8:30 a.m.

[Mr. White in the chair]

THE CHAIRMAN: This meeting is now in order. First of all, I'd like to welcome the Hon. Halvar Jonson, Minister of Health, and ask him to introduce his staff.

MR. JONSON: Thank you, Mr. Chairman. Seated on my right is Jack Davis, Deputy Minister of Health, and on my left Aslam Bhatti, our financial director and the only person of the three who's really familiar with the '95-96 financial statements. That's our delegation.

THE CHAIRMAN: Thank you, Mr. Minister.

Also, I'd like to reintroduce to you Mr. Nick Shandro, Assistant Auditor General. I'd like him to introduce his staff he brought along today.

MR. SHANDRO: On my right I've got Doug Wylie, who's an audit principal. He's had a major part to play in the audit of the health sector. As well, on my left is David Henderson, who also had a major part to play in the audit of the health sector.

THE CHAIRMAN: Might we have approval of the agenda that was predistributed? Would someone like to move the same? Julius is waving his finger.

MR. YANKOWSKY: I didn't receive an agenda, sir.

THE CHAIRMAN: I'm sorry?

AN HON. MEMBER: Me neither.

THE CHAIRMAN: You've not received a copy of the agenda? Perhaps we could have a five-minute adjournment on a motion?

MR. SHARIFF: Yes.

THE CHAIRMAN: Moved by Mr. Shariff, a five-minute adjournment.

[The committee adjourned from 8:32 to 8:33]

THE CHAIRMAN: We're back in session. Thank you.

MR. ZWOZDESKY: I move to approve the agenda as circulated.

THE CHAIRMAN: The agenda has been moved. Is it agreed?

HON. MEMBERS: Agreed.

THE CHAIRMAN: Those contrary minded? There being none, it's carried.

We have a motion that was tabled by Ms Blakeman. There are two parts to the motion. One part of the motion, the second part, and I quote, "to assess any government decision to privatize these entities prior to privatization," implies that the decision would be made by this committee prior to a decision being made. That is not the calling of this committee, and that portion will have to be ruled out of order. The mover is able to move the motion as it's put so long as the mover's aware that someone else will have to then amend the motion, otherwise it will be out of order. It's up to the mover whether she wishes to move it or to lay it over.

MS BLAKEMAN: Could I withdraw it?

THE CHAIRMAN: You could withdraw it, or you can lay it over. You can move it and have it tabled.

MS BLAKEMAN: I'll withdraw it and re-present it.

THE CHAIRMAN: Agreed. The motion is simply not put, actually.

We have nothing further to do other than to commence with an opening statement by the minister, if you wish.

MR. JONSON: Thank you, Mr. Chairman. Good morning, members of the Public Accounts Committee. I'll just make one comment, and that is that I do recall being on public accounts for quite a number of years, so I appreciate the work you have to do.

Mr. Chairman, during 1995-96, which is the fiscal year we're discussing this morning, we saw some of the most significant changes to health service delivery in Alberta in decades. The changes that took place posed both tremendous challenges and opportunities for the health system and for Alberta.

As a transitional year in the overall restructuring of the health system, there were significant pressures on the relatively new regional health authorities as they moved to consolidate hospital-based programs and reallocate resources to meet growing demands for home care and other community-based services. As a government we responded to these demands on the health system by adjusting our provincial spending targets to address clearly defined needs. We canceled a planned $53 million budget reduction for regional health authorities. We provided additional funding to relieve pressures on waiting lists for cardiac and joint replacement surgery and provided $40 million in new funding to support a further shift to community-based services.

Despite the challenges and pressures, however, progress was made during the year, progress in making our health system more efficient, more affordable, and ultimately more effective in meeting the health needs of Albertans.

Total spending for 1995-96 was $3.659 billion, which included $106 million in supplementary estimates which were required to meet increased service demands. Of this amount, $50 million was used to offset a shortfall in premium revenues resulting from more Albertans receiving full or partial premium subsidies. Our actual spending in 1995-96, the last year of health spending reductions, was $176 million less than 1994-95. Had expenditures continued, however, at historic rates of increase, expenditures in the 1995-96 period, which takes us up to 1997, could have been close to $5 billion.

In relation to spending, one of the key successes of the year was in our efforts to reduce administrative and overhead spending and direct more of these dollars into direct health services. Between July of 1994 and July of 1995 regional health authorities reduced administrative staff levels and costs by 20 percent. At the same time we were able to downsize the Department of Health by 126 full-time equivalents. These savings were obtained through increased efficiency in operation, divestiture of direct service delivery components to regional health authorities, and outsourcing of some administrative and support functions. Overall these accomplishments helped to substantially reduce administration costs and allowed more money to be directed to where it is needed most, and that's helping people stay healthy and providing health services when they are sick.

As I've mentioned already, one of the key initiatives in the restructuring of our health system that was particularly important in 1995-96 was the continuing shift to a greater focus on home and community care. Advances in medical technology, new treatments

in drug therapies have meant that many procedures that used to require lengthy hospital stays now require very short stays or, in many instances, can be done on an outpatient basis.

As well, Mr. Chairman, most Albertans would prefer, wherever possible, to be able to remain in their own homes and communities rather than being confined to an acute or long-term care facility. The $40 million we allocated in 1995-96 to regional health authorities allowed for that necessary enhancement and expansion in community-based acute, long-term, and palliative care services. For example, in 1995-96 close to 63,000 Albertans received home care services compared to just 55,000 in 1993-94, an increase of about 12 percent. The number of personal care hours provided to Albertans was up by 66 percent compared to 1993-94, while professional care was up by 13 percent.

In addition, Mr. Chairman, to assist Albertans with some very specific needs to remain independent in their own homes, the provision of short-term oxygen supplies at home was made a regular benefit under the Aids to Daily Living program. An additional $1.4 million was provided for an innovative home nutritional therapy program to support Albertans who can safely receive intravenous or tube feedings in their homes.

A further significant step in the enhancement of community-based services taken in 1995-96 was the establishment of the community rehabilitation program in all 17 of the health regions. The program provided for the co-ordinated delivery of services to Albertans requiring intensive rehabilitation, improved access for high-priority clients, and ensured access in all parts of Alberta to audiology, occupational therapy, physical therapy, respiratory therapy, and speech language pathology. A total of $40 million was distributed among the 17 regions to establish or expand these services, and the establishment of the program made Alberta the only province in Canada to provide a comprehensive community-based rehabilitation program for a defined clientele.

