LEGISLATIVE ASSEMBLY OF ALBERTA

Tuesday Evening, April 17, 1973

[Mr. Speaker resumed the Chair at 8:00 o'clock.]

INTRODUCTION OF VISITORS (CONT.)

MR. ZANDER:

Mr. Speaker, may I receive permission from the House to revert to the Introduction of Visitors?

HON. MEMBERS:

Agreed.

MR. ZANDER:

Mr. Speaker, it gives me great pleasure to introduce to you and through you to this Assembly, members of the 55 Edmonton Troop, accompanied by their leaders, Mr. Edward Godowsky and Mr. David Osborne. They are, Mr. Speaker, from your constituency, Edmonton Meadowlark considered by you, Mr. Speaker, and by most of us in the House to be one of the finest constituencies in the province.

They are seated in your gallery. I would ask them to rise and be recognized by the Assembly.

MR. TAYLOR:

Mr. Speaker, I also have the pleasure of introducing to you and to the hon. members of the Legislature five very fine young people who were former pages in this Legislature. I refer to Miss Donna Sanborn, Miss Kathy Wass, Bill Piers, Denis Faford and Al Jacobson. I am sure there will be hearty applause if they will stand up and be recognized.

ORDERS OF THE DAY (CONT.)

[Mr. Speaker left the Chair.]

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COMMITTEE OF SUPPLY

Department of Health and Social Development

[Mr. Appleby in the Chair]

MR. DEPUTY CHAIRMAN:

The Committee of Supply will please come to order.

DR. McCRIMMON:

Mr. Chairman, Subcommittee A has had under consideration Vote 25, the Estimates of Expenditure for the Department of Health and Social Development and begs to report the same.

I therefore move, seconded by the hon. Minister of Health and Social development:

Resolved that a sum not exceeding $167,164,330 be granted to Her Majesty for the fiscal year ending March 31, 1974 for the Department of Health and Social Development.

MR. R. SPEAKER:

Mr. Chairman, we have already gone through all the estimates in committee. There are one or two items that we would like to raise, one particularly, and then with a few comments possibly we can deal with the Health and Social Development estimates.

I really feel that the major items have been dealt with and any comments we would have would be definitely on principle or on direction of policy. This is where our remarks will be placed.

One item we didn't cover in committee is with regard to the future expansion of physiotherapy services, the policy of government and what the government sees happening during this fiscal year and the fiscal years ahead. I'd appreciate it if the minister would comment on that.

MR. CRAWFORD:

Yes, Mr. Speaker, I think the reference to physiotherapy can be made equally appropriately under the department or under the Health Commissions.

At the present time, as may be known to the hon. members opposite, the policy in regard to the practice of private physiotherapy has been made the subject of a policy bulletin by the Hospital Services Commission, which I approved. I believe it was distributed fairly widely in approximately the month of January.

By and large the policy takes note of the fact that the nature of the service is such that it can usefully be hospital based, and that the existence of the private practice of physiotherapists in the period of time that hospital-based services have not adequately covered the treatment area in the province has been treated as one that has two main features to it as far as the government is concerned. One is that the expansion of services into areas where they don't exist or the increase in the availability of the service in areas where they do exist, belongs very much in the hospital extended-service area or in connection with auxiliary hospitals.

The other principle is that since there are a number of private practitioners in several centres in the province who are providing a service at the present time, there is no desire to cause any difficulty or disruption with the provision of service by them. All of them have an existing number of patients, of course, and the physiotherapists themselves have a vested interest which they acquired as a result of being encouraged to fill the gap in service that existed a few years ago. Therefore, we wouldn't want to adopt any policy that would be harmful to the carrying on of a private practice within the sort of limits that now exist.

We therefore adopted the policy that expansion in the private sector of physiotherapy practice is not to be encouraged, but that there will be no unnecessary, or indeed in substance, no curtailment of existing services being provided by private practitioners. On balance one of the reasons for this is that the growth of the practices, in the sense of the private practices, has tended to show a history of fairly high cost when compared with the possibility of carrying it on through the public sector rather than the private sector.

There is no doubt that there have been some exchanges with practising physiotherapists who are of the opinion that the emphasis which I have adopted at the present time in regard to hospital-based services has caused some difficulty in the private practice. I think when the overall matter would be looked at, it would be found that although some hopes for future expansion may be frustrated by the existing policy, no actual harm is done to any existing practice or to anyone who has undertaken to provide services in the area where he is.

Those remarks are general. They relate to most of the features of the policy as it exists at the present time.

MR. R. SPEAKER:

As I see the direction of the policy, the only physiotherapists we will have in the future will be employees of the government. That seems to be the direction we are going, from what you have said.

There are also some concerns about the interim period that I'd like to examine, and that's with regard to people who are presently in practice. First, when they wish to cease operation, what is the value of that particular practice

that is built up as an investment? Secondly, if a practitioner is sick or has difficulties for some reason or another and has to be away from his business at that point in time, under the regulations as I understand them, his business would be closed. What is used as a substitute to take care of the needs of patients who require phsyiotherapy treatment?

MR. CRAWFORD:

Mr. Chairman, on the point that when a practitioner is not able as a result of ill health, to carry on his practice, that his practice is closed, I am not aware that that is the result of the policy. I think in the carrying on of any private practice, in the event of temporary interruption, the practitioner is in the same position as any other professional, when, because of his personal circumstances, some temporary interruption in his professional practice is made necessary.

I think it is apparent that a doctor or a lawyer, for example, who was sick and closed his office for a while has the expectation of opening again if the period of time that is involved isn't so great that the practice itself dissipates.

As to the value of practices at the time that a phsyiotherapist would choose to go out of practice, I recognize there are some difficulties in that consideration. I think that speaking in 1973 and saying that the overall desire is to see the services hospital based, means that at the present time there is no overwhelming difficulty in regard to the person who is still carrying on his private practice, because the policy does allow that if, at this time, a transfer of the practice is proposed, that by application through the commission to the minister an approval of transfer may take place. In the one or two cases -- I think it's two, but there may only be one that was finalized if my memory is right -- in the last year and a half the necessary approval was given. The theory was that it was not an expansion of the private sector but it was a continuation of the same level or the same volume of involvement on the part of the private sector.

So for the person who is, at this time, wanting to make a sale of his practice, it can be given the value it actually has based on the normal considerations there would be in valuing a practice. The only thing I could say, though, in respect to what would happen when phase-out, say of a person's practice is finally made and there is, at that time, no policy to allow for transfer of it -- we have said that the policy is not of such a long term that it can't be reviewed in order to take account of possible hardships like that. We have indicated to the practitioners that an overall review of the policy that was announced earlier this year would be made in about three years time.

But even so, and without committing in any way -- let's take the situation beyond three years. Let's take the situation, say, in 18 or 20 years when a practitioner faces the situation the hon. member has used by way of an example. It may well be that the policy at that time will still be that if there was no expansion in the overall service provided through that outlet, it could still be transferred.

But I realize a difficulty comes up at the point when you say, have I or have I not achieved the policy that this particular type of service is primarily to be placed in the public sector and primarily hospital based? I realize that in taking the matter to its logical conclusion there must be a point at which that would cause someone some difficulty, and all I can say is that we have told them there would be a review of it in about three years time to see if there are any unforeseen hardships.

MR. HO LEM:

Mr. Chairman, I wonder if I might be permitted to make one or two comments.

MR. HENDERSON:

Mr. Minister, the way I understand what has been stated, there is really only one new aspect to the policy; there has been a freeze in effect on the creation of any new private physiotherapy clinics. That goes back four years or more I think, four or five years. But I think the item of concern is -- the question of expanding the hospital facilities has been under way anyhow.

So the policy statement -- the crux of it really is that in future the government does not, as a matter of policy, agree to the transfer of ownership of existing private clinics across the board. This is basically the policy change that has come into effect. In fact as a general rule, you are saying,

Mr. Minister, that over the three-year period you really don't look favourably on transferring ownership or expansion of the staff in any existing physiotherapy clinics. This is the crux of the matter, is it not?

MR. CRAWFORD:

Well, I think I could, maybe, just qualify the conclusions the Leader of the Opposition is reaching, in one or two ways.

First of all, I wouldn't attach the greatest significance to the reference to three years in regard to a review. The policy that is in existence during that three year period is as I stated. I don't think it's right to go beyond that and say that we don't look favourably upon transfers during that period because the whole policy in regard to limitation of transfers is an attempt, not to ensure that some other person didn't carry on the same profession in the same location, but to make sure that the expansion of the private sector didn't run on, unchecked and unknown which would be possible.

I think there was one other point the hon. Leader mentioned. He mentioned the freeze was about four years old.

MR. HENDERSON:

No, five years.

MR. CRAWFORD:

I think the only thing that I would add to that is that I think what the physiotherapists were really looking for -- and I would be ready to say that they weren't unanimously happy about the policy that came out earlier this year -- but what they were really looking for was a clarification as to whether or not that was indeed the policy. By coming out with the policy earlier this year in some detail and advising them of it -- which we did -- the question of whether or not there was a freeze four years ago was something they got used to. They wanted to know where they stood now and where they were going to be going. So we indicated to them that over sort of a short-range period of time with review at the end of that approximate three year period we would outline certain specific guidelines we thought they would have to follow. Those guidelines were the ones that formed the policy.

MR. HENDERSON:

Mr. Chairman, the directive that went out from the Hospitals Commission on Administrative Order C.H.-2 contrasts somewhat with the statement the Premier has just made, and I think this is the crux of the concern; having some knowledge of the problem, I understand the dilemma the minister faces, but I also appreciate the concern on the part of the physiotherapists.

Section 4 of the particular order which the minister, I assume, approved in principle before it went out, deals with the restrictions and controls on existing approved physiotherapists -- approved private physiotherapists. Clause E of that particular Section says, "The Alberta Hospital Services Commission will not authorize the transfer of ownership of an approved private physiotherapy practice", period.

This represents the basic significant change in comparison to what the policy has been in the past, some four years or so, maybe longer than that. The policy, the freeze was in effect before I became minister of the department in 1969 and I think it was at least a year in advance of that.

But as I see the directive that went out, this is the main difference: the Hospital Commission flatly says that they will not authorize transfer of ownership of approved private physiotherapy practices. While the group has become used to the freeze, used to the implications of no further expansion of private physiotherapy clinics and approval of no more clinics -- and I recall well the exercise with a gentleman in Calgary who tried to use the back door to get into the business and the unpopularity of saying he'd better go back to the States, because he could practise but he wasn't going to get paid by the Hospital Commission or Medicare.

But this constitutes the significant difference in the policy. Before, while the private practitioners couldn't expand and there wasn't any prospect of additional clinics, they at least had some assurance that their investment in their business had some future attached to it and some value to it. But with the statement that the Hospital Services Commission will not authorize the transfer of ownership and approve private physiotherapy practice, this seems to

slam the door. This in effect says that as long as they stay in business under the names of the principal who operates the clinic they are fine, but don't try to change the name of the principal who operates the clinic because the commission refuses to make any transfers on it.

I think this obviously is a change in the rules of some significance from the standpoint of the private physiotherapist so far as the established clinics are concerned. The minister sort of softens the words a little bit to indicate that maybe the words of the commission are not quite that rigid. So I would appreciate the minister explaining a little further really what is the interpretation he places on that particular clause in the directive, and I'm sure the minister is familiar with the directive.

MR. CRAWFORD:

Mr. Chairman, I just wanted to reiterate that the concern at the time of transfer has not been whether or not some other individual might carry on the same practice; the concern was to try to control the expansion. It was one of the objectives of the director from the Hospital Services Commission to contain for example the habit -- I shouldn't perhaps say habit; it wasn't all that widespread -- but the device, which I don't say in any uncomplimentary way, of, say opening a branch office and staffing it with some other person who was employed as a physiotherapist.

You will note that the expansion is another area which is dealt with by the order. I would maybe clarify, in reponse to the hon. Leader of the Opposition, the other part of it as to transfer just on this basis and the exact wording he read out to me. I don't treat that as being more limiting than the situation was when, about a year ago I did indeed approve a transfer which did go through. But the circumstances of that were that the person in question was leaving the jurisdiction and would not be reapplying to carry on that practice in Alberta. Therefore it fulfilled the requirement that, in that transfer, there was no resultant expansion in that particular sector. It was for that reason, and I would say that similar reasons would continue to apply.

The directive of the commission I think as a matter of fact is subject to appeal to the minister. I would treat other appeals that were put on the same basis, in the same way as I treated this one. But if the transfer were going to defeat the policy and create more outlets and create a wider spread private sector of physiotherapists, in a community where the services already existed or where they were about to be introduced, and bring them into direct competition with the services provided through hospitals both of which, if it's a hospital facility, are paid for by public funds, it would seem to me to be defeating the commission order. My present view, subject to the understanding that it will be reviewed in about three years, is that that sort of expansion shouldn't take place.

MR. HENDERSON:

Mr. Chairman, I'm not unsympathetic, as I said before, to the problems the minister has. But maybe the answer has been given by the minister that, while the Alberta Hospital Services Commission will not authorize it, he has the authority, notwithstanding the position of the commission, to authorize the continuation of private practice simply by virtue of transferring the name of the clinic to a third party so long as it does not compromise the other basic policies that have been laid down for the operation of a private clinic.

I think this is the question and if we can have the minister on record to that effect, this should be of some consolation to the parties concerned: that the door to the minister is open in the event of a dispute with the commission.

