatment that another hospital manages at much lower, so it's important that you know why.

Those are things that really have to be addressed. Again, I have to say that I believe we have a far better chance of success with less numbers of reportings and some consistency in the reporting function.

MADAM CHAIRMAN: Mr. Wingate.

MR. WINGATE: Madam Chairman, I just want to add one small thing, and that is that immediately after the recommendation, in the second sentence I point out that the system has been useful to the University Hospitals Board in identifying differences in physicians' clinical practices. It has enabled them to identify outlyers. The physicians have been concentrating on that and that's been very beneficial, I think.

MS HANSON: Yes, I noticed that. I was curious whether that was going to go across the system.

MR. WINGATE: Right.

MS HANSON: Thank you.

MADAM CHAIRMAN: Thank you, Alice. Thank you, Mr. Wingate.
Barry McFarland.

MR. McFARLAND: Do we have time, Madam Chairman?

MADAM CHAIRMAN: Oh, yes. It depends on how long your opening remarks last. I mean, you're known to be very short.

MR. McFARLAND: Okay. I could kill time and then move an adjournment?

Madam Minister, this is hypothetical but relating to the past with the interest I have with auxiliary and long-term care. On page 103 of public accounts, at the very top of the page, financial assistance for long-term care, there's an underexpenditure of over a million dollars. Because this is looking at the past, could this have been because some of the communities who wanted to convert hadn't moved along quickly enough to access the money that might have been available for some of the conversions, or is that what this program is intended for?

MRS. McCLELLAN: On . . .

MR. McFARLAND: On 4.6.1., the very top of the page.

MRS. McCLELLAN: This is on equipment?

MR. McFARLAND: Well, when I saw financial assistance for long-term care under 4, two lines above it, I didn't know if that was an all-encompassing area of expenditures or if the $1.1 million underexpenditure was strictly on equipment grants. I guess that would have been a better way to ask.

MRS. McCLELLAN: I suppose the actual variance in there is because of the freeze we put on more than anything else. I don't think it would be entirely fair to say that we didn't allow conversions to occur.

MR. McFARLAND: I wasn't suggesting that.

MRS. McCLELLAN: No. But I think what is interesting to note is that it is not widely known how many conversions of beds have occurred and how many changes have occurred outside of the major centres and how responsible a number of boards have been in moving ahead to meet the needs of their communities and make those changes. Because of the type of reporting functions we have, they are not always reflected on a timely or immediate basis, so it appears that change is not occurring where indeed it has. I have to give full marks to most of the areas in our province that have concentrated more on delivery of health needs than on maybe other things.

MADAM CHAIRMAN: Thank you very much, hon. minister.

Because of the time, I'd like to move on in the agenda and convey my sincere appreciation on behalf of Public Accounts members to you, hon. minister, and your staff for making yourselves available this morning and being so open in your answers. Also, we'd appreciate it if any written responses went through Corinne, our administrative assistant. Once again, thank you to Mr. Wingate and Mr. Shandro for being in attendance.

Our next meeting on November 16, if we're still in session, will be with the Provincial Treasurer.

If there's no other business, I would now say that we stand adjourned. Thank you.

[The committee adjourned at 9:59 a.m.]