Mr. Chairman, along with the increased emphasis on home and community care, however, we also recognize that with a growing and aging population comes increasing pressure for continuing care services. Therefore, during the year we launched six innovative continuing care demonstration projects, delivered at 12 different sites across the province, to further enhance individual choice and the ability to remain independent in the community for as long as possible. The projects, which included services such as assisted family living and transitional care programs, will help many Albertans avoid or delay institutionalization. In the past far too many Albertans faced institutionalization as their only option when they became too frail or ill to stay in their homes. These projects and other initiatives of a similar nature provide alternatives and help Alberta maintain its position as a recognized leader in the development of innovative continuing care models.

As an integral part of the restructuring and transition of the health system, we also recognize that such significant change would have an impact on Albertans, both those working in the health system and those accessing health services. To ease the transition for individuals in communities affected by restructuring, the workforce adjustment program was established in 1994-95, a joint initiative of employers, labour, and government over three years. Much of this program was delivered in 1995-96, the year we are dealing with. By the end of March 1996 nearly 4,500 health workers had received assistance through the program.

Mr. Chairman, to help ensure that Albertans using our health system had input in the nature of changes and the ability to comment on the effectiveness of change, we took two initiatives. First, we established a standing policy committee on health restructuring to co-ordinate all aspects of health care policy development in government. It ensured that health care stakeholders had a one-window approach in terms of assisting government in developing health care policy. Second, we established the 16-member Provincial Health Council to consult with Albertans and provide arm's-length monitoring of the overall performance of the health system.

Last, Mr. Chairman, to ensure that we continue to receive direct feedback from Albertans, we continued in 1995-96 our annual Alberta health survey. Four thousand adult Albertans were surveyed, and it is very important to note that even in the midst of the health restructuring and during a year of significant change, 86 percent of those surveyed rated the quality of care they had received in our health system as either good or excellent, and 76 percent rated health services as easy or very easy to access in their communities.

8:43

In closing, Mr. Chairman, I want to emphasize that 1995-96 was indeed a year of substantial progress in health system changes and restructuring. It was a year during which very significant steps were taken in establishing a health system that provides all Albertans with access to high-quality health services when they need them.

Thank you for your attention. Perhaps we can proceed, Mr. Chairman, to questions with respect to the accounts.

THE CHAIRMAN: Thank you, Mr. Minister.

Mr. Zwozdesky first.

MR. ZWOZDESKY: Thank you very much, and thank you to the hon. minister for his overview. Best wishes for success in implementing all of that over the next few years, Mr. Minister. And thank you to the Auditor General's department for being here.

I want to begin this morning's public accounts questions by referring to the Auditor General's report for '95-96, page 121, dealing specifically with recommendation 16. In a brief overview I would just say that one of the things I consistently hear a lot about in my constituency and, indeed, as I travel the province, Mr. Chairman, is with regard to accountability of the Health department in terms of the types of services it provides and the type of performance information, if you will, that comes back to the public and making sure it's in some understandable and, perhaps, measurable terms. Following up on one of the comments made in the first paragraph under recommendation 16 is reference to the fact that "information for accountability, governance and operating purposes is not yet complete or integrated." I want to ask the minister, and perhaps have some comment from his staff as well if necessary, what steps he or the department has taken in conjunction with our regional health authorities to develop a reporting framework that provides the type of information the public can understand and digest in relation to accountability, governance, and general operations.

MR. JONSON: Mr. Chairman, first I'd just like to indicate that we certainly accepted that particular recommendation from the Auditor General. I'll mention three or four initiatives which fit together and respond to that particular recommendation, and then perhaps Aslam or Jack can comment further.

First of all, we are in the process of working with the RHAs and stakeholders in developing an accountability framework, as we refer to it, which would deal with who is responsible for what in the health system and making sure that is clear. The logical extension from that, of course, is that there are performance measures established and reporting mechanisms back to government, back to this Assembly and back, of course, to the public on how well we are doing.

The second thing is that we know that we needed a modern and

better system of gathering information on the health care system. I think members have heard me refer in question period and other places to the major initiative under way to develop an information system based on modern technology which is available to us now.

Thirdly, we have made a number of changes in conjunction with regional health authorities in terms of their business plans and reporting requirements so that there is consistency and they are reporting on the same things so comparable data and overall data will fit together. We can use that to better account for our performance in the health care system, account for dollars being used in the right places.

Perhaps, Mr. Davis, you would comment further.

MR. DAVIS: In addition to the accountability framework, as the minister indicated, we are also working on associated standards that would relate to the overall accountability framework, sort of macrostandards for the system. Those standards are being developed by a broad-based stakeholder committee. They will have specific targets and performance measures related to them. We're doing external benchmarking as well in terms of setting the targets. We do have a performance measurement section in our current business plan, but we're hoping to improve that in the upcoming plan. All of this will be greatly assisted as we move forward with better information gathering through the information technology initiative that's also under way.

Aslam, you may want to speak just briefly about the financial changes and the financial reporting.

MR. BHATTI: Sure. In terms of mechanisms for the reporting requirements, you have your health authority business plans, which they submit to the Minister of Health for approval. We're currently reviewing that for the coming year, and the minister will be going through the process of approving that. It is laid out in the plan for the health authority for the next three years as to what they need to spend to provide services to the residents within their region.

Along with that, coming in September will be the annual report of the regional health authorities for the work done in the previous fiscal year, '96-97 in this case. That will be tabled, and you'll have information on what they have planned and what they have done. So that's another reporting framework.

Another framework would be the audited financial statements of the regional health authorities that will indicate the financial viability of the RHAs, where they stand and, by expenditure categories, where they're spending their money. That also will be available in September along with the annual report, and it will be tabled.

MR. ZWOZDESKY: Just a brief follow-up. I guess a logical extension of that would be for the department, perhaps in conjunction with the Auditor General's department, to look at what type of value we're getting for the costs associated with the services we're providing. I think you've sort of alluded to that. Two quick things here: one is whether or not the components of the reporting guidelines that you provide or expect from the various RHAs could be made available in relation to performance information as suggested; secondly, whether or not it would be possible for the regional health authorities to perhaps issue some form of, say, quarterly reporting so that we would know whether we're on track or perhaps slightly off track. That would be very helpful. Could those both be released to us and to the public?

MR. JONSON: The answer to the question is yes.

MR. ZWOZDESKY: Okay. On both?

MR. JONSON: It's under way right now in terms of the quarterly reporting. That's something we're initiating as well.

