Title: **Monday, May 5, 1997** **Des.subcom: Health**
Date: 97/05/05
8:04 a.m.
[Mrs. Forsyth in the chair]

Designated Supply Subcommittee – Health

Forsyth, Heather, Chairman	Dickson, Gary, QC	Severtson, Mr. Gary
Barrett, Pam	Doerksen, Victor P.	Sloan, Linda
Broda, Dave	Fritz, Mrs. Yvonne	Tarchuk, Janis
Clegg, Glen	Sapers, Mr. Howard	Thurber, Mr. Tom G.

THE CHAIRMAN: We have a procedural motion that is required prior to commencement of our meeting, and I'll read it.

> Be it resolved that the designated supply subcommittee on Health allocate the four hours allotted to it pursuant to Standing Order 56(7)(b) as follows:
> (a) the minister responsible first addresses the subcommittee for a maximum of 20 minutes;
> (b) opposition subcommittee members then have one hour for questions and answers;
> (c) government subcommittee members then have one hour for questions and answers;
> (d) opposition subcommittee members then have one hour for questions and answers;
> (e) opposition subcommittee time of 120 minutes total will be split 90-10, with the third party New Democrats receiving a block of 12 minutes to be used in either opposition hour;
> (f) government subcommittee members have the remainder, and once those government members have finished their questions, the meeting is concluded.

I would invite someone to move this motion. Dave Broda? Is the motion carried then?

HON. MEMBERS: Agreed.

THE CHAIRMAN: I would remind that in order to conclude prior to the four hours allocated under Standing Orders 56 and 57, unanimous consent will be required. Failure to obtain unanimous consent for adjournment prior to four hours would be inconsistent with the undertaking by the House leaders in their agreement dated April 22 and 29, 1997.

Before we get started, we have a request from the hon. Member for Calgary-Buffalo that he's asked me to bring forward as chair. It's addressed to myself. It says:

> Pursuant to Standing Order 56(4) I request that the Assistant Deputy Minister of the Health Information and Accountability section (Mary Gibson) attend the subcommittee meeting scheduled for Monday, May 5, 1997, at 8:00 a.m.
> Thank you.

It's signed by Mr. Dickson. As chair I just received this about 2 minutes before 8 when I came in.

Mr. Minister.

MR. JONSON: Well, Madam Chairman, certainly we always try to co-operate with having all necessary personnel here from my department, but having just been notified of this particular request, that's impossible this morning.

MR. DICKSON: Madam Chairman, I might add that I appreciate that it's short notice. In fact, the decision I made only yesterday that I'd make the request, and I faxed a copy of the notice to your office yesterday, but I appreciate that you haven't had a chance to see it.

I made the request, but I expect that the minister can take back the questions and no doubt will contact this particular individual in any event in terms of providing a response. I just simply thought it would expedite some of the follow-up questions if before the end of our four hours this morning it were possible for that individual to attend.

THE CHAIRMAN: Mrs. Fritz.

MRS. FRITZ: Thank you, Madam Chairman. I just had a question for the hon. member. Does the employee know that the request was being made?

THE CHAIRMAN: Do I know?

MRS. FRITZ: No. The employee. I'm just asking the Member for Calgary-Buffalo, Madam Chairman, not you.

MR. DICKSON: Well, no, but as I understand the protocol, it's only the chair that can make the request. It's not up to a member to individually start contacting members of the department. I wanted to respect the protocol, which meant through the chair, to the minister, and that's been done.

Thank you.

THE CHAIRMAN: Mr. Minister, you have the floor now. Thank you.

MR. JONSON: Thank you, Madam Chairman. First of all, I'd like to introduce to members of the committee two members of Alberta Health staff. Seated on my left is Jack Davis, deputy minister, and on my right, Aslam Bhatti, director of finance and all things dealing with money.

I appreciate the opportunity to present and discuss the estimates of the Department of Health for the fiscal year 1997-98 with the committee. First, just to give a bit of perspective to the estimates that we will be looking at today, I'd like to point out that Alberta Health's system has undergone significant changes over the past four years, changes that involve both reducing out-of-control health spending and restructuring the way we govern, administer, and deliver health services. Now many of the major changes of health restructuring have been completed. Spending reductions are over, and indeed we are seeing significant reinvestment in key areas of the health sector.

I don't want to suggest that the changes of the past four years have been easy or that change will not continue, because changes always get difficult, yet it must continue to some degree to ensure that health reform continues and that our health system continues to evolve to meet the changing health needs of Albertans. The coming year, however, will be one of stability and consolidation. All of the targeted spending increases and all of the initiatives in the Health business plan are directed at maintaining and improving the quality of health services available to Albertans and the effectiveness and efficiency of the health system as a whole.

This year's estimates show an increase of 3.9 percent, or $148 million, over 1996-97 expenditure forecasts. This includes a $144

million increase in operating funding and a $4 million increase in capital and will bring total health spending to $3.957 billion. I should note that the spending increases for 1997-98 are in addition to the $196 million increase in health spending in 1996-97.

It is important to stress, however, that while we are providing more resources for the health system, we are not returning to the old ways of spending. The additional funding, both last year and this year, is directed toward specific areas of the health system with clearly identified results to be achieved. We have acknowledged that an increasing and aging population in our province results in some pressure points in the health system, and we have taken action to address those pressure points and areas of concern.

The program initiatives and funding we announced last November as part of our Action on Health package were significant efforts in ensuring access, quality, and stability in our health system. The funding in this year's estimates carries on and complements those initiatives and focuses our attention on the key elements of health care in Alberta. For example, Madam Chairman, we are providing an additional $20 million this year for provincewide services, those lifesaving procedures such as organ transplants, cardiac surgery, renal dialysis, and neurosurgery that are performed primarily in Edmonton and Calgary but for the benefit of all Albertans.

This $20 million is in addition to the $57.8 million we added to provincewide services last year, including the $17 million one-time allocation to purchase new equipment and the $41 million to substantially reduce waiting lists for these critical procedures, waiting lists which, I should add, develop despite the health system performing more of these procedures than ever before. With last year's funding we expect to have waiting lists within nationally accepted standards by this summer. The $20 million added this year will enable us to address physician and regional health authority costs for potential volume increases this year in these provincewide services.

At the same time we acknowledged last year that our increasing and aging population and their increasing need for health services was putting greater pressure on our frontline health workers. Last November, to address this problem, we provided an additional $21.7 million to regional health authorities directly targeted to hiring additional staff. This year we are providing another $21.8 million, and together this $43.5 million will enable health authorities to hire up to 1,000 more nurses and other frontline staff. These extra staff will relieve the pressure on frontline workers and enhance the quality of care provided to patients whether in acute care hospitals, long-term care centres, or in their own homes and communities through home care.

As a third priority this year an additional $105 million is being provided to regional health authorities. Combined with the funding for frontline staff this ensures every health authority at least a 4 percent increase this year. Together with the implementation of the new population-based funding system this funding now gives regional health authorities a solid, predictable, and stable funding base. It enables the authorities to deal with local pressure points and local priorities ensuring access to quality health care for all Albertans.

The estimates we are looking at today also recognize an inherent inequity that existed in our health system in the area of ambulance services. Albertans requiring emergent medical care will no longer pay the costs of an ambulance transfer from one eligible facility to another facility that provides a higher level of care. Our government is providing $7 million a year in additional funding to pay for ground ambulance transfers for emergency patients including interhospital transfers for nonpatients. This funding will cover transfers when a medical decision is made that the person requires care that isn't available in the first facility, and ground ambulance is medically required for transport.

Currently, Alberta Health funds health authorities for interhospital ground ambulance services for inpatients and home ambulance services for seniors and low-income Albertans with all other ambulance costs being the responsibility of individual Albertans or their insurance companies. This additional funding recognizes the changes in hospital services resulting from restructuring and will ensure a fairer system of payment by Albertans for ambulance services.

8:14

Another priority area recognized in these estimates, Madam Chairman, is the area of drug therapy. On a regular basis new drugs with major medical value and benefit for patients are emerging onto the market. Unfortunately many of these new drugs are also very, very expensive. This year we are providing an additional $35 million for emerging high-cost drugs. While there are a number of initiatives under way to keep drug costs down in Alberta and while we recognize the high cost of some of these new drugs, we are also committed to ensuring that Albertans have access to proven leading-edge drug therapies. We also acknowledge that while sometimes drugs are expensive, immediate and effective treatment with drugs can often result in longer term cost savings for the health system by eliminating the need for hospitalization and more intrusive and intensive medical interventions.

Also linked to our priority of providing Albertans with the most advanced level of care is our commitment this year of $7.5 million to purchase new medical equipment.

At the same time that we are providing additional funding to key areas of the health system, reinvestment which I might add is possible only because of our fiscal responsibility over the last four years, we are also continuing our efforts to reduce administrative spending and focus our resources on health services for Albertans. Administrative costs in the Ministry of Health have been reduced by over $5 million from last year and staff reduced by 245 permanent and nonpermanent employees. We have streamlined the way we do business while focusing on the core responsibilities of government.

Lastly, Madam Chairman, to further ensure stability in the health system, long-term care accommodation rates, already among the lowest in Canada, are being maintained at current levels with no increases this year, and Alberta health care insurance premiums are being maintained at the 1996-97 rates. These premiums will make up about 15 percent of total health expenditure this year.

In closing, Madam Chairman, I want to emphasize that the funding increases being requested for 1997-98 are targeted to achieving specific results in the health system. The funding being provided will ensure that as a government and as a province we meet our continuing commitment to providing a quality and accessible publicly funded health system for all Albertans. Though total health spending is increasing, we remain committed to continuing the process of health system reform, to continuing to find more effective and efficient ways of doing things, and to continuing to improve the quality of care received by Albertans.

Madam Chairman, I believe I have in these opening comments covered most of the major changes, major highlights of the Department of Health's budget for 1997-98, and I now look forward to discussing the elements in further detail. Thank you.

THE CHAIRMAN: Thank you, Mr. Minister.

Mr. Dickson, you're first.

MR. DICKSON: Thanks, Madam Chairman. Good morning, Mr. Minister. Putting to you an undertaking that had been given several times by your predecessor, and that is that before Alberta implemented a smart card health system, the Department of Health would co-operate with the Information and Privacy Commissioner to ensure that there was a formal, full impact assessment done prior to implementation of the program. I guess we can quibble over what we mean by smart card, but I think what you and I probably both understand is that it is a means of having personal information consolidated and a vehicle for it readily being accessed by components in the health system. My initial question to you, Mr. Minister, is: will you continue the undertaking given by your predecessor, and if not, why not? I'll let you respond to that, Mr. Minister.

MR. JONSON: I'm quite willing to do so, Madam Chairman, but I'm just wondering about the procedure here in terms of time allotments. I wouldn't want to take away from the opposition's time by giving lengthy answers. I can proceed this way; I'm quite comfortable with it.

MR. DICKSON: I hadn't wanted to subvert the rules, Madam Chairman. I've got a whole series of sequential questions, and depending on the response to this one, I can hopefully economize a lot of your time, Mr. Minister, for the balance of the morning.

THE CHAIRMAN: Mr. Minister, Mr. Dickson has the floor for one hour. At that time we will then go to the government members. If he asks a question and you answer in that total of one hour, it's entirely up to you.

MR. JONSON: Madam Chairman, first of all, the smart card as such is not by any means a top or first priority, and in fact there's been no overall decision to go with a smart card system in the specific sense. However, we have two initiatives under way. One is a process of extensive consultation on the development of a parallel piece of legislation to the protection of privacy legislation which would apply specifically to the health system. It's our full intention to table prior to the end of this session draft legislation which would be held over for further examination. But even before the preparation of that draft legislation, we have been engaged in a consultation process with the overall community on various key issues with respect to protecting health information.

Secondly, yes, we are also in a planning process with respect to a modern integrated information network within the health care system. One of the large needs of the future that I think all people looking at health planning agree on is that we need a better, more current database on which to make health care decisions and do health care planning. So the second initiative is planning for a technology-based modern health information system.

MR. DICKSON: Mr. Minister, perhaps I can ask you this – and I don't require responses to the follow-up questions at this time, thanks very much. Will the minister require that in any information system, personal identifiers will be segregated and scrambled before information is supplied to any other office, department, or agency other than that which acquired the information in the first place?

The other question, I guess, would be whether this government has either entered into an agreement with or solicited any proposal from Smart Health Inc., a wholly owned subsidiary of the Royal Bank of Canada, which has just entered into an agreement with the province of Manitoba and proposes to implement across the country in conjunction with provincial governments a health information management system.

The final supplemental question, then, would be whether this government intends to use the personal health information Act of Manitoba as a model for its new Bill in this jurisdiction.

MRS. SLOAN: I actually have a number of categories of questions that I would like to ask the minister this morning, but I'll begin with questions related to the ministry structure. I think it has been well documented and proposed by a variety of stakeholders and the public that the 17 regional health authorities and the structure therein have not been for all intents and purposes efficient, easily managed. I would relate that to the key performance measures that are utilized by your ministry. I do not see a single measurement that relates to the provision of service in a regional structure. I wonder why that is, particularly at a time when we have subjected the system to that type of delivery system.

Intertwined with that, I would pose the questions related to labour mobility and stability. I do not see any key performance measures that relate to that. We have been through the cyclical cycle of terminating thousands of qualified, well-educated, reliable health care professionals in this province. The majority of them have left the province to work, and now we are in the not at all surprising position of scouring the land for qualified individuals to staff our communities and facilities. So I would urge the ministry in the construction of subsequent business plans and budgets to intertwine the measures of regional delivery, labour mobility and stability, as an indicator of service.

8:24

MR. SAPERS: Good morning, Mr. Minister, Mr. Davis, and Mr. Bhatti. Thanks for coming out again this morning.

It's nice that you've made some opening comments about the reinvestment, but I thought that by now the rhetoric would have stopped about the out-of-control health spending. I can't help but comment on that. You know and your staff know and the Alberta public know that wasn't the case, and it's been pretty much debunked. I think that as minister you should stop perpetuating that particular myth, particularly when we're talking about your estimates.

My first set of questions has to do with program 1, and I'll ask them as a package. I guess I would appreciate a very brief response, and we'll look forward to a more detailed response in writing, as has been the practice. I note that under line 1.0.10, health plan administration, there's an almost $9 million allocation, which is about $800,000 or so less than last year for health plan administration. I was confused last year and I continue to be confused this year as to why that continues to be separated out, why it's not part of the deputy minister's office, and what exactly is being allocated to justify that separate line item for the $9 million. Does that count in your reduced administration charge, or did you separate it out so that it looks like there's been less spent on administration?

The second question I have about program 1 has to do with the Mental Health Patient Advocate's office. The budget is pretty much status quo. It has increased by a little bit. I'm wondering whether or not you're anticipating changing the status of that office so it can deal with voluntary patients. That's been an ongoing request of that office, the Ombudsman, and of course the opposition. I'm wondering whether this is the year that you're finally going to do the right thing there and include voluntary patients.