MR. CRAWFORD:

Well, Mr. Chairman, the thing that I think should go on record is, once again, that the policy is directed to the control of any expansion which is considered to be against policy. But if a person comes along and has reasons which are such that he could be replaced in his practice and wouldn't re-enter it himself again at some other point, certainly after having a full explanation of that it is quite likely that an approval would be given.

MR. HENDERSON:

Mr. Chairman, I don't want to belabour the point but I want to be sure we get the minister specifically on record. And he is a hard man to get nailed down. As he knows full well, the directive that went out from the commission has one section which deals with expansion. Section 3 says:

> Approved Private Physiotherapy Clinics No further growth of private physiotherapy clinics approved to receive payments under the Alberta Hospitalization Benefits Plan will be permitted for at least [the next] two or three years ...

That clause takes care of that question, but the clause I am talking about deals with the question of 4 "Restrictions on Controls on Existing Approved Private Physiotherapists". It does not relate to the qualification of expansions the minister talks about. It relates basically to the continuation of the existing clinics and the question of whether the private practitioner can leave the jurisdiction and go tc another part of Canada or leave Canada, and whether the commission will approve the transfer of that clinic with no expansion. In fact, you could argue there is a reduction of one in the clinic by virtue of the party who is leaving, who is the principal of the clinic.

I would like the minister to be more explicit because he is mixing up the question of expansion, and that isn't the section in the directive from the commission that the specific clause refers to. It refers to restriction controls on existing -- it says very clearly, and I read again, "The Alberta Hospital Services Commission will not authorize the transfer of ownership of an approved private physiotherapy practice."

I ask the minister again, because the way I am interpreting his remarks is that he is saying as long as it doesn't violate the principle of non-expansion and the party concerned is leaving the jurisdiction of the Province of Alberta, then there are ways and means whereby the transfer would be considered by the minister notwithstanding the rather blunt words in this directive from the commission.

So I think when the minister qualifies it with expansion, it really isn't the clause in the directive that the matter of expansion is dealt with. Because if you read the whole thing, it says:

> The following restrictions and controls become effective as at the date they are communicated tc the individual approved private physiotherapist:
>
> (a) Numbers and type of staff employed by approved private physiotherapists are to be frozen at existing levels or less.

That is pretty clear.

> (b) Each approved private physiotherapist must report monthly to the Alberta Hospital Services Commission providing names and positions of each employee.

That is pretty clear.

> (c) Each approved private physiotherapist must submit his monthly billing to the Alberta Hospital Services Commission in a manner that shows total service provided to each patient per month.
>
> (d) No absentee ownership is allowed. The approved physiotherapist must play an active practising role in the facility's operation.

Then (e) is the clincher which really, from my experience, represents the main policy change.

> (e) The Alberta Hospital Services Commission will not authorize the transfer of ownership of an approved private physiotherapy practice.
>
> (f) No new branch operations shall be allowed.

Then I come back to the concern over question (e). If the minister could just be a little more explicit, well then that would probably end the discussion on the matter but I think he is hedging on his comments a little too much. All I want is a statement from the minister that, notwithstanding the clause in the directive from the commission, the minister is on record as saying that where it doesn't violate any of the other principles that have been laid down in the directive for private physiotherapy clinics, the transfer of private physiotherapy clinics is not precluded.

MR. CRAWFORD:

Mr. Chairman, I don't have any hesitation at all in agreeing with the view that it is not precluded. I had to reserve, of course, the right to say that it depends on the circumstances of the case. In the case I referred to the party

was leaving the jurisdiction and the result would be, if we did not permit the transfer that the total investment of a number of years was lost. That's the type of hardship we don't want to contribute to.

So in such cases -- and I don't mean it has to be leaving the jurisdiction -- but in an appropriate case where the physiotherapist in question is leaving practice or for other reasons that would cause a hardship if the transfer were not allowed and if it were allowed would not violate the principle of expansion or additional branch offices or the like, then every consideration would be given and the transfer would not be precluded.

MR. HENDERSON:

Well, Mr. Minister, having said that, I have one further question. Are you prepared to have the commission issue a qualifying directive to that effect, relative to the interpretation that is being placed on this Order of the Commission No. C.H.-2? Or would the minister issue it? I assume he would want the commission to issue it.

MR. CRAWFORD:

Mr. Chairman, I'd be very glad to review my correspondence to see if there is any reason why I should draw to any practitioner's attention the facts that I've outlined and the remarks that I've just made. I think that would probably answer the question.

MR. R. SPEAKER:

Mr. Chairman, to the minister. In the first part of those directives there was an item with regard to freezing the level of staff that a clinic would have. I'd like you to clarify for me the reason for that. I feel that the physiotherapist or his clinic would charge "X" number of dollars for a certain act that he would perform. Now if he wishes to spend it on two people doesn't he have the right to make that decision, to spend his dollars as he sees fit or to run his operation uneconomically or economically? However, his limit of charge is what is paid by the commission. Why do we put the limit on his assisting staff?

MR. CRAWFORD:

Well, Mr. Chairman, the logic is in putting the limitation on the staff actually performing the professional services of the physiotherapist. I suggest that is essential.

MR. HO LEM:

Mr. Chairman, I would like to make a few comments generally on the department, and particularly as it relates to the Calgary area of course, because I am a representative from the city of Calgary. Some of my remarks will touch briefly on auxiliary hospitals, nursing homes, hospital extension services and other programs.

Mr. Minister, as we all know, for some years now there has been a constant increasing demand for additional medical services and more and more hospital facilities. In fact, in many instances throughout the province and throughout North America we find that as soon as one hospital is nearing completion plans are soon underway for another such institution, or alternately, plans for additions to already existing hospitals are constantly being proposed.

In the city of Calgary the situation is no different. Presently we have six active acute hospitals: the General Hospital, Holy Cross, Foothills, Rockyview, Grace and the Children's Hospital, with a total capacity of over 2,500 acute hospital beds. When you relate this to the population we find that the ratio per capita is between six and seven which is quite high and performs a real service to the population, of course. Of course, also going along with this, it is a costly proposition.

I heard the minister say previously that it is desirable to reduce this per capita rate to perhaps around four active hospital beds per thousand. By doing this you would have to impose a moratorium on all active hospital construction until such time as the population grew to a point -- in the future, perhaps close to 1980 -- where the ratio would be the desired 4.5 per thousand.

This goal, of course, cannot be achieved in the meantime by merely holding the status quo on the number of active hospital beds, but there must be other supportive health services developed to handle the increased demands by the

increased population in the way of developing more auxiliary hospitals, nursing homes, day hospitals and home-care programs.

In the area of these supportive services, we have in Calgary, of course, what we call the Calgary Auxiliary Hospital and Nursing Home Board, which is in fact the district board responsible for the development and coordination of these services.

The make-up of this board does not only consist of representatives from the city, but also representatives from the municipal district of Rocky View and representatives from the County of Wheatland. The board has as its responsibility the planning, developing and the operating of the auxiliary hospitals in the district. It is also charged with the responsibility that the level of care delivered in these auxiliary hospitals is of the highest level for the dollar that we are putting out.

In 1960, we started the first auxiliary hospital in the city of Calgary. We called it the Cross Bow. In 1962 the Sarcee Auxiliary Hospital was built and in 1965 the Glenmore Hospital was built. Now in addition to these, the Bethany Auxiliary Hospital together with the board-owned hospitals make a total of 700 beds. In addition, of course, to the 16 nursing homes which come under our jurisdiction, this provides 1,843 nursing-home beds all under the jurisdiction of the district board.

This is in keeping with the government concept and policy of relieving the active hospital boards by utilizing more auxiliary beds and nursing home beds and thereby cutting down the hospital patient-day cost by more than 50 per cent. Certainly we agree with this principle. As you know, Mr. Minister, the operation of the active hospital beds is around $50 to $60 a day as compared to $25 a day in the auxiliary hospital.

The district board now feels that there are additional demands for additional auxiliary hospitals and auxiliary hospital services. This is greater now than at any other point in the history of the board. In fact, we know that today there is a growing waiting list, to a point where it is very difficult to manage. In fact it's just about getting out of hand and something, and of course you realize this, must be done and done soon.

At the present time, the Calgary district board realizes this problem and in the hopes of finding a satisfactory solution to this problem has presented an application before the Hospital Services Commission, a request for the development of another auxiliary hospital in the area, which would include not only auxiliary hospital services, but services such as day hospitals and general geriatric care, including day care centres and so on.

The plans that are proposed for this new concept, as you know, have been discussed at length with many various groups in the city of Calgary that are interested and involved in the delivery of the health system in Calgary. It has received endorsation of the Calgary Hospital Planning Council, which is a planning council made up of representatives of each and every hospital board in Calgary. In addition, it has representatives from the agencies such as VON and various other groups that are interested in this type of planning.

This concept is supported, as I mentioned, by the VON, groups such as the Metropolitan Calgary Foundation, the Senior Citizens' Central Council, as well as by the Dean of Medicine of the U of C and many others. The advantages of this concept are many, but before I enumerate the points, I wish to mention just briefly, Mr. Minister, the outstanding record of achievement of the Calgary district board and their performance in this field of long-term care.

This fine record, I feel, was exemplified last year by the reputation it had gained throughout Canada as an example of efficient hospital operation and also by implementing effective programs in the delivery of high-quality health care in this area. Last year, for instance, Mr. Minister, we had a visit from the Department of Health in Ontario. They sent a team to study our procedures, our methods, our technologies and also representatives came from Manitoba and British Columbia. The federal Department of Health and Welfare also showed a keen interest in what we are doing in this area. I feel this is quite a compliment for our board as well as for the Department of Health and Social Development in Alberta.

Now, some of the highlights the visiting team were impressed with and commented on were:

One, the consistent, long-term care program developed for Calgary and district on an on-going basis by the district board. It wasn't just a one-shot

deal. They had a plan of action for the ensuing five years and then another five.

Secondly, they were very impressed with the coordinated efforts of the occupational theraphy-physiotherapy programs which were developed by our board to be utilized within the district.

The board also provides for services of medical doctors and medical directors who are specialists in the field of long-term care. As you know, Mr. Minister, these people are pretty hard to come by, because the area of geriatric treatment is not an exciting thing like modern day medicine where you dispense medicine and care and you see a response. Long-term care takes patience and these people who are specialists in this field, as I have mentioned, are very hard to come by. There are such people and they should be encouraged and they should be given the opportunity to develop their expertise for the benefit of the patients of Alberta.

Another point that the visiting teams from the other provinces were impressed by was that the board, over the years, has developed a program to meet not only the medical needs, the social needs and the physical needs, but all aspects of the patients' interests, to develop them rather than to make them feel that they are forgotten people, to make them feel that they are indeed important members of our society. I think this is very important in the area of rehabilitation, to make the person know that he is wanted.

Auxiliary hospitals under a one-board system makes it easier, Mr. Minister, to coordinate all these services, the volunteer services, and permit community input, in the way of volunteers of all ages, in the auxiliary and long-term hospital program.

We have developed, in the Calgary and the southern Alberta area, central laundry services which have been controlled by our board. We have nurse-consulting services which are available in this particular area to all the member hospitals. Also there is a central assessment service which is essential to ensure that upon application from various doctors and various institutions, we put the patient in the right hospital, because every hospital has its specialties in the way of treatments for certain individuals. For instance, in one of our hospitals we try to concentrate on MS patients; in another area, we like to put in a few mental patients and so on. We know exactly where and which slot the patient should got into by having a central assessment system operating under the one board.

The community board operates for the benefit of the entire community. It serves all hospitals in the area and all agencies, such as the Metropolitan Calgary Foundation, the VON, the Hospital Extension Services and so on. It is entirely different from the policy which has been set by some of the hospitals where they have the one-doctor-one-hospital proposition, thus precluding the use of any one facility by doctors merely because they don't belong on staff in that particular hospital. This is an overall thing, Mr. Minister. I would sincerely ask the minister to give some consideration to this application as there is a need and there is a demand, and I hope a decision in this area will be forthcoming soon.

I would like to comment briefly on other matters in the role of the Hospital Services Commission. I would like to commend the department and the minister for placing importance on the role of the Alberta Hospital Services Commission because it is the operating branch of the department. By its very existence I feel it removes from the minister the political pressures of making health decisions, doing it on a very businesslike basis. I would like to see -- and I'm sure it will be continued in the future.

In the area of the Calgary Hospital Planning Council which was only formed two years ago -- this Calgary Hospital Planning Council, as I have mentioned, is made up of the membership of all the hospital boards in the area, and it has as well input from the VON, the university and mental health and so on.

I hope the minister will see fit to put more teeth into this council by giving it a more responsible role in the health development system in the area. I think we should give the planning council more authority in decisions such as where should the next hospital go and when should it go in the area? What type of hospital should go in that area? What about the one-doctor hospital proposition which is in existence in Calgary and which prevents some doctors from practising in certain hospitals merely because they happen to hold membership in another hospital?

I think this is quite a problem because there are many doctors in Calgary, Mr. Minister, who are not able to get on staff in any of the hospitals. They have graduated; they have trained; they have gone through university and served their internship and many of them are qualified doctors and qualified specialists who are unable, at the present time, to practise because they are not able to get on staff at any of the hospitals. They make their applications and are informed, well, when there is a vacancy open, when there's a slot open we'll be in touch with you. Some of them I know have waited for more than two years.

