8:30 a.m.

[Mr. White in the chair]

THE CHAIRMAN: Good morning, ladies and gentlemen. We have a quorum. We shall now commence. Might we have approval of the agenda as presented?

MRS. O'NEILL: So moved.

THE CHAIRMAN: Mrs. O'Neill. Is it agreed?

HON. MEMBERS: Agreed.

THE CHAIRMAN: It's carried.

Might we have approval of the minutes as circulated for Wednesday, December 1?

MRS. O'NEILL: So moved.

THE CHAIRMAN: Is it agreed?

HON. MEMBERS: Agreed.

THE CHAIRMAN: Carried.

This morning we have with us the Minister of Health and Wellness. That doesn't refer to his own health and wellness. If he were taking care of either of those, he would be home in bed, because he was here at a quarter to 5 this morning, so some allowances will have to be given if he excuses himself a little early or something. We also have the Associate Minister of Health and Wellness with us, the Hon. Gene Zwozdesky. If the minister would like to commence with a brief overview. Perhaps we should have Nick introduce the staff too. Would you like to introduce your staff, Mr. Assistant Auditor General?

MR. SHANDRO: Thank you. On my right I've got Trevor Shaw, who works closely with me as an audit principal in the office, and on his right is Merwan Saher, who is responsible for professional practices and the production of this report.

THE CHAIRMAN: Mr. Minister, if you might.

MR. JONSON: Good morning, everyone, and thank you, Mr. Chairman, for the introductions. I'd like to just take a moment before proceeding with some introductory remarks to introduce Peter Hegholz, from our finance department, who's seated on my left. I'd ask the Hon. Gene Zwozdesky to introduce the staff that are with him.

MR. ZWOZDESKY: Thank you, Mr. Minister, and thank you, Mr. Chairman. Good morning, everyone. I am pleased to introduce, on my left, Mr. Jim Menzies. He's the chief financial officer for the persons with developmental disabilities programs and services at the provincial level. On his left is Mr. Jim McCutcheon. He's the chief financial officer for AADAC.

MR. JONSON: Mr. Chairman, ensuring quality sustainable health care that is accessible to all Albertans was a key direction identified in the ministry of health business plan and the budget for 1998-99, which is the year that we're discussing this morning. In reflecting the changing needs of an aging population and the views of health presented at the Alberta growth summit in September 1997, there was an increase in funding combined with more emphasis on monitoring the health status of Albertans.

Before I get into the details of the expenditures for 1998-99, I would like to begin my comments this morning with a look at the key directions that served as the starting point for the 1998-99 business plan. We set our sights on four major directions, which each posed specific challenges. First, we wanted to ensure that Albertans who are sick get the care they need. The challenge, of course, within that particular direction, is that we need to be increasing public confidence in the health care system. We need to and were addressing issues arising from the shift to community-based services. We're addressing the concerns of the health workforce. So there are those key subchallenges, you might say, to meeting that first direction.

Our second direction was preparing and planning for the future and working on health reform. The challenges we faced there were creating a predictable and equitable funding system, preparing the system for the impact of an aging population, and ensuring ongoing innovation and integration of new knowledge. Those are three elements that were very important to direction 2.

Direction 3 was to improve accountability and results. There we had the challenges of determining and communicating clear expectations; secondly, ensuring community input into decision-making; and thirdly, aligning physician incentives with patient and health system needs. Of course, in that particular area, as across our business plan, the work that goes on, we're always working to improve our information base.

The fourth direction was a focus on long-term health goals. There we faced the challenges of addressing major economic, social, and environmental factors that influence health and addressing major health problems that are preventable.

Mr. Chairman, I'm pleased to report that in 1998-99 we made steady progress in reaching the goals we had set. We were also able to reinvest in the health system thanks to this government's efforts to bring spending under control. We were able to reinvest saved funds back into the system to address additional pressure points that arose during the 1998-99 fiscal year due to an increased demand for services from an aging and growing population. As a result, Budget '98 increased total voted health spending to $4.182 billion, an increase of $224.3 million, or 5.7 percent, from the comparable 1997-98 figure. Of that total funding for health, health authorities increased by $81.9 million from the 1997-98 comparable budget, an increase of 3.4 percent.

I think it's important to emphasize that the increase, rather than going back to the old ways of spending on health, is instead a targeted reinvestment in specific areas of our health care system to achieve specific objectives. Some of those areas are as follows.

As part of government's ongoing commitment to reinvest in priority areas an increase of $29 million, or 16.4 percent over the 1997-98 budget, resulted in almost $207 million being provided to the Calgary regional and Capital health authorities in 1998 to provide highly specialized provincewide services such as cardiovascular surgery, kidney dialysis, and organ transplants.

Twenty million dollars in additional funding was allocated in 1998-99 to reflect the higher costs for new drugs as well as increased utilization. I noted that the increase in drug costs was featured yesterday in the debate in the Assembly. Certainly that is a very rapidly rising cost in the health care system, but of course the drugs promise treatment or control of disease and in many cases a cure, and they are much expected to be approved.

There was $3 million announced for a new initiative to enable more palliative care patients to receive appropriate care and support in their own homes. The new funds will improve capacity for palliative drug therapies at home.

Reflecting a priority of government, an additional $3 million was also allocated for the rural physician action plan to help attract and

retain physicians in rural Alberta. That, I am pleased to report, was a very successful initiative. Speaking still about the physician services, that particular budget area increased by $69.1 million over the comparable 1997-98 budget, an increase of 9.2 percent.

Mr. Chairman, in addition to the approved budget supplementary estimates were approved for items such as an increase of $124 million, or 4.6 percent, in additional funding to the regional health authorities to address various pressure points. This increase is in addition to the $81.9 million, or 3.4 percent, which they received at the beginning of this fiscal year. Also, a total of $51.7 million in additional funding was provided for physician services to cover the new fee-for-service agreement with the Alberta Medical Association, along with higher physician billings and academic health centres in Calgary and Edmonton as per recommendations in the report of the health system funding review, also known as the Laing report.

The other major supplementary estimates both fall under the area of human tissue and blood services: Alberta's share of transition costs in the new Canadian Blood Services agency and Alberta's share of costs for financial assistance to hepatitis C victims. These items were $30 million each, or $60 million in total.