My next question under program 1 has to do with line 1.0.13,

the Provincial Health Council. A status quo budget, Mr. Minister. I'm surprised about that. It would seem to me that the role of the Provincial Health Council is ever expanding. They've written a couple of excellent papers. You haven't fully responded to the recommendations in their work so far. The throne speech talks about some kind of mental health accountability framework. Dare we call it a health charter? I guess for reasons well known I can understand why the government wouldn't. But it seems to me that the responsibility for that would fall to the Provincial Health Council. If you could tell us a little bit about how that council is going to do its business, more work with the same budget.

Finally, in program 1 the budget reduction for the Public Health Advisory and Appeal Board. Now, it is a small reduction, but it seems to me that with the stated commitment in the business plan, in the throne speech, in presentations that you've made publicly and that the Premier has made publicly, there is this commitment to public health. Certainly we have a number of environmental concerns that have arisen out of the transfer of responsibilities regarding landfill and the disposal of biomedical waste. I'm wondering how we can afford to spend less money for that body.

I'll pause at this point. As I said, I would like some brief response before we continue.

MR. JONSON: First of all – I'm going in reverse order, if you don't mind – with respect to both the appeal board that you referred to and the Provincial Health Council, I agree that the functions here are important. We are committed to providing, in the case of the appeal board, service for appeals. The Provincial Health Council, yes, has done some good work, and they are planning for the upcoming year. Madam Chairman, the point there is that the work or mandate is being fulfilled with the amount of money allocated. In the way we look at things within Health, we are not automatically assuming that because there is a particular issue or issues or work to be done, that has to translate into a budget increase. I feel that the Provincial Health Council has an adequate budget for the coming year, and the appeal board, as I recall, operated within its budget last year. So we're not automatically tacking on additional money when we think the mandate, the important work can be fulfilled.

With respect to the question about the Mental Health Patient Advocate's office, we have an initiative under way which I think hon. members are aware of, and that is we're looking at and following up on the recommendations of the Provincial Health Council, which did, I think, a very good report on a task that was assigned them by the previous minister. That is to look at an overall more effective and co-ordinated approach to appeals on issues and problems within the health care system in individual cases. That appeal process, that review, that consultation is currently under way, and we will be coming forth with recommendations and actions before too long.

With respect to the reference to the health planning administration, if it's acceptable to the committee, I'll ask Mr. Davis to give you the details there.

I would like to just say one general thing, and that is that our department is largely an administrative department. There are some direct services that we provide, but the whole thing is administration, if you want to give it that label. What divisions we establish and who does what is our judgment of how best to fulfill that overall mandate. In terms of the total department's internal funding, we have reduced it significantly.

MR. DAVIS: Thank you, Mr. Minister. Since this area falls directly under Mr. Bhatti's responsibility, we might have him comment. I'm sure he'd have the details better than I would.

MR. BHATTI: Element 1.0.10, health plan administration, consists of two branches. One is the claims branch, that processes the claims for physicians and other providers, and the other one is the registration branch, which registers the 2.7 million Albertans for health services. Basically, most of the money is in manpower. About $8.5 million of the approximately $9 million is manpower oriented to deal with those issues. We have about 35 million claim items in the claims area and probably about 850,000 telephone calls a year through the registration branch.

MR. JONSON: Thank you.

MR. DICKSON: Mr. Minister, let's turn our attention to program 2. About 55 percent of the spending goes to regional health authorities. I've got a couple of questions there. You recall that on April 22 you were asked a question in question period about a population-based funding formula, and you asserted at that time that clearly that was in effect as of April 1, 1997. You also referred – this is at page 98 of *Hansard* – to

> a very credible council or committee to monitor the implementation of that formula and to recommend any needed adjustments . . . such as marked growth in particular areas . . . due to our strong economy.

Now, a couple of questions flow from that.

8:34

Firstly, from your comment it appears that even though we have a population-based funding formula, when population changes, there may be some need to move away from a population-based formula, which to me seems to be a bit of a tautology. Maybe I am misunderstanding what you said on April 22. Perhaps you could make available to us particulars of the formula. It appears that the formula is something more than simply a function of the number of people living in each of the 17 regional health authorities. I'm wondering whether there is some weighting in terms of age, in terms of income, all of those other variables that we know have a direct impact on the health of a population. My question in sum was: can you provide us with text that identifies very specifically the precise formula that went into effect on April 1, 1997, to apportion funding among and between the regional health authorities? Because on the face of it, when I look at the allocation, it looks to me like there are some weighting factors there, and it's not a straight, flat function of population.

Then my follow-up question would be: when we have as many people as you do working under Mr. Bhatti in the finance and health plan administration, why would you then need another committee to monitor population-based funding? You have regional health authorities who I know on an ongoing basis do plenty of advocacy in terms of what they think their needs are, and they're quick to point out when they think they're not getting the kind of resources they need. You have a very large finance and health plan administration. Why do we need yet another committee, albeit in your words "very credible," to monitor this? There may be something there I'm missing, but I'd sure like some clarification from you on that.

The final follow-up would be this. We've lost in Alberta I estimate about $160 million with the reduction in the federal transfer payments. Now, given the announcement on April 28 by Ottawa and the increase in the CHST, will that have any impact on the Action on Health program and the undertaking of you, Mr. Minister, and your government to increase funding either in the

current budget year or in 1998-99 or 1999-2000? I know we're dealing with the budget for the current year, but you've clearly referenced the Action on Health plan in your narrative that goes along with the budget. So I'd be interested in a clarification there.

Thanks, and I'll turn it over to my colleague.

MR. JONSON: Excuse me, if I could interject here for a few seconds on just one item for the assistance of members of the committee. The quite comprehensive report on the funding framework was released in July of last year. It outlines in some detail the factors that are used in the formula. So I would just draw that to your attention because it does answer, I think, all the questions you have regarding how the formula is structured.

MRS. SLOAN: Thank you, Mr. Minister. Just to supplement the questions raised by my colleagues. In relation to program 2 and the regional delivery, while the ministry claims success with respect to reduction of administrative costs, the ministry's budget in program 2 does not for the opposition or the public's consumption give any breakdown as to the administrative and service delivery costs per region. As well, there is no accounting in the ministry's budget tied to that of the accruing deficits that are occurring within the regional structure at this point in time. I think both of those figures, statistics, should be available for public consumption. They should be able to judge for themselves whether or not in fact costs, administratively and for program delivery, have increased or decreased. Without those we're not in a position to be able to do that.

I would also like to follow on the questions with respect to the appeals processes that are in program 1. I count there, Mr. Minister, no less than five, I believe, different advisory and appeal mechanisms, some new, some old, for the most part all subjected to decreases in their budget in this fiscal year. In light of the serious concerns, the increased incidence in reports that have occurred over the last three years, I question why that would be. What degree of, I guess, security and faith can the public place in a process that puts structures in place and then reduces their funding? I would question those allocations on that basis in hand with the fact that the Provincial Health Council process and report and the recommendations therein, which was marketed across this province by the Premier as the life raft upon which the system would be stabilized, have still not been acted on, in their majority, by this government. Again, I question a status quo budget on that particular budget line 1.0.13. Is it the government's intent not to allow that particular body, after all of their work and consultation, to be in a position to implement the recommendations or at least advise the ministry with the recommendations?

The third topic area that I would like to discuss – and it transcends all of the program areas – is privatization. I again believe for the public's knowledge and consumption it would be worthy to note what the overall costs of privatization of health care delivery services have in fact tallied up to, not only in the last budget year but since it was incepted in 1993. Certainly we see and hear discussions both in the House and publicly that this government is proposing further privatization. We know that is occurring at a variety of levels. It's occurring within the ministry itself. It's occurring regionally and to some degree at a provincial level. But while all of that discussion is occurring, the ministry fails to provide either in terms of budget figures or performance measures the hard factual data, Mr. Minister, that we as the opposition and the public as the consumers of health care need to know. Is private health care more efficient, whether that private health care is in the way of having laundry privately cleaned or laboratory services privately delivered? There are many speculations out there. I'm simply asking, with all due respect this morning, that those figures be provided to the public by the ministry in order that the public and the regions to some degree can judge whether or not it is efficient use of taxpayers' dollars to contract out health care services at any level in the service plans.

Thank you.

MR. SAPERS: Mr. Minister, I'm still actually in program 1. I'm looking at the capital investment: 1.0.5, health information and accountability division, a capital request for in excess of $5 million. I assume that's hardware and software. What I would like to know is: how much of that is software development, if any, if it's being contracted out or outsourced, or whatever the current government phrase is, for the software development, and is this the total amount of capital investment required to accommodate not just the year 2000 changeover but also the health information system, whether you call it a smart card or whatever it's eventually going to be called? If the answer to that is no, I'd like to know what additional funding will be required over what time frame.

8:44

Finally on that line element, Mr. Minister, does any of that include hardware and software that'll be given to practitioners or provided in some way to practitioners? As you know, one of the big concerns for medical doctors, for example, is that they will be expected to assume a tremendous cost burden once the government decides what kind of health information system it wants. Doctors have told me they're not interested in assuming that burden, either the hardware, the software, or the personnel costs required for the initial inputting or the maintenance of any kind of new database.

Still under capital investment but the next line, 1.0.8, health workforce and administrative services. I see that there is no money being requested this year. Why is that? Was the $35 million all spent, and are there no leftover investment needs under that line item?

Perhaps I should stop there, because the rest of my questions have to do with program 2.

MR. JONSON: Perhaps I could respond to those. With respect to the question on hardware and the health information system, the $5 million is not the total by any means. We're making a major effort in this particular area, and in looking over the course of the business plan, we're going to be committing more funds to getting that done. None of the money, however, is, as I understand it, for practitioners. It is for developing the overall system in the province. Perhaps I could ask Jack to just give you a quick overview of what is happening and what's in the budget.

MR. DAVIS: Thank you. In a moment I'll ask Aslam to speak to the $5 million, because it falls within a fairly narrow accounting interpretation.

In terms of the overall system, we're just now in the process of trying to select a suitable health information technology provider to work with us in developing the system and do a full costing analysis. We have a rather large stakeholder committee headed up by Dr. Tom Noseworthy that has representation from the regional health authorities, from the two medical schools as well as from the Alberta Medical Association and the College of Physicians and Surgeons to look exactly at how this system can be scoped out, how it can be made to work, and what the reasonable

costs and reasonable ways are to finance or pay for the system over time. This is going to be a bit of a process. It's a major undertaking, and we do need to be careful as we move forward.

We've allocated some money in the budget this year for system design and for a few things that we think are important early initiatives that the system get under way collectively. Unfortunately one of them happens to be the year 2000, which is kind of a catch-up and remedial problem and doesn't really move us forward but does need to get done. We are looking at some other initial areas in the area of telehealth and the pharmacy area. This is a long-term commitment that will need to be carefully managed.

In terms of software development within the department, there are always projects that are under way, enhancements or new projects being developed. They have always been undertaken by private-sector companies with the specialty in that particular area. This department and most departments have not done their own software development for years. Again our major focus this year in the department in terms of software development will be around the year 2000 compliance. We do have a pilot project under way on registry/stakeholder type of activity which will allow providers other than just Alberta Health to put people into the registry system.

Aslam, maybe I could turn it over to you in terms of this $5 million and exactly what that means, and I believe as well the $35,000 in 1.0.8.

MR. BHATTI: On the first one, going from $488,000 to $5.1 million, basically there is a change in accounting policy as to when to recognize the cost of software development. Previously what we used to do is that if we spent, say, $40,000 developing software, we would expense it in the year that we used the money. The Auditor General has come back and said that anything over $25,000 that enhances the life of a system should be amortized. Basically, we took our operating moneys and put them into capital. So it's really not an addition of more money; it's just changing between an operating vote and a capital vote.

MR. SAPERS: So I should be able to find corresponding decreases in some operating lines, Aslam?

MR. BHATTI: Certainly, and I can walk you through that in the written answer that we give you.

MR. SAPERS: That'd be great.

MR. BHATTI: That's exactly what's happened there.

In terms of 1.0.8, that's $35,000, not $35 million. We had set up a telephone system for STD and TB services, so it was a one-time purchase of equipment, which we did last year.

MR. SAPERS: I do have one supplementary, though, arising out of Mr. Davis' answer. I take it, then, that most of that $5 million is in fact system development money. That would be the short-form answer. I don't want to oversimplify it, but my question about that is: have you included in that estimate at this point, at the ground floor of this development, a global risk assessment of the privacy and security aspects of creating such a massive data set and system? Is that risk assessment under way, and will you be publishing the results of the risk assessment for some public input?

MR. DAVIS: Well, we are currently in the process of selecting a quality assurance group that'll work with us. We do take the complexity and the many issues around this very, very seriously. That's why we have this large stakeholder committee that was actually appointed by the minister and does make recommendations to the minister on how to proceed with these issues. A request for proposal, which you may have seen a copy of, highlights security as a vital component of the new system. The stakeholder group has been selected, I think purposely, from a group of people that will have those types of concerns. We have a number of physicians. Dr. Tom Noseworthy heads up the committee. We have Dr. Mo Watanabe on the committee, the two deans, the Alberta Medical Association, Dr. Dosseter from the Health Ethics Network. I think everybody that I've talked to in the system recognizes that this is vital to moving forward from a patient care, research, and administrative perspective but that it can't move forward unless those bases are covered.

So that's kind of the long answer, to say that we're looking at these issues and that there will be, as the minister's indicated, extensive reporting on what we're doing, but we're not going to move real fast. There's not something happening every week here because the homework is being done and being done very carefully on this one.

MR. JONSON: Perhaps, Madam Chairman, just very quickly I could cover a series of questions from the previous questioner.

The administrative component and the overall expenditure and budget of the regions is tabled in the Legislature through the RHA's financial statement, so this information is available, Madam Chairman, also the deficits and surpluses, of which there are a number.

THE CHAIRMAN: Gary, go ahead.

MR. DICKSON: Actually, just following up on the last round of questions, I'd specifically ask Mr. Davis, through the minister and through the chair – I listened carefully to your description of the stakeholders developing the new information management system. As closely as I listened, I couldn't hear anybody identified as being the advocate or the person whose sole interest was protecting the privacy of Alberta patients. Everybody else on the committee has a vested and direct interest in the use and application of information, so I'm just wondering who on that task force is the advocate for the protection of personal privacy.

8:54

A further question, Mr. Minister, would be: why was it that in the so-called consultation on information management systems for the province, you invited submissions in late December, the cutoff was the end of January 1997, and at least three or four days before the end of the period for submissions your colleague Dr. Oberg was speaking publicly about what the government had decided they would and would not do. So you might share with us what happened to the public consultation process and the extent to which the government intended to modify its plans based on what it heard.

The other point relative to this whole business of health information. Why, Mr. Minister, would you not ensure that the Information and Privacy Commissioner, who is in fact independent of government, or his delegate would be an integral part of the group that you've put together of stakeholders looking at the management of health information?

THE CHAIRMAN: Do you want an answer, Gary?

MR. DICKSON: If I can get an answer now, I'd be delighted, Madam Chairman.

