Standing Committee on Public Accounts

8:30 a.m.
[Chairman: Mrs. Abdurahman]

THE CHAIRMAN: I'd like to call us to order.

Could I have a motion to accept the agenda as circulated? Moved by Peter Sekulic. All in favour, say aye.

HON. MEMBERS: Aye.

THE CHAIRMAN: Any nays? Carried unanimously.

I'm indeed pleased and honoured to welcome the hon. Minister of Health, who's with us this morning, and once again our Auditor General. I'd ask you, hon. minister, if you could introduce your staff at this time and, once again, Mr. Valentine, if you could do likewise, and then we'll have an opening statement from the minister.

MRS. McCLELLAN: Sure. Thank you very much, Madam Chairman. With me to my left is Dr. Jane Fulton, the Deputy Minister of Health; to my right, Dave Cathro, executive director in finance and health plan administration. I'm also pleased to introduce AADAC's chief operating officer, Len Blumenthal. Also with me is Stan Fisher from the Wild Rose Foundation.

THE CHAIRMAN: Thank you.

Mr. Valentine. Peter.

MR. VALENTINE: Good morning, Madam Chairman. On my left is Nick Shandro, who is the Assistant Auditor General responsible for the portfolio in which the Department of Health falls, and the principal directly responsible for the engagement is on my right, Allaudin Merali.

THE CHAIRMAN: Hon. minister, if you'd like to make your opening remarks.

MRS. McCLELLAN: Thank you, Madam Chairman. I'll try and keep my comments relatively brief so we have lots of time for questions. In 1994-1995, which is the year that we are discussing this morning, the process of fundamentally restructuring the health system continued in earnest. It was a year of great activity in the health system. It was a year that we moved to a regional governance structure. All 17 regional health authorities were directed in that year to develop three-year business plans of their own in accordance with the guidelines that were set out in Alberta Health's business plan. These plans outlined ways of reducing waste and duplication, ways to streamline health services delivery, to shift more services to the community, and certainly to provide more focus on health promotion.

The budget targets in 1994-1995 for the regional health authorities were ambitious. Overall, institutional funding was reduced. Thirty million dollars was reallocated from acute care to community care, the first of three yearly additions to that area, which amounted to a $110 million injection into community services over the three-year period.

In that year the view of a more community-based system began to take shape. Services like home care expanded to meet demand that was created by earlier discharge from hospitals, and new models of care such as assisted living were beginning to provide alternatives for the thousands of Albertans who before this were used to more of the traditional institutional care. The main thrust was to support independent living in the community, and of course that was a key objective of health reform.

We have a proud tradition in this province of providing a very high quality, very comprehensive health service, but in an effort to provide one that was affordable and sustainable, some programs were adjusted to bring them into line with coverage from other provinces. Eye exams, for example, for Albertans 19 to 64 were deinsured. I should emphasize again that that is vision exams; eye health exams continue for that age group. Children and seniors continue to be covered for that service. Other services such as wart removal and general anesthetic for noninsured services were also deinsured for a savings of about $17.4 million.

While there is a strong fiscal imperative to restructure the health system, there's an equally strong need to integrate services so they're more accessible and more responsible to our clients' needs. We seen an end to the stovepipe type of delivery of services. It leads to better co-ordination, elimination of service gaps, and ultimately improved patient care.

The development of that integrated system of course is a gradual process, but there is no doubt that the system is moving in this direction, and one example of that is the community rehabilitation program. As well as removing financial and geographic barriers to accessing the five rehabilitation services, it provides a better service co-ordination for persons with complex needs, which is indeed the principle that this program was founded on. Alberta is the only province in Canada to provide a comprehensive, community-based rehabilitation program in Canada. Alberta Health continues to work with regional health authorities in the implementation of this program and through some implementation issues that have arisen.

Although our financial targets have been I think quite ambitious, one of the ingredients for successful health reform has been flexibility. Forty million dollars was provided in the year 1994 for transitional use, for bridging. Those were onetime dollars. Since then, as you know, we have responded in subsequent years to pressure points such as surgical and MRI backlogs. The government is committed to addressing those pressure points whenever and wherever they might occur to ensure that we do maintain the quality and access that Albertans expect and deserve.

The comments in the direction of the Auditor General continue to be a very important part of the evaluation process and have been extremely helpful to me and to the regional health authorities. While the department has formally responded to the Auditor General's report, I would certainly welcome further questions regarding the Auditor General's recommendations in our reply. Generally speaking, I would say that there have been great strides made in improving the accountability of the health system, although we do continue to work with our stakeholders to develop meaningful ways to measure efficiency and effectiveness.

Returning to the public accounts themselves, the department posted a surplus of $4.6 million. It is a minor variance, I will admit, given that the overall expenditures were slightly more than $3.8 billion. I would, though, like to recognize the efforts of all those people who work in our health system for their patience and their co-operation in helping us meet our targets.

Madam Chairman, I could highlight some areas in each of the program areas. Program 1, department support staff, a budget of $27.8 million, and the actual expenditures in that were $25.5 million, which led us to an 8.4 percent surplus. I think that surplus reflects the ongoing restraint and fiscal prudence of our department staff. Increased costs due to issuance of new personal health cards were accommodated in the actual expenditures.

In program 2, health care insurance, the budget was $1.195 billion, and the actual spent in that area was $1.209 billion. That led to a 1.1 percent deficit, the result of reorganization and system costs associated with charging health care premiums to all Albertans. On the revenue side higher than anticipated revenue from premiums was received.

In program 3, institutional and community services, the budget

was $2.432 billion. The actual was $2.421 billion, a .4 percent surplus. That probably was mainly due to the delay in the implementation of the workforce adjustment program. However, most of the savings that we realized in that area were offset by increased utilization of AADL, the Aids to Daily Living program, and increased costs to monitor the national blood supply. So that resulted in a minor variance in that area.

In program 4, mental health services, our budget was $141.7 million. The actual spent was $136.6 million. That resulted in a 3.6 percent surplus, and $4 million of the $5 million surplus was provided to regional health authorities for community-based services.

8:40

I'll speak just very briefly about AADAC. It's an important part of my responsibilities as minister. The contributions from the general revenue fund dropped from $28.4 million in 1993-94 to $26.85 million. However, higher revenue – fees, grants, donations – managed to compensate for that decrease.

The Wild Rose Foundation. Revenues from the lottery fund are the same as the year before, $6.6 million. Grants exceeded budget by $800,000, and that was accommodated by an accumulated surplus.

Colleagues, our system is not, in my view, underfunded, but it is in need of better organization. Obviously more discipline is being brought into the health system, but more work is clearly necessary in truly changing the way we deliver services.