Mr. Chairman, during the 1998-99 year Alberta Health received supplementary estimates totaling $245.7 million, resulting in a revised budget of $4.427 billion. Actual expenditures for 1998-99 totaled $4.29 billion, which means there was an overexpenditure of $1.573 million, or .04 percent. This overexpenditure was primarily due to the increased costs of physician services due to increased utilization rates. I'd like to note that 1998-99 was the first year of the new physician services agreement, which saw remuneration for physicians increase an additional 6 percent over that which was originally negotiated. This increase was, as I mentioned, due to increased utilization rates due to Alberta's increasing and aging population.

8:40

In conclusion, Mr. Chairman, I'd like to say that a quality publicly funded health system which is accessible to all Albertans is one of this government's highest priorities. I'd like to point out that we're making progress on many fronts, and today's health system is more secure and more stable than in years past. I'd also like to emphasize that we cannot be content with the status quo. Instead, we need to continue to seek new and better ways to deliver health services and improve the health of Albertans. We need to continue working with Albertans, those in the health system and those who depend on its services, to understand the issues and problems, to set clear direction, and to explore new opportunities to give Albertans what they want and expect: a first-rate health system.

Our government has continually stated our commitment to ensure quality, accessible health services for Albertans and our commitment that when additional resources are clearly required, they will be provided. The increased funding provided in 1998-99 combined with the population-based funding system provides health authorities with a stable and predictable funding base to support a public health system that meets the needs of Albertans.

Those are my opening remarks, Mr. Chairman. I would like to refer, if I might, to the Associate Minister of Health and Wellness, Mr. Zwozdesky, for remarks with respect to his areas of responsibility.

MR. ZWOZDESKY: Thank you, Mr. Minister, and thank you again, Mr. Chairman. Good morning, to additional members of the standing committee. I am very pleased to have this opportunity to speak with you this morning about the 1998-99 public accounts, specifically for the Alberta Alcohol and Drug Abuse Commission, hereafter referred to as AADAC, the persons with developmental disabilities, hereafter referred to as PDD, and, of course, the Premier's Council on the Status of Persons with Disabilities. I might point out that all three of these entities were in fact under departments other than Alberta Health and Wellness up until May of 1999.

I'll begin quickly with the AADAC scenario, which reported a very successful year in meeting its business plan goals and performance measures. The financial highlights include recording a $307,000, or 1 percent, surplus on revenues of $33,868,000. This results from about $1,257,000 more revenue and about $952,000 more expenses having been recorded for the year in question. Under the Children's Services initiative AADAC administered the fetal alcohol syndrome project with funding from Alberta Family and Social Services. A total of $727,000 was recorded as additional revenue for this project. Also under the Children's Services initiative AADAC recorded $53,000 as additional revenue and expenditure to host a prairie provinces conference on fetal alcohol syndrome in May of this year. It was basically a revenue-neutral project.

For partnering activities, AADAC undertook cost recovery projects with the Peace River school board, Capital health authority, and Children's Services. A total of $71,000 was recorded as additional revenue and expenditure. Another partnering activity was to organize and host the United Nations sponsored youth conference on addictions, which was held in April 1998 in Banff. A total of $101,000 was recorded as additional revenue over the anticipated budget for that particular project. The problem-gambling program continued to be enhanced, with $239,000 being recorded as additional revenue and expenditure. This includes the use of $186,000 received in prior years which was not expended but which was recorded as deferred revenue, plus about $53,000 of interest revenue that's recorded as being earned during the year. A private donation of $25,000 to youth programing was expended on capital assets at the request of the donor.

Turning to the Premier's Council on the Status of Persons with Disabilities, the total voted expending for 1998-99, summed up, was $612,000. However, only a total of $529,750 was actually expended during the fiscal year, and that left a total of $82,250 in unexpended funds. There was a surplus in manpower that is attributed primarily to the fact that the council had some vacant positions during the year. Staff had either retired or moved on, because the original 10-year term of the council was coming to an end and it was not known at the time whether the term of the council would be extended. It has, of course, as you know, Mr. Chairman, been extended to the year 2003. In addition, there was a shift from a full-time working chair to the appointment of an MLA as chair of the council.

There's a small overexpenditure in the telephone and communications area primarily as a result of some new telephone systems being implemented, one of which is very beneficial to individuals who require assistance, who are deaf. It's called the TDD, the telecommunications device for the deaf.

There were a few overexpenditures in repairs and maintenance regarding data-processing services – and that totaled about $15,000 – that were attributed to the installation and maintenance of a computer network system connection to Alberta Health and Wellness. The Premier's Council was not supported by any local or wide area networks prior to '98-99, so it was important to get them up to stream.

Finally, the overexpenditure of $35,000 or so in materials and supplies is due to the fact that the office needed some additional materials and supplies, including computer equipment and furniture. Some of that furniture was able to be obtained from government surplus. However, we did find that some also had to be purchased outright.

In reference to the grants line, Mr. Chairman, the Premier's council does not have funds to actually provide grants, but because of a large budget surplus, in relative terms, expected during the transition from Executive Council to Alberta Health and Wellness, a total of $55,000 in funds was provided this year only on a onetime basis for some broad initiatives which included $25,000 to the Alberta Disabilities Forum, $10,000 to the Canadian Paraplegic Association, and $20,000 to the Faculty of Business, University of Alberta centre for voluntary enterprise and social entrepreneurship.

My final area is the persons with developmental disabilities, and I'd like to just quickly provide you with some background. In April of 1998 Alberta family and social services handed over to the Persons with Developmental Disabilities Provincial Board the six community boards, one facility board, and one foundation board, and along with that came the responsibility for designing and delivering services to adults with developmental disabilities.

For the year '98-99 PDD received an increase of approximately $24 million over the previous year's operations primarily in response to two issues. One was the rather large uptake of new clients into the PDD program and, secondly, a 5 percent increase to community agency staff salaries.

PDD experienced a net deficit of $922,000 in their first year of operation, which was '98-99, and this deficit was incurred as a result of a higher than expected increase in new clients and the services being requested. There were a number of factors that contributed to this client growth, and I'd be pleased to comment on that should individuals be interested to know. I do expect that the demand will continue, and I will be addressing that demand in the forthcoming report at the end of this month, which I am now nearing completion of.

Mr. Chairman, I'd like to just close by thanking you for your attention and all the members for their attention this morning as well.