MR. JONSON: Well, I'd just comment very quickly. As far as the Information and Privacy Commissioner, certainly we will work with him, but it is not, as I understand his mandate, appropriate that he become an integral part of a policy development process in government. But in terms of being consulted on key issues and questions which may or may not in the future impact on his role, certainly we are committed to doing that. It is not – well, I'm just repeating myself, but it has not been the case that we pull the commissioner into a policy development process, because he has to maintain his neutrality and only be able to comment and to critique as necessary.

The other item, with respect to the consultation. The consultation was done and is ongoing, really, through the committee. It is very valuable, I think, and its messages are being taken seriously. In terms of what an individual member of the Legislature may propose as his view is his right and his, I guess, role to do so, but it is not government position in terms of the overall context.

My deputy would like to just comment on one further point.

MR. DAVIS: On the issue of having somebody at the committee level representing the privacy concerns, the committee recognized the difficulty of coming up with a single individual that could represent all of those concerns but in the end asked Dr. Dosseter from the Health Ethics Network to represent, as best he could, the concerns of the average Albertan. This committee, I should stress, is working to advise the minister of the technology and health system issues in terms of the legislation. The committee has input into that, but the legislation, as the minister indicated, will be tabled, hopefully in this session, and then sent back up for another round of further detailed public consultation. This committee is not controlling the process around the legislation. They're separate.

MR. DICKSON: I guess just a supplementary question coming out of the response. The individual you mentioned I understand has a background, certainly, in medicine and ethics. What background does that individual have in data protection and what is actually a fairly sophisticated area in terms of protecting and promoting privacy of individual Albertans?

MR. DAVIS: Well, if you're referring to him not having a background in the technical elements around protecting data in the system, I would agree. That is something that we'll be challenging our strategic partner with and also something that our quality assurance consultant will be looking at in terms of what's in place worldwide to deal with the protection issues, which are absolutely a fundamental piece of moving forward with this kind of an issue.

MR. JONSON: Madam Chairman, there's one overall point here that we, at least, certainly appreciate. That is that there are two parallel activities here. I think to provide integrity within what we're doing, we need to keep them somewhat separate. That is (a) to develop the health information protection of privacy legislation and controls, and the development of the overall information system. Certainly the two have to mesh. We are very sincere about wanting to make sure that we have very forward-looking health information legislation and regulations in place. We also want to have the best possible data system for health care planning.

MR. DICKSON: I would just say to the minister, Madam Chairman, coming out of those responses, that typically in information management the devil truly is in the detail. If in fact this task force is looking at the system that's going to be adopted, why wouldn't we build in privacy concerns? This is not, Mr. Minister, on the basis of what I hear, simply a policy group. My understanding is that there's a mandate to look at a system to be able to manage government health information. If in fact it's a question of selecting a system rather than just an abstract policy discussion, then why wouldn't you build in that kind of privacy advocacy, that privacy promotion, right at the front end rather than waiting until after the matter with legislation? The legislation is general and broad, and the detail is going to be done by way of regulation anyway.

THE CHAIRMAN: If I may interject just for a second. Gary, at the beginning when you started talking, you said that you didn't need an answer today.

MR. DICKSON: Right.

THE CHAIRMAN: So are you requiring answers now, or are you still waiting? We seem to be getting into a bit of debate here. So I need some clarification, as the chair of this committee, whether you want the answers later on, as you earlier indicated, or if you now want them now.

MR. DICKSON: No. I just wanted to take advantage of the fact, Madam Chairman. If the minister and the deputy volunteered some key information, I wanted to follow up now while they were here, but generally I think we're operating on the basis that we expect the answers to come in due course.

THE CHAIRMAN: The minister can respond to answers if he needs to clarify something in regards to questions.

Are you finished, Gary?

MR. DICKSON: Yes, I am.

THE CHAIRMAN: Okay. Linda.

MRS. SLOAN: Thank you, Madam Chairman. I would like to just continue on the vein of accountability and perhaps ask the minister to turn to the key performance measures. Then I would like to relate them back to your programs.

When I reviewed the program performance measures for the Ministry of Health on page 248, what I came up with was a compilation of subjective opinion measurement and some very I guess creative contrast between – I'll use the example of breast screening rates. I found it very interesting that the department as a measure would put out their rates of screening on breast cancer, not as a measurement provide the incidence of breast cancer in this province so that in any, I guess, logical fashion we can relate our performance to the actual incidence. Obviously, as well, breast screening is not the only way of attacking this disease. So it seemed to me, using that as one example, the measurements were very, very narrow.

9:04

I also wanted to draw attention to the first, second, and fifth as well as the second-last measurements. All of those, in my mind, are subjective opinion measurements. I would put this question to the minister. Why would you as a minister, as a department choose to define and measure your performance on the basis of subjective opinions rather than looking at comparable performance measures utilized by not only other provinces but other countries: infant mortality, morbidity, infection rates, readmission rates?

Even if you wanted to add them to all the subjective ones you have now, why would you not use and make those a published statistic upon which the public can base their opinions as to the performance?

I guess I would say, Madam Chairman, that the minister has chosen to selectively answer it. He hasn't answered any of my questions yet this morning, but if he's not prepared to answer them this morning, I would request a response in writing.

MR. JONSON: Well, Madam Chairman, I was sensitive to the discussion you just had from the chair.

THE CHAIRMAN: I just want to interject. The minister did clearly state at the beginning that he wanted you to have the time of one hour so that you could ask your questions. I don't think he's ignoring the answers; he's giving you your time allotted, which was one hour.

MRS. SLOAN: Thank you.

The other category of questions that I would like to raise to the minister is with respect to the health foundations. This is one of the number one growing industries within the health sector in this province, and we see now almost every region in a variety of forms creating private foundations whose sole purpose is to raise additional money to provide health services to regions.

In the most recent Auditor General's report the Auditor General made the recommendation that the Department of Health, regional health authorities, and health facility foundations needed to work towards an effective reporting relationship between the foundations and health authorities. He also made the very critical recommendation that the foundations not only need to be in the legislation but perhaps need to be outlined in legislation at more length. I do not see any accounting within the ministry budget of the revenue accrued by health foundations in the province. I think that would be a very useful measurement as the ministry chooses to reduce or to increase health spending. I think the public, we as the opposition would like to know how much additional money is being funneled to the system to support critical services and the critical purchase of equipment that is coming through the efforts of these foundations. Perhaps it may have been an oversight on my part, but is there any reference to those foundations in this budget in the measurements? If there is not, if my conclusions and review were correct, I would strongly say that the ministry should for the purposes of accountability include those in subsequent budgets.

Thank you.

MR. SAPERS: Mr. Minister, this is maybe going to be a bit of a barrage, because I have a series of questions under program 2. I guess I'll try to get the questions on the table. Maybe during your next hour you could answer some of them since you don't want to take up opposition time. I appreciate that.

AN HON. MEMBER: It's our hour.

MR. SAPERS: Oh, I hear that we don't have unanimous consent, Mr. Minister, to do that.

Under practitioner services, firstly, in program 2, a general question for all of 2.1. It seems to me that over the three years that the health system has been in some turmoil since the cutbacks began, we in the Legislature have been faced with supplementary estimates in each of those years for practitioner services, whether it be Blue Cross or physician services or what have you. I notice this year we're pretty much looking at status quo if you compare it to the net expense forecast to the end of '97, not compared to the actual '97 budget. I'd like to know what changes you've made in your department in terms of budget forecasting that give you some certainty this year that the numbers are right, since they've been wrong each and every year for the last three. I say that truly with respect and admiration for the senior staff in your department who have been faced with an almost impossible task of doing the projections given the political mandate they had to survive under. So I'm not being critical at all of Mr. Bhatti and the people that work so hard to keep the numbers on the right track, but I would like to know what changes you've made and on what basis we can be certain of these numbers.

Under provincial programs I notice in 2.2.7, out-of-province hospital services, that the amount of money budgeted is the same this year over what we expect this year's net expense to be. Certainly there has been a lot of media attention to a number of high-profile cases, increasing pressure on people to go out of province because they can't access services that they need here. The issue in my mind is again one of forecasting. I guess I would like some detail as to how those dollars have been spent. How much of that has been spent as a result of people going through the appeal process? How much of that money has been spent through the normal course of events, if I can put it that way? How much of the money that was in last year's budget remains allocated but not yet spent; in other words, people that may have been approved but are on a waiting list for an organ or something of that nature?

Also under provincial programs 2.2.11 deals with workforce adjustment programs. No estimates requested, no money requested this year. Is all the work done in workforce adjustment? I was just reading about some more layoffs at the Glenrose. I've been getting updates from some of the other regions telling me about staff dislocation, programs still being shut down as a result of last year's budget cut. We all know that that ball keeps rolling. I'm wondering why your government has backed away from funding workforce adjustment programs. You know, Mr. Minister, that there are many people who have been displaced in this process at all levels of the system. As the health workforce rebalancing process continues, there's going to be even more displacement. Why would you take that support away from those health care workers now?

Under 2.3, which deals specifically with the regional and provincial health authorities, first a general question. Where in this budget is the funding for the boundaries review process, which you confirmed is ongoing? Who exactly is doing that process? What will the cost be of that process? When do you expect it to report? Could you please provide us with terms of reference for this process? I'm also wondering whether or not you're anticipating expenses related to the election of two-thirds of the regional health authority members and when we can expect to see the breakdown of the projected expense for that.

9:14

Also, under the provincial health authorities, questions have been raised about the population-based funding model. While it has been articulated in a paper that was released last summer, I'm wondering whether or not you've taken the time to adjust that model based on the criticisms it's received: its inequity to rural Alberta, the difficulties with adjusting for in-and-out migration, the difficulty of costing out the same services because of different overhead charges from one region to another, and also the more general criticisms levied at that model because it failed to properly account for population growth and change in demographics, particularly the aging population and a population that has a

particular bulge, if you'll excuse the expression, of women who are at the peak of their utilization in terms of their age. While the model exists, it's been criticized, and are you responding to that criticism?

My last set of questions for the moment – actually, it's my second last – has to do with the Provincial Mental Health Advisory Board under 2.3.19. There's quite a considerable expense related to that board. I understand now that your government has changed its policy, Mr. Minister, that you're no longer committed to a dollar for dollar return to the community for mental health programs. It used to be that every time a dollar was saved on the institutional side of mental health, your government had made the commitment that same dollar would be spent in the community. My understanding is that that's no longer the commitment of government or the mandate of the Provincial Mental Health Advisory Board. I'd like some clarification as to why that change of policy, and I would love to be corrected if I've got that wrong.

Also, could you update us on the divestment readiness of the 17 authorities? Which ones are ready to go?

THE CHAIRMAN: Hon. member, I'm sorry; I have to interrupt. Your time is up, your one hour.

MR. SAPERS: You interrupted several times with procedural suggestions, Madam Chairman. My calculation is that I have a minute and 42 seconds left, so if I can continue, I'll take advantage of my time.

THE CHAIRMAN: Do we have agreement?

SOME HON. MEMBERS: No.

MR. SAPERS: The past practice has always been that procedural discussions get subtracted from the time allowed for questioning, and I calculated your interventions at a minute and 42 seconds.

THE CHAIRMAN: I will let you finish this question, and then we're going on to this one. Make it brief, please.

MR. SAPERS: Okay. Thanks.

The Provincial Mental Health Advisory Board I think we were discussing. I'd like to know which regions are prepared, which aren't, and how you are responding to those regions which say that they need a considerable amount of new dollars before they're ready to take over those services.

I will end my questions there. Thank you for your co-operation, Madam Chairman.

THE CHAIRMAN: It's now time for the government members to ask. I have Victor Doerksen first.

MR. DOERKSEN: Thank you, Madam Chairman. I will give the minister liberty to answer whichever questions he wishes, and if he doesn't wish to answer any, that's fine. He will then get back to me in writing.

The first question that comes to mind is capital investment. The capital investment plans for the individual RHAs are not reflected in the Health estimates but I think are located in Public Works, Supply and Services.

MR. JONSON: That's correct.

MR. DOERKSEN: Okay.

The first question I have is: the dollars that are itemized for capital projects under Public Works, Supply and Services, do those numbers reflect the announcements that were just made for the Capital region, or are these now for the next year?

[Mrs. Fritz in the chair]

MR. JONSON: Madam Chairman, the announcements made last week with respect to the Capital health authority projects are within the amount budgeted this year within Public Works, Supply and Services. In other words, this does not represent any increase in what I believe is a $108 million annual allocation to Health capital projects.

The other comment that I would make is that any given capital project, particularly a major one, usually takes up to three years to complete, sometimes longer when you consider the planning process. Let's say that it's a project estimated at $10 million. There might be $4 million, $4 million, and $2 million in three years of a budget with respect to that. That's where those projects are.

MR. DOERKSEN: Okay. The reason that I'm asking that question is that I am leading into some follow-up questions that have to do with the David Thompson region master plan. I have seen their master plan, and they're of course anxious for the minister to approve that plan. Included in their plan is some upgrading which would be required to the third floor of the Red Deer regional hospital for their palliative care unit as well as to allow for an expansion of the number of beds for the psych unit. I know you're well aware of their particular situation. Then following that, I think a third priority would be some plans with respect to the Richard Parsons auxiliary hospital. I'm just at this point merely putting in a plug for them. They've worked hard. I think the plan is good. They are seeking your approval on it. I didn't see them in the budget, which was why I was asking. At some point maybe you could elaborate on the process of how one goes about getting their capital plans approved and their master plans approved.

Madam Chairman, I have a lot more questions, but I'll defer to my colleagues, and if my time comes up again, I'll move on to my other ones.

[Mrs. Forsyth in the chair]

THE CHAIRMAN: Thank you. We have one hour, so I'm sure it will.

Gary.

MR. SEVERTSON: Thank you, Madam Chairman. My question to the minister is on page 242, reference 2.1. It follows a little bit the same as Edmonton-Glenora's question on physician services. The $767 million expended, is that the total expenditure of the AMA agreement, or are other things included in that? I share the same concern that last year it went up by $15 million over budget. What assurance do we have that it will stay at this level? This year you got $767 million. That's what you expended last year, but you'd budgeted $752 million. So it's actually two questions in one. Does that reflect the Alberta Medical Association agreement, the total expenditure there?

MR. JONSON: Well, that particular budget line dealing with physician services has a number of components to it. By far the overwhelmingly largest section is the AMA agreement, which is represented by $736 million approximately. Also, we have

salaried physician programs. I guess the best example might be the pathologists that work within your major hospitals. They represent about $9.8 million in terms of expenditure there. You've got an out-of-province medical reciprocal agreement; we're paying doctors under that program. That's another $11 million. There's the out-of-country medical and hospital costs, $3 million. Supplementary medical and hospital assistance: we'll have to explain that specifically. So we've got a number of components in that total. It's accurately reported, and it does go to physicians, but the portion that is the AMA agreement is $736.7 million of that. Then there were those other items that I listed.

9:24

MR. SEVERTSON: Thank you. Supplementary question. A tripartite process has been established with the regional health authorities and the AMA and Alberta Health. What is its purpose, and what do you expect to achieve in that tripartite process?