The work of the workforce rebalancing committee, which began in 1994, will ensure that a range of qualified providers are involved in delivering appropriate services. Better health information networks will enable our system to become more efficient and deliver better quality care. New funding models will ensure more careful utilization of health resources and emphasize disease and injury prevention rather than simply treatment. All of these strategies are designed to meet two main goals: the preservation of our publicly funded health system and an improved health status for Albertans.

I know I've given you a very brief overview, but given the activity level in 1994-1995, I'm sure that members have many questions, so we'll take those now.

Thanks.

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

Carol Haley.

MS HALEY: Thank you very much, Madam Chairman. Good morning, Madam Minister, Auditor General, and staff.

MRS. McCLELLAN: If you can really speak up loud. I have a hearing problem this morning.

MS HALEY: Okay. I'll try. I feel like I was just here; you know?

MRS. McCLELLAN: I was too. Can you give the pages that you're referring to?

MS HALEY: Yes. With regard to expenditures, volume 2, page 89.

THE CHAIRMAN: I was just going to mention that we only have one supplementary now, hon. minister.

Sorry, Carol.

MS HALEY: That's fine. On page 89 of your public accounts in volume 2 under the heading of departmental support services, the only line item showing an overexpenditure is finance and administration, reference 1.1.6. The overexpenditure is approximately $1 million. I guess my question is: how do you justify an overexpenditure in an administration area such as finance while at the same time expecting the regional health authorities and the provincial health boards to stay within their budgets?

MRS. McCLELLAN: Well, I never find an overexpenditure in administration tremendously acceptable. However, part of that overexpenditure I could justify to myself and to you by reminding you that we had a mail-out of new health cards. That was the year that everyone received their own individual personal health card. Also, we had to change our billing system in that year, because that also was the year we determined that all Albertans would be paying health premiums, depending on their economic situation. It did require quite an amount of adjustment.

On the positive side of that I will tell you that while the area showed an overexpenditure, funds were frozen elsewhere in the department to cover that. If you look at the total picture in program 1, you will see in fact that there was a surplus of $2.3 million in administration.

THE CHAIRMAN: Thank you.

Supplementary, Carol.

MS HALEY: Thank you. Again, Madam Minister, on the same page, if you look at all of the line items under the heading management and operations of the health care insurance plan and in particular lines 2.1.2 and 2.1.6, you have overexpenditures in every case. The total overexpenditures in the administration area of $3.5 million represents a substantial part of the total authorized budget. What reason do you have for these overexpenditures, and why are you allowing them?

MRS. McCLELLAN: In the case of the claims branch and the registration branch the costs are associated with severance of employees. There was a complete restructuring in those areas. In the case of practitioner services, again, it was due to the reorganization of the department. Funds were transferred in those areas; however, budget transfers aren't reflected in the public accounts. So that's a very good question to pose, and I hope that gives you a better understanding of why that occurred.

THE CHAIRMAN: Thank you, hon. minister.

Debby Carlson.

MS CARLSON: Thank you, Madam Chairman. Good morning, Madam Minister and everyone else. My question is with regard to closing down parts of the Grey Nuns hospital during that time period. What policy decisions did you make which influenced that?

MRS. McCLELLAN: If you're talking about the realignment of services that were delivered in the Grey Nuns hospital, there was a complete review done of the acute system in Edmonton, in fact an extensive review. We have to go back a little bit. If you would recall, there was in Edmonton – I'm trying to think of the actual name of it: the acute care council. It was a group that had been in place for actually some time working on how they delivered service in all of the acute care areas. Some of the work done by that group was as to how they would've reorganized services in acute care in Edmonton.

There was a subsequent report that was developed. Dr. John Atkinson, if you would recall, was one of the leaders of that report. Looking at the whole delivery of services, it was felt and I think well

documented that by consolidating some of the particularly high tertiary care services on less sites, they could offer better co-ordination of those programs, better utilization of operating room theatres, of surgeons' time. So that decision was made, and there were some higher tertiary care programs that were removed from the Grey Nuns and transferred. It's not that the programs were cut, but those programs were transferred to other facilities.

I think that if you look at the results today, you will see that the reconfiguration of the Grey Nuns hospital has been positive for the residents of Edmonton and the surrounding areas that it serves. Indeed today the Grey Nuns is doing more. They're doing far more deliveries of babies. They expect in fact to almost double that capacity. They have increased significantly the number of day surgeries. They are taking over far more of the day surgery programs indeed from other hospitals. They have provided in that building other community-based services for their residents. So the Grey Nuns hospital has truly become a model of a community health centre.

Now, I've said that all community health centres will not look the same in the province. We will have community health centres in other parts of Edmonton; for example, the northeast community health centre, that's due to come on, will not be modeled after the Grey Nuns. It will be a model that meets the needs of the northeast.

I met with the Caritas group about a week ago. I can tell you, I was extremely impressed with the abilities that they have had to increase the number of services they provide in their traditional role but further to that to increase the services that are available to the citizens of that Mill Woods area. If you have not had an opportunity to go over to the Grey Nuns, I would surely encourage you to do that and to have a tour of that health centre because I can tell you that the operators at that centre are truly and justifiably proud of what has changed there.

THE CHAIRMAN: Supplementary, Debby.

MS CARLSON: Thank you. As that's my local hospital, I'm there on a weekly basis and see that there are some units in that hospital that have never been opened and more that have been closed down during this time period. What's your policy with regard to utilizing the empty space?

MRS. McCLELLAN: It won't be my plans for utilization of space; it will be the Capital health authority working with the Caritas group. They are looking at some of that area to put it into a functional use. They have not completed all of their plans there.

If you're – and I'm not questioning that you're there on a regular basis. I'm glad that you are. I think it's important that we do understand the changes that are being made. If you do have that opportunity, you will understand, especially if you've had a chance to talk with the owners and operators of that facility, some of the things that they may be able to do.

8:50

As I said, they've had to expand their day surgery programs to meet the demand and have done that well. The important thing is that they look at the needs of the community. They look at areas of service that could be delivered there efficiently to meet those needs as well as the overall needs for the Capital area, and I think there is a strong possibility that there could continue to be some reconfiguration there.

The Grey Nuns hospital is a new hospital. It's an excellent building. It's a state of the art building. I'm sure that over time, as they continue the reconfiguration in this region, it will become more fully utilized and those empty spaces used for meaningful programs.

THE CHAIRMAN: Thank you, hon. minister. Thank you, Debby.

David Coutts.