MR. ZWOZDESKY: Oh, good for you. I'm encouraged to hear that. Thank you, Mr. Chairman, and thank you, Mr. Minister.

MR. JONSON: I would make one qualification, and that is that with this being in its developmental stage, I would not be able to commit right now to getting all the quarterly reporting out in some type of public report, but certainly the information on the overall performance of the year, yes. We are working on establishing that quarterly reporting so that we can try and pick up any difficulties much sooner than waiting until the end of the year.

MR. ZWOZDESKY: Will you bring it into the House, or will you be releasing it in some formal fashion in the House?

MR. JONSON: Quite frankly, Mr. Chairman, we haven't thought about that particular issue as far as the quarterly reporting is concerned. This is something we felt necessary for our management of this, working with the RHAs to manage the system. But with respect to the overall annual reporting, certainly.

MR. DUCHARME: Good morning, Mr. Minister.

MR. JONSON: Good morning.

MR. DUCHARME: Page 83 of public accounts, volume 2, reflects a $14.9 million surplus in the department's operating vote. However, the department received additional funding of $102.9 million through supplementary estimates. It appears that the department may not have required all the additional funding due to the existence of the surplus. My question is: why were these additional funds not utilized?

MR. JONSON: Mr. Chairman, the supplementary funding that I referred to in my opening remarks, and which is certainly, of course, an important point or item in the public accounts, was to address mainly certain specific, as I referred to them, pressure points in the system. The largest amount, as I recall, was the amount allocated to RHAs for cardiac and joint replacement services. The funds were utilized for this purpose. We also had the $14.9 million premium shortfall in terms of collections. I'll ask Aslam to deal with this specifically. But what occurred, I understand, is that when you are dealing with the budget and you want an increase in a particular designated program line, you need to identify that and get it approved. The $14.9 underexpenditure Aslam can comment on.

8:53

MR. BHATTI: Basically you have premium revenues. Any time you have a shortfall in premium revenues, you make it up from your operating expenditure. The reason we had a shortfall in premium revenues was that there were more people qualifying for premium subsidies in terms of full premium subsidies as well as for partial premium subsidies.

Overall in the department when you add the revenues and the expenditures together, the balancing aspect for '95-96 was $24,000. So in terms of having a budget of approximately $3.6 billion, at the end of the day we left on the table $24,000 in terms of expenditures.

MR. DUCHARME: You made reference in regards to the shortfall of the $14.8 million in the health care premium revenue. Has anything been done so that we don't face this situation again in the future?

MR. JONSON: Well, that's certainly a valid point, Mr. Chairman. I'll ask Aslam to give us the information as to how we make our projections. The only thing I would suggest is that when you're dealing with the impact of changes in subsidy programs, population growth or decline, but particularly where you make a commitment – and I think this is particularly relevant to Community Development with the seniors' program. Where you make a change in policy which reduces your premium revenue, it's sometimes hard to predict the exact impact that's going to have in numbers.

Perhaps Aslam could comment further.

MR. BHATTI: Certainly. Premium subsidies are based on income levels, and those income levels are determined by your income tax level for the previous year. When we're budgeting, we're budgeting for the future, so we're basing our information on two years back in terms of actual information on Albertans' income. You need very few Albertans' income to change to affect the premium revenue calculations. For instance, in the year '95-96 – we were discussing this – the number of registrants that we had figured would get partial subsidies was 146,000, and in fact 153,000 received premium subsidies. The impact of that contributed to the $14 million shortfall in collections. In terms of full premium waivers, we estimated around 4,300 would receive it and in fact 5,400 had received it. So a small change in population shift based on two years of past income can affect it that way.

We're working on averages of the last five or six years just to see where the trend is going. As our economy improves, this will significantly impact our revenue calculations in the sense that the shortfalls will not occur again. More people will have the ability to pay their premiums.

THE CHAIRMAN: Ms Blakeman.

MS BLAKEMAN: Thank you, Mr. Chairman. Welcome and thank you for attending. Thanks to the Auditor General folks for coming back. I apologize for making you all suffer through this wretched cold with me. I hope I'm understandable.

My first question. The reference is page 135 in the Auditor General's report. It's with regard to guidelines for tendering out services. The Minister of Health requested the office of the Auditor General to prepare draft guidelines to be used by the health authorities. The '95-96 report stated that the Department of Health has reviewed these guidelines. My question is: were the guidelines approved?

MR. BHATTI: We've been working with the Auditor General's office on preparing the guidelines, and we've just reviewed the final draft aspect of it. Perhaps I can ask Nick to comment.

MR. SHANDRO: Right. We finalized them with the department. At this point in time they're being circulated, I believe, through your office, Aslam, to the RHAs for any comments they may have.

MS BLAKEMAN: Will these be made public or circulated in any way?

MR. BHATTI: Yeah, certainly we can make them public.

MR. SHANDRO: I think the intention is to issue them, and of course by that time they will be public.

MS BLAKEMAN: Excellent. Thank you.

MR. SHARIFF: Thank you for being here, Mr. Minister and your staff and the Auditor General's staff. I feel very confident in reading some of the budgets here today. I do have a question pertaining to governance, and it's on page 118 of the Auditor General's report. Recommendation 14 indicates that the Department of Health should, with participation of RHAs, review their progress in establishing effective governance structures. It is noted that the same recommendation was repeated from '94-95. What is your responsibility to ensure there is effective governance within the RHAs, given that they collectively administer approximately $2.3 billion in health care expenses?

MR. JONSON: Mr. Chairman, again it certainly was a recommendation that was agreed to and accepted by Alberta Health actually with some enthusiasm. We have, I guess, all told three interrelated initiatives under way. First of all, the department has recently provided for a session with all the regional health authority members where the issue and the discussion was governance as opposed to the issues of the day, which are often what we have meetings over. Also the regional health authority chairs meet throughout the year where they are looking at how things are going from a governance perspective.

We have under way what we refer to as – we have two parallel initiatives. One is we have a governance review. We have a Mr. Cuff who is heading up a round of visits and discussions with respect to looking at the whole governance structure of RHAs, looking at how it's working, how we might plan to improve it and perhaps make it a little more structured than it currently is.

We also have under way parallel to that what we refer to as our Best Practices review. Discussions are being held with individual RHAs, getting them, instead of concentrating on the day-to-day issues and problems, as we all do when we sometimes get on board and so on, to sit back and look at what is working in the global context and what isn't and address the problems and enhance and promote the things that are working well. Our ultimate goal there is to bring together an overall report from all the RHAs where we can indicate the successes, the things that are working really well, some of the problem areas to be addressed.