MR. JONSON: Madam Chairman, the tripartite process is linked to the physician agreement of two years ago. It was comprised of the AMA, the RHAs, and the government, and its purpose was to look at new models, you might say, of physician payment, of service delivery, which would maintain or enhance the quality of care but also result in efficiencies, in cost reductions. It's taken quite awhile to get to this point, but we are at the point where we're moving to implement I think it is six pilot projects with new models of paying physicians, different clinic and delivery arrangements. So we hope that some efficiencies will come out of those examples being successful and then what we learn being able to be applied across the system.

MR. SEVERTSON: I have one more, Madam Chairman.

THE CHAIRMAN: Yes, go for it.

MR. SEVERTSON: Recently, well, it made the news quite a bit, reference to the AMA requiring an additional $50 million increase in their agreement. Is this accounted for anywhere in the budget, or would it have to be next year's budget?

MR. JONSON: The reference to the $50 million – certainly there's no additional $50 million in the budget. This is perhaps part of the opening of negotiations which are slated to begin around June of this year for the next round of negotiations. What is in the budget – and this is something that is different in budget number two as opposed to budget number one, is that there is an additional $20 million in these estimates, $10 million or less of which we anticipate being needed to pay for physician services that result from the significant amount of money that we've put into provincewide services on November 24, 1996. By putting that into the regional health authorities and that generating more services, more procedures, that of course in turn has a draw on the physician pool. So there is an additional $20 million here. We anticipate $10 million for physician services and a further $10 million for provincewide services.

MR. SEVERTSON: Where does that show up in the budget, Mr. Minister?

MR. JONSON: Let's see. The best page would . . .

MR. SEVERTSON: If you haven't got it handy, I'd . . .

MR. JONSON: We'll find it here. It would be in program 2, as I recall, 2.3.23.

THE CHAIRMAN: Item 2.3.23?
We have Dave Broda next, please.

MR. BRODA: Okay. To the minister. There's been a commitment made to communicate more with the public, to educate the public about the health system, yet in the budget under 1.0.3 public communications is down by 11.6 percent from last year. Doesn't that seem kind of contradictory?

MR. JONSON: Yes, I think it might if you just looked at it on the surface. As I've said throughout and I'll probably say again, Madam Chairman, in response to questions, I think that the government overall has tried to get away from the assumption that if you're doing something that requires adding some more money into the budget, there are ways of doing things more effectively and efficiently and still meeting your goals without adding to the budget. Sometimes you can reduce. In this particular case one of the real efforts that we'll be making is to sort out and not duplicate information and communication expenditures between Alberta Health and the regional health authorities. I think we've been successful to some degree in that, although we've got a lot more work to do. With respect to our own public communications work, yes, the expenditure is down, but that does not mean we are not making every effort to make sure our messages get out there both in co-operation with regional health authorities as well as directly from us in those things that are appropriate.

MR. BRODA: Okay.
A further question, if I may. Will the department have the capacity to do required policy work when the budget for the policy branch will have been reduced by about 58.6 percent?

MR. JONSON: Basically, Madam Chairman, my answer would be the same as for the previous question. That is a very significant percentage reduction, and perhaps if it's acceptable, I could ask Mr. Davis to reply.

THE CHAIRMAN: Jack, you'll have to put your microphone a little closer when you're talking, please.

MR. DAVIS: Okay. I think this reflects more on the internal reorganization of the department. We used to have a division in the department that did all the policy work, and now we have it distributed throughout the department, depending on the area of responsibility. So the policy work for health information and accountability would come out of that division now rather than being done in a separate area. I think in a lot of ways we've enhanced our capacity to do the strategic policy work we need to, and we have it done by the people that are actually working in that particular area.

MR. BRODA: Okay.
Madam Chairman, a supplementary question. What functions are included in the health policy division?

MR. DAVIS: In addition to health policy, the health policy division also looks after the pharmaceutical area. They look after issues management, they look after the federal/provincial relations area, which is a fairly active one as well, and they do the legislative planning and legislative work.

MR. BRODA: Thank you, Madam Chairman.

THE CHAIRMAN: Janis.

MRS. TARCHUK: Thank you, Madam Chairman. My question to the minister has to do with 2.3.20. I'm just wondering what is included in the program funding lines there that isn't included in 2.2.10?

MR. JONSON: You said 2.2 . . .

MRS. TARCHUK: Dedicated program funding, 2.3.20. I'm just wondering about the differences between that allocation and 2.2.10.

MR. JONSON: Well, we can get the details to you, but the whole area of dedicated program funding – we have a number of commitments vis-à-vis the federal government and other relationships. One of the major areas, as I understand, of dedicated program funding is the whole area of human tissue and blood services and the commitment that we have through the federal government and the Red Cross in that particular area. That would be one example. I can get the other specific items and provide them to you.

MRS. TARCHUK: Great. Thank you. Is it okay if I continue with a separate question, not quite related?

MR. JONSON: Yes.

MRS. TARCHUK: Okay; 2.2.11, the workforce adjustment programs. I'm just wondering why there are no funds allocated to that program for the '97-98 year?

9:34

MR. JONSON: Basically, Madam Chairman, this question has come up before, and that is that in terms of this funding, which is specific to Alberta Health, we have used, allocated, dealt with the different factors here as far as Alberta Health is concerned. Now, Mr. Davis might be able elaborate further, but we have done our reorganization here.

MRS. TARCHUK: Then I guess just one supplementary question: what will be done in the future to address workforce adjustment issues?

MR. JONSON: Madam Chairman, as I indicated, as far as Alberta Health is concerned, at this point in time we did not foresee the need to commit additional dollars as far as our own internal operations are concerned, but if there are further changes, certainly we will have to recognize that and propose or reallocate expenditure within the budget. What I'm saying is that we certainly recognize that there needs to be that type of program, that type of expenditure if we are in fact making more changes.

MRS. TARCHUK: Thank you.

THE CHAIRMAN: Mr. Thurber.

MR. THURBER: Thank you, Madam Chairman. Some of this, Mr. Minister, has been dealt with kind of peripherally by the opposition, but I want to talk specifically about subprogram 1.0.5. We're back into health information and accountability. I think it's a very important area, and it needs further outlining by yourself, if you could, please. My first question: I would like to know exactly what functions are included in that particular budget in health information and accountability. I don't think that's been made quite clear here yet this morning.

I have another couple of questions on that same thing.

MR. JONSON: Madam Chairman, I think previously this morning we concentrated mainly on the planned information systems and the anticipated operating and planning of that, but also under the budget line we've got our whole area of library or, I guess you could call them, research services that we maintain right now. Secondly, there are information services provided to and in conjunction with physicians and the overall development of our accountability framework for the health care system. Those activities come under that as well.

MR. THURBER: Thank you.

Could you clarify for me and this committee actually how much of this budget relates directly to health information?

MR. JONSON: As I indicated, I think, Madam Chairman, in the question with respect to the $5 million which was primarily involving an accounting change – I think that question was previously answered, but in this particular budget line there's approximately $18 million budgeted for this overall effort in health information and maintaining current programs as well.

MR. THURBER: One final, if I might, Madam Chairman. Does that approximately $18 million cover the costs that are going to be incurred by the regional health authorities as well, or is that strictly an internal thing?

MR. JONSON: That doesn't include the funding that we anticipate with respect to the regional health authorities. The amount budgeted for the RHA-related information systems is $20 million.

MR. THURBER: Just one final.

THE CHAIRMAN: Go ahead.

MR. THURBER: Just a quick one. Now, is that included in the RHA budgets as opposed to including them in your own budgets from the department?

MR. JONSON: The money that I just talked about, the $20 million to the RHAs, is another example under that dedicated program funding line that I referred to earlier.

MR. THURBER: Thank you.

THE CHAIRMAN: Mrs. Fritz.

MRS. FRITZ: Thank you, Madam Chairman. Thank you, Mr. Minister, as well. Some of these questions have already been answered, but in your opening remarks you mentioned that a thousand front-line workers would be hired in the field of medicine, and I often hear that being referred to as RNs. I wondered if you could comment on that. Do you anticipate that's registered nurses?

MR. JONSON: Madam Chairman, certainly not entirely. We have the LPNs, licensed practical nurses. We have institutional aides. In some cases regional health authorities, I'm sure, will see perhaps in the maintenance support to the system their

primary needs. So we're talking here about staffing at the front of the system, whether it is in terms of maintaining facilities or – I think in most cases it would be people who are in direct contact with patients. We never indicated it was confined only to RNs.

MRS. FRITZ: Okay. Thank you, Mr. Minister.

Also, I'm interested in "health access – are services available when people need them?" on page 195. I've read them in three different documents now over the past week: the business plan update and then the post-election update and also the estimates book that's here before us. I think they lead us as a government into areas that we see are of importance to you. I know I have to thank you, too, in commenting on the number of initiatives that I have seen come forward from your ministry in regards to health promotion, prevention, wellness, all of that area.

I wonder if you'd comment on 5 where it says, "length of stay in emergency after hospital admission." That's one area where I didn't notice a percentage of target dates. Perhaps it's an unfair question at this time, but I am wondering: what is the average length of stay now?

MR. JONSON: Well, that would depend on what condition we're dealing with here. I would undertake, Madam Chairman, to respond in detail with respect to the different categories of patients and what our targets are there. I'm just glancing over some of our statistics here. Perhaps the best way to respond is in detail. We'll get that to you.

MRS. FRITZ: Thank you. I'd appreciate that.

Then as I go down, as well, number 10, "provincial rate of injury deaths including suicide," I noticed it was going to 13. The 45, I think, in one of the books I had read was back in 1994 or so or '93. Do you have any current stats for '95-96 as to what the rate is now?

MR. JONSON: I'm just looking at the material here. Our current rate, as I understand it, is 45 per 100,000. Our target is to go to 13 per 100,000, which is quite an ambitious target.

MRS. FRITZ: It is.

MR. JONSON: Nevertheless, it's a very tragic area of modern life. So that's what we're aiming at there.

MRS. FRITZ: Okay. Thank you. I saw that. It's just that I felt the rate actually is higher than 45 per 100,000. I'd be interested in that information as well.

Then on a level with the childhood immunization coverage, I noticed in the budget somewhere that I think the immunization for – I can't remember if it was a million dollars or whatever, but it's increased in cost. I also noticed that the immunization rate is relatively the same. I wondered what that cost was for – I didn't know if it was for the red measles that has happened recently – and if that came through the ministry or through the RHAs to immunize even the teens. I think it is in grade 9 or so now that they're giving the booster immunization. I wondered if that was what that was for.

MR. JONSON: Madam Chairman, I think that's essentially correct. At least in terms of the single largest component of that increased expenditure, it would be the overall measles initiative.

MRS. FRITZ: It was. Okay. Thank you.

Then on 12, "number of deaths due to cervical cancer." I applaud you, noticing that that number, the target, is zero. It is certainly a death that is preventable through Pap smears and especially with women over the age of 15. My question is how you plan to reach that target. That may be unfair. I'd appreciate some information on that, simply because I've noticed – as I say, I do applaud the initiatives you've shown, especially in the area of health for children, youth, and women. In this area I wondered if you would be developing a task force to do that or if it's something through each RHA or . . .

9:44

MR. JONSON: Well, I think, Madam Chairman, in this area of cervical cancer we're not anticipating a task force, because the medical community, the people in the health system, have overall consensus on what needs to be done. The key to it of course is early screening, and our plan, our intention, is that we meet a standard in terms of screening which, as I remember it, is that there should be a Pap test, or Pap smear, procedure undertaken every three years after a woman is 15 years of age. That seems to be the standard in terms of one of the most effective measures in dealing with this problem.

MRS. FRITZ: Thank you.

This is a bit of a different question from this area of the budget. When I was door knocking, as many of us did during the election, I certainly heard from seniors at the door that we were no longer subsidizing their health care at the rate we had been, and it was creating a hardship for the seniors. My question is: what are the premium revenues that are collected from seniors versus non-seniors? That, too, might be an unfair question at this time, but I'm hoping you do have an answer to that. Also, I was looking for how many seniors are exempt from paying premiums and how many had actually received a subsidy.

MR. JONSON: Well, we can provide you with that detail breakdown. I think there is an overall figure, though, for – is it half a million people that have some degree of premium subsidy? We can get you the breakdown in terms of seniors versus other categories in the population, but by far the largest component of that $500,000, I think about $250,000, is seniors, subject to more details, Madam Chairman.

MRS. FRITZ: Okay. Thank you.

Then one last question, Mr. Minister: how many nonseniors are subsidized?

MR. JONSON: Well, that's a fair question, but it'll be in the breakdown of the subsidies that are provided.

MRS. FRITZ: Okay. Thank you, Madam Chairman.

THE CHAIRMAN: Mr. Clegg.

MR. CLEGG: Thank you, Madam Chairman. My question certainly isn't going to be to try to get more resource people or more programs. I'm a great believer in an effective and efficient system of health care in this province, and having more programs and more resource people doesn't always help health care. I say that as a general statement. I'm always happy when we spend less money, not more money. I guess that's the Scotch coming out in me, but I don't think spending money always leads to more services. I think, like I said earlier, it's the effectiveness of our programs, and that's what really is important. I'm always happy

to see that the administration cost has gone down 5 and a half million dollars over the last year. Could you, Mr. Minister, tell me how much it has gone down, say, in the last two or three years in total?

MR. JONSON: Well, Mr. Deputy, would you comment on that? You've been leading it significantly.

MR. DAVIS: The question was: just the dollar value of the reduction?

MR. CLEGG: Yes. What I'm always interested in, Mr. Minister, is dollars. That's what our society is based on.

MR. DAVIS: The total reduction over the last couple of years was in the $12 million range.

MR. CLEGG: Okay. That sounds great to me.

In the last year how many of these were the result of outsourcing, and what is the difference between the management and the nonmanagement?

MR. DAVIS: We would likely need to get you more detail, but there are roughly 60 positions that were involved in outsourcing, primarily the movement of the operation of some of our computer systems over to ISMA in Alberta. About 10 percent of our total reductions have been management and the balance nonmanagement. I would like to point out that as we moved through this process, we worked extremely hard with each individual employee that was impacted to see if we could place them in other locations in government or work through arrangements with them that were best suited to their individual needs.

MR. CLEGG: That leads to my final supplementary question. What provisions have been made for salary and wage adjustments? I always like to be fair to our employees. For departmental staff and certainly for the RHAs, has there been some adjustment in the budget to reflect some increase in salaries?

MR. JONSON: Perhaps I could interject here. With respect to the regional health authorities, there are two or three points to be made. One is that all of the regional health authorities received, if you looked at their budget bottom lines, a 4 percent increase. Yes, 2 percent was targeted towards the hiring of additional staff, but we also have a 2 percent guaranteed increase overall for all RHAs. I think it would be fair to say that the salary component, or the payroll component, of RHAs would be somewhere in the range of 60 to 70 percent of their overall operations. So there is money with respect to that. The other thing is that, for a number of the regional health authorities, through the application of the formula their increases were over the base 4 percent. So there is money that has been put in the system for RHAs to meet increased costs, which might very well be in that area of remuneration.

As far as the department itself is concerned, we are certainly, in our budget projections here, planning for our commitments that we have right now. In terms of negotiations that may be upcoming, that will have to be part of an overall government approach.

I don't know if there are any more specifics there.