MR. COUTTS: Thank you, Madam Chairman. Good morning, Madam Minister, ladies and gentlemen of the staff, Auditor General and staff. I'm going to touch on an area that generally gets the questions towards the last, and that has to do with the Alberta Alcohol and Drug Abuse Commission. Very often we get going on Health, and we tend to run out of time before we can address some of those, so I thought I'd like to do that first this time.

I'd to look at volume 3 of the public accounts, in particular from pages 168 through 172. On page 172 the disclosure statements of salaries, wages, and benefits for the Alberta Alcohol and Drug Abuse Commission show decreases in almost all of the cases there, and I note that that's consistent with the 5 percent reduction that was implemented. However, there are some instances where there is in fact a salary increase from the year before, and I wonder if the minister could explain how this would come about given the 5 percent reduction coupled with a compensation freeze.

MRS. McCLELLAN: AADAC in fact has frozen all management compensation levels in keeping with the general – I guess I'm trying to think of a good term to use when you have to freeze the salary levels of hardworking people – direction of government through this time of restructuring. The anomaly, though, that is reflected in those statements is due to payout of accumulated vacation time, and even in a time of freeze and restructuring, you do have to follow those.

Leonard, close? Good?

MR. BLUMENTHAL: Great.

THE CHAIRMAN: Supplementary, David.

MR. COUTTS: Thank you very much. In doing so, they do a great job.

My supplemental is on page 168, volume 3 again. It shows the balance sheet for AADAC, and I wonder if the minister could explain the reason for the increase in the operating fund deficiency from '93-94, an amount of $2.3 million, to the '94-95 amount of $2.9 million.

MRS. McCLELLAN: Okay. I will. I understand, Madam Chairman, if I recall from my last visit here, that staff members can jump in, and I may call on Leonard to help.

My understanding is that AADAC's share of the unfunded pension liability for the unfunded management employees' pension is included in there, about $256,000, and the 5 percent reduction that was implemented on April 1, 1994, for all AADAC's bargaining unit was delayed by about nine months. So the budgeted savings or reductions were not fully realized in that year.

Have you anything that you'd want to add to that, Leonard?

MR. BLUMENTHAL: The reason that delay happened is because we bargain a separate contract from the general service, and in our bargaining with the union, the first agreement between the bargaining people was turned down by the union membership. So we had to go back and do it over again, and that was the delay.

MR. COUTTS: Thank you very much.

THE CHAIRMAN: Thank you.

Peter, I think there was a bit of distraction there. I'm sure it was very difficult for Mr. Blumenthal to say his point. It was distracting from both sides. So we'll have some order please when people are

answering questions.

Peter Sekulic.

MR. SEKULIC: Good morning. I think we were distracted by Howard's absence, and that was what the minister was referring to. She was concerned for his well-being, I think. Question period just wouldn't be the same for the minister without Howard.

Madam Minister, I will refer to page 93 of volume 2 of the public accounts. Specifically I'll be referring to the fees, permits, and licences. You know, from the opposition point of view when we're trying to hold the government accountable, one of the more important tools that we have is comparability from year to year. Yet for the health revenue in health care premiums and Blue Cross nongroup premiums, although we have a figure for 1995 – health care insurance premiums were just over half a billion dollars, and Blue Cross nongroup payment premiums were $20 million – we don't have a figure from 1994. Now, given that during this year, this time period, there was a significant transition occurring in the department, it would have been helpful to have those items listed. So my question is: why aren't they provided for in the 1994 column?

MRS. McCLELLAN: I'm going to get Dave to help me answer this because this is very much a technical, accounting-type question. It is because of the change we did. But I'll ask Dave Cathro to give you the reasons for that.

MR. CATHRO: In the previous year these revenues were shown as part of the health care insurance fund, and at the end of 1993-94 that fund was terminated and all of the transactions were brought into that portion of the general revenue fund of the department.

MRS. McCLELLAN: It really amounts to changes in accounting. I don't know whether it's permissible for the Auditor General to help us on this, but we do have some new ways of showing our budgeting, consolidated statements, moving toward that, that change the way we do things. I don't know whether that has any effect on this, Peter.

MR. VALENTINE: Well, let me make a general remark that in public-sector accounts the concept of amending the prior year's figures to put them on the same basis for reclassification purposes as the current year is not generally done because of the voting that goes on with the approval of the estimates, that system. So perhaps one should be thinking about footnotes that would provide the appropriate explanation when there's been a reclassification of numbers, as there has been, as I understand it, in this case. At the end of the day the consolidated accounts of the province would not be incomparable. They would be comparable because you've got all of the revenues in one place. In here you don't have it because the complement of the 562 million bucks is in the GRF in the prior year. Excuse me, it's the other way around.

THE CHAIRMAN: Supplementary, Peter.

MR. SEKULIC: Yes. I was puzzled given that those were the only two that were absent, so I would have assumed that that explanation would've held for that entire column of 1994 and not just the premiums because that was a significant change. In fact, that year we were questioning the government about the additional fees and premiums and calling them taxes, and the government was saying: no, they're premiums. So that's why I was curious to that. It's very hard to trail.

9:00

My next question. In the minister's opening comments the minister made a comment that she's confident the health care system isn't underfunded. I myself have trouble determining what's the appropriate level of funding. I can't claim that it is overfunded or underfunded, and I want to come to some level of comfort. I'm referring now to page 127 of the Auditor General's report. In the second paragraph he states, "I believe that better information systems are needed to help determine whether the resources provided are used effectively." To give me some level of comfort, I would have assumed that prior to assessing an appropriate level of funding for a department or a ministry, we would have gone through the exercise of planning and then performance and outcome measurement. The result of that would have been the conclusion that we are overfunded or underfunded and then the explanation as to where the waste was and where the duplication was, yet we seem to have the flip of that. Could the minister just comment on what numbers or statistics she has that lead her to believe that we are overfunded?

MRS. McCLELLAN: This is probably one of the more – all questions on what we do are important, but the understanding of this area is probably the most important. We talk about the need for better information systems so that we can do better planning and allocation of health resources in the future. When we talk about that, we're not saying that we don't have any information or that we don't have any data. We have a lot. The problem is that we don't have it brought together in a way that can easily be utilized, analyzed to make decisions. So we need to do a better job of that. While we do that, we also have to look at the information we're gathering and make sure that we are asking for information from our institutions, from our care providers that is important to help us make those decisions.

I can tell you that when I became minister, I attended two or three conferences quite quickly. The health unit conference was one, and then the acute care people were the other. The interesting part of this is that at both conferences, and I'm sure unprompted, the question came from the audience, because I always have a question and answer period: we send you all of this information – and in their view, it dropped into a black hole somewhere – and it was never to be heard of again. Their question was: we are spending a lot of energy and time to get you this information, and we'd like to know how you're using it. I can tell you that we do use and did use a lot of that information. However, it wasn't and it isn't yet today in a way that we can present it back to our caregivers. New information systems can assist us in doing that.