THE CHAIRMAN: And to the questions. We have Dr. Pannu, Mr. Herard, followed by Mrs. Forsyth.

DR. PANNU: Thank you, Mr. Chairman, and good morning, everyone. My questions relate to observations made by the Auditor General in his report on pages 193, 194, and 195, Mr. Minister. The observations made by the Auditor General suggest that older facilities that exist in the province "may not meet standards." He refers also to deferred maintenance on the facilities on page 193. This would seem to reflect his concern on page 13, where he makes some general observations about government policy with respect to whether to defer costs or to find funds to invest in maintenance now, which might be more economical than deferring. So my question to you is: do you agree with the Auditor General's concern about the risks involved, risks related to backlog and meeting maintenance needs of these facilities?

8:50

MR. JONSON: Mr. Chairman, certainly we recognize and agree that there is a need in the system for what is generally referred to as capital upgrading. I would just like to comment on that in a moment.

I would want to indicate that from the capital budget that existed during this period of time a significant emphasis was placed on needed repairs and renovations in health facilities across the province. If I recall, the budget in public works, as it was then, now Infrastructure, was in the neighbourhood of $100 million that was being spent on, quote, health capital, a good portion of that for addressing the more urgent capital upgrading needs. Certainly we recognize that there's need for more attention to that. That has been recognized in the recent capital announcement that was made with respect to health capital spending. It's been increased. There's been an increase in the amount going for urgent renovations and repairs. As well, of course, is an emphasis being placed on expanding our long-term care capacity in the province. So those are my general comments, and yes, we do recognize the concern and the need noted by the Auditor General.

There is one other comment, though, that I would like to make here about something that has had a great impact on government's capacity to spend on health capital projects, construction and repairs. That is the whole issue of having to respond on an urgent basis to the Y2K needs of the system. Although the amounts are split between, I believe, about $130 million that was allocated in 1997-98 and then a further $70 million in '98-99 and onwards, that total comes to about $200 million that has gone into Y2K preparedness in the health system. That has taken away from what would have been, I think – I'm not saying that we would have an additional $200 million for capital projects, but certainly we would have had more to spend on capital projects than we had available to us because of that.

DR. PANNU: Thank you.

Mr. Chairman, a related question on page 194. The upgrading or maintenance of facilities, of course, is closely related to their use and their availability for use and the distribution of facilities. The Auditor General indicates that there's a "lack of benchmarks or standards to understand what should be in place." How do you spend the money when you don't know what should be in place?

MR. JONSON: Once again we acknowledge and we're working with Infrastructure to, I guess you'd say, develop a template for the overall meeting of capital expenditure needs in the health care system, but we do have a set of criteria right now for the approval of capital projects which is based on needs within the system with respect to the type of facility, condition of the facility, and location of the facility. So it is not an ad hoc process right now. We do have criteria that we run our projects through in order to make a good decision as to the priority they should be given within budget.

THE CHAIRMAN: Thank you.

Mr. Herard, please, followed by Mrs. Forsyth.

MR. HERARD: Thank you, Mr. Chairman. Good morning, ministers and staff. December 8 has already been a long day for some of you.

I was looking through section 1, schedule 7, and that's a comparison of expenses by element to authorized budget. I note that there are a number of RHAs with unexpended balances, and I was surprised to see that my own was part of that. Does this mean that they didn't get all of the funds they were entitled to?

MR. JONSON: No. They'd get the funds they were entitled to, but perhaps in terms of the way that is recorded, I could ask Peter to respond.

MR. HEGHOLZ: The reason we show the surpluses in some of the RHAs is that they were transferring funds to the Wellnet initiative and the financial statements do not reflect those transfers of funds. Consequently, you'll see in the Wellnet initiative, under program 2, that there is a deficit. That deficit, in fact, is what the RHAs were going to be contributing towards that initiative, and it's at that total, about $12.8 million.

MR. HERARD: Okay. Well, that explains it.

Now, the biggest number on that page is under dedicated program

funding. Why was there such a significant surplus there? It's actually 2.3.20.

MR. JONSON: Sorry. Which section again?

MR. HERARD: It's 2.3.20 in schedule 7, which is page 89 in that book. That's got the highest amount of unexpended funds at $14.722 million, and the question is: why is there such a significant surplus there?

MR. JONSON: We'll get it in a second. Good question. We're having to dig deep. Can we come back to that one?

THE CHAIRMAN: Certainly. There is another possibility. If you wish to answer in writing, something that takes a little more work, it could be circulated through the secretary. That can be done. That would be fine. Is that agreeable, Mr. Herard?

Mrs. Forsyth, if you wish, followed by Dr. Pannu.

MRS. FORSYTH: Thank you, Mr. Chairman. Good morning, Mr. Minister and Mr. Associate Minister. I have some questions in regards to the Auditor General's report, page 188, and it's recommendation 38. It states that the department "assess the impact of new requirements for managing equipment" and determine whether these new requirements have sufficiently reduced "the risk of health authorities not meeting [their] equipment needs." I'd like to ask you if this assessment has been undertaken, and if so, what are the results, and are the health authorities at risk of not meeting their equipment needs in the future? That's the first part of my question. I have one after that.

MR. JONSON: The answer is yes. We have reviewed the equipment needs of health authorities in the general sense. Again, I won't repeat the answer, but we would have liked to have been able to allocate more to equipment than we did. We do maintain that in the global funding that regional health authorities get under the funding formula, they should be planning for the maintenance or keeping in repair and up to date their basic equipment as well as their furnishings and should be budgeting for replacement. Nevertheless, in the recent announcement connected with health capital, we put an additional I believe it was somewhere between $8 million and $10 million into high-tech equipment in the province. We hope in the coming business plan to be able to further respond to the need to replace and upgrade equipment across our health care system. We do recognize the need, and we've been responding, in our view, as resources are available.

9:00

MRS. FORSYTH: Thank you.

MR. JONSON: If I could, Mr. Chairman, respond to Mr. Herard's question.

THE CHAIRMAN: Certainly.

MR. JONSON: Certainly schedule 7, I think, shows that a number of RHAs had unexpended balances, and that was the question that was asked before. The answer was given in terms of Wellnet. Further, that dedicated funding line doesn't, unfortunately, reflect internal reallocations that were done during the year. The surplus funds shown under dedicated program funding were used to offset expenditures in other programs in the ministry such as human tissue & blood, allied health, and extended health benefits. So what we're doing here is in effect, because we had some surpluses, believe it or not, in some parts of our budget, shifting them to areas where we had overexpenditure – and I've referred to, for instance, the tissue and blood area, which is connected to the Canadian blood system and its growing needs for funding – in order to keep our budget in balance as much as possible.