MR. CLEGG: That leads me to one question. I think we're all familiar with increments. I have two daughters working in the health system, so I'm very familiar with that. One of my daughters is a nurse. We also know that when you get increments, they are automatic. We've got a lot of people in our health care system that in fact aren't on that system, and they fall behind because they don't belong to the specific union that has the automatic increments. Is there any adjustment there? It really bothers me that because somebody has this increment system in place, then they do automatically, unless they're at the top of the level. Some people work there and are very good workers, but they don't have that system in place, so they don't really get any increase. That really bothers me. Is there any thought put into that, Mr. Minister?

MR. JONSON: I note the question and the point being made, Madam Chairman. What is planned for, certainly by the RHAs and in the context of the department itself and the civil service ourselves, is that where you have your collective agreements, we plan to, on the basis of the costs that we're going to experience in terms of payroll – but certainly the point that you made is well taken. There are certainly differences in the way people are paid under these arrangements, and one is to have increments in some cases, not all.

MR. CLEGG: Thank you, Madam Chairman.

9:54

MR. DOERKSEN: I'm going to ask some questions related to transfer payments. Now, when I ask these questions in the House, of course the Opposition House Leader doesn't like it when we ask questions about federal transfer payments. But I noticed that when his colleague did this morning, there was no objection, so I think I'll be safe in this committee this morning.

I want to point out that on page 250 – because this isn't always talked about a lot either, I don't think – if I read the numbers correctly from the '95-96 actual figures, the Canada health and social transfer contributed $712 million to Alberta. In '97-98 the estimate will be $472 million, which is a decrease of $240 million from the federal government. That's not to say I disagree that that didn't have to happen. I think we are advocates of the federal government getting their books in order too, so I want to make that statement. But during that same time period, the contribution from the general revenue fund increased by over $500 million. So this is money that came from Alberta and I think is a reflection of the fiscal policies of our government. Being able to do that I think is something that Albertans need to be proud of. It's not something that's well understood, I don't think, in terms of the impact we had to absorb from the loss of transfer payments, and to pick up that shortfall, plus add to it, is significant.

With that little bit of a lead-in, the question I have on the transfer payments – and again there have been several announcements during this federal election. We're making some presumptions in terms of perhaps what the outcome of the election might be, so I know that some of these questions may be speculative in nature but, at the same time, I think need to be considered because they will have impacts in terms of our funding.

The first one has to do with the transfer, the announcement that they're going to cancel out part of the transfer that we are expecting. The question would be: how much money would that be with respect to Health? The question that follows from that then is: would that mean an automatic increase to the Health budget if that were to happen?

The second question relating to some of the announcements again has to do with this national pharmacare proposal which has been talked about. I think it's going to have significant cost implications. I'm not sure what time frame we might be looking at in terms of implementation, whether we even had any discus-

sions about that, what the Alberta position might be or whether we've developed a position on that pharmacare program.

So those are my two questions with respect to the federal transfers, if the minister has any comments at this time.

MR. JONSON: Madam Chairman, first of all, with respect to the pharmacare proposal, this is a general statement, general proposal that seems to be now being made by the federal government in the course of the election campaign. It originated most certainly from the Canadian health forum, this overall discussion and consultation exercise that was done by the federal government and led to their final conference report in I think it was February of this year.

So all we have right now, Madam Chairman, is that report and its recommendations and a statement or statements from the federal level indicating that they are going to propose or take some action in this area. The statements I have made are that we can see some merit in certain features of a pharmacare program, but we can only say that we want to see what the proposal is, what the details will be, particularly with respect to financing. We should not be raising people's expectation about coverage in this area unless there is, you know, adequate funding available, particularly from the federal government since they are proposing it. So we have many questions here, just as I'm sure the general public does. Perhaps at the upcoming ministers' meeting we will learn more about what they might be proposing.

The second thing, with respect to the transfer payments. It was kind of interesting, Madam Chairman. Earlier in the discussion today one of the members of the opposition Liberals indicated that there had been an announced increase in the transfer payments. We welcome the statement, but the statement is really that the planned decrease will not take place, which is a little different.

In any case, the money from the government of Canada is not directly affecting our overall budget in Alberta Health. There will have to be a decision made by the provincial government in terms of how this lack of reduction, if you will, will be utilized in the context of overall government policy with respect to these transfer payments. It doesn't directly mean that we'll be factoring that cessation of the reduction into our budget. The budget is here, put before the Assembly for its approval, and once we actually know the details of this announcement about the hold on reductions and transfer payments, then it'll be a decision for government and Treasury to deal with.

THE CHAIRMAN: Go ahead.

MR. DOERKSEN: Okay. Thank you, Mr. Minister. This is a new question to do with our drug budget. Something that's been pointed out to me on several occasions – and I guess this is more of a policy issue than it is a budget issue, but it does have budget implications. I hope I describe it correctly, not being a pharmacist by background. I hope I get this correctly. The specific situation would be a home parenteral – is that how you pronounce that? – program, which is really outpatient delivery of medication. There would be some units given to the patient at home for prescribed therapy. If they were to have that drug therapy administered in the hospital, the cost of the drug is covered. By having the therapy done at home, there's no cost to the hospital system – in one sense I guess you could say we're saving the hospital system money – yet now we are asking the patient to pay for the drug therapy. It's a difficult issue, I know, but it is a situation that's been raised with me on several occasions, and I think it needs to be looked into. I guess the most difficult part is that some of these particular treatments happen to also be among the most expensive treatments. I'm wondering if we're doing any thinking along that line to address that particular seeming inequity. I wonder if the minister would have any comments about that.

MR. JONSON: Madam Chairman, the member identifies, yes, certainly a problem area and from an ideal point of view certainly a deficiency in the continuum of drug coverage. We are looking at that as one of the issues, one of the areas in terms of the overall picture in long-term care that we would like to be able to address in subsequent years in some way. There is, of course, Blue Cross coverage available, but even there, particularly with seniors, they see that co-payment as something that is discriminatory, in hospital versus in continuing care. So I acknowledge it as an issue, one that we need to work on. The only other comment I would make, though, is that we will have to work our way through this carefully and, I hope, fairly. But for the person who may not have been in hospital but has extremely high, let's say, blood pressure medicine or something of that nature, at what point do you stop with, say, the full coverage, of saying we were able to do that? It's one that needs an overall look, but I acknowledge it is an issue certainly, something we'd like to work on.

10:04

THE CHAIRMAN: Are you done?

MR. DOERKSEN: I had some more, but I'll let . . .

THE CHAIRMAN: Okay. We'll have Mr. Thurber.

MR. THURBER: Thanks, Madam Chairman. I just have one follow-up question, Mr. Minister, on the health information thing. I've had a lot of concerns expressed to me during the election and before that, in fact for the last seven or eight years, where people would like to know what it's costing the health care system when they go and see a doctor. Now, in your deliberations on the health information part of it, is there a thrust toward trying to get that information out to the patient, to the consumer in this case as it were, so that when they leave a doctor's office – and I think it might be more difficult in hospitals – they would in fact know what the taxpayers of this province have paid on their behalf for that visit? I'm just wondering if that's part of your deliberations, to try and come up with a system that would better inform the consumer as to what it does cost when they go to the doctor.

MR. JONSON: Madam Chairman, this system that we are developing would certainly facilitate that, I think, and make it more easily done. As to whether we would put in some regulation, though, requiring the issuing of statements to people using the doctor's office, or whether we would go back to something that was tried in this province at one time, and that is the issuing of an annual statement to all Albertans on their utilization of the health care system and how much it had cost, is something we would need to make a decision on as government. The information system we're talking about is the vehicle for doing that efficiently, but that's a decision we will have to make.

MR. THURBER: My concern and the concerns that have been expressed to me are that hopefully that would be part of the discussions at some point in time so that it can be on the table as part of the agenda.

MR. JONSON: Noted.

THE CHAIRMAN: Are you done, Halvar?

MR. JONSON: Yes.

THE CHAIRMAN: Gary.

MR. SEVERTSON: Thank you, Madam Chairman. I've got a couple of questions I would like to ask, somewhere on the same line as I did last time. On line 2.2.10, dedicated program funding of $17.8 million: is it the same as the physician services? Does that include other programs? What kinds of programs? There's more than one dedicated program, I would take it. And what would they entail, the different programs?

MR. JONSON: Madam Chairman, there are a number of different programs under 2.2.10. I'll just quickly run through them. There's support that we provide to federal nursing stations, which we do have in the northern part of the province. We have a capital debt repayment program and a capital upgrade program for nondistrict nursing homes. The funds for that come out of here. We provide funding to AIDS agencies and the HIV screening program. We have our health promotion programs in a number of areas. We have a dental outreach and cleft – it should be lip, not hip – palate program, and a number of different initiatives in the area of aboriginal health. So they're listed there, and I could provide you with information in terms of exactly how much money is in each category. Roughly that money is broken down to: nondistrict nursing home capital upgrades, 4 and a half million, and the rest of the allocations are in that 1.5 million dollar range.

MR. SEVERTSON: My supplementary to that question, Madam Chairman.

THE CHAIRMAN: Go ahead.

MR. SEVERTSON: There's a reduction of $3.5 million, which is a fair amount of reduction when you consider the total amount of spending. Percentage-wise it's pretty high. What's the rationale for that type of reduction on that?

MR. JONSON: Well, the primary reason for that line going down relates to the overall nondistrict nursing home capital upgrade program. This particular program and the construction and so on related to it has basically concluded, and our obligations in terms of paying for that capital plus servicing – we had an agreement with respect to servicing debt. That draw, should we say, on our budget is coming down. It's an initiative that essentially is done. We're still paying the bills for it.

MR. SEVERTSON: Madam Chairman, could I ask on a completely different line on that, or do I have to stay with the same main question?

THE CHAIRMAN: No. We still have time left, so you can ask it.

MR. SEVERTSON: Okay, Madam Chairman. To the minister. Earlier in the first hour of discussion there was some mention that the regional health authorities weren't accountable and it wasn't lined out. I think you started to explain how the regional health authorities do account for their spending and it is in reference to administration and other lines. How do they report their administration for the general public? Could you expand on that?

MR. JONSON: The regional health authorities are required to file with us, first of all in the sequence of the process, their overall business plans. Then at the end of their fiscal year they're required to file their financial report with the breakdown of expenditures in various categories. As I've said, those finalized reports are tabled with the Legislature. Because, of course, there also have to be audit statements done, they are subject to the scrutiny of the Auditor General, whether the Auditor General does it directly through contract through his office, which some of the RHAs use, or whether the RHA engages its own auditor. So there is a whole process which is reported on there in terms of where they are spending their money.

We in Alberta Health have periodically summarized for more easy reading the trends in terms of expenditures, and it's in our annual report. As Mr. Bhatti has just indicated to me, on page F39 of our annual report you'd find that right now.

MR. SEVERTSON: Thank you.

MR. DOERKSEN: I just have a question or two relating to the population-based funding formula that's coming out. I want to say from the outset that I'm positive on the funding formula; I think it's a good move. But there are some questions that arise out of it.

You will recall, because you were the minister at the time, how we approached the funding for education, which was on a per student basis. It essentially accommodated system growth so that if your population increased, there was an automatic increase to your budget. I don't know if the population-based funding is based on the same model or whether it's just a pot divvied up by whatever the population of the region happens to be. One of the reasons, of course, I ask that question is that we are expecting some significant growth in the central Alberta region with the plant expansions there. The question arises out of that.

Secondly, also what I thought was a good move in the Education formula was the administration cap per school boards, that they had to come within it. I wonder if there has been any thought given to doing the same thing with respect to the regional health authority.

MR. JONSON: Madam Chairman, with respect to the admin cap, I have certainly given some thought to it, but to this point in time there's been no decision to establish a hard cap, although we've certainly been working with the regional health authorities and other entities in the health care system. I think it's been a theme, and that is to try and make sure that administrative costs are kept as low as possible. We've had, I think, some success or some response in that regard.

Madam Chairman, some of the earlier questioners perhaps have not been able to avail themselves of the report that was put out in July. But yes, the whole idea of a population-based funding formula – albeit right now it would only be adjusted annually. Some people would like it adjusted every month if the population is going up; those whose population is going down would like it every three years. Yes, it does respond to the total numbers of the population, also to the changing demographics. For instance, if you have an aging population, that additional factor – it's in the formula for the older population. It would come into it as well. So it does respond annually to the changing nature of a region's population.

10:14

THE CHAIRMAN: All right, it's now the opposition's turn. Gary, your gang has one hour.

MR. DICKSON: Thanks very much, Madam Chairman. I want to turn to the issue of mental health, Mr. Minister, and perhaps I might start by asking you this. I remember when the Alberta Mental Health Board existed. The concern at that time was that we were spending $145 million for mental health facilities and $97 million of that was going into tertiary facilities, specifically the big psychiatric centres. Now, what's not apparent from the budget we have in front of us is the extent to which you've been able to do what the provincial Mental Health Board had determined was absolutely essential, which was just transferring dollars out of the big institutions into the community. I wonder if you could particularize for me the extent to which you've been successful in starting to redress that imbalance?

The related question would be: as a percentage, I know that back in 1994-1995 we were looking at 69 percent of the dollars going into either psychiatric hospitals or psychiatric units in general hospitals, with just a tiny portion of the overall pie going into funded agencies, care centres, and so on. I'd like some particulars in terms of the extent to which we've been able to redress that imbalance, Mr. Minister.

Now, the other thing I want to turn to is in program 2, and it's related. You'll appreciate now that Calgary, with the closure of the Holy and then the Bow Valley centre, no longer has psychiatric beds in the downtown portion of the city. I'm curious, Mr. Minister. The last comprehensive community needs assessment done in terms of acute care psychiatric services had been done in 1994, but I know from just representing a good chunk of the downtown area that what was described in that community needs assessment hasn't changed. In fact, from my perspective, it's been exacerbated with an increased number of people in the inner-city area. The recommendation in that community needs assessment was they talked about the need for acute care psychiatric facilities in beds proximate to where the biggest concentration of that population is. So I'd like some particulars from you, Mr. Minister, in terms of how you plan to address this need. If somehow this situation's been ameliorated and the need is demonstrably smaller than it was in 1994, I'd like you to share those particulars. I suspect it isn't, in which case I come back and ask how we're going to meet that need now that we don't have a hospital downtown.

[Mrs. Fritz in the chair]

I should tell you I had a chance to tour the 8th and 8th clinic. There is a mental health worker there but certainly no psychiatrist, and there's certainly no facility or prospect of having beds for the most seriously ill in terms of the mental health population.

I think what I'd also like to do, and this still relates to program 2, Madam Chairman – a number of specific concerns. The government has now accepted that the role of a midwife is an appropriate role in the Alberta health care delivery system. My question is about funding for midwifery. I don't see it in the budget, and perhaps, Mr. Minister, you'd be good enough to indicate where in the budget we have in front of us for 1997-1998 there is funding available to deal with that particular program which has only recently been sanctioned in this province.