What did we use in planning? Hon. member, we use a lot of information that is nationwide, and in fact you look at some world figures as well. The figures that we used in coming to a bed count of the appropriate inpatient acute beds per thousand for Alberta was 2.4. That's within a point or two variance of what each province in Canada is looking at. Some are looking at 2.5. Some are saying that 2.3 is the right one. We felt this was the balance, and obviously we'll adjust that as we go along.

The same thing with long-term care. We were at 65 beds per thousand for people who needed long-term care, and the anticipation is that with new ways of delivering those services, allowing people to remain in their own homes longer, we could reduce that to 50 beds per thousand. That is again work that's done across Canada, and in fact, as I say, we look at some world figures.

So we use a lot of information that is available in a lot of places. What we'd like to do is be able to have that information so it's more easily presented to you so that you understand it, rather than having it collected in a number of places. Remember, prior to 1994 our own department dealing with Health was very fragmented. We had a

number of divisions. We had our long-term care division, our acute care division, public health division, mental health division, and on and on it went. Frankly, while we were concerned that the people who were providing the services in the field weren't communicating, we found that even in our own department we weren't communicating well between those areas because of the structures that we had in place. By making some changes, bringing those services together, getting that data and that useful information collected, we think we can better target the dollars we have to the areas they should be expended on.

The Auditor General's report every year since I became minister has made that point. When you become minister, you become more focused and read those pages more closely, I can assure you. If I could paraphrase it, it has really said: Madam Minister, how do you know the money that you're spending is truly going to make a difference to someone's health, a positive difference? How do you know that your allocations of dollars are the best way those dollars could be spent? And that is what we are striving to do in developing new information systems and new ways to use those information systems.

I guess the one thing that we can all be sure of: there are a lot of information systems out there. This is an information technology age, so perhaps we're fortunate in that way.

It's a long answer, but it's an important area.

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

Jocelyn Burgener.

MRS. BURGENER: Thank you, Madam Chairman, and good morning, Madam Minister. May I compliment you, by the way, on your efforts last night. They were well received.

I'd like to have a look at the Auditor General's report, page 129, and the recommendations that are listed there. It's number 24. There's a suggestion from the Auditor General that the RHAs be held accountable "for the cost and effect of all health services" within their regions, and they need to be able to determine if "the effects of physician services" and related costs "are meeting the health needs of their communities." He acknowledges that drug costs, for example, "are not reflected in regional costs." What is being done to address this concern?

MRS. McCLELLAN: That was a mouthful, and I'm not sure I have it all. I'm just looking for my copy of the report.

THE CHAIRMAN: Do you want to talk a little bit more, Jocelyn, to focus . . .

MRS. BURGENER: Page 129. I think in a nutshell what we're realizing is that they have global budgets, and within that global budget, though, there are some variations which might make it difficult to deliver the services most effectively. I'm wondering how they can tighten that up.

MRS. McCLELLAN: I agree totally with the comments that it's imperative that the regional health authorities and physicians work more closely and in conjunction to meet the health needs of the regions. In our AMA agreement of a year and a half ago there was an agreement to set up physician liaison councils that were designed to work with the regional health authorities. Unfortunately, there was not a mechanism for that loop to actually function well, and neither party, in some cases, came together well in planning. The AMA agreement that we have most recently signed puts in place a mechanism for a tripartite process.

A tripartite process is the Minister of Health, the government, who funds the health system; the physicians, who are very important players in the system; and the regional health authorities, who manage the resources that physicians require for treatment or providing other health services to their patients. I shouldn't call them all patients because physicians deal with wellness as well. So that agreement we see as very positive. Our tripartite committee leaders have met and are in the process of setting up some working groups that can meet those needs of ensuring that physicians work much more closely with the regional health authorities and the minister to deliver those services.

9:10

THE CHAIRMAN: Mr. Valentine. Sir, to you to comment.

MRS. BURGENER: For my second supplementary . . .

THE CHAIRMAN: Excuse me. We had a supplementary reply from Mr. Valentine. Peter.

MR. VALENTINE: To the hon. member. The point that we're making at the bottom of page 128 and at the top of page 129 is that at the moment we're not gathering all these costs together. So when you don't have the drug costs and you don't have the physician costs that are incurred in a particular regional health authority, you don't know what the total cost of health care was in that authority. That's the first point we're making.

Then as to who should be responsible for the measurement of the cost and the effect on the health services provided, that's the part that I think the hon. minister was referring to when she speaks of the tripartite committee.

THE CHAIRMAN: Thank you, Peter.

A supplementary, Jocelyn?

MRS. BURGENER: Yes. Thank you for that, because I think that it's important for us to realize that in addition to the ministry working to address that issue, there is also support coming from your office to identify and monitor areas where they should be focused. So I'm pleased to see that that relationship is there.

On page 130, Madam Minister, the Auditor General has recommendation 25, and it goes on to recommend that the department and the RHAs "establish a system to optimize the use of . . . public funds by community, voluntary and private organizations" in delivery. This does raise again the issue of operational effectiveness by the RHAs. Can you tell me, please, what steps have been taken to address the concern of the effective use of public funds?

MRS. McCLELLAN: Again the Auditor General may want to supplement my answer here as well, because this is an area where, I can tell you, we are asking for help from the Auditor General's department. We want the utilization of public funds for the delivery of health care to be as transparent and as accountable as we can possibly make it. We know we have to establish a system that will optimize that, and that is why we've asked for help. However, I would point out that the RHAs are responsible and are held accountable for the provision of services in their regions and, as a result of that, develop working or service agreements with other groups. For example, the Capital health authority has a service agreement or a contract or co-operation agreement with the Caritas group to provide particular services.

It's important that we are able to account for those dollars that are used. We as a department are working with the regional health authorities to facilitate this process on the accounting and accountability, and we obviously review their service agreements.

So I guess it's a matter of us continuing to work on how we better show the accounting but, most importantly, that we review the service agreements to make sure the services that are being funded are being provided in those areas.

THE CHAIRMAN: Mr. Valentine. Peter.

MR. VALENTINE: Yes, thank you, Madam Chairman. The comment that follows under the recommendation and, for that matter, the recommendation itself were made as a consequence of the formation of the regional health authorities and the realization that there are a number of organizations that aren't within the ambit of those authorities. The authority that I have under the accountability Act allows me access to the RHAs, and we will be reviewing how they hold these independent organizations accountable to them. In the course of our activities if there are things that we believe should be brought to the attention of the Legislative Assembly, then they will appear in future reports.