DR. PANNU: Mr. Minister, again, towards the end of your answer to my supplementary, you used the words that we don't make decisions on an ad hoc basis. The Auditor General seems to have serious reservations with respect to that assertion. Again, the bottom of page 194 I think suggests rather clearly that if you don't have benchmarks, how do you make decisions about planning? That's precisely his point. The decisions do become either ad hoc or are driven by considerations which may be ideological rather than based on system information.

My second question related to that now is on top of page 194, which again, I guess, illustrates the nature of the problem. There's no "current and complete information" inventory on available facilities in the system. You certainly preside over a rather complex and large system. How is it that the Auditor General observes that there is no reliable inventory of facilities available? Clearly the question is very important, because during the debate in this session, Mr. Chairman, with your permission I'll say how much time we have spent on saying that facilities are not available. We need to go out of the system to private, for-profit hospitals. Why is it that there's no inventory available, and how do you explain this? Why this failure?

MR. JONSON: Well, Mr. Chairman, first of all, it is my understanding that certainly we do not have the comprehensive, detailed inventory that would be ideal, and we are not taking issue with the Auditor General's observation here. However, it's my understanding that we certainly know where we have health facilities, and we know their general capacity and their general condition. In terms of the specific measures that are in place, this is an area where we work closely with what is now Alberta Infrastructure. We do not administer the health capital construction budget directly from Alberta Health and Wellness; that is the purview of Infrastructure.

DR. PANNU: How is it, then, Mr. Minister, that the reference is made repeatedly to government wanting not to waste money on bricks and mortar when you don't even know how much in bricks and mortar is already in place, which would be available for use? It makes the whole argument specious about this government trying not to spend money on bricks and mortar when bricks and mortar are in place but government doesn't know where it is and how much is available and how it's being used.

MR. JONSON: Well, Mr. Chairman, I fully acknowledge that we can improve and they're working to improve – and we're working with Infrastructure here – our overall inventory reporting and knowledge as far as the health care system is concerned. However, as I indicated earlier, we know where the facilities are. We know the nature of the programs offered in those facilities, and Alberta Infrastructure more than ourselves makes it a business of theirs to visit and review and respond to the submissions and information that's available to us with respect to health facilities. I can assure you that the projects we have been able to approve and certainly the repair and restoration projects that we're funding are needed there in the health care system.

THE CHAIRMAN: Thank you.

Mr. Lougheed, followed by Mrs. O'Neill.

MR. LOUGHEED: Schedule 1, page 82, indicates premiums for health care: more were received than were budgeted, by about $40 million or so. Is there any particular reason why that would have occurred?

MR. JONSON: Yes. The general reason is that we have a growing population in this province, and that brings in more premium revenue. There was also an item here which affects these statements – I'd like it to be every year, but it was a onetime payment to us from at that time, I guess, Alberta Transportation for costs incurred by the health care system and, as I understand it, covered and related to automobile insurance. That led to, I think, about $17 million additional revenue going into the premium account in this particular year. I guess I shouldn't put a value statement on it. It was a onetime adjustment from motor vehicles to the budget in this year.

MR. LOUGHEED: Second question, and perhaps it's best answered by the Auditor General's department, although I'm not sure. Of the fees collected – the premiums – what proportion would be paid by employers, whether they be school boards or government employees or whoever? Is there any kind of idea what kind of breakdown that would be? And I guess social services as well paying premiums on behalf of clients. Is there any breakdown or any way of finding out what percentage would be paid by individuals themselves?

THE CHAIRMAN: I wouldn't think it would be the Auditor General. Actually the department might have to make a stab at it.

MR. JONSON: We'll see if we can come up with that from our details here. I have a figure in my mind, but I'd better not guess.

THE CHAIRMAN: It's quite acceptable to answer subsequently also.

9:10

THE CHAIRMAN: Mrs. O'Neill, followed by Mr. Herard.

MRS. O'NEILL: Thank you, Mr. Chairman, and good morning, ministers and staff.

My question is rather simple, and that is: in 1998, what did it cost to collect the health care insurance premiums?

MR. JONSON: As I recall, the collection factor was about $20 million, so it's a significant amount.

MRS. O'NEILL: Would you be able to tell me what percentage of the direct individual premium billings were not paid?

MR. JONSON: This gets to a question that was asked previously, but approximately 23 percent of direct individual billings are in arrears, and we do have a process of follow-up in terms of exchange of letters, of ultimately the use of a collection agency if appropriate. Ultimately, about 60 percent of that 23 percent of these cases are resolved. Either we have to make an adjustment in our books because their ability to pay or circumstances for the individual or family have changed, or we are successful in collecting what is owed to Alberta Health Care.

The actual collection process is $11 million. That's how much it cost in this year.

THE CHAIRMAN: Mr. Herard, please.

MR. HERARD: Thank you, Mr. Chairman. Actually, the previous two questioners asked what I was going to ask, so my questions have been answered.

Thank you.

THE CHAIRMAN: Oh, it has. Okay.

On to Dr. Pannu then.

DR. PANNU: Mr. Chairman, I had a different set of questions to ask, but I guess I'll follow up on some my colleague from St. Albert has raised.

Mr. Minister, do we know the exact amount that collection agencies take from potential revenues in the process of trying to collect money for the province on these Alberta health premium collections?

MR. JONSON: I don't have right in front of me the amount they collect, but I know that of the . . .

DR. PANNU: I mean the cost to the province of collection agencies collecting this money. What's the cost to the province?

MR. JONSON: I'll have to take that one under advisement and provide it to you. We don't have the specifics right in front of us, but certainly we will find it out for you.

DR. PANNU: Is there any information on whether the default rate on payment by individuals or families is going up or down? Given that certainly all the time we're talking about '98-99 we're somewhat limited, I would ask that question of you. Does the department have any information on the default rate's fluctuation and default rates?

MR. JONSON: I think it's been running pretty stable over the last two or three years that I've been involved. It is still a concern, however, that we do have, you know, still a fairly significant default rate. Particularly the group plans – of course, you don't encounter that particular problem, but it is still a rate that we would like to see lower than it is.