I think that perhaps we should give some thought to the better utilization of our operating room facilities. As you know, the operating rooms in various hospitals are mainly used from 6:00 o'clock in the morning possibly 9 or 10 o'clock and the rest of the day they are left vacant because many of the surgeons that are using them are called back to their offices in the afternoon to keep their appointments with their patients. I think with the expensive expenditures in the way of capital costs in setting up these operating rooms, certainly we should use them on a rotating basis where we can get maximum benefits out of this very, very heavy investment.

In the area of our nursing home program, I would like to know whether perhaps, and I have asked you this question earlier, there might be an increase in the $7.50 per day allctment. I know this is under consideration. You did mention it and some of the nursing home operators, the Alberta Nursing Home Association, are very anxious that something in this area should be decided on.

My concern is not only with the nursing homes in the city. My concern is in the rural areas where the nursing homes are not operating on an optimum basis. This creates quite a hardship for them to make ends meet. As you know, the cost per patient in a smaller nursing home is much higher than in the city. I feel that they, first of all, should receive some consideration in the way of help.

I'm not entirely satisfied that the one-rate system for all nursing homes is the best. By implementing a one-rate system, the minimal level of care becomes the maximum level. There is no incentive for them to introduce or implement additional services. But if these additional services were considered on a commissioned basis where they were implemented and the commission would take a look at them and perhaps pay something extra for them, it would encourage better care in the way of occupational therapy, physiotherapy. social programs and so on.

I think that we are very fortunate, Mr. Minister, in Alberta, and in Calgary and Edmonton, where we have so many volunteers in our institutions. In our institutions we have various church groups; we have school groups, volunteering services. Some of them are showing films on a regular basis. Others come in just for reading. Some of the younger students come and read to the old people and various things such as this. I think that we are very fortunate in having our volunteer groups serving the nursing homes and the hospitals.

Just one final question, Mr. Minister. In the matter of a supplementary requisition, now that they will be picked up by the province, will this be done by the commission or will it be done on ministerial discretion? Some of the people are anxious to know what the guidelines are on this. Or is it just a matter of formality where they make out an application for supplementary requisition?

MR. DEPUTY CHAIRMAN:

I would like to point out that the hon. Member from Calgary McCall has also been discussing the appropriations in the Health Commissions, and I would ask you in the future to confine it to Health and Social Development until we finish with that appropriation.

MR. HENDERSON:

Well, Mr. Chairman, I really wonder seriously whether it might not expedite the discussion of both. It's a little difficult to separate the two from the standpoint of discussion. It's pretty narrow, shifting back and forth. I wonder whether the House would agree rather that we discuss both the Health Commissions appropriations and this one when we have the latitude to do it at this time.

MR. DEPUTY CHAIRMAN:

Well, I only have the motion for the one appropriation before me at the moment.

MR. HENDERSON:

Even though we don't have the motion, if the Chair would allow us the latitude of discussing both of them, it will simply save time when the other motion does come before us.

MR. DEPUTY CHAIRMAN:

Are you agreed then to go ahead with both?

HON. MEMBERS:

Agreed.

MR. ZANDER:

Mr. Chairman, at this time I also can feel sorry for the hon. Member for Calgary McCall. But I also feel that he is sympathetic to the rural areas of the Province of Alberta.

I certainly hope, as far as the assistance of nursing home service and auxiliary hospital services can be extended out into the rural areas, that the hon. members will appreciate that in the area west of the city of Edmonton we have only one home. I think that the constituency of Drayton Valley and the constituency of Edson haven't any. I think we are looking at a population, Mr. Chairman, of approximately 50,000 people who have to travel many miles to get into these homes. I am especially concerned because in the last year I have attempted to move some of the people in my constituency to the nursing homes, the auxiliary hospital in the city of Edmonton, and to the city of Calgary, and I would say, Mr. Chairman, that I was only successful in one instance to get one into Lethbridge.

I think that the concern expressed by the hon. Member for Calgary McCall is the concern that I also wish to express. In looking at the nursing facilities, the home facilities in our area, there are none. There are no facilities whatsoever. The active treatment hospital, as the hon. member has expressed, is jammed to capacity with senior citizens who should be in a nursing home or in an auxiliary hospital rather than an active treatment hospital.

But I had hoped that the hon. Member for Calgary McCall would also mention why was this program not followed up many years back? Now we are faced with a situation where we have to make the huge expenditures for these facilities, when these cases and the need existed many years ago. I was a member of the council, and for many years we have paid into the supplementary requisition for the Norwood Auxiliary Hospital, but in our area at any time in the past 15 years, we have never been able to get one patient into the Norwood Auxiliary Hospital or into the nursing homes in the city of Edmonton. We were only able to get some into the privately owned homes.

I can only stress, Mr. Minister, that in the past two years it has become more and more evident that we are simply trying to push our senior citizens into whatever place we can get them. As long as we don't have a place to put them we'll put them in any home and in some places the private homes accepting senior citizens who require nursing services are really not fit. But where else are we supposed to put them?

So when we look at the cost of the active treatment hospitals -- and I may also add that we have citizens who are afflicted with cancer and we have to move them out of the hospital because there is no room. Unless we get an emergency these people have to go. Consequently, we have to send them home and then we find that we can't get any extended benefits as far as their drug needs are concerned because they can only receive these drugs while they are in the hospital.

I'm sure, Mr. Minister, that if it was at all humanly possible to try and get some of these auxiliary hopitals, whether you call them nursing homes or whatever facilities that we need, we could certainly cut down on the construction of our active treatment hospitals and save the taxpayers many millions of dollars. I'm fully convinced that unless we embark upon a program, and I say immediately, Mr. Minister, in the next few years it is going to become abundantly clear that we will not be able to find room even in the private homes

where some of the people in the city of Edmonton are accepting three, four or five of the senior citizens who need nursing home care and probably are not getting the care because the drugs are administered, and they have to be transferred either by ambulance or taxi to the doctors' office. Really there is no supervision as far as medical treatment of these patients is concerned.

I would certainly urge the hon. minister, Mr. Chairman, that we must have a hard look at the nursing home facilities and auxiliary hospital facilities in the province. I think we are, as the hon. Member for Calgary McCall mentioned, constructing active treatment hospitals, and I think we can alleviate that problem entirely if we move these patients to the homes they should go to.

I know, in the case of the Royal Alex that when a patient has been operated on, after a few days of medication he is moved over to the Norwood. This is the place he should go, because the cost of hospitalization there is half the price of the cost in an active treatment hospital.

So I would close in this -- I have some other things I want to mention, but as the hon. member of the opposition has said, we should stick to the votes as they come up. I'm particularly interested in the area west of the city of Edmonton where there are 50,000 people. They are governed by the Norwood Auxiliary Hospital Board and that board administers the nursing home facilities and auxiliary hospital care for approximately 700,000 people. I would certainly urge that the board be broken down so these people can render some valuable service. I think the Hospital Services Commission -- certainly I have to commend them on the attitude they have taken -- but certainly we can't get 18 miles out of the city of Edmonton as it exists now. I don't care -- you can open another 400, 500 or 600 beds in the city of Edmonton. It doesn't do us people out in the rural area one bit of good because we'll never get one person into that home. I wish you would consider that.

MR. D. MILLER:

Mr. Chairman, I have no comment on what has already been given but I would like to pose a question to the minister. Will the minister explain how the physiotherapist's practice, where he is serving in several hospitals in a region -- is the physiotherapist expanding his services or is the hospital's service expanding him?

MR. CRAWFORD:

Mr. Chairman, there are a number of questions I have been noting. I'll try to deal with them all at the same time.

MR. NOTLEY:

Mr. Chairman, I wonder if I can move to a question which the hon. Member for Calgary McCall raised just at the concluding portion of his remarks. It really deals with an appropriation under the Hospitals Commission but since we are dealing with these two subjects together I think that perhaps it would be appropriate to raise some questions respecting the new funding program for hospitals in the province.

I have a number of questions, Mr. Minister. The first question is with respect to the global budgeting program of the Hospitals Commission. I understand that budgets are submitted by the various hospital boards but there are, nevertheless, components designated by the commission. I gather that an allowance is made of seven per cent for salaries, and five per cent for supplies. That is my understanding, anyway.

What I am interested in is how you deal with the problems that arise in the hospital system. You are going to have some hospitals which run a very efficient, streamlined operation. On the other hand you have some hospitals which have a good deal of 'fat'. If you take 1972 as your starting, base year and you apply your global budgeting on that basis, do you not, in effect, reward the inefficient and penalize the efficient? At least this was one of the submissions made to me by a hospital administrator in the province.

Then, following up directly from the question raised by the hon. Member for Calgary McCall, the question of what happens to the deficit, if there is a deficit, is an important one because before, as we know, the hospital boards could requisition. If they were four, five or ten per cent in the hole then they would simply go to the local ratepayers and obtain that requisition. But today, it seems to me, we find ourselves with this problem: if a hospital incurs a deficit, the only way that deficit can be met is somehow out of funds allocated by the provincial government through the Hospital Services Commission

which would mean that in the following year they would have to reduce their services in order to pick up the deficit from the preceding year.

Now if that isn't going to be the case then the other problem you get yourself into is that, if you pick up these deficits, what possible restraint do you have on boards from overspending? In other words, it seems to me that you get yourself into a difficult position regardless of which way you turn. If you pick up the deficits then you are not going to have any restraint on local expenditures at all. You are going to have, in effect, a blank cheque given to every hospital board in the province without the discipline of them formally having to go to their ratepayers to pick up the difference.

On the other hand, if you don't pick up these deficits you could be in the position of where you are reducing the quality of the hospital service in a given region.

Another question I would like to pose to the minister is, what happens to hospital boards when salary negotiations take place where there is a sizeable settlement after the budget has been sent in to the Hospital Services Commission? I understand that the boards sent in budgets last fall. Let's assume that hospital A sent in its budget in October but in April the various collective agreements come due. As a consequence of negotiations, or perhaps even of arbitration, their salary agreements are over the amount budgeted for.

It is rather difficult, it would seem to me, for the hospital administrator to be able to guess in October what a collective agreement might or might not result in three, four, five or six months down the line. So I'm wondering just what allowance there is, what flexibility there is for costs that occur once the global budget is set.

That really leads me to the final question. Is there some appeal procedure beyond the commission itself? Because it seems to me that if the commission is entrusted with the responsibility of disbursing the funds on one hand, but is in the final analysis the court of appeal on the other, you've got a rather difficult position for your local hospital board. Is it up to the minister in that case? Will there be appeals then from the Hospital Services Commission to the minister? And if there are, it seems to me that's putting the minister in a pretty difficult position because there is the chance at least, at that stage of the game, of the minister becoming involved in one hospital controversy after another. I'm wondering whether there is some appeal mechanism beyond the commission.

The final point, Mr. Chairman, Mr. Minister, is not really so much a question, but rather an observation. It deals with the question of local autonomy. I'm convinced that there really has to be unfettered access by every level of local government to some form of tax. For a long time I took the view that the provincial government should be funding various programs such as education and hospitalization 100 per cent. But the more I thought about it, the more I've come to the conclusion that once you undertake 100 per cent funding, there is really no way that you can maintain local autonomy.

The whole question of local autonomy surrounds, in my judgment anyway, not having control over 100 per cent of your funds but having control over that portion of funds or funding which gives you the leeway to be able to say to the Hospital Services Commission, or say to anyone for that matter, whether it is the school board or a local county councillor or what have you, that we disagree with you and we're going to the ratepayers within our jurisdiction and we're going to get the money to go ahead anyway.

So these are some of the questions which I would pose to you, Mr. Minister. It seems to me that the government's proposal does represent a departure.

One final question I'd like to put to the minister is with respect to nursing homes. I'd like to be advised how often and who inspects nursing homes in the province. To what extent is this an on-going proposition, and what is the present mix in nursing homes in the province? How many are provincially operated, municipally operated, and how many of the present facilities are privately owned?

MR. HENDERSON:

On a point of order, Mr. Chairman. I'm wondering about the debate and the nature of it. I believe the minister in the subcommittee indicated that he would be bringing in amendments dealing with the question of eliminating the right to local taxation.

I'm sure many of us wish to speak on that particular subject, and I was wondering if the minister is going to get the particular amendments into the House shortly because it might be better for a great deal of the debate on that subject to take place on the bill rather than at this time. But it depends to some extent too on when the minister is going to bring the bill forth, because many of the matters that were raised by the hon. Member for Spirit River-Fairview, I think, came up in the subcommittee and were touched on in principle.

So before we go further I wonder if the minister could give some indication of the priority in getting that particular legislation in the House, with the idea that we might be able to restrict debate on some aspects of the estimates which specifically relate to the legislation due at that time.

MR. CRAWFORD:

Mr. Chairman, the amendments that are required are consequential amendments in the bill that was introduced today by the hon. Minister of Municipal Affairs and appear in the last several pages of The Alberta Property Tax Reduction Plan bill.

MR. HENDERSON:

Mr. Chairman, on a point of order, I wonder if we could have some general understanding with the House. While I appreciate that every member has the right to pursue the matter at this point in time are we going to debate the terms of the amendment of the bill in committee? Does the minister have any suggestions on the matter? Could we more appropriately do it under the bill?

I am sure, Mr. Chairman, there is going to be a lot of discussion on the particular amendments in question. All I am putting is a procedural matter to the House: is any general understanding we can have between both sides as to which is the most appropriate place to discuss the matter?

MR. DEPUTY CHAIRMAN:

Would the minister like to indicate his preference here?