THE CHAIRMAN: Thank you.
Terry Kirkland.

MR. KIRKLAND: Thank you, Madam Chairman. Good morning, Madam Minister and staff and Mr. Auditor General. My questions will be extracted from the Auditor General's report, specifically on page 133, Madam Minister, in the top paragraph there.

MRS. McCLELLAN: I'm sorry. What page?

MR. KIRKLAND: Page 133, in that public reporting clause that starts it off there. I see the Auditor General's comments that in fact there was a need to "establish procedures to report publicly on the cost of the services," and then he goes on to state that in fact it was necessary to have

> a consolidated report that links the funds provided by the Province with the nature and cost of health services delivered by the health authorities.

Now, my question really would be based on this: has that consolidated report been developed, Madam Minister? I would ask it in light of the fact that it is on record in my particular constituency that I would be the best salesman for the health authority if they were delivering their services on a cost-efficient basis. I have difficulty extracting that information, and I would think that this particular report would assist me with that. Has the department moved to fulfill that obligation?

MRS. McCLELLAN: I guess this whole area is evolving, and I can repeat what I said before. Our desire is to make all of the activities, both service provisions and expenditures, as transparent and open to the public as we can possibly make them. We're looking at how we can improve that; for example, the filing of the budgets of the regional health authorities as well as the business plans. As you know, when I receive the business plans from the regional health authorities, they're filed, tabled in this Legislature. We think that that has to be improved so that not only those of us in the Legislature understand those reports but so that the general public can pick up those reports and understand them as well.

We are working with the Auditor General's department. We're in consultation with the financial management people of the regional health authorities to see how we can better report that. I can tell you, though, with a great deal of certainty that the reporting is far more transparent than it ever was in the past. Actually, the only annual reports that were filed in this Legislature previous to the change were those of the five provincial hospitals. Actually as Minister of Health I seemed to get very little information from boards and agencies and so on that were operating and expending a great deal of money in this province. So we've come a long way in a couple of years. We think we can improve it further.

Again, if the Auditor General or his staff want to comment on the work that we're doing in that area, I'd be happy to hear the comments.

MR. VALENTINE: Well, there is a great deal of effort going into the issue of financial reporting in the sector, and I certainly would acknowledge that the department is making substantial progress in this area. It consumes a substantial portion of the resources of my office. In fact, the gentleman on my right doesn't do anything but that, to my dismay sometimes. The progress is entirely dependent upon the resources available in the Department of Health, in the RHAs, and in my office. So if we get to the end of the year and we need more resources, there's another committee that I have some connection with that'll hear about that.

THE CHAIRMAN: And we all know which one that is.

MR. KIRKLAND: Well, I guess I'll continue along that line, if I might, Madam Minister. The Auditor General indicated on the next page that four out of the 17 RHAs had provided consolidated financial statements that provided relevant information. Have the other 13 followed through with those that have set that fine example?

MRS. McCLELLAN: Actually, the four, I would say, did it rather on a voluntary basis the first year. We didn't require it. As you know, the regions came into being partway through the year. You would also recall – it seems like a long time ago now actually – that they assumed the operation of the facilities that they were taking over and the functions they were taking over at varying times. You would recall that in your own area of Crossroads, the transfer of facilities happened at different times. They will all now be doing that, but 1994 was the first year. It was a transition year, so we didn't require them to do that.

9:20

The other thing is that all of the somewhere between 150 and 200 boards and agencies that were consumed by these 17 regions had acceptable accounting and reporting, but many of them did it in a variety of methods. To bring those all together and try to present a picture that was accurate would have been very difficult in that year. They ensured that all of those financial statements were audited in an approved, acceptable way and then will bring that whole financial reporting into their methodology in what would be '95-96.

THE CHAIRMAN: Thank you, hon. minister.

MR. VALENTINE: Madam Chairman, I can't help but make a comment, and it is appropriate that I do. Those four are commended in my report for having put the effort into ensuring that the appropriate financial reporting was made. The others in various forms did present information, none of which I find is of a very particularly high quality, and that's why I've been critical of it. It lacks comparability across the sector, and when it comes to adding them all together, you do not get comparability. Therefore, it's questionable what conclusions one can draw from that information. So I'm critical of it. The minister knows I'm critical of it, and I say that publicly.

THE CHAIRMAN: Thank you very much. And thank you, Terry.
Pearl Calahasen.

MS CALAHASEN: Thank you very much, Madam Chairman.

Good morning, Madam Minister. It's great to see Stan Fisher here, chairman of the Wild Rose Foundation.

However, my question is regarding regional health authorities. If you look at volume 4 of public accounts, pages 227 to 324, regarding the disclosure of salaries and benefits for regional health authorities.

MRS. McCLELLAN: The page again? I had to find the book.

MS CALAHASEN: Page 227. I think there's a problem relative to the inconsistency with respect to reporting of salaries and benefits. The question I have is on page 257 actually, Madam Minister. Capital health authority salaries and benefits are shown for all staff, but on page 290 for the Lakeland RHA only the RHA members, the CEO, and management are reported. On page 291 for Mistahia RHA there's no disclosure. Could you tell me what the reason is for this, and will it be required in future years?

MRS. McCLELLAN: A good question. This is a transitional year and probably the most difficult to get the comprehensive information for. In 1994-1995 the regional health authorities were not required to disclose compensation information because it was a transitional year. A few of the regional health authorities, however, did choose to provide some information earlier than required, and I can assure you that I encouraged them all to provide that. In 1994-1995 the regional health authorities were required to disclose salaries and benefits paid to RHA members, officers, and senior employees in the audited financial statements of the RHA's central administration division. This, I guess, is why you see again some variances in the way that's presented. Lakeland regional health authority is showing on page 290 the salary and the benefits of that division only.

For 1995-1996 and future years the RHAs must disclose compensation paid to board members by name, the CEO and all executives reporting to the CEO, or a board member by position, and various other employee categories as a group. So there is far more visible reporting, and you will see that in next year's public accounts. These requirements apply to salary and benefits. They don't include expenses for which board members or staff are reimbursed, such as travel for business. The disclosure requirement is very similar to what is required by the Alberta government for disclosures of salaries and benefits in volume 2 and volume 3 of the public accounts.

MS CALAHASEN: Just on that issue in terms of salaries and benefits. You're saying that volume 2 is where the information is regarding salaries and benefits about the specific RHAs?