[Mrs. Forsyth in the chair]

Mr. Minister, in terms of region 10, the Capital health authority, there had been a report done on October 18, 1996, by the medical staff. It is entitled Report of the Critical Assessment Committee Region Ten Medical Staff. Now, presumably this was one of the stimuli or part of the input that resulted in the November announcement of additional funding, but from everything I hear from region 10, it seems there is a whole series of concerns that have been raised that have not yet been addressed. I'm wondering if you can in fact respond to those recommendations from the critical assessment committee in late 1996 that are still outstanding and have not yet been addressed.

The other question I was going to ask is: you talked earlier about you're in the process of developing benchmarks for waiting lists and what would be acceptable and what is not. Perhaps you could clarify the Premier's council on quality care that had been created with much fanfare some years back. Perhaps you can clarify for me the current role and immediately prospective role for the Premier's council on quality care. Is that the agency that's going to determine what is an appropriate waiting list in this jurisdiction? Or is in fact that council moribund? I don't know, Mr. Minister, and I need some clarification from you on that.

Now, I'm hopeful to get updated numbers in terms of medical specialists working in Edmonton and Calgary. One of my problems, Mr. Minister, is when I hear you talk about the number of specialists in Alberta. What I find confusing is that it appears to me – and I'll use an example. Dr. David Jenkinson, who is an outspoken advocate in terms of inner-city health care needs and certainly would be well known to your department, now practises in the U.S., but he still shows up on the rolls of the College of Physicians and Surgeons. He still shows as being a specialist in the province of Alberta, but of course he hasn't practised here for some time. So when you indicate the number of specialists available in the province, I wonder if we can distinguish between those who are actively engaged in the practice of their specialty and those who have long since left the province. I know that's a particular concern in Calgary.

Just before I turn it over to my colleague, a specific concern that had been raised by a constituent. I wanted to ask you, sir: I understand that for patients who are dependent on transfusions, it's fairly common that they get an iron overload situation, and there's an injection that has the effect of dealing with the excess iron in their system. It's my understanding that the difficulty is that this isn't funded in the province, so what we end up doing – again, this may be an example if something happens more often. This often leads to the onset of diabetes and heart disease, all of which end up being more costly than the initial iron removal treatment. So I'd be interested in some particulars in terms of why we don't fund that. I understand in Ontario that's totally funded by the province, presumably because it's a good preventative health measure.

With that, I'll give my colleague a chance to ask some questions, Mr. Minister.

10:24

MRS. SLOAN: Thank you, Madam Chairman. Mr. Minister, for the purpose of clarifying my previous statements and then subsequent questions that were raised with respect to the regional health authorities' accountability, I would draw the committee's attention to recommendation 16 in the Auditor General's report. Specifically what that recommendation outlined was that the Department of Health must establish a "reporting framework" that provides the necessary information, in relationship to management and operating staff, public, MLAs, and board members, to measure the "accountability, governance and operating" criteria for regional health authorities. The Auditor General outlined that that information is not available in a complete or integrated form and that the vision for accountability in the system has not been made clear. It follows through with four other points in relationship to "performance information" being needed, that "two-way

communication" must occur, that "the information reported should be useful," and that "external reporting should be aligned with internal reporting." Those are a portion of what I was referring to in my earlier comments, and I wanted to ensure that my questions were recorded in that context. It may in fact be that the annual report provides some measure of that. I'm not sure if it does, and I would be most interested in having the opportunity to hear further from the minister on not just what is going to be undertaken this year but in subsequent years to ensure that occurs.

I would like to raise a specific question in relationship to program 2. In 2.2.3 I note that the ministry allocated a significant increase in funding for the purchase of vaccines and sera. I'm wondering if the minister can indicate to me whether or not that money incorporates dollars for the purchase of syringes, needles and for the manpower to administer those vaccines. It is a rather urgent question, Madam Chairman. The reason I ask it is that my understanding is the regional workforce has been given a mandate that they must complete this vaccination program by early spring of '98. I think it's a very prudent piece of information that is needed, as to whether the ministry is assuming costs for syringes, needles, and manpower or if that's being left for the regions to incorporate somehow in their budgets.

MR. JONSON: Madam Chairman, in terms of what I understand is referenced to the measles vaccination program, Alberta Health is paying for the drug or for the serum, not for the basic operating supplies. This is done through the regional health authorities, as it has been done for years through hospital boards and public health units.

MRS. SLOAN: If I could just make a supplementary rebuttal, I think this is a very beautiful example of how our process of reporting, budgeting, and planning is somewhat unraveling in this province. It's well known that we've had an increased incidence of measles and, obviously, for the benefit of all people in the province we have to undertake a vaccination program. For the ministry to only purchase vaccines when a significant amount of money is then required for the purchase of equipment to administer and the manpower is, I believe, a significant oversight or, perhaps, a purposeful oversight. It seems to me that it stresses the system, particularly a system, a community service delivery system, that is already stressed and trying to meet the demands that have been placed upon it.

When I contrast that with the supplementary estimates where you have taken it upon yourself to make additional allocations for physicians' services because of increased demand and increased need, why, Mr. Minister, do those same principles not apply when it comes to the administration of vaccines to schoolchildren in this province and the provision of funds to pay for registered nurses or other equipment required to administer that? I would certainly not only hope for some degree of answer to my question, but I would also seriously request some degree of action with respect to that. My understanding is that we have a significant amount of management overtime being allocated to deliver those vaccines as well as caseloads having to be neglected, while nurses are mandated to have those vaccines administered by a deadline that the Ministry of Health sets.

If I could switch, then, to the workforce rebalancing initiative, not referenced specifically within the budget in the performance measures. I guess I raise some questions again with respect to accountability. Obviously, public stakeholders have been aware of this initiative, that it is undergoing consultations. Some degree of consultations have occurred. Specifically in relationship to the budget, I found it of interest that in program 1, 1.0.15, the health disciplines and advisory appeal services warranted an allocation in this year's budget. My understanding of what was proposed in the health disciplines legislation was that that advisory and appeal mechanism would be put in place upon the passage of that legislation. I find it curious, Mr. Minister, that we're allocating funding already for that purpose and the legislation itself has not been debated in the Legislature. I don't know if there's any reasonable rationale for that, but it is a significant amount of money and it seems to me we're to some degree putting the cart before the horse on that.

I would also like to relate this initiative to the workforce adjustment budget line and the previous questions raised with respect to that, the response by the minister saying that restructuring is complete. It is of interest to me that that statement would be made when, in fact, one of the principles that seems to underpin the health disciplines legislation is a move in this province towards an increased utilization of unlicensed and unregulated staff. In hand with that, if that is the intent, I would anticipate that we will see a significant reduction, that being layoffs of other classifications of providers. It is curious to me, Mr. Minister, that in the face of that occurring, the ministry no longer sees fit to provide workforce adjustment funding.

Another initiative which relates, is in fact very intertwined, is the LPN regulations and the continued suggestion that that is going forward. There's widespread understanding that that is going to be utilized in a widespread fashion across the regions, to utilize LPNs as primary staffing for the delivery of nursing care. So again, relating that to the health disciplines process, the workforce adjustment, it doesn't appear that there is any funding.

There is, as well, another related topic: the lab restructuring which continues in the broader sector to be discussed. Calgary is raised as one example where there is proposed to be more restructuring of that sector. Again, I relate that to the workforce adjustment and why we would not deem it prudent or justifiable to provide adjustment moneys in those instances.

Thank you.

10:34

THE CHAIRMAN: Gary.

MR. DICKSON: Madam Chairman, thanks very much. Just turning back to program 2 again. I want to talk for a moment or ask some questions in terms of a hospital closure, but before I do that, certainly a lot of notoriety is being attracted to the changes at the former Grace hospital and the prospect that there will now be a for-profit corporation operating on one of the floors of the hospital. You, Mr. Minister, have been quoted as saying that you wanted to do some kind of review or inquiry to determine whether it would have an adverse impact on waiting lists in other parts of the region. I'm wondering whether in fact you've completed that study, what conclusions you've come to as a consequence your investigation, what criteria you or your department identified as being the matrix through which you were going to filter the information and come to a determination of whether this was something that was prejudicial to the needs of Calgarians or not. I'd be most interested in that.

Speaking of hospital closures, the advisory group that had been set up to deal with the disposition of the Holy Cross site – which must be about 10 months ago now – I understand has done some shortlisting of those people that had come forward in response to the advertisement you had published probably in November, December of 1996. What's the status of that process, Mr. Minister? Since you will have the last word after you get the report from the Calgary group, tell us please what criteria you're

going to be using in determining what will be an appropriate disposition of the Holy Cross site.

I think my same question would apply in terms of Bow Valley. My question there would be: since it appears that the CRHA is, from all reports, determined to demolish the building as quickly as possible, what steps have you or your department taken, Mr. Minister, to determine that there can be no future use of any part of that facility? I'm thinking specifically of buildings F, D, and G, all of which have been newly renovated since 1972. What consideration has been given to keeping one of those three more modern towers for some other health-related purpose, whether it's geriatric care or some other service which has a particular need downtown.

The related question would be that I know when the province of Manitoba closed hospitals in Winnipeg, they had a very sophisticated program to study the short-term and near-term impacts on the health of people living in a particular region. My understanding is that it was the Manitoba Centre for Health Policy and Evaluation. They have what's called a populist data base, and it apparently allows them to track the impact on public access and quality of care as well as the general health and population as a consequence of closing 20 percent of the acute care hospital beds in Winnipeg. I'd like to think, Mr. Minister, that we're at least as smart as the people in the province of Manitoba. I'd like to know what sorts of measuring tools you're going to apply to determine that impact of hospital closure, particularly in Calgary where it's been of particular concern.

I think those are the key questions I have at this time. The other thing I'd ask you to provide me with is: the 8th and 8th clinic in Calgary has the capacity to monitor an enormous number of variables. They have a software system at work in the 8th and 8th clinic which allows a very sophisticated kind of tracking. I'd like assurances from you, Mr. Minister, that Calgarians and all Albertans will have the benefit of seeing that kind of statistical information that's going to be presented in a way so that all Albertans can judge not just the decision made by the Calgary regional health authority but the kinds of impacts and consequences that flow from making Calgary the only city on the continent that doesn't have 24-hour emergency service downtown.

Those are my questions at this point, Mr. Minister. Thank you.

MR. SAPERS: Still on program 2, the question I have relates to the amount of money your department, both pre-election and now in this budget, has reallocated to the regional health authorities. First of all, I would like to know whether or not you've done the analysis to show how this money, once adjusted for inflation and population change, compares to the actual, in adjusted dollars, per capita expense over the whole time line of the restructuring in health care, going back to '93 and then projecting out to the end of this business plan. I'd like to be able to make an apples to apples kind of comparison. There's certainly a lot of cloudiness in the minds of the public about where we really stand on health care spending through the regional authorities based on those announcements.

Also, there has been some misinformation circulated about the people to be hired to fill the thousand full-time equivalent positions. From time to time they've been referred to as a thousand full-time nurses, other times a thousand full-time equivalents, and other times up to a thousand people will be hired, some of whom will be nurses. I'd like the definite word on that. What do these thousand positions truly represent, and how do you perceive that they will be allocated across the regions? What mechanisms do you have in place to ensure that these dollars go into the creation of new full-time positions? Are you setting actual targets for the regions and saying that the analysis done by Alberta Health indicates that this region or some other region is short this or some other number of registered nurses, LPNs, et cetera? If you produce that kind of matrix, we'd certainly like to see it.

On the same lines, Mr. Minister, I'm curious as to what penalties, financial or otherwise, there will be when a regional health authority or another provincial board is unable to deliver on its mandate or uses the money in a way that wasn't intended. Of course, going along with the notion of there being some kind of consequence or penalty, there would have to be some kind of detailed monitoring. So I'm curious to know what specific monitoring you've set up on this allocation of apparently new dollars and what the consequence will be if your monitoring determines the money has been used in a way contrary to the purpose set out by government policy.

10:44

Several years ago I had an opportunity to query your predecessor about the number of registered nurses that was projected to be the adequate number of registered nurses to meet the health care needs of Albertans in community and hospital settings. We never got a complete answer to that question. We're considerably farther down the road in terms of both health care restructuring and setting up an evaluative framework that I've heard you talk about over your tenure as Health minister. So I'm wondering: can you help me understand how we now know how many physicians we need, particularly in nonurban centres; and going along with the number of physicians, could you let me know whether or not it's your department or the college that is going to continue doing the assessment of what deficits there are for specialties and subspecialties for physician services.

While we're in the projection business when it comes to meeting your business plan, how many emergency room beds do you now calculate we need? We've had the experience now of the loss of several ERs across the province. I'm curious to know whether or not you've done an evaluation and whether you have a sense of: do we have the right number of spots in the province offering emergency medical services? How many beds do we have that are available? And have you answered the criticism that I've heard in so many smaller communities, that there is no certainly as to the hours of operation? Mr. Minister, I'm not referring to the sort of crisis things that happened, like Redwater over this past weekend. I'm referring to the decision made by Health authorities to stagger or reduce hours based on personnel availability across the province, to close down ERs over the weekend or to post handwritten signs that say: between these hours go to some other community a few kilometres down the road. So I'm wondering if Alberta Health has determined the need for a standard array of emergency room hours. And how are you going to enforce that, and is there a funding element attached to that?

The next set of questions I have has to do with some of the key performance measures in the business plan. I'm concerned about the injury deaths performance indicators. The target for the rate per 100,000 for 1999 is 45. The good news is that in Alberta we've seen the rate steadily decreasing. The last published numbers you have, however, are for 1992, which is already five years old. I'm wondering whether you can update us as to whether that trend has been continuing. You know, we were at 57 per 100,000 in '92. The target is for 45 by '99. But where are we today? How involved has the centre been in developing this target? I'm also curious if you could tell me whether there are some particular industrial sectors that we should be really watching. I've heard anecdotally that there are some industrial

sectors where the injury rate and the death rate from injuries are actually increasing, and I'm wondering whether or not you can confirm that. It would certainly be useful if we could see a more detailed breakdown here so we know where we have to perhaps look at development of some new policy.

The other question I have is about smoking rates. The year 2000 target is that only 25 percent of Albertans would be smokers. Ever since I've been in the Assembly there has been a private member's Bill dealing with nonsmokers' health. Mr. Minister, when are you going to bring forward a government Bill dealing with nonsmokers' health, to deal with the issues that have been raised year after year after year after year in private members' business? It would certainly demonstrate some required leadership.

MRS. SLOAN: Thank you, Madam Chairman. The next series of questions I would like to ask relates to long-term planning and the vision and allocations with which the ministry is going to address some of the broader health statistics we are now coming to know about in this province. I think most of us that have any relationship to the health care system or have practised directly in it know that the definition of "health" is broadly defined and that there are a number of social determinants that lead to healthy Albertans and healthy environments for us in this province.

I guess one of the areas where I do not see significant allocations in this budget, nor in the measurements, relates to the interrelationship between the government ministries. I'm speaking directly about Family and Social Services, the Education ministry, and Health ministry. When we look at some of the most telling statistics about how Health in Alberta is deteriorating, I do not see an integrated approach by those three ministries.