MR. CRAWFORD:

Yes, Mr. Chairman, I think it would certainly be better if it was done on the bill, if for no other reason than the fact that at that point hon. members will have both the bill and the estimates before them, whereas if we debate the issues that may be answered by the bill now, which was only introduced today, the same situation won't prevail.

MR. DEPUTY CHAIRMAN:

Is it agreed then?

HON. MEMBERS:

Agreed.

MR. WILSON:

Mr. Chairman, to the minister. I would just like to acknowledge the very considerable cooperation that I enjoyed from the minister during the subcommittee debate. And from that, I would just like to highlight a few points.

First of all, we would encourage the minister to try to arrange some form of allowance for those on public assistance to earn more than $25 per month, particularly those with physical disabilities. A graduated scale or something of that sort may be the answer.

We appreciate, Mr. Minister, the continued recognition and financial support of the good work being done by the private sector organizations, particularly in my constituency of Calgary Bow. Here I am thinking of the good work being done by the boys' and girls' clubs of Calgary, and advanced industries and we do also sincerely appreciate the new announcement that you made regarding assistance for the Beaumont Dental Clinic in Bowness.

One area, sir, on which I would like to place the most emphasis this evening is the Wood's Christian Home. I might mention that it is my understanding that an interim report is on its way to you at this time.

The research that has been going on for the past two years in the Wood's Christian Home is not complete at this time, but I understand that they have reduced their per patient cost from $165 per patient per day to $36 per patient per day.

They are conducting three experimental programs simultaneously: the first one treating patients at the Wood's Christian Home, the second one treating patients in their own homes and the third one training parents to treat their own children in their own homes.

The Wood's Christian Home people and the professionals they have engaged and who are assisting have been comparing the clinical effectiveness and the cost effectiveness of these three programs simultaneously. It is my understanding that they have determined that in all likelihood, one program is more suitable for boys and another program is more suitable for girls.

It is my understanding, further, that the present arrangements terminate at the end of this year. Before you make a final decision as to what you may or may not do, I would like you to seriously consider the interim report which is coming and consider the merits of extending the program for a further period of time, particularly when I recall that mental health was in the Throne Speech last year and it was a very important facet of your government's programs, and that in subcommittee we did determine that you weren't able to use all of the budget last year in mental health because of the inability to hire the professional people to carry out the work you had in mind.

So here we have a private sector non-profit organization doing very valuable and experimental work in the mental health field, and I would like you to very seriously consider that, sir, when you get the interim report.

Finally, I'd just like to say a word about the Baker Sanatorium adjacent to the Calgary Bow constituency. Last year it serviced a total of 245 in-patients, made up of tuberculosis and mentally handicapped patients. You did advise, sir, that there were additional facilities available on that site. It is a very picturesque site and there are buildings that are not being used now; there is space for expansion, and it does provide employment for people in the west end of Calgary where industries, as they are commonly regarded, are not suitable. So institutional developments and things of this nature are desirable and do provide employment where it is badly required; we would encourage further research and investigation into what additional uses the Baker Sanatorium site might be put. At the top of the list we would like you to consider a senior citizens' home, sir. Thank you.

MR. DEPUTY CHAIRMAN:

Mr. Dixon, followed by Mr. Taylor.

MR. DIXON:

Mr. Chairman, I would like to speak for a few moments on a situation in Alberta to which I'd like to draw the hon. minister's attention. It has to do with the abortions that are being carried out in our province at the present time. Statistics show that last year, under Alberta Health Care Insurance alone, over 3,300 abortions were paid for at a total cost of over $300,000 for the medical services -- that is the doctor's services -- and over $800,000 for hospital costs, making a total of $1,100,000 that has been spent for 3,300 abortions in our province. I notice that a doctor in Alberta received almost $12,000 for carrying out that kind of operation alone.

I'm wondering if we aren't making a mockery out of our law as it stands in Canada today, as far as the Criminal Code is concerned, not only here in Alberta but right across Canada. But we as a Legislature are responsible for Alberta. According to the laws of Canada an abortion can be performed only for therapeutic reasons, that is, if the life or health of the mother would be endangered unless the pregnancy was ended. I'm just wondering how many of these abortions really pass that so-called law that we have set up here in Canada. I suppose they must all be legal or we wouldn't be paying the money out. But we are paying in the neighbourhood of $1,100,000 a year, according to recent figures, that is for the period of January 1, 1972 to January 1, 1973.

This is destruction, really, of our unborn youth, our youth of tomorrow. I think that if there is any country in the world that can stand more population, and population by our own people, it's here, right in our own province of Alberta. There is certainly no shortage of space and there is no shortage of food.

Looking at it from the other end of things, if you read your own report, Mr. Minister, in the child welfare branch, adoptions have dropped drastically. There are many people who are desirous of adopting children. So we have in Alberta opportunities for these children.

I'm just wondering what the government is going to do to investigate the situation because it seems rather ridiculous in the eyes of a lot of people in Alberta. In particular, are the hospital committees that are approving abortions in Alberta not paying too much attention to them and just automatically have a regular form that you just say, "Sign this", and the abortion is carried out? There have been charges made by organizations who are interested in speaking on behalf of the unborn in Alberta; I'll just read you part of the brief that we all received, including the hon. minister, I am sure; they make a very serious charge. It says:

> In Calgary, apart from the scandalous situation in some of the large hospitals, there is now an outside package deal available for cutting the time in waiting for abortions. This is being run by the Calgary Birth Control Associations and the abortions in these deals, which take an overall time of three days from the first visit to discharge from hospital, are being carried out at the Foothills Hospital. As these deals are passed en masse through the abortion committee it seems this is another instance of deliberate abuse of the intent of the law.

These are some of the charges that are being made.

I think the onus is on the minister and in particular his department to investigate whether these are being carried out according to the law of Canada. We should do either of two things: we should either do away with the law or abide by the law. It is a situation that certainly warrants investigation. It is a situation that is costing a lot of money as I pointed out. Over $1,100,000 was spent in the last 12 months, the 12 month period from January 1, 1972 to 1973. The situation is made that much more serious when you consider that we are moving rapidly. Abortions represented 10 per cent of the live births in Alberta, but it is going to be close to 15 per cent very, very shortly at the rate it is going on here in our province.

They have the same serious situation in the province of Ontario and the Minister of Health there personally feels the government is going to give serious consideration to paying for this type of service from the Medicare funds. So, Mr. Minister, I would urge the government to look at this situation, especially in light of the fact that in your own department, the child welfare department, there are a lot of people who would be anxious to adopt babies. Maybe if we could get to some of these people who wish to have an abortion and say that if you think the child may not have a good home, or that you may not be able to provide a good home for him and you don't want him, then maybe your department could do some work in that field and find a home for these children and maybe cut down on the unnecessary procedures that are going on now.

In a country such as Alberta and Canada where we have all the great things the good Lord has blessed us with to look after our people, if it is a problem, as I mentioned earlier, Mr. Chairman, that these people feel the child might be unwanted, I think if you could get to them and show them that there is a great demand from other couples in Alberta who cannot have children and are anxious to adopt a new born baby, I think we would be doing a service to these unborn children who we are all so concerned about. Thank you, Mr. Chairman.

MR. TAYLOR:

Mr. Chairman, I am introducing another topic, as a matter of fact two items that I would like to mention. The first one is in line with the government's decentralization policy. I would again like to bring to the attention of the hon. minister an excellent opportunity for decentralization regarding hospitalization.

The town of Strathmore is very anxious to have a hospital. It is a reasonable distance from Calgary; there is a good highway and the highway is improving, with a double lane probably almost complete by the end of this coming year. There is an excellent opportunity for accommodating some of the doctors that were mentioned by the hon. member for Calgary McCall, Mr. Ho Lem, because the driving distance is only a few minutes. As well as looking after the local population, it is so close to Calgary that I think there is an excellent opportunity to provide good medical attention and good hospitalization by decentralizing our hospitals from a large metropolitan area to smaller centres. I would again recommend to the hon. minister that he take another look at this. I think there is a real potential there. The people there are most anxious to

have a hospital. I think he would find tremendous cooperation from the chamber of commerce, the town council, from the County of Wheatland, et cetera.

I think also, it might be welcomed by the doctors of Calgary who have been unable to get into the hospitals in Calgary, and as I said before, the driving distance is very reasonable.

The other item that I would like to mention is really to point out to the House, two tremendous services that are being provided for inebriated -- or people who are unable to control their appetites for alcohol.

I refer, first of all, to Recovery House. I have visited Recovery House on more than one occasion and I've been most impressed by the work that is being done by the dedicated people in that house. I haven't visited the Vegreville section, although I want to do that. But the idea of responsibility -- and this caters to people who are really down and out; they just haven't got anything; they have no place to go; there is nobody to look after them and in many cases nobody wants them. It's a tremendous service. I think you have to give these people real credit for looking after people who have lost all hope, who have become complete alcoholics. They are what you would call down and out. The work that is being done there tc build responsibility and the dedication shown by the workers is really tremendous.

I am very happy that the hon. minister said the other day that arrangements were being made to continue this tremendous work. I hope that the hon. minister, if he hasn't had a chance to do so, will take a trip to Recovery House.

It's not a wonderful building. It may be run-down, but it does provide accommodation and every one cf the people who goes in does his share. They get a chance to build responsibility; they do their own cooking; they clean their own rooms and they have some excellent counselling, particularly by a man who was an alcoholic himself, who has given not only of his life, but of his worldly possessions. He's gone the second and third mile in that regard, in trying to help those who have become the victims of alcohol.

The other institution does a similar type of work but it endeavours to catch people before they are down and out, while they have a problem but they haven't yet lost their home. They haven't yet lost their entire bank account; they haven't lost their wife or their husband, whatever the case might be -- or their children. They are getting to the point where they just can't stand up under the pressure. I'm talking about Collingwood Acres in this regard. Here a distinctive service is again being given to people who are not completely down and out, but who are people on the way, and unless something is done it's not going to be too long before they reach that point.

So while the two institutions are doing similar types of service, by the same token they are distinct services for people who are in different categories, different degrees of inebriation and loss of responsibility. These people still care but they are unable to cope with the world and everything; the pressures are getting heavier and heavier. I was most impressed with the program that I've seen in operation at Collingwood Acres, where again responsibility is instilled into these people. They look after their own rooms, they do -- it is definite that they have to do certain things. It's not done for them. They don't have somebody carry their suitcase to their room. There is an endeavour to build responsibility. Again we have some very highly trained and highly dedicated workers.

Both institutions cater to those who are unable to pay if they are able to help. I believe the Alberta Alcoholism and Drug Abuse Commission and the hon. minister have done well in providing some assistance, not entirely grants because Collingwood Acres is a case of taking part of their program and carrying out a program to the satisfaction of the Drug and Alcoholism Commission which I think is good. I think they like it and I think it's a very excellent program in that regard.

On the other hand at Recovery House, these people have absolutely nothing and somebody has to look after them; they are human beings. I think if the rate of recovery is anything at all, and I know it is, it may not be high. I don't know exactly what it is, it probably varies from month to month. But it is providing a service and it is giving some of these people who have no hope a little bit of hope and a little bit of encouragement to try to make the grade and get back into a position of responsibility.

In connection with Collingwood Acres, it provides those people with help when it's needed before they become pressed down completely by the heavy load of

pressures above them. Many of them, as a matter of fact a very high percentage, are able to recover and get back into the stream of things and continue to get help.

So I want to commend anything that we are able to do publicly for this type of institution. I have seen both of these places at work and have been most impressed. I want to say to the minister that in my view he and the Alcoholism and Drug Abuse Commission have made no mistake in giving some assistance to these two fine institutions, both of which are doing similar work and yet a distinctive type of work among people in different categories.

MR. COOKSON:

Mr. Chairman, Mr. Minister, I wasn't able to participate in the subcommittee because I was tied up in another committee so I thought I might just take a few minutes and express some of my concerns with regard to hospitals and hospital costs and so on.

The sign of a good politician I suppose is one who is able to listen, and in the case of this evening I suppose that puts the minister right up on top. The Member for Calgary Mountain View on occasion is able to get re-elected and he never listens so the analogy doesn't always follow through.

MR. HENDERSON:

He just doesn't listen to you.

MR. COOKSON:

There you are you see, he doesn't get the point yet.

One of the problems that perhaps I could discuss in the Assembly is the fact that the government is able to pick up the supplementaries for the various hospitals throughout the province. I don't have any quarrel with this. I think it's of great merit, although I was interested in the comments from the Member for Spirit River-Fairview suggesting that he felt perhaps a supplementary or words to this effect should be passed on in order to control costs. It's a good thing to remember in the future because it not only applies to hospitals. I think the rule can be applied to many, many other things such as education, insurance and this sort of thing.

The supplementaries -- I'm just checking through the municipal statistics for 1971 -- indicate that we will be picking up supplementary mill rates ranging from a maximum, this is in 1971, of 12.91 right down to 0. This really concerns my constituency. I have two hospitals there, one of 50-60 bed capacity. In this particular hospital the administrator has discussed this with me and pointed out what she considers some of the weaknesses in the fact that supplementaries are picked up.

When one analyses the reason why these supplementaries vary so greatly, assuming that the mill rate is the same amount of dollars, you can come up with alternate answers. You might, for example, suggest that the reason is some inequity that we inherited from the former government. As far as grant structure goes, that would be a reasonable way to explain the differences. Or you might argue that it was due to an inefficient operation which might be due to an old hospital, an inadequately equipped hospital or possibly poor service and insufficient accommodation in a patient-bed ratio.