MRS. McCLELLAN: The disclosure requirement that we have for the future is very similar to what's presented in volume 2, that the Alberta government requires, and you see that in volumes 2 and 3 of the public accounts. That will be the type that is shown. The information that was required in this year was required to be in their annual reports, and these were tabled in the Legislature. They also had to provide compensation information that was reported before by the former facility boards. This applied to the provincial hospitals and the two mental hospitals. I think they also report severance information in that.

THE CHAIRMAN: Supplementary, Pearl.

MS CALAHASEN: Actually, that was my supplementary in terms of where it was reported. So I think she gave me that information. Thank you.

THE CHAIRMAN: Thank you.

Debby.

MS CARLSON: Thank you. My question this time is with regard to AADAC. We've seen a significant growth in addictions over the past few years, particularly gambling addictions, and in the most recent report that was tabled here in the Legislature, you specifically identified a high-risk group as being males under the age of 40. I'm wondering if there were any dollars allocated to prevention during the year in question in your department and if they were specifically targeted to that age group.

MRS. McCLELLAN: I'll ask Leonard to deal with the specifics. There were more dollars.

MR. BLUMENTHAL: In the year that we're looking at here today, we were just really getting started. We didn't start into the problem gambling issues until January '94. During that first year we were really trying to sort out where the main problems were, and I think that's why the money was put into these things this year. We found some of that out last year in the background research we did. We're trying to pinpoint where we should be focusing and where we should be directing the most of our energy, and that's one of the areas.

MS CARLSON: Are the results of your studies available for us to take a look at? If so, could you provide them to us?

MR. BLUMENTHAL: Some of the research stuff on gambling? Sure. We can give you some of that background stuff. That's no problem.

THE CHAIRMAN: Thank you very much.

David.

MR. COUTTS: Thank you very much, Madam Chairman. I'd like to look at continuing with the Auditor General's report, Madam Minister, and particularly looking at recommendation 26 on page 134. It deals with performance measures, which I find is difficult to do at times, to come up with what is the measurement that best analyzes performance. Anyway, the Auditor General's report recommends that the department "advocate those accounting policies which best support performance [measures] and reporting by [the RHAs] and Provincial health boards." I'm just wondering if there's any progress being made to address the Auditor General's concerns.

MRS. McCLELLAN: The financial statement reporting standards for 1995-1996 were developed in consultation with the health authorities and other stakeholders. A financial directive was issued prescribing the format of those financial statements for '95-96. As I indicated earlier, in 1996-1997 we're going to require that they include the budgets. We have heard clearly that people want that information.

The other concerns that the Auditor General has raised are being addressed as we continue negotiations into redefining the reporting requirements. We have a health authority reporting requirements group that has representation from the health authorities and from the Auditor General's office looking at the ways that we refine those standards and improve our reporting.

9:30

I have to say that it is quite a challenge. We accept the criticisms that the Auditor General has raised in our transitional year, but when you move from the number of boards and agencies and bring those together under 17 regions and try and bring together all of the

various types of accounting – and they were various, although they were probably all very acceptable – it was quite a challenge in that first year. We've recognized the need to work with the Auditor General's office and in fact initiated the request, I believe. Perhaps we're the reason that the gentleman to the Auditor General's right is spending all of his time on this task, but I want to say that we do appreciate that time and assistance that we're getting.

THE CHAIRMAN: Thank you.
Supplementary, David.

MR. COUTTS: Thank you very much. In doing that redefining and when we're working with the budgets, I'm sure that'll help in performance measures. I'm just wondering if there have been any considerations to having the RHAs and the provincial health boards report on outputs rather than strictly having to deal with financial reporting and that redefining. It would seem that outputs would be a more effective way of measuring rather than just saying: here is the budget and here we spent X amount of dollars. Is there any mechanism being put in place to look at outputs?

MRS. McCLELLAN: Well, I agree completely with the hon. member. Albertans want to know the results of the spending of their tax dollars. In particular, I think they want to know and be assured that their health system is functioning effectively. I think the best way to do that is to provide clearly defined and measurable program inputs. The first practical opportunity, though, that we will have to introduce reporting of health expenditures based on those measurable outputs is 1997-98. That's because the budget targets for '96-97 use current categories, and 1996-97 financial statements then reflect those actual results related to those budgets.

Hon. members would know that we have put some performance measurements in place. We're constantly looking at ways to improve those and refine them. When we started this process, we had to look to what was available and what was generally acceptable to start this. I think we're learning every year how we can measure outputs better and reflect that in our expenditures.

There have been comments and criticisms made both by health providers and health economists that much of what we do does not create a positive impact on a person's health. We want to ensure that when we say that, we can back that up with some fact.

THE CHAIRMAN: Thank you, Madam Minister.
Peter Sekulic.

MR. SEKULIC: Thank you, Madam Chairman. Madam Minister, my questions are from volume 4, and I'll be referring to pages 246 and 257. Those are the accounts for the Calgary regional health authority and the Capital health authority.

THE CHAIRMAN: Could you just repeat the page numbers? Just give us a second to find them, Peter.

MR. SEKULIC: Sure; pardon me. It's page 246, the Calgary regional health authority, and page 257, the Capital health authority.

THE CHAIRMAN: Thank you.

MR. SEKULIC: What I'm looking at is the totals for the honoraria, and I note that there's a difference. I believe the Calgary regional health authority total is $149,000 and the Capital health authority is $366,000. I'm curious as to why there would be this discrepancy. I would have assumed that there were more similarities than there were differences.

MRS. McCLELLAN: Okay. I guess if you're looking at the actual schedule of honoraria, salaries, and benefits for the authority members, those depend on the number of meetings that a board member attended. For a variety of reasons board members may not all attend every meeting, so you'd have some variances there. I'm not sure if you are more concerned with the actual board or if you are more concerned with the salaries and benefits when you get into the CEOs and managers in that area.

MR. SEKULIC: I'm just curious as to the difference.

MRS. McCLELLAN: It's the actual boards.

MR. SEKULIC: Yeah.

MRS. McCLELLAN: I'm just trying to draw the two pages together. The costs were $149,000 in Calgary – is that right? – and Edmonton was $366,000, and you want to know why there'd be a difference.

MR. SEKULIC: I'm curious why there would be such a discrepancy between the two. I would have assumed there was a larger number of similarities than there were differences.

MRS. McCLELLAN: I think that if you look, you will see where the largest differences in that area in the Capital health authority are on members of disestablished entities. Actually, if you recall, I mentioned earlier that that was the year that the regional health authorities took over the institutions. The boards, for example the Royal Alex, may have operated much longer into that year, so they were paying honoraria and salary and benefits in those areas. There were different times that authorities assumed the operations. So if the Calgary authority assumed the operations of district 93 and the other hospitals quicker, those other boards would cease to exist. That's mainly where it would be.