So without rambling on too much further, Mr. Chairman, those are some of the initiatives we have under way. I don't know if you wanted to add, Mr. Davis.

9:03

MR. DAVIS: I think the government's review will attempt to more clearly define the roles of the board chair and the administration, the CEO/board orientation that the minister spoke of. This is the first time we've run these sessions, and the plan is to assess how well those sessions actually went and build a sort of ongoing board/ CEO orientation package that would be available as new boards come into existence after the appointment and election process. So we're really trying to tie the governance structure to the training and orientation.

MR. JONSON: It might be of interest to members that in this overall effort in addition to our own expertise or leadership in the department we have engaged the advanced school of business to assist us with that overall effort. They, of course, as I think everybody would agree, are very highly regarded in terms of these matters.

MR. SHARIFF: The Auditor General goes on further on page 119 to indicate that the department now needs to assess if the system used for governance addresses all critical issues related to governance. I'm just wondering if you can elaborate whether these critical issues have been identified and how they will be incorporated in governance.

MR. JONSON: Mr. Chairman, the answer would be that we're not to the point where we have our final report from the governance review that I just referred to headed up by Mr. Cuff. I don't think we can ever say that we've covered everything, you know, all the possible issues, because there'll be more that come up next year. I think that we have put in place a process which is nearing completion, at least for this year, where we will have a report back where deficiencies or places where we need to strengthen the governance structure are identified. We would certainly follow up on that, but we don't have that final report just yet. It should be in our hands within a month.

MR. SHARIFF: If I could just end on this question then: did the Auditor General have any specific issues in mind when this statement was made?

MR. SHANDRO: Yes. In our work with the regional health authorities we notice at times that the process sometimes at the board level consists largely of reviewing rather than assessing what the principal risks might be. In other words, they don't sometimes establish processes that would help them identify what the principal risks might be, what systems they have in place to mitigate against those risks. It's not their place, in our view, to develop those systems, but it's their place to make sure that such systems exist. So they should have appropriate processes for them to be confident that the risks inherent in their operations are being mitigated by management and the systems that are in place.

I think, also, that sometimes the communication policies and the like are not well articulated between what management are responsible for and what the board is responsible for. That in turn, I think, leads to further risks at the organizational level.

MR. JONSON: In keeping with the last comments, I think it was in answer to the first question that Mr. Davis was pointing out that as part of our overall accountability, we're looking at clearly defining the roles and responsibilities within the RHAs. Then there are really three components that flow from that, our work that we've been doing with the RHAs on strategic planning. What comes from that, of course, is the emphasis that we're putting on the development of the business plans. Then the anchor to all of that is the performance measures that they will measure their efforts against. So we do feel we have a logical sequence of initiatives under way.

THE CHAIRMAN: Dr. Pannu.

DR. PANNU: Thank you, Mr. Chairman. My question to the minister is on recommendation 15 from the Auditor General's report, on page 120. The recommendation calls on the Department of Health to

> implement a framework that allows health authorities to provide health services that take advantage of the best practices for providing quality care.

In making this recommendation, the Auditor General draws attention to a lack of provincewide focus, the development and availability of these guidelines. So I'd like the minister to comment on that, to perhaps report what steps have been taken in response to this observation.

The related observation made on the same page, page 120, calls on the department to

> collaborate on a process that will support decisions on the appropriateness and effectiveness of medical services on a Province-wide basis.

Have the department and the minister taken initiatives to enroll frontline health care workers in developing this collaborative process?

On page 121, part of the same recommendation, the top point there, the first point: what areas of treatment have been identified where improvements would be needed for the development of such guidelines?

MR. JONSON: There are two things. In responding – I think it's recommendation 15 we're referring to here – first of all, I just want to repeat that in the process that I referred to earlier of setting up health authority business plan requirements, the document that sets those requirements includes the requirement that health authorities begin to examine current programs and services in terms of the quality of the service provided.

A more direct answer to your question is that we have under way an initiative with the Alberta Medical Association, and as I recall, there's a multidisciplinary group working on developing and expanding our current capacity as far as having clinical practice guidelines for different medical services. These then become I guess you'd call it a framework or a standard for ensuring they are providing quality in those particular areas. Now, in terms of a specific area I guess the example that I've become a little bit familiar with is the whole area of cardiac surgery, where there do exist clinical practice guidelines, I think, even at the national level. We're working on establishing them, refining them at the provincial level. Perhaps Jack might elaborate.

MR. DAVIS: We've just had one issue done, treatment of ankle sprains, that relates to what's X-rayed and what isn't. These clinical practice guidelines are seen as a very positive initiative by the medical profession. They're voluntary in terms of whether they're fully complied with by the practitioners, but they do provide a guideline, as the minister says, a standard of care that emphasizes both efficiency and also best possible outcomes and not using unnecessary procedures. I was made aware of a guideline the other day on treatment of ulcers as well using certain medications, and it was pointed out to me that through the use of these guidelines and new medications, we've essentially eliminated the need for surgery relative to ulcer treatment. There are some real positives in this area, but it is a slow grind because it requires a lot of stakeholder involvement and input to produce a guideline.

DR. PANNU: Thank you.

THE CHAIRMAN: Mr. Yankowsky, please.

MR. YANKOWSKY: Thank you, Mr. Chairman. Good morning, Mr. Minister and staff. On page 402 of volume 4 of the Public Accounts the 1995-96 statement of operations and changes in the fund balances for the Palliser health authority reference is made to both an operating fund and a capital fund. The question coming out of all this is: is having two separate funds an effective and efficient way to fund RHAs?

MR. JONSON: I would say yes, Mr. Chairman. I think it's fairly common and necessary to have the two categories, but Aslam is the accounting person, so he would give you a better answer.

9:13

MR. BHATTI: Well, currently there are the operating funds and the capital funds. The capital fund pertains to moneys for capital construction as well as equipment purchases and so forth. The operating fund, which is the vast majority of it, is for delivery of services. Now, we are working with the Auditor General's office, because one of their recommendations deals with combining these in the presentation of the financial statements. Perhaps Nick would

like to comment on the different match methods in terms of bringing the statements together.