You might argue also that it is due to the inefficient operation of the hospital. This is the area I would like to touch on because in assessing this with the Hospitals Commission, I think that here we are still not on top of the real problem in some of the hospitals.

I can take the one, for example, at Lacombe which is a 50 - 60 bed hospital. I look over the indices. I have the statistics for the indices for this particular hospital, and I was interested in the analysis because it is certainly an efficient method of bookkeeping. It breaks the operations of the hospital down into different categories and attempts to assess where a hospital is efficient and where it is inefficient. When we assess the one in Lacombe -- and this is for the period from January 1 to October 31, 1972, which is part of a year -- the particular hospital under this administrator was, at that point $7,600 below the median for a group of 16 hospitals in the area of laboratories. In the x-ray area this particular hospital was $10,000 below the median for 16 hospitals in this category. In the area of laundry this particular hospital was $6,000 below the median for the 16 hospitals. I could go on and list these discrepancies. In the dietary area it was $8,000 below the median; for graduate

nurses, $22,000 below; and for medical and surgical costs, $4,500 below the median.

When you add up all these figures this particular hospital, after three quarters of the year was completed, was $82,000 below the median for 16 hospitals. This isn't exactly a new hospital, so it can't be credited to that. I think it is credited to the efficiency of the operation of the hospital. This has to include not only the administrator, who is probably one of the most important people in the hospital, but also the doctors who work with the administrator. This hospital, I would say, is probably one of the -- and I think the minister will agree with me -- more efficient operations in the province. The net result is that absolutely no supplementary has been passed on to the municipalities.

Yet we have other hospitals in the same sort of category that have passed on up to 13 mills as supplementary. I think, Mr. Minister, if I may make the point, we still haven't zeroed in on efficiency of operation. I can't accept the fact that the Hospitals Commission has faced up to the real problem of efficiency.

Now if we are going to set guidelines and standards and pick up all of the costs, then I don't think we can go in through the back door and bail out a particular hospital because they can't run an efficient operation.

There is a hospital reasonably close to me that in 1971, through some means, was able to acquire an equalization payment of $36,000. There were other hospitals in this category that also picked up equalization payments. This same hospital was able to pick up through some form of equalization payment, which I haven't been able to interpret, a further $25,000 in 1972. Now my administrator at the Lacombe Hospital is deeply concerned that rather than face up to some sort of efficient operation, we may be trying to solve the problem by coming in through the back door and supplementing the hospital operation.

I think I've made my point that I'm concerned, and I know the administrator of this hospital is deeply concerned. When the payments come for 1973 and 1974, she is advised that because you are an efficient operation, you can operate within those boundaries -- that the equivalent amount you will recap through grant will be restricted accordingly, or at least limited to what it was in the prior year.

Now what position does this put a hospital that is operated on a really inefficient basis for a long term? What sort of argument can we use in this case? I think possibly, Mr. Minister, that we'll have to take another closer look at some of the operations of some of these hospitals, that we may even have to interfere more with the administration. There are many, many ways that hospitals can operate inefficiently in all these areas. Doctors carelessly use equipment, if they over-use drugs.

This particular administrator can tell me exactly to the ounce how much laundry is used by a patient. In fact when I went to talk to her with regard to this problem it was in the afternoon and I turned on the lights; I couldn't see too well, it was dull in the room. She said, "We don't turn the lights on until 4:00 o'clock."

But I simply point this out to indicate that we must explore more efficiency in some of these operations. I hesitate to say this, but I think I could readily volunteer the services of this particular administrator to the Hospitals Commission if she were willing to assist in order to perhaps improve some of the operations that are going on around and about her.

MR. HENDERSON:

Mr. Chairman --

MR. DEPUTY CHAIRMAN:

I wonder, Mr. Henderson, if we could have the indulgence of the committee just for a minute while we have the other resolution brought in on the Health Commissions.

MR. HENDERSON:

Are we going to deal with both those resolutions?

DR. McCRIMMON:

Mr. Chairman --

MR. DEPUTY CHAIRMAN:

Then you can speak after that, but we'll have both resolutions.

MR. HENDERSON:

Right now?

MR. DEPUTY CHAIRMAN:

Right now, and we'll get the other one in on the Health Commissions.

MR. HENDERSON:

[Inaudible]...call them separately.

MR. DEPUTY CHAIRMAN:

Yes, but I would like to see them both and I've only got one here. Go ahead, Dr. McCrimmon.

DR. McCRIMMON:

Mr. Chairman, Subcommittee A has had under consideration Vote 24, the Estimates of Expenditure for the Health Commissions and begs to report the same.

I therefore move, seconded by the hon. Minister of Health and Social Development:

Resolved that a sum not exceeding $290,876,268 be granted to Her Majesty for the fiscal year ending March 31, 1974 for the Department of Health and Social Development.

MR. HENDERSON:

Mr. Chairman, I just want to comment on one or two particular aspects of matters that other members have brought up and on the whole, I think, support some of the propositions that have been presented to the minister. I might say, Mr. Minister, I don't particularly expect a response to them because I think in general they are offered in support of the job the minister faces.

I think, starting with the question of global budgeting and excess costs, of course the minister is well aware of the fact by now that no matter how much money he gives out to any hospital, he's wrong. He's either over paid them or under paid them and unless he writes a blank cheque that's the only way he is going to keep everybody happy. Then the Treasurer would be unhappy.

But there is no question about the experience in this area that legislators all across this country have to bring the question of exploding, rapidly increasing costs of health services under control. It was about a year or two ago, I haven't seen the most recent statistics, but the costs of health services in Alberta and Canada had doubled in five years. And anybody with a command of Grade 8, or elementary arithmetic doesn't need much imagination to predict the financial consequences of letting that situation continue. One of the problems, very clearly, is getting the message across to the public as to what the problem is.

We've faced a similar problem in education costs that doubled in about five years. There seems to be some difference between health and education. In education people always seem to think in terms of somebody else's children. When it comes to health costs, it's a very personal matter, even much more personal than the educational business is and it is a little more difficult to deal with.

I don't think the public has a clue as to what it really costs to run these services. I think the government is going to have to do more in the area of publicizing what the problem is. Just a public relations exercise saying they are doing more, spending more money on mental health and spending more money on this and that and so on and so forth obviously isn't really dealing with the basic problem, which I want to come back and touch on again in a second or two.

But I want to suggest to the minister that I hope the commission does make allowances in the global budgeting exercises for the unforeseen. In large hospitals, particularly in the larger urban centres, the costs are fairly predictable, in the sense of predicting labour costs, utilization, and so forth.

But on the global budgeting problems in smaller hospitals, the costs are highly susceptible to influence by say, the professional orientation of the doctors involved. A hospital has only one, or two or three doctors using it and one doctor leaves; another one comes in; the amount of surgery jumps dramatically because of that one particular physician. His predecessor didn't have the same interest, the amount of surgery goes up, costs shoot up astronomically and there is very little the local board can do to control it.

I am sure the minister is aware of this. It is a matter of the change in the utilization pattern of the facilities and the costs are changed accordingly. There can be other cases where the cost could go down. But there obviously has to be some allowance in the global budgeting system to deal with these particular problems.

When the minister goes into a global budgeting program and then on top of that eliminates any flexibility at the local level relative to access to local taxation that enables the board to deal with those variables, then very obviously the minister is going to have to deal with them. Simply turning the deficit over to the following year and saying "You have to tighten your belts, fellows," is really not going to deal with the problem. It might severely jeopardize the services the hospitals are providing, but that's maybe a little too steep a price to pay for dealing with the problem.

The small hospitals are highly susceptible to the manner in which the doctors are using them and to a large extent the problem rests beyond the control of the hospital board, unless the board is going to start decreeing very specifically what type of work a doctor can do at a given hospital. And I restrict my remarks specifically to the smaller hospitals.

Similarly, I know from experience in some areas of the province, particularly in the northern areas -- and I use the case of Lac La Biche as an example -- a couple or three years ago there was a very serious outbreak of chest infections in the district. The occupancy rate and the utilization rate in the paediatric ward in the hospital shot up very dramatically. It went up to about 120 per cent of its rated capacity. They had beds all over the halls and so on.

I recall at the time there was some definite pressure to even expand the hospital, which I declined to respond to because we had to see if it was short term. Eventually it came down again. And I recall very definitely we had to make some adjustments in the payments to the hospital in that case, to take care of that unforeseen development in that particular incident in a small hospital.

And so, I favour the global budgeting system in principle, having introduced it. But there are some very definite pitfalls and shortcomings relative to the operation of small hospitals and the commission, I am sure, is aware of them. They simply have to make allowance and provide sufficient flexibility after the fact to deal with some of these unforeseen factors which significantly affect costs and budgeting in small hospitals. I hope the commission is making allowances for those possiblities in those instances.

One thing I haven't heard the minister say, but I assume, Mr. Chairman, that the commission is going to continue to exist; that the government has crossed the bridge and has decided that the commission should continue. If I'm wrong, I would like to be informed of such. Nevertheless, I think the government has made a wise decision.

In my own view, having the commission as an administrative tool was one of the prerequisites to dealing with the problem of tackling the costs of health services because of the significant political pressures that are going to develop if the minister is to try to carry out and follow through on some of the suggestions that have been forthcoming from, for example, the Member for Lacombe. I basically have to endorse some of his concerns.

But there is one other major thrust and major change that the government should really be examining in the area of policy. Quite directly this touches on the remarks of the Member for Drayton Valley, Mr. Zander. The member Mr. Zander has his head in the sand, as usual, as to what existed before 1971, particularly as it relates to nursing homes, because as the minister is well aware -- but the Member for Drayton Valley is obviously still unaware -- up until the last election in Ontario when the Government of Ontario made a

commitment to introduce a nursing home program, Alberta stood alone in all of Canada as the only province with a universally public-supported nursing home program. So when one talks about tremendous influx of capital to deal with the nursing home program, it's obvious that the Member for Drayton Valley is completely unaware of the reality of the situation. I know the minister is aware of it. In relation to the other provinces, there isn't another province that can come anywhere near the province of Alberta in the level of services that are provided in the area of beds -- active beds, auxiliary beds and nursing home beds -- and that touches on one of the main problems the minister has to deal with.

But while I can't accept the political rhetoric of the Member for Drayton Valley, I'm nonetheless sympathetic to his concerns about the problem of providing custodial and extended care services of an auxiliary hospital nature in the rural areas.

This relates to a large extent, in my view, to two things; one of these is the existence of the large auxiliary hospital districts which are unrealistic. I have said they are unrealistice since the day I took my seat in the House and told the Minister of Health and Social Development at that time that I disagreed with it.

The first meeting I had with a minister of the Crown after my election was on the Wetaskiwin-Leduc Auxiliary Hospital District. I was the mayor of the town at the time the thing went in. I refused to allow the supplemental requisition to be paid to the auxiliary hospital district in the first place. In the final analysis I had to agree to pay it, but the auxiliary hospital districts and the large areas they cover -- when a place like Drayton Valley is lumped in with the city of Edmonton for auxiliary hospital services and nursing home services -- is completely unrealistic.

It was that realization that prompted the government and myself in 1971 or 1970, I forget which, to introduce the amendments to The Hospital Act providing the legislative vehicle to allow for the disbanding of the large auxiliary districts, and in connection with that, the integration of the hospital and health authorities within a given area, and a smaller area, under one jurisdiction.

It just isn't quite simply the large districts. There are, quite simply, too many local authorities in the health business. Can you imagine the chaos that would exist in education if every school in Alberta was under a different board? But that's exactly what the hospital system and health delivery system are. The active treatment hospitals, with very few exceptions, have a separate board for every active hospital. The auxiliary hospital district was a step to try to minimize the number of boards by setting up a big geographical area to look after auxiliary and nursing home care, but it doesn't deal with the reality of the attitudes of people in the rural areas. It was impractical.

I suggest that the answer we hope would be another step toward coming to grip with hospital costs. And primarily in Alberta with its super-abundance of active beds, of beds in total for custodial care and treatment of one sort or another, one of the major problems is to get the maximum amount of mileage out of the facilities that exist in the province today. The job is going to be extremely difficult, when you get five or six autonomous boards in a given area, one looking after health units, one looking after an auxiliary nursing home district, and the district board in Edmonton couldn't care less about the nursing home needs in Drayton Valley and the board out there in the active treatment hospital doesn't have the jurisdiction to deal with it. You get in the larger centres where there is a multiplicity of active treatment hospitals. The hospitals compete with one another for prestigious projects and items, and they do.

I sat on that side of the House and accepted criticisms from the members from Calgary, who sat on this side of the House, about the refusal to allow the General Hospital in Calgary to go into open heart surgery, simply because there had been a surgeon on staff in that particular hospital who felt he was entitled to his God-given rights and the taxpayers of Alberta had to fork over tens of thousands of dollars to set up the equipment in that hospital, notwithstanding the fact that the Holy Cross in Calgary was adequately equipped with those facilities and they were substantially under-utilized.

So then some secret donor or benefactor is going to come along and contribute the funds to buy the facilities, to buy the machinery and the hardware required to go into the business. Then the political pressure goes on the government to find the operating cash to maintain two under-utilized open heart surgery units in the city of Calgary. I just use this as an example. I

use it as an example of the problems government has to deal with in controlling costs when you have hospital boards competing with one another in the area of prestige.