I'll raise an example for you that I witnessed last week in attending a funding-model discussion that was called a consultation, but it really didn't turn out to be a consultation. A mother stood up at the microphone. She was a mother of a young child who was mildly handicapped. Their experience with this child has been that the speech therapy she requires in the health system has been subject to cuts and eroded. So for that child her ability, particularly at a very, very critical time in her life, to receive those services is being reduced. The government is subliminally making her ability as a child to achieve and to have a successful life – you're reducing her ability to do that by taking away those services. The second example she raised in conjunction with that was: the child was scheduled to commence grade 7 in a public school. On the day of school commencing, they received a letter from the school board saying that the child could not attend that school because the special-needs supports had been reduced or eliminated and therefore they would not be in a position to provide for that child in that fiscal year.

Now, need I make the point that the higher your level of education, the higher your level of income? The higher the level of intervention in a child's early childhood, the better chance we have, Mr. Minister, of addressing some of the root problems our health care system is after the fact trying to address today. This example I raised for you this morning is a perfect example where a lack of vision, a lack of integration, and a lack of addressment are causing, I think, an acceleration of poor health statistics in this province.

Again, when I scrutinize your budget overall, I see allocations and significant allocations being made for particular providers; I see a significant amount of money going towards administration. But when I look for targeted programs that offer, even if just in an initial way, integrated programs and services that are going to address the increasing incidence of teenage pregnancy, the increasing incidence of violence towards women, the very obvious increase in incidence of aging in this province, I do not see programs that either the ministry or Education are providing. I raise teenage pregnancy as an example; it's certainly one of the most significant statistics where we are 60 percent higher than the national average, I believe. Granted, there are to some degree in the public health area specific programs, but I ask: how far do those programs go, and are they in fact being delivered with scope, that it's not only the female students that are being targeted with respect to the issue but the entire student population, male and female?

I noted the special mention that has been made of AIDS program funding. Again, that's another good example if you contrast it to in fact: is there an equal amount of priority in funding that this government is placing on interventions with respect to STD or sexually transmitted diseases? There's the root, and one of the categories where AIDS is increasing very significantly is in the younger population. I'm not saying that we should necessarily cut funds from the programs and services that are slated to be delivered after the diagnosis has been made, but why not also place your targets and your priorities at an intervention stage that puts our younger population in a position where they can make healthy decisions.

Thank you.

10:54

THE CHAIRMAN: Gary.

MR. DICKSON: Thanks, Madam Chairman. A couple of further questions, Mr. Minister. I think there's no question that in this jurisdiction and probably every jurisdiction in Canada the fastest growing health care expense continues to be the cost of drugs and medication, both prescription and nonprescription medication. I know the program the provincial government has to use lower cost alternatives when they exist. I'm assuming that because this is such a fast growing item of health expenditure, your department is attempting to do everything it can to manage this and adjust for the future. So I wonder if you could give us particulars, Mr. Minister, in terms of the strategies and the plans your department has to address this. This is something we talked briefly about in the House in terms of this whole business of drug cost. Particularly in view of the National Forum on Health and the recommendations there for a national program and that sort of thing, I'd be very interested in particulars in terms of what plans your department has developed to deal with this and address it.

Even if we look at the information in the current budget, this is a big cost item. It's just growing so much faster than any other element of your department. It seems to me this is going to require a lot of attention. Maybe it's received a lot of attention, but I'd sure be interested in a really detailed report, Mr. Minister, in terms of how you plan on getting a handle on those items.

Then, of course, I'm interested in terms of why as a province we'd be making representations, although the decision has now come out from the C-91 review. I mean, that report's been done and we know what's in there. I guess I continue to be concerned that it seems that we as a province have accepted that the benefits in terms of investment in Alberta are there, are demonstrable, and are in some fashion adequately offsetting the spiraling costs of medication. If there's empirical data to show that, Mr. Minister – and I understand this overlaps into other departments, but your department is the one that has to pick up the tab – I'd sure be interested in seeing any particulars you can give me there.

I guess one of my other concerns is that there had been a physician manpower task force or committee, co-chaired, I think,

by Dr. Wasylenko from the AMA and somebody from your department, to identify the number of physicians required in the province. My understanding is that the report that came forward really doesn't do that, so I'm wondering what step 2 is or the fallback plan is to do this. This ties in, I think, with questions asked by colleagues earlier. If you have a different assessment of the report that you received from that joint AMA-department task force, if you think that provides you with the answers in terms of the number of physicians required in the province, I'd be most interested in hearing that as well.

In terms of communicable disease control, Mr. Minister – and you and I have had a bit of a brief exchange on this recently as well – how are you as a minister or how is your department monitoring the impact of decentralized control? Once we start abandoning, if you will, the historic role that's been played by the province of Alberta and the Department of Health in terms of monitoring communicable diseases provincewide and formally or informally divesting that responsibility to 17 other bodies, not elected, not subject to the freedom of information Act, what kinds of consequences flow from that, particularly in the sense that this has always been a sort of badge of honour, a matter of great pride to your predecessors that we had such strong communicable disease control in this province because of a strong, centralized, and very well co-ordinated and well-resourced office? What is the impact going to be from decentralizing those kinds of services?

The changes to AADAC, Mr. Minister. I have trouble reconciling the numbers that are committed to AADAC with what seem to be growing needs. This has been touched on by others as well, but I'm most interested, Mr. Minister, in terms of hearing your response to that.

I'll give my colleagues a chance to ask some questions now, Madam Chairman.

MR. SEVERTSON: Madam Chairman, could I just intercede for a minute on a point of order? I have a sense that in the last 10, 15, 20 minutes we have been getting away from estimates and getting more into policy. I thought this subcommittee was to look over the estimates of the minister.

THE CHAIRMAN: That is the mandate of the subcommittee.

MR. DICKSON: The mandate of the subcommittee, I respectfully suggest, is to review the material put in front of us by the minister and by the government of Alberta in terms of spending for the province of Alberta. This is a little bit akin, hon. member, to inviting me to go into a car lot to buy a car and looking only at the price tag on the windshield and refusing to let me lift up the hood and look to see if there's anything underneath. The budget doesn't drive process. It's the policy and the legislative intention of the government that's inextricably tied up with the way the dollars are spent, and you can't divorce the two, hon. member. If I didn't make enough reference, I've tried to preface my questions by referring to particular program areas, but we're talking about how health care dollars are spent.

MR. SEVERTSON: Madam Chairman, I didn't mean just your questions – the last from both your colleagues. We've gone into various reports, what is he doing on the reports, and different things like that which are not in the budget. That's why I brought up the point of order.

THE CHAIRMAN: I just need a clarification as the chairman. Gary, the last question you asked the minister was about AADAC. AADAC is part of community services, and I think in actuality that is a question that should be directed to community services. It's not part of this budget. We're getting a little bit off topic when we discuss AADAC. So if you're next, colleague, then let's keep on the focus of the business plan. Even though AADAC has health related incidents, it's not part of this business plan.

11:04

MRS. SLOAN: Madam Chairman, if I could just raise this as an option. I think the minister has left his chair and is not here to hear the questions raised. It's curious that he would choose to do that during the opposition's questions and not his members' questions.

THE CHAIRMAN: Excuse me, Linda. Let's get on with the questions. He has capable people here that can pass that on. Also he has his deputy minister here. So, please, let's carry on with the questions. We have someone capable of passing the information on to him, and what you had wanted originally was to have it in writing.

MRS. SLOAN: All right.

MR. SAPERS: Thanks, Madam Chairman. I will note that that exchange took three minutes to the second.

THE CHAIRMAN: To 11:19. Let's go on please.

MR. SAPERS: Right. Plus three minutes.

My questions deal with the business plan tabled of course as part of the budget. I'm looking at major strategies listed in the business plan, and I need some clarification on some of the wording of these strategies. The first one has to do with establishing "an accountability framework outlining responsibilities and reporting results." I'm wondering if that is in specific response to the Auditor General's ongoing concerns about information management and whether or not that accountability framework is what was contemplated in the throne speech. It would be nice to know if there's a time line attached to that. Is this something we're going to see over the life of this particular business plan, or is this a long-term strategy? I mean, I'm assuming that reporting results is long-term, but I guess I'd like to know specifically about when we're going to see the establishment of the framework and whether you're going to be going to the public or stakeholder groups. Or is it just something that's going to be created entirely within the ministry?

The next question that I have out of the business plan is the point about reviewing and developing policy and legislation, and particularly you make reference, Mr. Minister, to policy "for publicly funded drug programs." Is this something that's going to happen quickly? Is this a response to the National Forum on Health's recommendation that we have medicare extended to prescription drugs? If so, could you point to me in the budget where you've allocated new or ongoing funding for this policy? If we're going to develop a policy for publicly funded drug programs, I'm assuming that there's a budget implication. Is this a current-year expense that you're contemplating?

MR. JONSON: Thank you. If I might, Madam Chairman, with respect to the two points, which I think are key ones, raised by the member. When we're talking about policy for publicly funded drug programs, yes, one aspect of that could very well be the work on the pharmacare proposal when that really comes forth so we have something we can deal with. But we also are looking at

some issues within the whole role of Alberta Health in terms of working with RHAs and professionals to administer drugs. When it comes to the whole policy planning initiative here, that is provided for within the budget in our policy and planning line, which we've had questions on earlier today. We have the resources to do the policy and the planning. If it comes to a point, which we hope it will at some point, when we've got definite decisions and programs to be implemented, then of course we will need a budget allocation.

The other item that you raised, which has been referred to several times today, is with respect to the accountability framework. Now, first of all, we have moved a set of accountability measures into our business plan, and this has been general across government but also in Health. It's not ideal; we wouldn't say that. There's a lot of work to be done. But we already in our current business plan that is before you have put in a number of measures. In terms of an overall comprehensive accountability framework, our target is to have that in place for the next business plan.

MR. SAPERS: For next year or the next cycle starting when this business plan expires?

MR. JONSON: For next year.

MR. SAPERS: Okay. Thanks for that clarification. I appreciate it.

A couple of other questions coming out of the major strategies as reported in the business plan summary. The statement to "develop options for paying health professionals that encourage ongoing improvements in health and the performance of the health system" is either, with respect, an entirely meaningless statement or one that is so heavy with meaning that it requires a fair bit of explanation. Are we talking about going fee for service for some providers who are currently not fee for service? Are we talking about putting on salary some providers who are currently fee for service? I guess the questions I would want answered are: what kinds of options, and how are you going to measure the improvement?

We've already seen, Mr. Minister, that a tremendous amount of energy has gone into the pursuit of the $50 million worth of other systems savings to be obtained by doctors. You know, I don't want to push the point too much, but we've seen that discussion about the $100 million worth of savings to physicians go to $50 million worth of savings on drugs and $50 million elsewhere and then all kinds of discussions through the AMA negotiations and what that discussion has brought to the table. If this is just rhetorical, perhaps you should scratch it from the business plan. But if it's substantive, could you tell us exactly what direction you're going in? I think we need that kind of clarity.

The next question I have has to do with the strategy about communications expectations with community members. I've had several concerns passed along to me from members of community health councils around the province. What they are reporting to me, Mr. Minister, is that they're beginning to feel like they are supposed to be a mouthpiece or, in the words of some members, puppets of the regional health authorities. I'm concerned that if the communications strategy through the regional health authorities is to allow the community the impression they're being heard and represented through community health councils, that's going to create quite a backlash. So could you give me some clarity on the communications plan that takes the communication and discussion about health care concerns away from rhetorical questions and comments and, some might even say, communications with an incredible bias and really gets into a dialogue about people's concerns at a very local level and how they're going to be addressed by government policy?

One more question before I relinquish the microphone. It has to do with an ongoing concern that the opposition has had about the legislation that created the regional health authorities. I raise it during estimates debate because it's specifically to do with financial accountability. The current legislation does not require but only allows for the Auditor General to be the auditor of record. Certainly you don't have to go any further than the Crossroads health authority to see the kind of trouble you can get into when you don't pay enough attention to accountability structures, particularly during a time of transition. Why have you not moved to change your legislation so that the Auditor General must be the auditor of record, to not just simply review the work of another auditor? We all know how auditing works: you do sampling. When the Auditor General comes in to review the work, they're simply looking over the shoulder of somebody else's work, and it's not anywhere near as thorough or as complete as being the agent doing the original audit. We're talking about, I think, nearly $2.7 billion tax dollars going to the regional health authorities. That's a sizable expense, and I know the Auditor General maintains some responsibility in a general way, but why not in a specific way? I think it's about time for that.

11:14

MR. JONSON: Perhaps, Madam Chairman, if I might comment just on this last item with respect to the audits. It is quite correct that the current legislation provides for one of two options, and that is having the audit done via the office of the Auditor General or directly through contract with the RHA.

In any case, it is the case, as I understand it, that all RHA audits would be done by what we might call private firms. The difference would be whether they had contracted directly with the RHA or through the Auditor General. Although the comment of the member is duly noted and to be considered or at least thought over, what's important here, Madam Chairman, is that under section 19(1)(3) of the Auditor General Act it's quite clear that the Auditor General has a role to comment upon the financial statements of the RHAs and does so, if you'll notice his report. So I think I just wanted to emphasize that the Auditor General is performing that function now.

THE CHAIRMAN: Who's next? You've got a few minutes left, Gary.

MR. DICKSON: Thanks, Madam Chairman. I'll try and speak quickly. One of the concerns that was raised with me recently is some changes in acute care settings in Alberta, particularly in Calgary. Well, what's happening is that there is so much pressure to turn over activity in the operating rooms as quickly as possible that there's some concern in terms of the degradation in hygiene and cleaning. What used to happen is you used to move a lot fewer people through an operating room in an acute care facility, but you had an exceedingly high standard of cleanliness, and that meant that there were the people and the time taken to ensure those things were addressed before the next patient was wheeled in. I'm curious, Mr. Minister, whether that's one of the things that your department is able to monitor. It ties in with the concern that as we centralize more of our acute care facilities in simply a smaller number of locations, the potential for infection seems to increase significantly. I'm interested in terms of what

kinds of safeguards or steps are taken to address that particular issue or concern.

The other thing I want to ask, Mr. Minister, has to deal with the home care wait list, which continues to be a problem. I understand what's happening in some centres now is you have physicians who are in fact admitting patients to hospital for a day because when they're discharged from hospital, they then will be assured of a home care placement, whereas without that detour through the hospital they simply can't get it. Now, I'd like to know how widespread that is. The home care lists continue to be probably the number one concern I hear from my constituents and from many in Calgary. I know it's a problem in the Capital health authority as well and some other ones. I'm most interested in your response to that. Now I'll just see if either of my colleagues has a quick last question.

THE CHAIRMAN: You're out of time.

MR. DICKSON: All right.

MR. SAPERS: Madam Chairman, is that timing adjusting for the three minutes on the point of order?

THE CHAIRMAN: Yes. Actually, you were supposed to be done at 11:16, and we've extended it by the clock here to 11:20, so you got even more time than originally.

The fourth hour goes to the government members, please. Any questions from the government side? Mr. Minister, would you like to respond?

MR. JONSON: Yes, I would like to respond to some of what might be more the policy areas that have been raised. Certainly I'd just reiterate, Madam Chairman, that we will respond to some of the specifics in writing if I cannot cover them.