MR. SHANDRO: Right. If you remember, for the last two years the regional health authorities have been reported as having significant losses in the press. The reason that these amounts have come out and been reported as losses is because there's not a matching of revenues and expenditures. Let me say that had government provided grants to a for-profit organization, the accounting would have been different. They would not have been using fund accounting, and they would have been matching the revenues with the expenditures in order to set the bottom line in a way that is useful for comparing whether or not your revenues are covering your expenditures.

The fund accounting method that has been used in the not-for-profit sector for a very long time has been deficient in that it's very difficult to tell whether your revenues are covering your expenditures, because there's a mismatch of revenues and expenditures between period. It is for that reason that we recommended a new method that has been recommended by the Canadian Institute of Chartered Accountants called the defer and match method, which then provides suitable information to determine whether or not revenues are meeting expenditures within a period. So as of next year the department has provided directions that they are to use the matching principle in accounting for all revenues.

MR. YANKOWSKY: Mr. Chairman, my supplementary may have been partially answered. When I peruse this, it appears that all our RHAs are reporting somewhat of a shortfall in their capital funds. The question here is: does this mean that they are maybe not receiving an adequate amount of funding for their capital expenditure?

MR. JONSON: If I might just clarify, Mr. Chairman. You said: a shortfall in their capital funds?

MR. YANKOWSKY: Yes.

MR. JONSON: Aslam can answer that.

MR. BHATTI: No, that doesn't mean that they're not receiving sufficient funds. What's reflected in the capital fund is the depreciation of the capital assets. The way the government funds capital construction right now is that they provide it when the facility is to be replaced, so in fact the revenue is represented in the year that we provide the funds rather than amortizing it over the life. With the new method that we're going to, that will smooth out, and that's what Nick was referring to in terms of the treatment.

THE CHAIRMAN: Mr. Zwozdesky, please.

MR. ZWOZDESKY: Thank you. Just flowing partly out of the questions I asked earlier, I want to direct the panel to pages 124 and 125 of the AG's report, specifically recommendation 18. There are a number of points here, Mr. Minister, that I would hope you and the Auditor General will address.

I note, for example, that going back to the previous year's reporting, '94-95, and certainly in this current reporting year of '95-96, there have been a number of references made to developing some consistency in the type of financial accounting or financial reporting that is necessary across the system for comparative reasons, efficiency reasons, and so on and the inability, I guess, of the restructuring to sort of catch up with itself in the short period of time that it's taken place. There have been delays which presumably have resulted in extra costs, perhaps some problems with service delivery. I note that some deadlines were missed in that reporting, that some incorrect information was also cited, and that there are problems in categorizing some of the expenditures. I would conclude by saying that on page 126 the Auditor General says that

> health authority staff are experiencing difficulties in classifying expenditures on a basis which can be compared among regions. This matter has not yet been resolved.

So I'm wonder if the minister and perhaps the Auditor General could comment on what it is that you've done specifically now to address the concerns that I just raised and to perhaps help the RHAs comply with the recommendations in the effort of presenting better reporting and understandable reporting.

MR. JONSON: Well, Mr. Chairman, the short answer is that, yes, we have accepted that recommendation; we've followed up on it. I referred earlier to the work that's gone on and is pretty well complete in terms of standardizing our approach to the format for business plans and for financial reporting. In terms of the specifics of where we're at and what might be outstanding issues, I'll ask Mr. Davis.

MR. DAVIS: One comment I should make is that we've fully accepted all of the recommendations and advice from the Auditor General, and we're in the process of implementing those recommendations. We've instituted quarterly financial reporting. We've implemented, as I say, most of the major recommendations and guidance from the Auditor General's office. We've established a position in our financial area that deals specifically with financial reporting by RHAs, so we can actually work on this with them on an ongoing basis notwithstanding the fact we're requiring more frequent reporting.

I think it's important to note here that we're moving from a system where we had financial reporting through a myriad of boards and entities – hospital boards, public health boards, et cetera, et cetera – to what is referred to as enterprisewide reporting for 17 very large, complex regional health authorities and two provincial health authorities, the Cancer Board and the Provincial Mental Health Advisory Board. So there is quite a challenge as you merge all of these financial systems from the myriad of boards and entities that were there before.

I think we've got some solid advice from the Auditor General. We've got a good focus on accountability, and I think we're making some good progress in this area finally. I don't know, Aslam, if you want to say anything.

MR. BHATTI: I think Nick wants to add to it.

It is an evolutionary process. Mr. Davis has mentioned that we brought 160-odd entities together and they reported expenditures according to the business that they were delivering in the localities that they were delivering for their clientele. Now, to standardize that, we have doubled up expenditure categories which all of them will be reporting on, but that is not a given set to be continued forever. As we get more into outcome measurements and so forth, those categories will start to match more as to what we want for our dollar value versus just saying salaries, you know, acute care, and so forth. We are working with the AG's office to promote that type of thinking within the RHAs as well as working with the RHAs to double up those categories. It will take three to five years to do that.

MR. SHANDRO: I wanted also to say that '95-96 was the first full year of operation by the RHAs. There were a number of predecessor organizations with a variety of accounting practices and understanding of accounting, different levels of expertise and so on.

Some of the issues that we had to face in coming up with an accounting standard were very, very difficult indeed. I think that the piece reflects the difficulty that we ran across. There were some delays of course. I'd hoped that it would have been easier to handle had we started out a little earlier in addressing these. At the same time, I want to say that it was a very complex exercise to put this together. I have a great deal of respect for the system having been able to do this even though we do point out the difficulties that we went through.

By the way, I also wanted to say that the department now has had two of our employees in their department, and we'll carry on.

9:23

MR. ZWOZDESKY: Yes. Thank you. I think we all appreciate the massive undertaking of restructuring that's gone on, and we all understand that some of that to a greater or lesser extent was even necessary. I do want to say, Mr. Chairman, that I note that the Auditor General has said in his comments, too, that significant progress has been made. We are moving toward a more standardized format of the generally accepted accounting principles and preparation of financial statements.

I wanted to specifically ask: with regard to the directives that are placed before the RHAs in relation to this point, have you now, first of all, placed those instructions to the RHAs? If so, what type of instructions have you given them to ensure this compliance? I think I heard some reference to it perhaps taking three to five years to implement. I'm just wondering sort of where we are at now. Have you at least drafted the basic directives and said to the RHAs: here's what the instructions are, and here's how we expect you to go ahead in complying with this particular recommendation from the Auditor General?

MR. JONSON: The short answer is yes, Mr. Chairman.

MR. ZWOZDESKY: It's been done now?