You also face the reality when you have a separation between active, auxiliary and nursing home care, they are under separate jurisdiction and the pressures are on the local authorities for their budgets. The nursing home, the private operator, he naturally says, "Boy, I don't want anybody in my nursing home who is going to run my costs up," so he tries to put the patient in an auxiliary hospital. Then the auxiliary hospital on a different level, they don't want this particular type of patient running their costs up, "We have to keep within our budget so we'll put him in the active treatment hospital."

And so the separation into this multiplicity of jurisdictions in the system when it comes to custodial care and treatment, almost dictates, with the pressures that are on local authorities and boards, with the multiplicity of them, that the patient gravitates to the most expensive level of service that can be justified. It's not whether he needs it or not, but the budgetary pressures are there to force him up into the higher level of service. It is automatic when one looks at the financing of the programs.

I stand convinced, and I haven't changed my opinion, that one of the primary steps required is to disband the large auxiliary hospital districts and establish districts based more on the lines, at least in the rural areas, of the active treatment district and have one board that is responsible for active nursing home and auxiliary hospital care. Then one board can have the authority and the responsibility of getting, under a total global budgeting proposition hopefully, maximum utilization out of the total facilities that are available, with the idea of getting the patient plugged into the level of care that is adequate for his needs, and eliminate this pressure.

But once you come to the large urban areas, nobody will convince me that if a school board in the City of Edmonton can run all the schools in Edmonton, why on earth one board in Edmonton couldn't run all the active treatment hospitals in Edmonton just as well. Or maybe split the city. But there are simply too many authorities involved at the local level in the area of health services, delivery of the services, that is going to make it overly difficult for the government at the provincial level to come to grips with the politics, the political aspect which really has to be dealt with in the final analysis in the problems relating to the control of costs.

So I suggest, Mr. Chairman, now that the government seems to have made at least one decision to retain the services of the Alberta Hospitals Commission, which I think is a sound decision, I suggest they should start much more aggressively examining the question of the multiplicity of authorities that exist at the local level, that relate to the delivery of health services.

If one looks at the health services, custodial institutions or institutional cares that exist in the province there are simply too many of them. This exists all across Canada. It's really, fundamentally, that the total system was not planned.

The only effort that I'm aware of that really related to planning in the final analysis was the development of the nursing home program an effort to reduce the high cost of services relating to auxiliary care. But as a general rule the system has evolved. It evolved at a local level, it evolved under the aegis of volunteer organizations groups all across the province and all across Canada. But now for practical purposes it's all strictly and entirely, particularly since the advent of Medicare, in the public sector. And the government, primarily the provincial government, has the task of trying to come to grips with dealing with the costs involved.

I simply would conclude by emphasizing that one of the steps that has to be taken, in my view, is the reduction in the number of local authorities. And I suggest that it is going to take a little bit of intestinal fortitude to achieve something of a realistic nature in this way.

And while I would indeed be surprised, Mr. Chairman, if when it comes to the arguments over the means of controlling hospital costs and health costs there weren't some difference of opinion, I want to say, personally at least, that I certainly support in principle the efforts on the part of the government.

But I haven't really seen many efforts yet in this direction to do something about flattening out the growth-rate curve and the cost of health care services in the province. Again, Mr. Chairman, I think the government is going to have to display a little more initiative in looking at the proliferation of

local authorities that exist within the system today. I say this with full realization that it was not the existing government that was responsible for that situation.

It is an unfortunate fact that the delivery of health care is sickness-oriented. Logically, the preventative ends of the services should have been developed first. You would only put a person in an institution as an absolute last resort. But unfortunately the system that has evolved is primarily a result of the federal government's cost-sharing programs, which literally forced all the provinces to go along with it and encouraged the provinces to develop comparatively high-cost institutional services. Now we are saddled with the problems of trying to run them. But it does bring out, as a secondary need, the need for developing far more effective and efficient preventative services with a view to keeping people out of these institutions in the first place.

MR. GHITTER:

Mr. Chairman, would it be appropriate now to make some comments about the Alberta Alcoholism and Drug Abuse Commission or do you wish to deal with that after?

MR. DEPUTY CHAIRMAN:

If that's part of the appropriation --

HON. MEMBERS:

Agreed.

MR. GHITTER:

Mr. Chairman, I would just like to go on record to discuss a few matters with the hon. minister with respect to a concern of mine relating to the Alberta Alcoholism and Drug Abuse Commission.

I would first like to say that I totally support the basic intent of this commission, and also the fact that we now have a permanent director of the commission. However, I am somewhat disturbed over happenings and directions that I am seeing within the commission. I would like the hon. minister to consider how this commission can get the maximum advantage in the community to perform a most needed service within our community in an ever growing area of abuse and concern to all Albertans.

I'm firstly concerned, Mr. Chairman, with the area of the loss of certain personnel within the commission since the appointment of the new director. I note that Mr. Wacko and Mr. Birch have now left the commission and also note that they were devoted servants of the commission over a period of time. I hope, Mr. Minister, that we will be able to obtain adequate replacements.

I am concerned, Mr. Minister, over what appears to be a centralization of programming within the Alcohol and Drug Abuse Commission. I see a tendency from statements made by the new director, for example, relating to the Calgary drug and information centre, which was a community-oriented growth area that was structured to develop and deal with the problem of drugs within the Calgary community. I see the possibility that this will now just become an arm of the government, of the commission, and it will lose the flexibility and the community orientation that it has at the present time.

I think it is indeed important that the commission provide liaison, that the commission provide expertise and that the commission provide encouragement for new directions within the community-oriented outlets that we have throughout the province.

But I hope the commission in its new directions will not overcome the local bodies that have grown within the community and performed such excellent work within the community, so they will merely become another arm of government and lose their identities within the community, which I think would indeed be unfortunate.

There have been representations made, for example, in the City of Calgary by the Riverside Villa Association which is a group of local Calgary ladies who have performed excellent work in the area of a home for alcoholic women. This type of work, their desire to have support from the Alcoholism and Drug Abuse Commission, I would hope would be highly encouraged by the commission and your department.

I think one only needs to study the Cooperative Commission on the Study of Alcoholism, a report to the nation in the United States which clearly identifies the treatment programs that they recommend to help combat alcohol problems. One of the overriding recommendations of this report lays out a stress on community-oriented programs, deep within the community, emanating from the community, with the overall use of non-professional people who can well relate to people who are having alcohol problems and drug abuse problems within the community. I would hope that we do not embark on a highly centralized program within the Alcoholism and Drug Abuse Commission, which will result in programming coming out of one source and not being derived from within the community itself.

I would also hope, Mr. Minister, that through your good offices the commission will endeavour to create more energetic programs at a community level from the point of view of dealing on the street where many of the problems occur. I note with a considerable amount of concern that if one were to look at the records of Henwood where one-third of the alcoholism and drug abuse commission funds are allocated, that out of some 719 individuals who were treated in Henwood, only 54 of these people were Native people. I think, knowing the problems that the Native people have with respect to alcohol and drug abuse; it seems to me somewhat incredible that such a very, very small proportion of the Native problem is being dealt with in Henwood.

Now I know there are out-patient treatment situations which apparently are being extended by the commission, but I think many of the people within the commission are doing the comfortable thing. They are going into the Henwoods, they are going into the comfortable offices, they are going off the street to try to perform their services. But I don't think they are going where it counts. I don't think they are moving out into the gaols. I don't think they are moving within the Native community where the problems readily exist. I think this is where the action is and this is where they should be.

In the areas of the problems with the white-collar people who have alcohol problems, they seem to be readily acceptable within the Henwoods. Some of them can afford to go to Collingwood. All these agencies perform excellent work, as the hon. Member for Drumheller has mentioned. But the real problem, the majority of the problem, I believe, still exists at the lower levels and I don't think that the Alberta Alcoholism and Drug Abuse Commission is getting to it.

I would hope that the direction of the commission under their new director would be to get into these areas to perform this valuable service to the people where it counts, on more of the street level.

I'm also concerned, Mr. Minister, about what appears to me to be a extreme lack of programming in southern Alberta. It seems to me that many of the resources and funds are being allocated in northern Alberta and there is an extreme lack of programming in southern Alberta. For example, I note the total case load that was dealt with by the Alcoholism and Drug Abuse Commission in its last reporting year was some 6,731 patients. Out of that number, only 1,734 were treated in southern Alberta through the Calgary Out-Patient Clinic, the Calgary Correctional Institute, the Lethbridge Centre and the Lethbridge Correctional Institute. I am sure that there are not more alcoholics or drug abuse individuals in northern Alberta than in southern Alberta. I am sure this relates throughout the province.

I would also stress and certainly urge you, Mr. Minister, through the commission, that there should be a heavier emphasis and direction of programming within southern Alberta as well. It seems that because the main people and offices of the commission happen to be in Edmonton, when they embark on a new program they do so in northern Alberta. As a result, it starts to grow and grow and it becomes a northern Alberta program and our southern neighbours seem to go without, to a certain degree, to the extent of the services that are needed.

So, Mr. Minister, I would certainly recommend for your consideration the areas of my concern in a very difficult and frustrating area, an area that is growing unfortunately and an area that we must become more and more involved in in our programs. Although I am still somewhat skeptical of the success of the program to date, and I am somewhat skeptical of the directions I think the commission is taking right at the present time, I will just more or less hold it in reserve and hope that some of these thoughts I have expressed to you this evening will be an approach of directions where the commission should be in future years.

MR. PURDY:

Mr. Chairman, during the committee's study on the Alcoholism and Drug Abuse Commission the Collingwood Acres concept was brought up. At that time the word

got out that Collingwood Acres was the place for the rehabilitation of the executive alcoholic. I don't believe this is quite correct. I received some feedback on this as Collingwood is situated in my constituency. When the minister sums up tonight, I would like him to correct this statement. I think it is an institution set up for those with the ability to pay, but it certainly isn't a place for an executive drunk, or alcoholic, I should say.

MR. BENOIT:

Mr. Chairman, I would like to raise the question of how Collingwood was established in the first instance, whether it is a private establishment or whether it is established with the assistance of government funds, and if so, under what circumstances?

MR. TAYLOR:

Mr. Chairman, just before the hon. minister answers, I wonder if he would also deal with the detoxification centres, where they are going to be located, if they are going to replace other services, and so on?

DR. BOUVIER:

Before the minister gets up, I was wondering, when he is discussing global budgeting, whether he may give us some indication of what he is going to do or what they plan on doing with situations that we have heard about tonight, where a hospital in Lacombe is obviously -- this wasn't given -- running at a very low occupancy, is doing a very low surgery and has got long-stay patients. That is the only way they could come up with the figures that we have heard tonight, in comparison to another place where they are running a very high occupancy rate, but are doing a lot of surgery and have a lot of short-stay patients. How are you going to compare the two when you start giving out budgeting on a global budget basis?

MR. CRAWFORD:

Mr. Chairman, I might make just a few remarks.

[Laughter]

But I probably won't. I'll perhaps even make a great many remarks. I do want to say first, Mr. Chairman, -- and I mean this -- that I have observed that despite the many and varied subjects that have been covered and the many parts of the province from which the expressions of opinion have come, there is on both sides of the House a concern which is shared and a desire, I think, to achieve objectives which are in many respects similar.

I would like to go over the various questions in the order in which they were raised. Now what I will try to do, I have noted what each hon. member raised, is to come back to some because, for example, the hon. Member for Calgary McCall is out for the moment. I will try to deal with the remarks of some who are here and then come back to the others.

Both the hon. Leader of the Opposition -- but for the moment I'm speaking in respect to the remarks made by the hon. Member for Drayton Valley -- spoke in regard to the unsatisfactory nature of organization of districts for auxiliary hospitals and nursing homes.

Because of what the hon. Member for Drayton Valley had said to me over the past several months in this respect, the particular situation which he describes quite accurately in Drayton Valley is one that we are reviewing I suppose just for the information of the House, I would say that we are reviewing it as a result of his representations.

I should mention that he has, to my knowledge, been going over the matter with the local board here in the hope of finding something of a solution, at the same time that the commission and I are reviewing the difficult question of boundaries. It would have to be said that even with the situation as unsatisfactory as it has been over a period of years, I think he received a good hearing from the Norwood board on this most recent occasion. It is possible that it can be resolved.

Even if that is done, I think the question of the size of the units and their apparent inappropriateness is something that we will definitely consider. In assuring hon. members that all the remarks that were made this evening by way of suggestion, I'll try to deal with the questions specifically, but all of the

remarks made by way of suggestion will indeed be given full consideration, both by myself, the department and, of course, by my colleagues.

Now the hon. Member for Spirit River-Fairview is here, I'd like to deal briefly on the understanding that maybe more will be said, as we suggested a little while ago, when the property tax reduction plan and the reference in regard to The Hospitals Act and the right of requisition and so on are being debated.

But I don't have any doubts that whatever the difficulties are, the concept of global budgeting is, if not the only means to succeed in what we are setting out to do, at least the best known means. There are several reasons for this. The question was asked, for example, and this was raised by a couple of hon. members, what do you do when you are faced with the apparent inequity, when you start out to assume what we will call final dollar support, the ending of the requisition and the full funding by government? When you start out to assume final dollar support you find that by then the inefficient operator has run up a big budget on his average over the years and the more efficient one has run up a smaller one. So your weakest link is in the administration with the most dollars and your best people, you might say, with the least.

I think the answer is that the surveillance which is on-going by the commission is adequate to detect it when that happens. I gave a brief description of this surveillance last year. It was being nicely developed at that time and I think it is becoming more useful each year. They have a number of indices of the different types of operations and calculate the per-day and per-unit cost of various types of services within each hospital, and classify the hospitals of the province into I think nine categories, from the very few large major ones down to the very few small and extremely inefficient units, and then in between, the majority of the actual hospitals and boards. By working with the data they get and using medians that are set up against each of the groups, they learn a great deal about what it should cost in a particular size and type of hospital to have the best type of operation that can be had in that type of unit.