THE CHAIRMAN: Supplementary, Peter?

MR. SEKULIC: Yes. My supplementary is from the same volume, page 290. My understanding is that the chair of an RHA is a voluntary position, and the total amount provided to this volunteer, the RHA chair, for the Lakeland regional health authority was $44,281. I'm just curious as to the kinds of costs that the chairman could have incurred to bring the total. Perhaps it was meetings and the costs associated with meetings, not just reimbursed to him but facilities that may have been rented.

MRS. McCLELLAN: The actual numbers relate to the number of meetings that a person will attend, and I can tell you that in that formation year, the 17 regions operated differently. That doesn't mean one was right in the way they did it and one wasn't. Some of the regions and their board or subcommittees of their boards went out to all of the communities, did their needs assessment work themselves. Some of the boards hired a company to do it for them. Actually, you will see the expenses of those boards who have long distances – and you're familiar with Lakeland; it stretches right from Sherwood Park, which is at the city limits, to the Saskatchewan border. You know the expanse of that. Obviously, they tried very hard to meet across the region, especially when they were trying to determine the program changes. In the case of Lakeland I can tell you that the chairman is very active, played a very proactive role in ensuring that he did attend a lot of those meetings, in fact probably most. That's where the real difference is. It showed up in other areas too, where it would appear that a board had a much lower operating cost, but upon review of that, which I did, I found that

that's exactly what had happened.

THE CHAIRMAN: I can certainly vouch as chairman that the chair of Lakeland visited every MLA in their constituency offices.

MR. PHAM: Good morning, Madam Minister. I would like to turn your attention to volume 2 of the public accounts, page 93. For the past several years we have heard a lot about the reduction in transfer payments from the federal government. When I look at this, there's actually an increase in transfer payments: $164 million. Can you explain why that is the case?

9:40

MRS. McCLELLAN: First of all, I have to remind you that we're talking about 1994-95 public accounts, so we're back. Yes, we have been talking about a reduction of federal transfer payments, but most of those reductions of federal transfer payments kick in this year we're in right now and in the future. The cash flows that are shown there have some adjustments in them, and Treasury officials in fact confirmed that the actual cash entitlement due to the province decreased from 1993-94 to 1994-95 by approximately $1.6 million. In fact, the reductions that we're talking about that are most significant, upwards of $300 million, begin to occur now, and some occurred in this budget year.

THE CHAIRMAN: Supplementary, Hung.

MR. PHAM: Thank you. My second question will focus on the Wild Rose Foundation. I have heard a lot of good news about this foundation. Ever since I was elected, I've heard nothing but good things about the foundation, and my congratulations to the people who run it.

I look at the general grants expenditure for the year 1995.

THE CHAIRMAN: If you could give us that page, Hung.

MR. PHAM: Yeah. On page 174 of public accounts, volume 3, there is an overexpenditure of $862,000. Can you explain why that is the case? Is it because there is an increase in demand?

MRS. McCLELLAN: I'll ask Stan to get it because I'm still finding the page.

MR. FISHER: Thank you for that note of confidence in the foundation. I think that principally the reason we were in an overcommitment was based on the accumulation of moneys that we'd had from the years before. We had budgeted $4.5 million as part of an ongoing basis, but we were allowed to carry over moneys that had accumulated from previous years. Thus we were able to go over by this particular amount. However, at the end of this particular fiscal year that ability to tap any of the reserve funds that we had for the expenditures, that door, has been closed. So why we were over in these particular amounts is that we had a reserve that had been accumulating over the last couple of years.

When we first started out a number of years ago, our funds were increased from 1 and a quarter million dollars a year to $5 million a year. We never expended the dollars as quickly in a couple of the years because it was getting up to speed. Thus it was the savings of moneys from the years before that allowed us to go over, but now we have closed that loop, and we're regulated to spending just $4.5 million per year.

MRS. McCLELLAN: If I could just add to that. I can assure members that the Wild Rose Foundation now receives far more requests than they can possibly fund within what I think is a quite generous budget. In a time of restraint we've managed to maintain that. It is difficult for the Wild Rose Foundation board to make those determinations because there are so many worthwhile projects.

I guess one of the very interesting things, if I might throw this in, Madam Chairman – we haven't spent a lot of time on the Wild Rose Foundation. I think the success of its support to the volunteer community is becoming more well known. It's well known in Alberta. I do want to point out that the Wild Rose Foundation – and I give them the credit – was able to bring an international volunteer conference to Canada, to Alberta, to be held in 1998. This is a biennial conference. I think it does demonstrate the work that this foundation has done. They competed against some very tough competition from other countries. So we can be very proud of the foundation and its work and the recognition of that work internationally as well as at home.

Thank you for letting me put that little plug in for a very good foundation.

THE CHAIRMAN: I don't think any member would object to that coming to the province of Alberta, Madam Minister. Thank you.

Terry Kirkland.

MR. KIRKLAND: Thank you. Madam Minister, I'm looking at volume 4, page 237, note 7 in particular. When I look at that situation . . .

MRS. McCLELLAN: Could you give me the volume?

MR. KIRKLAND: I'm sorry. Volume 4, Madam Minister, page 237, note 7 at the top there, pension costs and obligations. In looking at that situation, it talks about an unfunded pension liability. In this case it's dealing with the Aspen board alone. My question to the minister is: who would be responsible for the unfunded pension liabilities of the regional health authorities? I didn't extract that from that particular statement when I looked at it.

MRS. McCLELLAN: The regional health authorities.

THE CHAIRMAN: I see the Auditor General's head nodding as well in agreement.

MR. SEKULIC: There's got to be a supplement to that.

MRS. McCLELLAN: No. It's very simple. They're included in there.

MR. KIRKLAND: There is no backstopping of that particular unfunded liability, then, by the provincial Health budget?

MRS. McCLELLAN: It's the same as government employees, but we're showing their share of that in their consolidated statements. It's the employer share of that.

MR. KIRKLAND: Thank you.

THE CHAIRMAN: There seems to be general agreement and nodding heads. Thank you.

Julius.

MR. YANKOWSKY: Thank you, Madam Chairman. Good morning, everyone. The answer to my question is found somewhere, if it's there at all, between pages 227 and 324 of volume 4. I was flipping through these pages looking for severance information for

any RHA but was unable to find it. My question is: is there indeed any information regarding severance that was paid out for board members and management staff? Has that been reported?