MR. JONSON: In terms of the initial directions, yes, that's done. The point that the Auditor General's department makes, however, of course is that this is going to be something that will take three to five years to refine. Then by the time we get to the end of five years, I'm sure there'll be other issues. It's going to be, you know, a year-by-year adjustment process. In terms of I guess the basic directions as to where we're headed, yes.

MR. SHANDRO: The directive was issued approximately five months earlier this year than it was last year. So I think it's been issued on a timely basis. However I want to also point out that as instructions are provided, unanticipated circumstances arise. For example, we've just had a new pension valuation that was totally unanticipated that we're going to have to be dealing with as we speak.

MR. JONSON: Although I think the Auditor General and ourselves and the RHAs would agree that we don't mind the news that we received on the pension liability because it's been a significant improvement, so that kind of change you don't mind too much.

THE CHAIRMAN: Some say that actuarials can come as angels at times.

MR. LOUGHEED: Page 81, public accounts, volume 2, looking at element 2.2.4. It refers to the Blue Cross nongroup benefits. There's a surplus there of $17 million, and there is supplementary funding of about $9.3 million. You end up with a surplus yet requested supplementary funding. The question is: how did that happen?

MR. JONSON: As I understand it, the way it's reported here, there was a $17 million surplus in Blue Cross nongroup benefits, but that surplus does not reflect the fact that there had to be an adjustment made over to the ambulance services program, a payment I believe of $9 million. As far as the supplementary estimate request, it's based on the pricing information and expenditure trends at the time, and it was at the time anticipated that increases in utilization and the prices for drug benefits would be higher. These increases did not occur and the surplus arose, as you have identified.

It's again an issue where we agree that in a more perfect world or in a situation where we had the data to anticipate and project right on the dollar, we'd prefer it to be that way, but it was a case where the best projections were out. Aslam might want to comment further.

MR. BHATTI: With the drug program budget, on a weekly basis we monitor the ups and downs in terms of utilization. When new drugs come on, it skews the utilization level because there's a large uptake at the beginning and then there's a falloff and so forth. When we did supplementary estimates, we were basing our information on seven or eight months of actual expenditures to that time and then went through supplementary estimates assuming that if the worst case scenario came along, this is what we would require. Of course we want to make the allocation in the worst case scenario in this case, which we did, and then it didn't materialize in the last three months of the expenditures. Expenditures dropped off.

MR. JONSON: One of the activities which relates to this specific matter of the drugs is that it's our policy to receive the report and recommendations from our expert drug committee in terms of authorization of new drugs, delisting of others, authorization of substitute drugs, and so forth twice a year. One is usually in April and the other in October or November. Because of the way our fiscal year works, it's hard for the department to assess the impact of that second announcement, because at that point in time we're developing our business plans, our budget projections, and so forth. Sometimes, as Aslam has pointed out, we can be projecting on the positive or negative side.

MR. LOUGHEED: A supplementary question then. Over to page 82, 3.3.20, dedicated program funding. Maybe the answer is similar for different reasons. But you've got a surplus of about $36 million, and back in March a supplementary estimate of about 11 and a half million dollars was requested. The reasons behind that occurring?

9:33

MR. JONSON: Aslam, would you specifically . . .

MR. BHATTI: Certainly. At the beginning of the year in the dedicated program funding we had certain programs we were delivering from within the department and providing moneys to the RHAs directly. As the year progressed, we transferred those programs to the RHAs to manage themselves and provide the money. The way the public accounts work is that you start off with the estimates as approved by the Legislature and the actual expenditures. It doesn't take into account adjustments of programs during the year. So about $18 million to $20 million in dedicated programs was actually provided to the RHAs. That in fact is not a surplus. You will note under the RHAs that there is an overexpenditure because of the fact that they don't indicate the receipt of these funds as well.

As well, we had certain funds for systems development with the regional health authorities and bringing the RHAs together to decide

on common information systems. We did not receive this as quickly as we had hoped to, and that resulted in a surplus in our budget.

MR. JONSON: I wonder, Mr. Chairman, if I could introduce three people in the gallery, because they were referred to. We have Mei Hung and Shaukat Moloo, two individuals that are now ours and were part of the Auditor General's staff, and also Lorraine McKay, who's a continuing member of our staff and is the liaison person with the Auditor General's department. I'd like to introduce them to the committee.

THE CHAIRMAN: Thank you.

Ms Blakeman, please.

MS BLAKEMAN: Thank you. The reference page is 81, and it's regarding vote 2.3.2, the rural physician action plan. This is an issue that's come up a couple of times in my constituency. It's indicated that there was $173,000 unexpended in this area. I'm wondering if the minister could explain why the money was unexpended. Given the problems we're having finding physicians that are willing to relocate in rural Alberta, why wasn't the money used for recruiting fairs or promotion of some kind, other initiatives or foreign qualification candidates? We're now looking – this is the second one in a short period of time – at a crisis in the Redwater hospital. Why wasn't the money expended to do more recruitment or do something with it?

MR. JONSON: Well, first of all, in the rural physician action plan we work with the College of Physicians and Surgeons and the AMA, and while I certainly agree – and I think you've heard me agree before – that we do have an issue in this area, we're looking to do more. But it is a matter that has to be approached carefully and has to be done in co-operation with regional health authorities, particularly the doctors. For the loan remission program, for instance, or for the assignment and obtaining of a locum force to go in, we have to work with the Alberta Medical Association, and they always want to establish certain criteria, quite frankly, for eligibility for this program so it doesn't appear that some of their profession are getting advantages over other members of the profession without there being certain criteria to be met.

The overall point I'm making here is that the various sites and various individuals involved in the rural physician action plan have to meet these criteria, have to be approved; therefore, it's not a matter of us just being able to spend exactly what's in the budget. You've got to have X number of approvals, and you have to pay at certain rates and certain amounts. So yes, we have $173,000 left over, and I don't think we left any recommendations on the table from the AMA and others by doing that.

What I'm saying is: as I understand it, with the $1.679 million we were able to meet all the approved situations that came to us, and there was that little bit of money – sorry, not a little bit but a relatively small percentage left over.

MS BLAKEMAN: Somewhere I've read a statistic that there's a move of 42 percent of doctors from rural practice. I'm wondering what the plans are of the Department of Health to deal with the shift of doctors moving away from rural areas. It's a supplementary to the same question. This is becoming more and more a difficult situation for us. These hospitals keep popping up and all of sudden they've hit the wall, their physician's gone and they're in trouble again. What's the overall plan to deal with this?