DR. PANNU: Mr. Chairman, the minister's answer seems to be somewhat tentative. Could you get more precise information on it later on?

MR. JONSON: Oh, yes. I'm giving a general answer.

DR. PANNU: You're giving a very general answer, which I don't find very satisfying.

THE CHAIRMAN: Right. We look forward to that.

Further questions of the committee?

DR. PANNU: Mr. Minister, I want to pursue the matter of inventories and what's available. On page 195 the Auditor General talks about the use of facilities, not the availability of facilities but the use. I'll just read this to you.

> Information on use of facility space is not readily available. The utilization of present facilities, capability of meeting service standards, consideration of alternative use of space, and the disposition of surplus space would be important features of facility planning. Based on information gathered, there is a risk of under and over utilization of health facilities.

Do you concur? If so, why is that the case? Again, it would seem to me that before you start seeking nonpublic providers and facilities to meet the shortfall, you would ask these questions and have information that's reliable with respect to user facilities. So would you like to address that issue?

MR. JONSON: Well, first of all, Mr. Chairman, I think I might sort of draw a conclusion that there are really two points being made.

First of all, with respect to voluntary organizations who provide health care services or the private sector that provides health care services, there are a number of arrangements in the province where space in the system is leased by one of these entities, whether it's somebody offering food services or laundry or they're utilizing public health care buildings for laboratory space, that sort of thing. So it is not correct to indicate that existing space is not being utilized by the voluntary and the private sector as far as health and wellness programs are concerned and infrastructure buildings.

The second part to the question is that I have acknowledged – and I'm acknowledging it because I don't think the Minister of Infrastructure would disagree with me – that we do need to work to have a more detailed and comprehensive inventory of what the exact condition of all facilities are and what their nature is, but I still maintain that in terms of being able to make reasonable decisions about capital spending with the resources and the budget available, we are still able to do that with our current information.

DR. PANNU: Thank you, Mr. Minister. In your answer you used a couple of examples, and one of them was that private laboratories, medical diagnostic services, I guess, have under lease publicly owned facilities. You said they're one of the parties that uses public facilities through leasing arrangements. Would you have information to share with us for the year under consideration: how many such parties, private medical diagnostic and testing services, were using public facilities? How many leases were in place, and what was the revenue generated through these leases for the public health care system?

[Mrs. O'Neill in the chair]

MR. JONSON: The answer, Madam Chairman, is: no, I don't have that detail. I would need to ask that question of Infrastructure because they have the data bank, you might say, with respect to the overall health care system.

DR. PANNU: We're relying on your office to get that information for us because you are the minister of health, not Infrastructure.

9:20

MR. JONSON: That's correct.

DR. PANNU: So I'm asking you to give us the undertaking that you will get the information for us, for this committee, through the secretary, to the chair.

MR. JONSON: I will undertake to contact Infrastructure with respect to this.

MR. KLAPSTEIN: I notice that some health authorities are audited by the Provincial Treasurer and others are audited by private audit firms. What's the reason for this?

MR. JONSON: Well, the straight answer is that under the current laws and regulations it is the choice of a regional health authority whether they utilize the Auditor General's services or contract with a private accounting firm to do the audit.

MR. KLAPSTEIN: Well, I'm not sure that's the reason. That might be what's happening, but anyway I don't think . . .

MR. JONSON: I think that would be similar to – perhaps the officials from the Auditor General's department would want to correct me here – the situation with respect to school boards and local governments.

MR. SHANDRO: If I can just comment on this. The Regional Health Authorities Act permits the minister to appoint the Auditor General, and if he doesn't appoint the Auditor General, the health authorities can appoint any auditor they wish. Now, our legislation also requires us to examine the health authorities from the point of view of our larger legislative auditor mandate, and the health authorities thought it would be a good idea to have the Auditor General involved with them right in the beginning so that we can work with them in terms of dealing with the issues of risks in their systems.

In all cases where we're the auditor of a health authority, we're using a private-sector accounting firm to do the actual financial statement audit, and on top of that we do whatever procedures are necessary to fulfill our mandate as a legislative auditor. I think this arrangement provides for efficiencies in meeting the terms of our legislation and our responsibilities under that legislation for the audits, which is nonfinancial but more the operational aspects of it that we're required to report to the Legislature, and to be able to produce the report that we're producing and that you have in front of you today.

MR. KLAPSTEIN: Okay, a subsequent question. I do not find the health foundations accounted for in the ministry's annual report. Is there a reason for this?

MR. JONSON: I would defer to the Auditor General here, except to say that the health foundations are not directly under our government, but there are regulations or requirements of health foundations. I'd defer to the Auditor General's department.

MR. SHANDRO: The health foundations are incorporated and are separate from the regional health authorities, and their audit arrangements are provided for by the foundations themselves.

MR. KLAPSTEIN: My recollection is that they were accounted for in prior years, and now they're not. So what's the reason for the change?

MR. SHANDRO: I think it's a change in the legislation.

MR. KLAPSTEIN: So you're saying that there was legislation introduced to make a change within the last year?

MR. SHANDRO: There have been some changes in the legislation as it relates to the health foundations, not last year but I think a few years back. Perhaps we could come back with an answer to that in more detail.

MR. KLAPSTEIN: Okay. I'll pass for now.

THE ACTING CHAIRMAN: Okay. Mr. Johnson, then Mr. White.

MR. JOHNSON: Thank you, Madam Chairman. Good morning, Mr. Minister. I'm referring to page 78 here of the annual report. Note 10 of the financial statements indicates that the department has a contingent liability in respect to the 294 claims – this is in regards to sexual sterilization claims – totaling $301 million. This seems to be significantly more than the amounts recently announced. Is the liability in these statements overstated?

MR. JONSON: Madam Chairman, this is one of our newly assigned areas of responsibility, this whole area of liability claims. Now, mind you, a portion of the liability was the responsibility of Health through the mental health system, but in the reorganization of

departments and the move of responsibility for persons with developmental disabilities, this issue was moved over to Health. In this whole process, Justice and, as it was before, family and social services and ourselves have worked with the legal people to ascertain what our total liability might be, and this is the figure of some $301 million that's being projected.

MR. JOHNSON: Thank you.

THE ACTING CHAIRMAN: Mr. White has left the chair, and I would acknowledge him for a question.