MRS. McCLELLAN: The RHAs were instructed to report severance information in a separate schedule to the annual report. The minimum information that was required was severance that was provided to board members, the CEOs, and management positions reporting to board members or the CEOs. We did it in a separate reporting. You would recall, we asked that that information be provided because it wasn't required in that year.

THE CHAIRMAN: Supplementary, Julius.

MR. YANKOWSKY: Thank you, Madam Chairman. What is being done now? Is it going to be reported, or is it being reported?

MRS. McCLELLAN: Yes. For 1995 and 1996 and all subsequent years severance will have to be disclosed according to the same requirements as salary disclosure. That means it will be reported individually for board members and executive members and then in a collective group for managers. So this will be shown as a part of the salaries and benefits schedule of our financial statements in the future.

9:50

MR. VALENTINE: I'd like to draw the hon. member's attention to page 246. The very last line in the table presents the severance payments for one of the boards for which my office was responsible for the audit. This points out the reason that we are encouraging the department to ensure that there is a comparability of information.

MR. YANKOWSKY: Thank you.

THE CHAIRMAN: Jocelyn, do you have a question?

MRS. BURGENER: Madam Chairman, thank you. I, too, would like to just draw some focus on the Wild Rose Foundation, if I may, Madam Minister. I'm looking at page 177 in public accounts volume 3. I want to focus just a little bit on the international development program. I have had the opportunity of discussing with Stan some of the long-range implications of that, but I don't understand the question of the grant recovery, the $26,727 in brackets at the bottom of that column on schedule 1. Could you explain? That would look like a deficit in grant recovery. That's my first question. My supplement would be: what are some of the long-range implications of that grant expenditure in the international area?

MRS. McCLELLAN: Well, I can explain what grant recovery is, but I think I'll get Stan to do an explanation of the detail. Grant recovery, from my understanding, is simply: when grants are provided, if they are not expended in the nature that they were intended for, we bring them back, which I think is sound and probably well accepted by all members in this House. I mean, that can happen. A project will be defined. The funds will be raised to provide that project. Remember, these are international development projects, and a number of things can affect the ability to carry that project out, including what's occurring in the particular country. Some of the areas of the world that we work in have rather volatile political regimes, and what may be acceptable in the year you start to fund-raise might not be acceptable by a subsequent government.

I don't know if Stan could give you the actual detail on your question of the $26,000. If you need a little bit more clarification, I think the chairman would let you ask.

MR. FISHER: Madam Chairman, yes, that is exactly correct. Part of the agreement of accepting our funds is to spend the dollars in the fashion that they were awarded, and when they don't do that, we ask them for an accounting. We're very concerned about our accounting procedures for those dollars. So the minister is quite correct.

I think we're all aware that we are a global community. Albertans have always shown their caring side, their humanitarian concern for others. This program has been in effect with the Alberta government getting on to 21 years, I believe. The longer term impact is that we see there's a return to our province by way of a sharing of information. Many of these developing countries are buying Alberta technology or buying Alberta materials or buying Alberta resources, both human resources and technical resources. So we see a continued application for this program, and we see a continued use by our nongovernment organizations in our province wanting to access these dollars.

All of them are matching. These dollars are matched, here with $24,000 from the Wild Rose as a maximum and $24,000 by the group, and very often that group will be recognized by CIDA, the Canadian International Development Agency, so there's now $96,000. You can buy an awful lot of Alberta PVC piping for a water well project in a developing country around the world. Again, it shows our goodwill and good nature as Albertans, and I think that adds to the Alberta advantage, if I might.

THE CHAIRMAN: Thank you. Thank you, Madam Minister.

Because of the hour and I have no one else on the list . . . [interjections] Sorry.

Debby.

MS CARLSON: We have questions.

THE CHAIRMAN: You do? Okay. Well, there will be time for one question.

MS CARLSON: Okay.

Madam Minister, my question is with regard to the shortage of rural doctors. If we look at the Auditor General's report on page 130, he speaks to the "RHAs' responsibility for delivering . . . effective health care." I'm wondering, in a case like this, where we've had an ongoing shortage, how your ministry works with the RHAs to solve that problem.

MRS. McCLELLAN: You raise a very good point, probably one of the more difficult challenges to respond to in delivery of health services. However, I have to say that it's not a new problem. I think there's been more emphasis on it very recently because there has been a concerted and concentrated effort to improve the situation. I can assure you as a rural member that there has always been a difficulty in distribution of physicians in the province. We don't have a shortage of physicians in Alberta as a whole. We have a shortage in some areas, and we have a shortage in some specialty areas. In the areas of specialty obviously recruiting is done to try to improve that.

The area of rural physician placement is one where we made an effort to try to understand why doctors were not locating to rural communities. Those of us who live in rural communities can't understand why everyone doesn't want to live there. We found indeed in that discussion that they do want to live there.

The challenges of practice in a rural community are the other things. I can tell you, quite frankly, that for a period of time we did not train our doctors for rural practice. We kind of quit doing that.

That's not the case now. In fact, we have training of family practice medicine, and our family medicine practitioners are being recruited very aggressively by the U.S. and other places because of the quality of their training.

I can tell you that we have the rural physician action plan in place. You know that it's going into, I believe, its fourth year. We had a report card done of that initiative, and this year we have added some more dollars. But the year that we're talking about, 1994-95, was an early year in that time.

If we could finish on this subject, just as quickly as I can, I can tell you that we have increased the funding to university training. There is now a six-month rural rotation, where all students go out to rural communities. In speaking to the students themselves, they explained to me that it is not money, that it is not living in rural communities. It is primarily isolation from their peers, not isolation by community. There are some initiatives that can improve that. We've improved the opportunity for educational opportunities through distance learning. We have Telehealth and Telemedicine initiatives, pilots that show promise.

The chairman says that we have to quit. This is an area we could spend a lot of time on, but we do see some progress being made. Half of the doctors in rural communities in this province are graduates of the University of Alberta, I'm proud to say.

THE CHAIRMAN: Thank you. If there's anything further to that question, certainly it can come through the administration.

I'd like to, with permission, just revert to introductions. The Auditor General would like to introduce some staff members.

MR. VALENTINE: Thank you, Madam Chairman. I would like to thank Mei Hung, who is the manager of audits, and Doug McKenzie, who is a principal in the office, for being here this morning.

THE CHAIRMAN: Thank you for being in attendance.

Madam Minister and staff and Auditor General and staff, once again thank you very much for your very open way of addressing the questions.

Next week, Wednesday, April 3, is the Hon. Tom Thurber for Municipal Affairs.

With that, we stand adjourned. Thank you.

[The committee adjourned at 10 a.m.]