MR. JONSON: I'd like to make two points here.

THE CHAIRMAN: May I interrupt here? That in fact is a question of policy, so the minister needn't answer it if he doesn't wish to, although I'm sure he's prepared to say something on it, obviously.

MR. JONSON: Yes, I could talk at some length about it, Mr. Chairman.

First of all, specifically with respect to the accounts we're dealing with relative to the future, we have had a report or a study done on the rural physician action plan. As we've indicated very precisely, we know there's a concern there; we know we need to improve our overall effort and improve our plan. So we had an independent assessment of the rural physician action plan. Just recently we received the recommendations of that particular report. We are certainly wanting to act on those recommendations, in fact perhaps go even beyond them, in terms of trying to strengthen our effort in this particular area.

MS BLAKEMAN: Thanks.

THE CHAIRMAN: Mr. Melchin, please.

MR. MELCHIN: Yes. I'd like to go back a little bit to recommendation 18, page 124 of the Auditor General's report. It's a mammoth undertaking to have to consolidate accounting systems and reporting for the huge number of groups that have been consolidated and now down to the number of regional health authorities that exist. I guess I'm pleased to see that we're also moving to a better matching of the revenues to expenses. I must admit that it must have been a nightmare trying to assess where we were if we didn't do that in the past.

If we're moving to a quarterly reporting methodology or system for having regional health authorities report, I guess, throughout the system, my question is: how often do they actually report? Is the objective to go quarterly? Do they actually report monthly? Do they produce their own statements in-house monthly, or is it a quarterly objective? How frequent are you getting information to assess progress on their expenditures versus their budget?

MR. JONSON: Could I just ask a question?

THE CHAIRMAN: We're speaking of '95-96; am I right? Does the question relate to what is occurring today?

MR. MELCHIN: Well, even in the past. I'm just curious how frequently in the past they actually did report to you. In your objective of going forward with the Auditor General's recommendations talking about quarterly reporting, did they even report more frequently?

9:43

MR. JONSON: Just a point of clarification, Mr. Chairman. Is the question with respect to reporting to the department or reporting to their own boards, having to report at their own board level?

MR. MELCHIN: Both.

MR. JONSON: Both. Okay, Aslam.

MR. BHATTI: Certainly in '95-96 we did not have quarterly reporting; we had annual reporting. As the Auditor General's staff has indicated, that was the very first year the RHAs came into being. Looking into the future and the year we're in, '97-98, we've asked the RHAs and the AG's office to work together to come to quarterly financial reporting to the Department of Health. We have prepared

a format for it. We've distributed it to the RHAs, and they're providing us with comments as to how much of that information they can provide in a timely manner.

In terms of reporting to the board, I believe they do a quarterly one. In some cases they do a monthly one. That's a management decision for the RHAs on a day-to-day operation perspective, but we will be asking from the department's perspective on a quarterly basis.

MR. MELCHIN: How long is the objective after the quarter to be able to provide you with the quarterly reports? You've had the first quarter pass. How long thereafter do they have to submit that report?

MR. BHATTI: To start off for this year, we're giving them two months to provide that information to us, because they need to get through the payroll, they need to get through their expenses and so forth.

MR. MELCHIN: So the first indication you have is five months after the fact as to how the year's going?

MR. BHATTI: That's correct for this year.

MR. MELCHIN: I suspect and I would hope that they must know a lot sooner than that as to their progress.

MR. BHATTI: They would probably know about four to five weeks after the quarter ends, but they want to walk through their managing process, walk through their board before they submit something to the Department of Health.

MR. DAVIS: I would point out that this is about eight or nine months earlier than we knew last year.

MR. MELCHIN: I am thrilled with the progress. They must have a number of monthly indicators to assess their progress.

MR. BHATTI: They do their forecasting in terms of their plan as to, you know, what they intend to spend on a quarterly basis and so forth. What we're talking about is actual performance for a quarter versus what they plan. You can only do that once the quarter is over.

MR. MELCHIN: I understand that.

MR. JONSON: Perhaps, Mr. Chairman, the Auditor General's department might comment on how this compares with the standard of government.

MR. SHANDRO: I could make some comments. We haven't looked at this area as an audit itself, but my observations are that right now at the RHA level there are a variety of methods being used. I think they're being cleaned up as we speak because of the new quarterly reporting initiatives that have been put in place. For previous years, certainly reporting was not on a regular basis. Quite often the quality of information being presented was not complete in that selected funds were being presented to boards whereas other funds were not being presented. It's quite common not to budget for the capital fund. It's quite common to budget for any funds that are not the source of government grants. So we've been encouraging the RHAs to have a comprehensive view and to report on a comprehensive view.

Now, another deficiency I've noted is that quarterly reporting is often presented without a forecasted expenditure to compare against. In other words, they may only look towards where they are in a particular year in terms of their expenditures without looking towards what they've incurred plus what they are forecasting to incur. Therefore, by the time the expenditures actually incur, it's a little late in terms of putting some controls on it.

THE CHAIRMAN: A very, very in-depth answer to something that's in the future as opposed to what we're supposed to be looking at. You'll have to excuse the chair for allowing it to go on, but the questions were asked and answered. It does occur that information . . .

MR. MELCHIN: For the past '95-96 then, if they reported on an annual basis, how far after the fact did you actually get the information?

THE CHAIRMAN: That's the only legitimate question on '95-96. That might be hard to find. That's rhetorical, I assume, because it could be quite late.

MR. MELCHIN: The answer is nine months.

THE CHAIRMAN: It was after that actually.

MR. DAVIS: Three months.

THE CHAIRMAN: Three months.
Dr. Pannu.

DR. PANNU: Thank you, Mr. Chairman. My question is related to the review undertaken by the Auditor General of the Calgary regional health authority's system of acquiring laundry services. On page 140 the Auditor General recommends that the authority "consider issuing a new Invitation to Bid for laundry services." Now, I understand that events subsequent to this have happened. In view of that, what is the status of this recommendation, and is the health authority still resolved to implement this recommendation?

MR. JONSON: The particular issue that the member raises, Mr. Chairman, is related to an earlier question with respect to establishing tendering guidelines, as I understand it. The Capital health authority has to be in compliance with those tendering guidelines, as I understand it. Am I correct in the relationship?

MR. SHANDRO: This Calgary laundry tendering process occurred. We were asked to examine it, and we made this recommendation. Now, we haven't done any follow-up work relating to what they've done subsequently, so I'm not really able to answer. I'm assuming that – well, the recommendations we made are consistent with the issues we raised in the tendering guidelines themselves. So they've agreed to comply with our recommendation; therefore, I'm assuming the issues will be resolved thereby.