MR. WHITE: Yes. Thank you, Madam Chairman. My questions centre around the SPC, the standing policy committee, I believe, on health.

MR. JONSON: Health and safe communities.

MR. WHITE: Health and safe communities; that's it. I'd like to know where I would find the costs related to that committee in your department, including the cost of the chair, the space and occupancy costs, the secretarial costs, the travel, and all those associated costs. Where might I find that?

MR. JONSON: There is a line in the elements; it's 1.0.15, standing policy committee on health planning. The 1998-99 authorized budget was $89,000, and the 1998-99 actual expenditure was $77,000 for an underexpenditure of 13.5 percent.

MR. WHITE: Is the audit trail through the Auditor General also? The Auditor General actually audits those accounts then?

MR. JONSON: Yes.

MR. WHITE: It does? That particular line, the audit trail does include those costs as outlined by the minister of the SPC?

MR. SHANDRO: Our audit includes all of the transactions. We audit our transactions on a testing basis, so it doesn't necessarily mean that every transaction is audited. In fact, very few, on a sample basis, would be audited directly.

MR. WHITE: Okay. Thank you, Madam Chairman.

THE ACTING CHAIRMAN: Mr. Herard, followed by Dr. Pannu.

MR. HERARD: Thank you, Madam Chairman. Mr. Minister, I read with interest recommendation 42 of the Auditor General. It's to do with clinical practice guidelines. He's again recommending that "the Department of Health and Wellness establish a process for assessing the benefits and cost of issuing clinical practice guidelines." I remember five years ago when I was working on the Alberta health network project that I was one of those who was quite excited about the potential of clinical practice guidelines in terms of improving the effectiveness of the treatment of health as well as controlling costs. But I read that after five years, according to this report, there are 18 clinical practice guidelines that have been issued and 12 more in progress at a substantial cost. I guess I'm really surprised at how long it seems to be taking to get these clinical practice guidelines in force, and Mr. Minister, I'd like to understand what the complexities of those things are and why it is taking so long. At this rate I may not live long enough to see the benefit.

9:30

MR. JONSON: Well, first of all, just to comment on what we are providing by way of funding here. Alberta Health and Wellness pays about two-thirds of the total funding, which is about $550,000 annually, for work on the clinical practice guidelines, and the other one-third is provided from the medical services budget. That was the situation from 1994 to 1997, and now the $550,000 is split equally between the physicians' services pool, which is physician money, so to speak, and Alberta Health.

Now, the comment that I would make is that I think the best place to appreciate the complexity of this process within the medical field is to pick up one of the – I think there's the Canadian journal of medicine. I might not have the title exactly right, and it's not that I sit in bed at night reading the Canadian medical journal. Because the clinical practice guidelines are an important topic and an issue, I have read some of the articles on clinical practice guidelines, and it is a very complex and slow process within the medical fraternity.

However, in all the ability that I've had to become informed on this particular topic, the medical profession consistently supports the value of having clinical practice guidelines. When you read some of these articles and listen to physicians in the field, you'll find that it's a very sort of methodical but cautious step-by-step process, because you start from having no agreed-to guidelines and then you're trying to bring together to a certain standard and a certain approach hundreds of doctors working in a particular field, and you're trying to have a process which is going to be credible to them. Yes, it does end up being very slow from our perspective as members of the public.

MR. HERARD: A supplemental, Madam Chairman. So do I take it, then, that in order to achieve consensus, essentially all the doctors have to sign off on these things? What about the fact that technology today is changing treatment on a large number of diseases and surgeries and all of that stuff? It looks to me like they're moving targets, and you go around and around in circles. It just seems like a very complex and long process, and I'm wondering if that shouldn't be looked at to streamline the thing.

MR. JONSON: I think, Madam Chairman, that's a fair point. I think it would also be fair to say that the medical profession itself would like to be able to streamline the process. The changing scene in terms of technology and so on, of course, complicates it. You're quite right. But all I can say is that where there are clinical practice guidelines in place, the comments that we receive or our assessment of the situation is that the doctors find them to be very useful. They are supportive of the process. They are supportive of having clinical practice guidelines, albeit I think they would acknowledge, too, that it's a slow process, and sometimes the ground does change because of medical developments in the middle of the process.

THE ACTING CHAIRMAN: Thank you.
Dr. Pannu.

DR. PANNU: Thank you, Madam Chairman. Mr. Minister, on page 218 of the Auditor General's report, that section dealing with regional health authorities and auditing of their annual statements. The Auditor General expresses some concerns on page 218 where he gives instances on noncompliance with financial reporting standards, and instances that he gives include

- eight health authorities not disclosing the Provincial government as a related party;
- six health authorities not presenting comparative budgets in the statement of changes in financial position.

And the next one is particularly significant.

- ten [health authorities] not disclosing the expense categories associated with $517 million of payments to voluntary and private sector operators.

This to me is an exceedingly serious matter. There's a $4 billion or more budget of the department. We are told every day almost how much we are spending, yet accountability seems to be lacking, particularly when it comes to regional health authorities entering into contracts with private-sector operators. There's no transparency, there's no accounting of how that money is spent, and the accounting practices used remain inaccessible in terms of their transparency even to technical specialists, professionals such as accountants. What do you have to say about that?

MR. JONSON: Well, Madam Chairman, there are two parts to the answer. First of all, from the point of view of Alberta Health and Wellness we acknowledge the need to work with the regional health authorities to improve their overall reporting process, and there are other references in the Auditor General's report to that as well. So certainly we agree with that.

I think the other point, though, that I'd like to make is that the regional health authorities feel that they must comply with the provisions of FOIP with respect to the internal nature of these contracts and what might be called proprietary interests. As you know, in the discussions that have been going on during the past number of days in terms of our overall health policy that we put out there, we would want to see cost-benefit analysis of private contracts and so forth.

So those are the two parts to my answer, and perhaps the Auditor General's department would want to comment further on the progress that is being made with respect to regional health authorities overall in terms of setting up their financial statements.

MR. SHANDRO: I'd be happy to do so, Madam Chairman. First of all, I want to acknowledge that the issue of reporting by health authorities has become much more transparent in recent years, and that's as a result of the leadership shown by Alberta Health and Wellness in their issuance of guidance in this area.