So how do you use that? Well, that is one of the devices by which the least efficient is first identified. You find it. Secondly, you can through regulation or administrative leadership, either at the board level -- because it does happen, of course, that with good administrators a lot of leadership is provided locally -- or with the suggestions that the commission and its people are able to make themselves in regard to areas where money is being wasted and things are not operating in the way that they should, bearing in mind how other similar ones of the same size do operate; then make corrections.

It sounds, when I say that, like the process must be a gradual one, and it is. It is not the sort of thing that can be achieved in one or two years, even with an individual board. When one is working throughout the system it can't be achieved in one or two years, I suppose, except one at a time or a few at a time.

Using that type of approach, I think it becomes apparent that anything would cause more difficulties than the global budgeting system. You have to have the amount of flexibility in order to make allowances for things that are, in fact, variations from one type of hospital to another similar type of hospital.

Now you will note that I have left the word "inefficiency" for a moment and referred to variation, because as the hon. Member for Lac La Biche-McMurray mentioned, there are many, many other factors that could relate to this. Therefore, any other ingredients that would go into the budget of a particular hospital -- and I hope in part, although only in principle, I am also answering the question recently raised by the hon. Member for Lac La Biche-McMurray.

I recognize, for example, that when requisitions were regularly done in many districts the situation varied not only on the amount of money spent or on the amount of efficiency that there was then. It is quite clear that the value of assessment in the community, the mix of the assessment in the community that's available, may be the factor that determines whether or not you had 1 mill or 12. No other direct comparison of the operation might yield as much significance to that variation as the simple fact of a difference in an assessment base and the fact that in certain communities a mill yields very little indeed. We take the example of the City of Edmonton. Their hospitals cost them about 1.75 mills last year. That represented in the neighbourhood of $1.5 million. And of course that would have financed a great many hospitals, all of them out requisitioning 5 mills or 6 mills, in various parts of the province. That's just stated for the purpose of giving that type of comparison.

I think the basic issue is one of the containment of cost escalation, and that is central to the issue of having the municipalities no longer made subject to the requisition by the boards. Let's remember after all, that that's what it is. It is not that the municipalities and the province between them have strictly speaking been funding the province out of general revenues and the municipality out of its property tax. What really happens is that the board is in between them both and you have the board in the position where it actually has two sources of income. As soon as you have any body which has two sources of income, you find that your financial accountability becomes very shaky.

I'll go just a little bit further into it by reiterating what is really happening. The board says, "We require this amount of money." The Hospital Services Commission says, "Your budget for the year is approved at so many dollars." That's the way the situation has been up until 1972.

At that point, it is the board which goes to the municipality, not the municipality which goes directly to the people, but the board goes to the municipality and says to them, "Because of the law as it exists up to the present time, you must now go and get us the additional moneys we want." You've heard the municipalities try to refuse the requisitions when they were made and there was no legal way that could be done. So the amount of control the municipality had over the board was none at all.

I'm not saying that on the whole the boards have acted irresponsibly. They have not; they have acted out of the best motives in all cases. But, what it does, is when you get to the point where a requisition is going to be made, because of the belief on the part of the board that, say, an additional service should be performed in their particular area that maybe hadn't been performed up until that particular time, or that some hard view at inefficiency might have told them that we don't really need to spend this much money, but we're going to spend it anyway -- I say that not with malice, but because that's the way things are when you have 150 boards across the province, there will be some like that -- away they go to the municipal government, put out their hands and say, "Well, let's have the money."

So long as you have a situation where the boards can do that, so long as they can go to two different sources for the amount of money that they require, then it would be awfully hard to go to them and say that this or that is an area in which you should try to control the rate of escalation, this or that is an area in which you should try to contain your costs.

Only with that type of leadership from a central structure such as the Hospital Commission with the data that it has available to it and the ability that it has to relate to the problems of all the hospitals and understand, I hope, the wide range of problems there are in different parts of the province -- only when you have that do you have the real ability to start to put the squeeze on the expansion of costs.

I mentioned that part of it because putting the squeeze on the expansion of costs has been declared several times to be the objective of most governments in Canada, including the federal government; not out of the desire to provide any less service or to provide services that are in any way inadequate, but out of the desire to have sufficient regard for the cost that the taxpayer has found he has had to bear in the way that health and particularly hospital costs have been rising within the last few years.

I know there are other issues that I think maybe I could leave, having said that much in regard to the requisitions -- maybe leave it until another debate -- but I will just mention in passing that at that point I would like to deal a little bit more with the question of local autonomy. I regard that as important too, and I think that I could have something to say that might be more reassuring in that respect.

The question of the appeal procedure -- I think the appeal procedure works better than one might think. It is said that the appeal goes to the same body that makes the original decision, and that's undesirable. But in fact, what happens is that the budget section is the one that has the direct dealings with the hospital board, and there are two additional appeals beyond that: one to the executive committee of the Hospital Services Commission and another one to the full commission, which represents citizens from various parts of the province who are appointed and who are not civil servants. When you have that, the experience in the last year has shown the number of appeals that are actually made is not large. That points, therefore, to the fact that in a normal situation agreement can be reached with the board and the budget section. But in the cases where an appeal is made, only a few go to the full commission and

some of those have been allowed, so it makes a system which I suggest is workable.

Now the hon. Member for Calgary Bow raised one item that I thought I would respond to and that was the amount of limitation there is on earnings of people who are on social assistance and how much they might be allowed to earn in addition to their public assistance income without being penalized.

I have said before that subject is one that has come to my attention and we are concerned about it. I suppose the thing I might say about it now is that it must be difficult to see why such an idea that commends itself so well isn't just implemented. The reasons are clearly budgetary. It is my strong belief that by the next budget we will be in a position, probably, to act on a suggestion of that type; we have not been, in my view, as of this time.

Now naturally when the hon. Member for Calgary Millican made the several remarks he did in regard to abortions, he was dealing with an area that gives rise to two sharply divergent opinions in our society. I don't know that anyone would ever regret more than I do the occasion upon which any person would want to have an abortion performed. It is something that is personally repugnant to me and I regret the situation in every case.

Yet, the issue is not all that simple and I know the hon. member didn't suggest it was. Many of the people who feel the need to make an application to the Therapeutic Abortion Committee are not the ones we might look to, to give the child up for adoption. The hon. member, in those cases, would have in mind mainly young, single girls. This is normally the area from which adoptions have come.

Now, a large number of people who seek abortions are not young, single girls. They are married people. If a married person is going to decide not to make an application for a therapeutic abortion, based on adoption as a goal, if they are going to go ahead and have the baby, in all likelihood there is going to be a great change of mind right away about the adoption and the family will keep the child.

Now that is the result I would find to be desirable and the very best thing that could happen in the case. But as it does happen, since they don't want to get to the point of having the baby, the abortion then comes.

I think the only other thing I want to say on it is that it is well known -- I will always be with those who approach me to take a stand against abortion. I represent people in a Legislature that does not have the jurisdiction to deal with that subject.

There are people from Alberta and elsewhere in Canada who represent the citizens in a parliament which does have the jurisdiction to deal with that subject and they have done so. They have enacted provisions in the Criminal Code that relate to it. They have been under great pressures over the years to change them; in recent years they have indeed changed them. So the proper body to enact legislation in regard to abortions has been handling it.

What then is our responsibility? I don't think that it goes beyond the same responsibility that we have in regard to health, health care, hospitalization and medical care that we have in respect to any other medical procedure that's performed in a hospital or a doctor's office. If a medical procedure is legal and is done because of the advice of a doctor, and in the cases of abortions, not only the advice of a doctor but with the concurrence of a committee of doctors, the doctor-patient relationship which exists in that case, acting under the overall area of competence of the federal parliament, is what decides that is going to be done.

Our duty is very simple. Whether the medical procedure then, on a particular day and a particular hospital in Alberta, is one that others who feel the same way I do, would find more desirable and more in accord with my own feelings; or is that type of ordinary surgical procedure, or repairing of an accident injury or what have you; or if that procedure happens to be an abortion, duly approved and carried out in the proper way, our duty is the same: to provide safe and healthy facilities and proper care for that procedure to be carried out.

It's a difficult issue. I don't underestimate it. Many people speak to me about it. I know that they won't all agree with the views that I've just expressed, but I think that they are the views that, quite apart from personal feelings and having regard only to the public responsibility that I have, are correct.

Now, the hon. Member for Drumheller mentioned in particular two items in regard to the Alcoholism and Drug Abuse Commission. We did have a discussion the other day and I answered a question in regard to Project Recovery and said that the commission had met with those representatives of Project Recovery some two or three weeks ago. Today the cabinet, on my recommendation, having received it from the Alcoholism Commission, did make a grant to that body to encompass the arrangement that was worked out between the commission and Project Recovery. If I'm not mistaken, the amount of it was $15,000. The arrangement provides for a further continuing communication and review in the future.

Collingwood Acres was raised by two hon. members. It's just a little bit interesting to look at that. The hon. Member for Stony Plain raised it, the hon. Member for Drumheller, as I mentioned, had raised it and the hon. Member for Highwood also made mentiCn of it.

Collingwood Acres came about as a result of a private initiative, not an initiative of the government. I must say that I had some considerable doubts about whether or not the government should interfere at all with the original concept. Its original concept was that it would operate at private expense and not in any sense at government expense. That was the way it was put to me. It was put to me in order to clarify, as the hon. Member for Stony Plain asked me to do, the type of patient that Collingwood was expected to take, the executive alcoholic -- is that not the right term?

Certainly it would have to be someone who was in a position to pay a substantial daily amount on his own, if it was ever going to fulfill the role it was originally planned for. When the representatives of Collingwood discussed with me a month or so ago -- maybe it's more like three or four months now -- the difficulties they were having, it was put to me on the basis of faith in the ability of the scheme to work cut so that it would in fact support itself on its own, albeit high fees from the private sector.

The faith was still there but because of starting up costs some help was needed. After much consideratiCn by the commission and their recommendation, a grant was made to Collingwood Acres to help them with deficits that had been incurred in the starting-up costs, the understanding still remaining the same, that at the time of that grant having been fully used up, we expected they would have come into the projections that were originally made by them and would be able to support it on the basis of the private sector. I must say that I think if it can't be done on the basis of support from the private sector it would constitute almost an over-service of the people there when one considers the other types of service that also have to be provided and must be provided at a cost that the taxpayer can bear. By that I mean that, if I'm not mistaken, the Henwood costs are substantially less. The facilities don't perform precisely the same role but they are similar enough that you have to look at the cost effectiveness of it.

Now while I'm on the commission maybe I could try to deal with some of the points that the hon. Member for Calgary Buffalo made. These are points that we have discussed in subcommittee. I was happy to hear the new chairman of the commission make the statement in subcommittee, and I think it was well received by members from outside the Edmonton area, that one of his objectives would be to bring services in the southern part of the province to the same level as in the northern part of the province and to treat that as an important matter and one that the people in Calgary and the other areas in the south are entitled to expect. I think that is one of the more serious items the hon. Member for Calgary Buffalo raised, because it did appear at the subcommittee hearings that services were heavily concentrated in the Edmonton area.

The concern over the downgrading, be it voluntary or otherwise, of the private sector services and the voluntary groups -- reference was made to the drug information centre -- is something I would like to touch on too.

I would be concerned if that sort of result came from the new programs that the commission is undertaking. I have a great deal of confidence in the ability of the private sector to serve on a volunteer, and indeed on a purchase of service basis in this field. I think the undertaking I should make to the hon. Member for Calgary Buffalo is that I will be meeting with the chairman of the commission this week. This will be one of the few meetings that we have been able to have, since he took over his full time position only last month. I will raise that issue and pursue it with him and will expect that the programs of the commission will not cause any less volunteer involvement in any community in this type of work.

The hon. member also recommended more energetic street programs, a subject I will be glad to take into acccunt.

I speak without having specific figures available on the question of whether or not the patient mix, when you refer to race in Henwood, is appropriate or not. The figures the hon. member gave were ones I had not previously directed my mind to. The only observation I would make is that I hope no suggestion is being made that there is any deliberate passing-by of any potential patient on the basis of race. I don't think that was an allegation. It is something though that would be sufficiently serious whether alleged or not, if it occurred. But once again I would like to look into that. The only comment I have on the figures given, I think it was 54 Native patients out of 719 patients, is that it is substantially higher than the proportion of the Native population of the province. That would be in the neighbourhood of between 7 and 8 per cent of the patients, which is substantially above the percentage of Natives in Alberta.

I know, though, that the record of the correctional institutions is that the number of Natives there far outweigh what would normally be expected from the comparative populations -- in the case of the correctional institutions far outweigh the inmate population that there should be on a straight comparison basis. So that is another matter, which because of the hon. member's reference to it I would be glad to take up with the commission.

One more thing I did want to say about the commission is that I hope it is not overlooked that in pursuing the idea of the commission and restructuring it we have placed a fair amount of faith and confidence in the ability of ordinary Albertans to guide us in the direction of programs and overall policy.