DR. PANNU: Supplementary. Correct me, Mr. Minister, if I'm off base on this. My understanding is that the laundry workers' strike was related; it was a response to the implementation of this recommendation. If that was in fact the case, does the recommendation still stand, or is it withdrawn or modified? As I said, I'm not entirely sure if there was a relationship between the two, this recommendation and its implementation and the laundry workers' action.

MR. JONSON: My only comment would be a very general one, and perhaps there's somebody that remembers in more detail. As I recall the dispute, it was certainly not solely or even in a major way related

specifically to the tendering. There were certain issues with respect to contract requirements and conditions and amounts and so forth. It was an overall negotiating dispute, as I recall. I wasn't directly involved in it at the time.

MR. DAVIS: I wasn't there myself. We could undertake to provide a bit more information.

MR. SHANDRO: The dispute was in place at the time we went in to review the process. We carried our review out of the process, examined the system, and made this recommendation to management. They, in turn, released our recommendations publicly.

MR. BHATTI: There was no direct relationship between the strike and the tendering aspects of that. The issue the strike was related to, as the minister indicated, was contract negotiation, the desire of the Calgary health authority to have someone else do that work. The tendering process as to how you go about getting somebody else to do the work is the subject the Auditor General took on subsequently.

THE CHAIRMAN: This is a classic case of the Auditor General being unable to comment on the policy proper but on the implementation of the policy, and that's what the comments were for. Your questions, as I understand it, were more related to the occurrence of the whys, to the effect of the policy statement on some of the workers. It's a little difficult for them to answer now in hindsight in any event, but it is a question that has more to do with the RHA's policy at the time. It's a darned difficult question for these people to answer on that basis.

9:53

DR. PANNU: Mr. Chairman, there was a recommendation here by the AG, and my question was specific to the recommendation and its consequences.

THE CHAIRMAN: Yes. I understand that.
Mr. Shariff.

MR. SHARIFF: I have a question with regards to volume 4, pages 254 and 270, which are the consolidated statements for the Calgary and Capital health authorities. Out of curiosity, I'm looking at line 5, which is donations. Albertans are very generous. I notice that we have about $10 million in Calgary and close to $15 million in the Capital health authority area. I'm just wondering (a) what these funds are used for and (b) whether they are taken into account when you're preparing your budgets. Are you expecting those annually, or is it something that just comes up and you use it as it comes along?

MR. JONSON: First of all, the straight answer is no, we don't expect them annually. This whole area of donations, I think all members know, fluctuates a great deal, is hard to predict. But the answer is no, we don't expect that to be a steady trend line. It will vary. There are campaigns or there are, I guess, people with money available. Sometimes there's a very large contribution, as I understand it, from a particular person that wouldn't be repeated in subsequent years, that type of thing.

MR. SHARIFF: If that's the case, then I just look at the bottom line. I'm wondering whether that amount has a bearing on the bottom line at the end of every year in terms of operation of the two authorities. What would happen if those amounts weren't there? Would programs suffer?

MR. BHATTI: Some donations are provided unrestricted in terms of somebody giving $50,000 and saying: use it for your purposes within the region. But most of them are fairly restricted. An individual comes in and gets some service, is very happy with it, and says: here is $100,000 or $50,000 for particular equipment. Those moneys are restricted and have to be applied to that purpose. Hence, annually we cannot budget for that type of donation.

No, programs would not suffer if the donations were not provided. This is just on top of that that Albertans are willing to provide, and the hospital units advise us of the case it was provided for or in general.

MR. SHARIFF: Thank you.

THE CHAIRMAN: Mr. Zwozdesky.

MR. ZWOZDESKY: Thank you. I would refer to public accounts, volume 2, 1995-96, page 82, vote 3.2.1, which is Alberta Aids to Daily Living benefits. Just following the nature of this area, I'm well aware that it services primarily handicapped individuals and people with chronic difficulties. I'm interested in the fact that approximately $4 million was overexpended in this area for the reporting period '95-96, and I'm hoping that the minister or the Auditor General could just comment and account for that overexpenditure. Apart from the obvious, which suggests a higher use, I wonder if you could give us some specifics in relation to the number of users, or is this tied up in administration costs, a little of both, or what is it?

MR. JONSON: Mr. Chairman, as I recall, in my opening remarks I mentioned that this was one of the major changes taking place in this fiscal year we're dealing with: a shift of funds and a shift of emphasis to long-term and community care, and enhancing that particular area. Now, that particular initiative in turn had implications for other budget lines, particularly the utilization of Alberta Aids to Daily Living. That in a nutshell, Mr. Chairman, is the reason for the overexpenditure. There was increased utilization of the program because of the shift to community from institutional services.

MR. ZWOZDESKY: So that means there are more people requiring the service of the Aids to Daily Living program.

MR. JONSON: That is correct, Mr. Chairman.

MR. ZWOZDESKY: How many more? Do you know, roughly?

MR. JONSON: We can get you that specific information, yes.

MR. ZWOZDESKY: The reason for asking it is because I'm wondering if arising out of this fact of the overexpenditure, you'll be divesting this to the regional health authorities, as I understand it, or is that not the case? Is there some way of accounting for that and sort of passing on the recommendation that they look at a higher expenditure in their forthcoming budgets?

MR. JONSON: Well, certainly we in our planning as a department and also the RHAs are trying to better anticipate and project the needs in that particular area. If I could just perhaps explain a bit further, Mr. Chairman. When you have a person institutionalized, the building structure, the site they're at has sort of their internal, integral equipment that is part of that institutional setting. But when the person goes out into a home care setting or perhaps into some long-term care facility or housing such as a lodge, they need to have their own personal aids to daily living. That is what I'm talking about, in that the shift to community care provides an additional

draw on this program.

THE CHAIRMAN: The chairman would request that for any information forthcoming on this subject and other subjects you'll be providing to the members, if you could pass it through the secretary so that information can be distributed to all members, that would be appreciated.

We have on the agenda an item called other business. We have notice of motions here. There being none, we shall move along. The next meeting is a week hence, May 21, with the Hon. Gary Mar, Minister of Education, present.

Might we have a motion for adjournment, there being nothing else today? Mr. Ducharme. All agreed?

HON. MEMBERS: Agreed.

THE CHAIRMAN: Contrary-minded? Carried.

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