The second thing I want to point out is that we're drawing attention to these issues in our report, because these are areas where there has been noncompliance with these standards that we have observed. We have not come to a conclusion that they were significant enough for us to issue a reservation of an audit opinion on the financial statements of the authority, but we think these are practices that ought to be promoted.

9:40

I don't think the level of disclosure that we're providing here should be a FOIP-type issue. If it is, I'd like to understand that issue a little further, and we can have a look at that issue itself. This is just an overall summary-type reporting which doesn't require detailed disclosure of individual contracts as such. So those are the comments that I have to make.

DR. PANNU: Thank you.

My next related question deals with, again on page 218, the last comment in the margin on the left-hand side: "Most annual reports do not yet contain management discussion of performance using information such as cost of outputs." I suppose that if you don't have information on cost of outputs, we can't have cost-benefit analysis, Mr. Minister.

Looking at the next page, continuing with the second bullet on the top of page 219, midway down the paragraph:

> However, many . . .

Which means the regional health authorities.

> . . . did not disclose significant business risks and describe how the health authority addressed them. Such risks might relate, for example, to the availability and deployment of human resources, the maintenance and upgrading of buildings and equipment, under or over utilization of health facilities, integration of health services, and . . .

This is again very significant.

> . . . the ability to control costs and balance budgets.

I really don't understand how you or anyone else in the government could stand in this House and say that services are not contracted out unless we know that they're cost-effective. Here's a clear statement by the Auditor General that there is no basis on which you could assert that the contracted out services are being contracted out because they're cost-effective.

MR. JONSON: I'm not sure, quite frankly, that there are any questions here, but perhaps a viewpoint. I will exchange a viewpoint, and that is that in terms of the overall reporting of the financial situation of regional health authorities, this is something that Alberta Health and Wellness has been working on with regional health authorities. We have been working on additional accountability requirements as far as regional health authorities are concerned. We are working on establishing a quarterly update of financial positions from the regional health authorities to Alberta Health and Wellness, and we are certainly putting effort into improving that situation overall.

With respect to the second comment, Madam Chairman, which goes to, I think, our overall policy statement and the discussions surrounding that, certainly we want to work to being in a position where there will be the information base to make comparisons between the costs of services offered by the public and the voluntary or private sector. We would have the information to do that, certainly now in the long-term care sector, but I don't think we've broken down the different elements of service within, say, acute care, to be able to make those comparisons. That is a goal of the policy statement, to make sure that we're able to do that.

[Mr. White in the chair]

DR. PANNU: Mr. Chairman, I just wanted to make an observation. You have been of course presenting your case with respect to the new policy on the basis of hip surgeries and replacement surgeries. Where is the information to justify that?

THE CHAIRMAN: Might I interject here? It appears to me – I may be wrong, not being an expert in the field – that the questions have moved over from that which we are intended to do, examine the accounts, which is the history of this department, into a policy area. If you can narrow it and rephrase the questions such that the questions relate to the implementation of the policy as displayed in the accounts, then it would be a little more acceptable.

Thank you.

DR. PANNU: I was just responding to the minister's inadvertent invitation to me to comment on this.

THE CHAIRMAN: You have further questions of the minister, Dr. Pannu?

DR. PANNU: No. Oh, are there no more questions?

THE CHAIRMAN: You're it.

DR. PANNU: I have a few questions here, Mr. Minister, from your Alberta ministry of health, section 1. There are some interesting figures that you quote here on pages 16 and 17. We could probably

spend a few minutes being enlightened from your side on the ramifications of some of the numbers that you present there.

Let me start with bullet 3 on page 16:

> Most Albertans who have personally received health services continue to rate those services positively. In 1999, 78% rated the quality of service they received as good or excellent, down from 86%.

That's about an eight percentage point decline. You might want to comment on that. Is that in any way related to or a consequence of restructuring or reorganization and underfunding?

MR. JONSON: Mr. Chairman, first of all, I acknowledge point 3. I'm aware of the statistics there, and the 78 percent from 86 percent in past years is an area of concern for us. However, I was surprised that the next statement was not quoted: "Ratings of the effects of this care on their health, however, were unchanged at 83% positive." It seems to me that that is the more important statistic here. Not that the first one, which is a more subjective one, isn't something for us to be concerned about, but ratings of the effects of care "on their health, however, were unchanged at 83 percent positive" is, I think, a positive statistic.

DR. PANNU: Does that mean, Mr. Minister, that the reduction in the quality of care is justified in your view as long as the other number remains at 83 percent? Is that what you are guaranteeing to Albertans?

MR. JONSON: I think the quality of care is reflected by the 83 percent. I think some of the problems or challenges facing the health care system, such as the waiting lists quite frankly – and the one, of course, that's most often referred to is joint replacement or repair surgery. That particular factor is the one that probably affects the 78 to 86 percent area, but the quality of care that people are receiving in the system I think is more reflected by the 83 percent.

DR. PANNU: Thank you, Mr. Minister.

Can I go to the next bullet, Mr. Chairman?

THE CHAIRMAN: No. No. You've had a primary and supplementary. Since you started questioning, we've had two other members ask for questions.

DR. PANNU: Sure. Sure. That's fine.

THE CHAIRMAN: So we'll go to Mr. Klapstein and then Mr. Herard. Then if we have time, we'll come back to Dr. Pannu.

MR. KLAPSTEIN: Thank you, Mr. Chairman. I have a comment, a request, and a question, and I'll do it in that order. My comment is to the minister. The fact that you're here this morning is nothing short of amazing after what you've been through, and you're doing very well.

My request is to the Auditor in reply to my earlier question when reference was made to a change in legislation that affected how health foundations are accounted for. I'd like to have that legislation identified for me.

My question. On table 1 of the annual report, total administration costs of all health authorities have increased by 11 percent between 1997-98 and 1998-99. Do you know the reason for this?

9:50

MR. JONSON: Yes. The costs of system upgrades in the way that regional health authorities categorize these things – and this relates to the Y2K upgrades that are being done and other system upgrades – is charged to that category of administration. If we took out that particular special spending that is going on right now to address those problems, the percentage for administration would be 4 point some percent. In fact, there's been a very small decrease overall, from I think 4.7 to 4.5 or something, in terms of the percentage of regional health authorities' resources that go into administration in the traditional sense. Eleven percent is reflective of this, quote, systems redevelopment that's going on within the regional health authorities.

MR. KLAPSTEIN: Thank you.