There are eight members of the public who serve on an occasional basis -- I am not sure if they meet weekly or every two weeks -- for one of the smallest remunerations of any government agency. They meet alternately in Calgary and in Edmonton and discuss these subjects with a great deal of dedication. I think that with the new structure the commission has recently been given, we will see even more benefit from the fact that we have the advice of Albertans from various parts of the province who have a keen interest in the subject and that our programs will be ones, on the whole, that have been arrived at as a result of the proper amount of consultation and reflection. They are, therefore, -- this is the point I wanted to leave with you -- not programs that are imposed by the officials of the commission or the department. They are more than that.

Now there were a few other hon. members who spoke and I am fast losing track of the notes I made on them. I think the hon. Member for Drumheller asked me about detoxification centres. Briefly, this month -- and if not by the end of this month then very shortly after -- the detoxification centres in Calgary and Edmonton, which are admittedly small to begin with but are thought best to be small in the beginning, will be in operation, and the recovery centres in connection with them will also be in operation.

There have been slight delays in regard to getting the necessary space allocated. I don't think in this particular case there is any further difficulty over staff. I think staffing is probably available. The function will be to deal with the alcchclic or the abuser of drugs who is in need of intensive treatment on an emergency basis. It is a very important and significant role which must be fulfilled in both our major cities. That is the purpose of them.

Rehabilitiation programs would be steered more through the recovery rehabilitation units which would be larger and would be operated in conjunction with the detoxification centres. Since we are on estimates at the moment, I will just mention to hon. members, as those who were in the subcommittee would know, that there are items in this year's budget for those centres.

I see the hon. Member for Calgary McCall is back and I had left his remarks until he might return to his seat. I think, other than saying to the Leader of the Opposition in respect to his remarks that I am going to be dealing with the whole question of global budgeting as I mentioned under one of the bills. But as far as the continuation of the Hospitals Services Commission is concerned, we intend that no change be made in that respect in the foreseeable future.

Now in coming back to the hon. Member for Calgary McCall, I think he actually made some very comprehensive remarks on the role that is being fulfilled by the auxiliary board in Calgary and I think it is agreed that a very useful role is being fulfilled by the Calgary board. The setting of priorities for adding to the substantial facilities are matters that are under discussion between myself and the commission at all times.

I think I owe the hon. members opposite a return, which I'll be providing. It's ready now; it covers the question of construction, up to the present time,

of facilities of the auxiliary hospital and nursing home types as well as active hospitals, and there will be references to Calgary in that. By that I don't mean that any new programs will be announced in the mere filing of a return, but a summation up to the present time will appear there; also some forecast of capital in the immediate future.

Now in closing, I think the hon. Member for Calgary McCall raised the usefulness of alternative services in the areas of health care and raised them in conjunction with some of the remarks that he made about the auxiliary hospital district there. All I can say is that this is a subject which is discussed and in respect to which I do feel progress is being made.

I don't know of a health minister in Canada, including the federal one, who isn't anxious to see a continuation of the development of alternative services of the type mentioned by the hon. member. Some of the difficulties relate to financial arrangements with Ottawa as hon. members well know, and these are areas on which we go after them as much as we can.

Others are in the area of pilot projects or certain small projects in various parts of the province, and I can promise that we will be alert to appreciate the significance of these programs wherever we may be able to find alternative and extended types, out-patient services, home-care and mobile services and the like. We are very alert to the relevance of that type of service and we will be bringing in programs within our ability to handle it.

MR. RUSTE:

Mr. Chairman, just a couple of questions to the minister. I understand there are clergy who are supplying certain services to some of the institutions and my question there is, do you contemplate making any adjustments in those payments?

Then my other one, could I have under Vote 2513, Public Assistance -- Persons with Dependent Children, just a figure showing the allowance that would be made to a mother with three children, one 15, one 16 and one 19, all boys? Just for an example.

MR. CRAWFORD:

Mr. Chairman, those schedules were filed in a return that I put in a week or so ago. It would be easy to calculate them from that, if I could leave it on that basis.

On the first question, I wonder, Mr. Chairman, if the hon. member would repeat it because I missed the first few words.

MR. RUSTE:

I understand that clergy are supplying services to certain institutions, and my question is, is there any adjustment being considered in the amount paid to them?

MR. CRAWFORD:

Mr. Chairman, that's an interesting subject. I don't know if they are the majority or not, but a large number of services provided to hospitals by clergy are provided on a voluntary basis. The hospitals which are large enough retain full-time clergy budget for them, but usually no more than one, even in a very large hospital. They, being under a global budget system, simply provide for that and they have been able to supply that service.

The only other type of situation I can think of is that some of the institutions too small for that do have a small allowance which they are able to make available, in conjunction maybe with other hospitals, for part-time service. But it seems to be reasonably under control, and I've had good meetings recently with the gentlemen representing the Pastoral Care Institute.

MR. TAYLOR:

Mr. Chairman, I don't want to prolong the debate. I appreciate the information the hon. minster has given that Recovery House has been given a grant. I think this is very excellent.

There are just two things I'd like to point out about Collingwood Acres. Number one, the services there have been made available to people who are unable to pay. Secondly, I would like to see the hon. minister consider using

Collingwood Acres in conjunction with Henwood, perhaps to carry an overload and then to compare the results of the two to see if they are comparable. The objective is to get the best possible results and recover as many of these people as possible. I would hope the hon. minister would consider it from that angle, for comparative purposes.

MR. DEPUTY CHAIRMAN:

Very well.

MR. HENDERSON:

Question.

MR. R. SPEAKER:

Mr. Chairman, I'd like to make a remark or two in summary with regard to the study in the subcommittee and also in the Committee of the Whole.

First of all, I would like to say to the minister that we appreciate the answers and the information that have been provided to us. We also appreciate that the amalgamation of the Department of Health and Social Development will continue. We certainly support the move in that area.

I believe one of the main concerns we have, though, is in the direction the department is taking. We feel that there is an inconsistency at the present time between the objectives that have been established and some of the action that has been taken. In three particular areas this, I believe, can be seen. First of all, in the area of citizen involvement, secondly, in the area of decentralization of authority and thirdly, in the area of coordination of the programs. With due respect to the hour, I would like to make just one or two comments on each one of those three areas.

In the area of citizen involvement: in our examination of your program and of the department's programs, we really ask what new developments have taken place and what new involvements citizens of Alberta have at the present time?

We examine the emplcyment opportunity program, we examine the public assistance committee that hear appeals and they seem to be as they were before.

In the area of mental health we see no new evidence of extensive amounts of citizen involvement in the programs. For example, the Calgary Mental Health Advisory Committee doesn't seem to be functioning at the level at which it was functioning at an earlier pericd of time. We note in this area more in-house planning in the department, with not as much involvement of the general professicnal community and other communities of Alberta. I feel, Mr. Minister, that certainly should be examined at this point in time in the development of the objective of citizen invclvement.

In the area of decentralization of authority -- I believe we both agree that the term "decentralizatien" has many interpretations and can take on various meanings. We can talk about decentralizing the actual bureaucracy of government into each and every community of Alberta. We can, within that bureaucracy, talk about decentralization of decision-making or we can also talk about, on the other hand, more decision-making for local bodies, such as municipalities, in the province of Alberta.

When we look at some of the programs that have been introduced, particularly the tax program with regard to 100 per cent payment of local hospital requisitions, the 100 per cent payment of local health unit requisitions, or an increase of 10 per cent in payment of public assistance or social assistance at the local level, it indicates that the funding being taken care of at the central level is certainly going to reflect on the priority setting and the decision making at the regional level or at the community level.

We feel that this certainly has to be examined in the policy making and in the programs that evolve from this point on. That particular area, as we have commented earlier, should be examined more, under the bill. We'll have further remarks at that time.

In the area of mental health across the province, the minister has indicated in subcommittee and also through press releases that the guidance clinic concept will be expanded across the province. Last year in the estimates I made the point that I felt guidance clinics should come under some kind of local jurisdiction and not be responsible to a central authority, because there are certain priorities in each community, certain responsibilities they can

take, and I felt they would dc a better job by having more local involvement in that sense.

But as we examine the program, the guidance clinic concept is an extention of the Department of Health and and Social Development the actions and the priorities are certainly ccntrolled by your department. I feel that a re-examination should be made of that area in your department.

With regard to the topic of coordination, there were two or three items raised in the subcommittee and in the discussion here this evening which I feel should be examined. One of the areas that hasn't been raised is with regard to the information system, or the data system of government. In our subcommittee examination I felt it was indicated that no real planning for coordination had taken place between the Provincial Treasurer, who will have the central responsibility for the information system, and the Department of Health and Social Development. The money, $5.8 million was made available, but there wasn't any real understanding of how the Department of Health and Social Development would fit into that program as it was announced in the budget. I think the minister has a responsibility to have his planning and programming section of the department examine that to make it one of their priority responsibilities.

Another area that has been mentioned by my colleague, Mr. Henderson, is with regard to coordination cf local bodies. Under the act there is power to establish health and social development boards. I can agree that there are two areas that are proceeding as pilot projects, but certainly I don't feel that a real emphasis or direction or thrust, a word that has been used quite often in this House, has been given to this type of concept. In the coming fiscal year I think we would expect much more action and determination in attempting to evolve and bring about this concept in a more practical manner.

One of the other items cf coordination was with regard to the Metis program for housing. The question was asked in the subcommittee, will this program be coordinated with the program under the Housing Authority? I have quotes from the discussion at that time, and the quote said, "We don't know what the Housing Authority will do." Well, I feel that when we are talking about Metis people, or housing, whether it is because one Metis lives on the colony and others live off the colony, this is no reason that the program shouldn't be coordinated. I think the minister should examine that particular area.

One of the other items we raised in the area of coordination was the coordination of grants from different departments, and it wasn't clear as to any mechanism or routine through which this type of coordination could be brought about.

I think, Mr. Chairman, those are just a few of the comments I have with regard to those three areas. We feel that if the department is to be responsive and carry out its objectives of citizen involvement, decentralization and coordination, it should concentrate on those areas and be aware of the fact that it is moving towards more central control rather than these particular objectives that have been enunciated, not only this year in the House but last year during our study of these estimates.

MR. CRAWFORD:

Mr. Chairman, just a few comments on that. I think the reference to citizen involvement, of course, is something that cuts across the whole area of government and doesn't just relate to the Department of Health and Social Development.

In my view the whole attitude of this government has been one where involvement of the citizens has been given a premium priority. We have certainly gone farther I think, than most governments have in regard to the consultative process with associations and local boards and getting together with people in their own communities is concerned, plus the ability of the cabinet and the ministers to travel and see people in their own communities instead of just here. Taken all together, this is a great deal of involvement of the government directly with the citizens.

We have distinctly always had an open door policy in regard to the people of Alberta and we will continue that. I know that all governments attempt that. I think we work pretty hard at it, and there aren't many citizens who would come forward and say that one of the criticisms that should be levelled at this government is a lack of citizen involvement.

Mr. Chairman, just briefly on the other points. In regard to the guidance clinics, I had the feeling that we are, of course, interested in having the services decentralized and localized in that area as much as possible but we are in the position where we need at least to provide the service first. It seemed the existing structure of the guidance clinic was one way in which we could field additional manpower with existing administrative and management structures there. That is why it was done that way. I don't think that any of the steps taken in regard to the guidance clinics, some of which are taken in the short term, as I have mentioned, for the actual purpose of providing services where they didn't exist before, need in the long run have any harmful effect on local autonomy, on the ability to structure bodies in local areas throughout the province that will adequately reflect local feelings.

In conclusion, on the reference to coordination, in regard to Metis and other programs, with other departments and the coordination of the services of the department at a field level, I know it is difficult, particularly in programs that relate to remote areas and scattered communities such as the Metis, to bring about that coordination. All I can say is that we have been working on it, I certainly have been working on it today and many other days, and though it is one of those things which is not free from its difficulties and pitfalls, we expect that we will continue to see an improvement.

MR. DEPUTY CHAIRMAN:

The question is called. We have two resolutions, the first one moved by Dr. McCrimmon, seconded by the hon. Minister of Health and Social Development.

Resolved that a sum not exceeding $167,164,330 be granted to Her Majesty for the fiscal year ending March 31, 1974, for the Department of Health and Social Development.

[The motion was carried.]

The second resolution also presented by Dr. McCrimmon, seconded by the hon. Minister for Health and Social Development:

Resolved that a sum not exceeding $290,876,268 be granted to Her Majesty for the fiscal year ending March 31, 1974, for the Department of Health and Social Development Health Commissions.

[The motion was carried.]

MR. CRAWFORD:

Mr. Chairman, I move that both resolutions be reported.

MR. DEPUTY CHAIRMAN:

It has been moved by the hon. Minister for Health and Social Development that the resolutions be reported. Are you agreed?

[The motion was carried.]

DR. HORNER:

Mr. Chairman, I move the committee rise, report progress and ask leave to sit again.

[The motion was carried.]

[Mr. Appleby left the Chair.]

* *

[Mr. Speaker resumed the Chair.]

MR. APPLEBY:

Mr. Speaker, the Committee of Supply has had under consideration certain estimates, reports progress, and begs leave to sit again.

MR. SPEAKER:

Having heard the report and the request for leave to sit again, do you all agree?

HON. MEMBERS:

Agreed.

DR. HORNER:

Mr. Speaker, I move the House do now adjourn until tomorrow afternoon at 2:30 o'clock.

MR. SPEAKER:

Having heard the motion by the hon. Deputy Premier, do you all agree?

HON. MEMBERS:

Agreed.

MR. SPEAKER:

The House stands adjourned until tomorrow afternoon at 2:30 o'clock.

[The House rose at 11:15 c'clock.]