THE CHAIRMAN: With respect to Mr. Klapstein's questions of the Auditor General, you'll return those through the secretary to circulate? Thank you.

Mr. Herard, followed by Dr. Pannu.

MR. HERARD: Thank you, Mr. Chairman. It's kind of interesting that we're almost at the year 2000, and the airline industry is seeing a lot of cancelations and flights and so on that have been taken off the schedule, but I don't imagine that that's going to impact how many people show up at our hospitals. I guess I'm wondering – and I wasn't able to find it – whether or not there has been a lot of additional expenditure to get ready for the year 2000 and also your opinion on how ready the health system might be at this point.

MR. JONSON: First of all, as I alluded to earlier, we know that about $170 million will be spent for sure on preparing for Y2K, and this is broken down into actual replacement of systems; i.e., equipment and programing. A very significant part of that $170 million, however, went into the investigation and assessment of the systems and the equipment and so on across the health care system.

In this whole effort, the risk involved in the health care system was priorized into different categories. The top category was, of course, the actual equipment that's involved in patient care, and then there was a continuum down to sort of basic office operations and so on, which were given a lower priority.

We have had regular reports that were reviewed by Treasury Board on Y2K compliance. According to our last assessment, we are well prepared in the area of critical medical equipment and services. There's still some work to be done on what we referred to as the administrative systems of the regional health authorities. All indications are that the core services – as I say, there are reports with bar graphs that have been prepared on where regional health authorities are comparatively and so on, and we feel that we have done everything. Probably there is something else that is possible, but the government has certainly I think been very responsible in allocating money in this year for health, which is probably the most sensitive area affected by this Y2K worry.

MR. HERARD: A supplementary, Mr. Chairman. I'm pleased to hear that; it should be comforting to people.

There are things that happen outside of the realm of control of the health care system. I'm talking about things like major power outages or something like that. In all of this expenditure to get ready for the year 2000, what kinds of contingencies were put in place for the potential of, say, a major power outage or something catastrophic like that?

MR. JONSON: Well, in some cases, yes, it was found that although their system worked, it needed to be, as I understand it, expanded as to its capacity. What I'm referring to here is auxiliary power units, generators, heating services, and so on. Those were very high on the list of the systems that were assessed and in many cases upgraded as a result of this overall review.

Not every hospital has auxiliary power and auxiliary generators, and in those cases part of the contingency plan is to have a plan in place: where would you move patients, or what was the contingency plan if you had to move people?

THE CHAIRMAN: Thank you, Mr. Herard.

Dr. Pannu, we have two minutes. Can you get one in quickly?

DR. PANNU: I'll try to put the question in in the next minute, and then the minister can see how much time he needs to answer it.

Mr. Minister, one last question that's related to three observations under those highlights of measures and results. The first one has to do with "rates of deaths from cervical cancer remain higher than the provincial targets" in spite of the fact that the rate of PAP tests utilized in this province is higher than the national average.

The second effect:

> Alberta's rates of deaths from injury and suicide declined in 1997 but remain higher than the Canadian average. Many of these deaths affect young and healthy people and can be prevented.

That's a second observation that you offered here to us.

"The percentage of babies born with low birth weight in 1998 continues to be higher than the provincial target."

The last one is on the top of the second page, where you have reported some good news, which is welcome news, that the incidence of AIDS has declined and so forth. Then you say, "But rates of E. Coli Colitis, salmonella" – and in particular and very disturbing – "tuberculosis appear to be increasing."

The last one: "Alberta immunization rates continue to be lower than the target of 95 percent."

I just wonder if you'd comment on what those indicators say about whether or not your restructuring is indeed working for the people of Alberta.

MR. JONSON: Well, first of all, with respect to the targets that we set in this area – and since you mentioned the 95 percent, I think you would find that we've set a very high goal there in terms of immunization. Ideally, we would like to have a hundred percent, but there is a component in the population that have certain philosophical objections to immunization no matter what, and also we do have a challenge of making sure that we reach everybody. Immunization is still a voluntary matter, and I hope it always will be, but I think that actually the target we've set for ourselves is an indication that we're very serious about this area, and our rate of coverage is improving.

10:00

With respect to tuberculosis, this is an area that has arisen in other provinces as well. Yes, it's related to living conditions, certain other practices of people, but I think one of the challenges that all health care systems face – and certainly that's the case here in Alberta right now – is that tuberculosis is something that society seems to feel has been eradicated. Consequently, there's not the alertness within the population to what the causes are or what precautionary measures and so on should be taken with respect to tuberculosis. It seems to be popping up and increasing in our country somewhat, but it is an area of concern.

You mentioned AIDS.

Low birth weight. We are certainly looking at and trying to take action in those areas where we know what is accounting for the low birth weight babies with respect to programs of nutrition and emphasis on primary health care centres such as the Northeast health care centre, where you don't just have the physicians and the nurses present, but you have a dietary department, a dietician that can work with young mothers in this particular area. It may, though, quite frankly, have something to do with fashion and lifestyle too. I won't go any further in my comments there, but it is an area where we don't have all the answers as to why this is the case.

Injury and suicide. I think Alberta Infrastructure is aware of this, that we have higher rates of traffic injuries. This is the primary one, I think. Our record in terms of industrial accidents is very good in the province, but our record in terms of traffic accidents particularly is not. In terms of the prevention side we have a number of initiatives in terms of our new centre for injury control at the University of Alberta. We certainly want to work with Infrastructure on their approach to traffic safety, whether it's the controversial matter of photoradar or whether it's speed limits, those particular areas.

We're making an additional effort in our business plan with respect to screening for both cervical cancer and breast cancer in the coming year, so we are responding to those particular areas.

DR. PANNU: Mr. Chairman, I want to thank the minister and also compliment him for his wakefulness in spite of serious sleeplessness. Thank you, Mr. Minister.

THE CHAIRMAN: Yes. There's certainly no sleep disorder in that family. On behalf of the committee I would also like to add our thanks to the minister for showing up. That's above and beyond.

Should we be sitting next week, members – that's December 15 – we have the Hon. Lyle Oberg, Minister of Learning.

Any further business to deal with? There being none, a motion to adjourn. Mr. Herard. Is it agreed?

HON. MEMBERS: Agreed.

THE CHAIRMAN: Carried. We stand adjourned. Thank you kindly.

[The committee adjourned at 10:05 a.m.]