With respect to the last questioner, I think the whole area of infection control is certainly a priority with regional health authorities across this province. They monitor, act quickly in a situation if there are problems, and it's always a challenge for the health care system in terms of infection control. I'm not trying in any way to be an expert here, but as I understand it with respect to your intensive care units, where on the one hand I have been told that to operate efficiently a full ICU service you should be occupied somewhere in the 80 to 85 percent range in terms of your beds, on the other hand that presents real problems for infection control.

Just as an aside, one of the major components of the recent Capital announcement here in Edmonton is to reconfigure and thoroughly modernize and actually rebuild the setup at the university or Walter C. Mackenzie Health Sciences Centre with respect to emergency and ICU structures. One of the goals or objectives that's going to be at the forefront of that whole capital project is infection control and planning for it.

Madam Chairman, with respect to a couple of other very key areas that have been raised. The question was raised by the Member for Calgary-Buffalo with respect to our overall approach to endeavouring to deal with the rising costs of pharmaceuticals in the province. We do have an overall approach to that. First of all, as was mentioned, through Blue Cross and through the parallel or associated expert drug committee, they work towards authorizing the least cost alternative when they're looking at new authorizations. They are also part of an overall effort to keep prices reasonable. I think we could improve our effort in the whole area of looking at comparative prices, but they do run across cases where a particular pharmaceutical is a much better price in, say, Ontario than it is in Alberta. So that's another item to be monitored, and also to try and keep the overall price of these items down.

Secondly, we have in place the Institute of Pharmaco-economics and the associated committee. This is an overall combined effort of doctors, pharmacists, and related professionals to look at more efficient and effective drug utilization, and I hope that coming out of that we'll see some concrete work in the relatively near future.

A third area where we are working, and it's been alluded to several times this morning: we continue to hopefully achieve some drug savings through our discussions on drug utilization with the Alberta Medical Association, which has been ongoing, which is still a goal we have in terms of addressing cost savings.

One other comment with respect to Bill C-91. Madam Chairman, what I've said in the Legislature and I think should be our approach here is that there's always a balance governments have to achieve with respect to pharmaceutical approval and support, and that is that we want the research, we want the work to go ahead, and we do not want to be negative towards research and development of new treatments, new drug therapies. So that is, I think, a sound thing to support. On the other hand, of course, as the member was mentioning, we have this issue of public cost in terms of funding drugs under health programs. So the position the Alberta government takes is one of saying that we want there to be a reasonable climate and support for research and development on a broad base, not just in this area of health but in all types of treatment and research across the health sector, while on the other hand we want to make sure that drugs are as low cost as possible.

11:24

A third point in response. I share, Madam Chairman, the Member for Calgary-Buffalo's comment about the physician manpower report. It provides pretty good background, in fact at great length, but it is a bit short, I think – it has to be studied further – on specific recommendations. Perhaps the information and the work done by the group will be useful. We, I think, in Alberta Health and as government need to have more and take more direction in this particular area than the report provides us with. It's very general, and we need to take some specific action and arrive at some specific conclusions about future manpower needs in the province as far as doctors are concerned and in a number of other areas.

There was a question raised, Madam Chairman, with respect to communicable disease control. I have responded to this in the House, but I would just like to emphasize that there has been no backing away from wanting to continue our record of having good standards, good controls with respect to the whole public health area and particularly communicable disease control. The point here is that it's a matter of delivery, in this case working, as we have decided, with the two major RHAs in the actual delivery of these programs. But in terms of still very much being part of the process in terms of providing leadership and standards and controls, Alberta Health is still very much involved.

Madam Chairman, in many of the comments both from government and from opposition members, the topic of long-term care has been referred to: references to housing, references to particular individual cases. There are two points I would like to make there. That is that in the Alberta Health budgets there has been an increased commitment to funding of long-term care and particularly home care, but I acknowledge that every health care system in this country – if not probably all across North America, but in our publicly funded system across Canada – every single province has the same issue. They are addressing the need for

long-term care and home care, which we are in this province, and expanding their services, but they realize and we certainly in this province realize that we need to take an overall look at the implications on our health care system of an aging population and develop a comprehensive plan with respect to dealing with that, which of course involves everything from appropriate housing, appropriate strength in home care services, drug coverage, a whole list of items. That's one of the overall initiatives we will be undertaking.

There was a question with respect to the whole area of frontline staff. Mr. Sapers raised this, and others did as well. We clearly stated in our initial announcement on November 24 that there was specific targeted funding for frontline staff. We used, I feel, very consistently 1,000 nurses and other frontline staff. The answer to one question is: no, we are not specifying the mix among health care providers. We costed the amount on base pay for 1,000 nurses, but it's up to the regional health authorities, because they will have different needs, different pressure points within their workforce, and they need the flexibility to hire as they see fit. It may well be that in a particular RHA the higher need may be in home care and long-term care, that we've just been talking about. In another it might be in the emergency room. This is the way we see the approach there.

However, the other set of questions that was asked in this particular area was accountability for these particular dollars. When the funds were allocated, it was clearly communicated to regional health authorities that we would be following up in the course of the budget year to see that they account for how and where this particular money was spent in terms of staffing. That has been communicated to the regional health authorities.

I'm trying to group together some questions here and my comments. The issue, Madam Chairman, with respect to this major activity that we have through professions and occupations and the whole health force rebalancing effort was referred to in several of the comments. I think it is important here because there seem to be many concerns about it. Currently we have in this province 29 recognized professions with their own legislation and regulations, et cetera, et cetera. I think most people would agree within the system that the ideal is that health care professionals and providers work as a team and do not get completely fixated on their specific scope of practice.

I had a conversation fairly recently with an intensive care unit nurse just recently retired from one of the major hospitals in the city. What she pointed out and I took some pride in was the fact that the team they had working within that particular department worked together, respected each other's area of expertise, knew what each person was responsible for, and did not worry about very, very specific, rigid scopes of practice. In this overall health rebalancing effort the goal is to respect the core services that professions have, make sure there is the appropriate training and initial experience to qualify people for their various roles, and deal with, of course, ultimately and most importantly, protection of the public.

In terms of some of the debates and some of the tensions that there are periodically in the system, we have to keep in mind that there are examples where a particular profession is lobbying or has lobbied for expanded scope of practice. In doing so, they have argued very strenuously that they should have this extended scope of practice if they have the training and qualifications to do this additional duty. On the other hand, that same profession argues very strenuously in reverse order, because another related profession says: "We think we can provide these particular services within the system. We fully acknowledge that we had to have additional training, et cetera, but we feel we are in an appropriate position to do that." The important responsibility for government is to make sure there is the proper training, there is the proper initial experience or apprenticeship, if you want to call it that, and to make sure the public interest is served and the quality of care is maintained. Then from that perspective, try to as fairly as possible sort out some of these interprofessional disputes. There are one or two key ones right now, but there are many. When you have 29 professions it seems to be an ongoing challenge for government, but we're certainly trying to address it.

By the way, are there further questions? I can respond in writing to many of these. There's just one other area I was going to touch upon.

11:34

THE CHAIRMAN: Sorry; it's the government side, Gary, so put your hand down, please.

MR. SAPERS: On a point of order then. It would require unanimous consent to adjourn before the four hours which is allocated. If the minister is willing to entertain further questions, we have some.

THE CHAIRMAN: Well, I think, first of all, there has been no suggestion that we've asked for unanimous consent for adjournment. The minister is talking and still has the floor, and the government members have not had the opportunity to ask further questions if they want.

MR. SAPERS: I just thought it would be better to raise that point before the motion is put so the chair is aware that it's not likely that consent would be granted.

THE CHAIRMAN: Well, we'll cross that bridge when we get to it. We'll let the minister continue to speak.

MR. JONSON: Madam Chairman, another related issue that was raised relative to the professions. The specific concern is with respect to whether a particular profession is going to be covered by public funding. One of the things that we've been endeavouring to do, on the same theme of getting the professions and occupations to work together, is to try to work through the regional health authorities – I'm speaking particularly here of midwives – to set up a working relationship with the nurses, with the doctors, with the people in the system, and to be funded through the regional health authorities. This would seem to be logical in that one of the strong arguments that's been put forward is that midwifery is cost-effective. We've provided for their registration now, and we have allocated in the budget some $800,000 towards pilot projects, through RHAs, for developing models of midwifery service. So that is the status of that particular initiative.

There were several questions with respect to overall mental health care planning in the province, Madam Chairman. The Provincial Mental Health Advisory Board is working through and will I think in the fairly near future have its interim business plan out. It is a business plan which will put some additional emphasis on community care and certainly on improving the equitability of funding for community care across the province. However, we must keep in mind in the whole mental health picture that the amount of money in the budget is only a portion of the commitment of government to mental health care. It's just an estimate, and I hope it was taken that way.

There's probably about $160 million of the expenditure in Family and Social Services around the whole area of children's

mental health care and associated services and supports. That's just part of the way supports and programs have evolved in the province in the area of mental health care. One of the goals of the Mental Health Board after considerable discussion and consultation and work is to bring together an overall mental health policy in the province which takes in the different ages in our population. Likewise, a fairly significant part of our acute care hospital budget in this province is and has for decades been devoted towards acute psychiatric care. Perhaps we have to always keep that in mind in terms of the total commitment that the province has to these services.

Perhaps I'll stop at that point, Madam Chairman, and see if there are any further questions. If not, I'll talk about rural physicians.

THE CHAIRMAN: Mr. Clegg.

MR. CLEGG: Yes. Thank you, Madam Chairman. I've got a couple of questions. They're not even related, but I was glad the minister did say that he was going to talk about rural physicians because that was one of my questions. In the last election we had doctors quitting work in three of our hospitals. Ironically, it had to happen at election time. I haven't got the slightest idea why that would possibly happen at that time. However, everybody can think what they want to. What really bothers me – and I did meet with the physicians, the general practitioners, in the area. When I met with them individually, most of their concerns were with their own association. It was not with government. Of course, a lot of the workers in our system tried to blame us, but that's really not the fact.

It really bothers me. Why would anybody go to a rural hospital in Alberta when they can sit in a medicentre and in fact make more dollars than somebody in Spirit River or, using my constituency, in Grimshaw or Fairview, make considerably more money and work eight hours a day when our physicians have to work 24 hours a day? Do you believe, Mr. Minister, that we would in fact ever get a solution from the association that would take in the fact that that is taking place? That is a real concern to me. I haven't been a doctor yet – I'm thinking about taking some training – but certainly why would I want to go to Fairview or Spirit River, except that it's the best area in the province? Why would I want to go there when I can make twice as much money going to a medicentre eight hours a day? That is the real concern.

The other concern – you have commented on it, and some members of the opposition have also mentioned that – is the funding formula. I personally don't think we'll ever get a funding formula that's truly fair. I'll tell you why you can't get a funding formula that's truly fair. It's because you have a moving object. When you have a moving object, it's extremely difficult to in fact get a funding formula in place. You know, in our schools – and I didn't want to bring in schools, but a member of the opposition did bring up special-needs funding, so I guess I have a little leeway there, hon. Madam Chairman.

THE CHAIRMAN: Very small.

MR. CLEGG: Oh. But the fact is that we have a moving target. We don't know whether there are going to be 40 patients in the hospital or whether there are 25, so it's a very difficult thing to get the proper funding. I do know that we in the Peace River area do in fact pay 63 cents a litre for our fuel, and in Calgary and Edmonton they pay roughly 45 or 46 cents. Really, that alone and the distance that either the providers or the individuals have to go to get services is extremely different than in a large city. Again, I'm just putting in a little plug, a very little one that I hope turns out to be a big one, that we in rural Alberta certainly need a larger percent per population funding than they do in urban. You know, it's kind of like MLAs. I and Mr. Friedel from Peace River probably represent a third of the province, and it's a lot more difficult than in 12 square blocks. [interjection] Well, Innisfail doesn't have any problem either.

Those are my two real, main concerns with Health, and I really am concerned. I could go into education on the same formula, but she only gave me a little bit of leeway here to talk on education. If we could ever get a formula that's fair in Health, it would go right into all our other services that government is required to provide in rural Alberta.

Thank you, Madam Chairman.

11:44

THE CHAIRMAN: Questions?

Mr. Minister.

MR. JONSON: I'd just like to respond, if I could, on the rural physician issue because it's been brought up before at this committee meeting, Madam Chairman, and also in many other venues. Right now we have a rural physician action plan, and it deals with such programs as the locum program, or relief program, for doctors on weekends, holidays, and so forth. We have three or four different income or student finance types of incentives, I guess you might call them, and there are other things as well that are involved in the overall effort. I think we have had some successes. Doctors have been recruited. I guess Smoky Lake and Grande Cache are examples where it seems to have been helpful in getting physicians.

I just want to indicate to the committee that one of our many priorities is to see if we cannot improve the rural physician action plan and also respond to one of the complaints that I understand we've had through the medical profession. That is that the plan is very complicated although well intended and, as I said, to a significant degree effective. There are all kinds of formulas and allowances and so forth in terms of calculating whether a person is eligible or not for specific funding. This is something we want to address in conjunction with the doctors, particularly the rural doctors, in the year ahead to see if we cannot improve that whole area.

With respect to the funding formula, Madam Chairman – and this has been mentioned by other members as well – it is, I think, an improvement over what was previously the case. It is a response to population need and the nature of the population in terms of health needs. In terms of the northern part of the province, through the committee chaired by Dr. Guenther, that I mentioned earlier, we are going to be looking at the possible adjustment of the formula. But remember that when you adjust a formula one way, you have to adjust it somewhere else. You have to make sure that you have your arguments well prepared before you change a formula which might be more favourable to one part of the province than to another. But the northern areas have raised this issue, and we are having a look at it.

THE CHAIRMAN: Mr. Thurber.

MR. THURBER: Thank you, Madam Chairman. Just a follow-up question. You spoke briefly in your opening remarks I believe, Mr. Minister, about the extra funding that went into interhospital transfers for the ground ambulance. I'm wondering: does this apply in cases where they're not admitted, or does it in fact allow them the flexibility to admit them at no cost to the regional health

authority? Is that the way that works? I'll give you an example of what has been happening, say, in the Drayton Valley area. If they came from, say, 20 miles east of Drayton Valley, went to Drayton Valley, and they didn't feel they could handle them and then sent them on to the Capital region, to Edmonton here, they were looking at a $2,000 to $3,000 ambulance bill in a lot of cases. One of the reasons this wasn't paid for by the regional health authority was that they were not admitted, say, in Drayton Valley, and they were passed on. Now, does this cover that? Can you indicate to this group how that works? Does it make it easier for them to admit and pass on? Or do they not have to admit them but can pass them on anyway with this still being covered by your increased funding?

MR. JONSON: I'm trying to think. The quickest answer is that, yes, it makes it easier for them to admit and pass on. The situation, as you know, used to be that if a person was transported from Alder Flats to Drayton Valley, the individual was responsible for that cost. Whether they had insurance or not, they were responsible for that cost. Then if they were admitted at Drayton Valley, their cost was paid by the regional health authority into Edmonton. If, as sometimes was the case – I won't get into the reasons for this, but fairly often this was the case – they weren't admitted, even though they might have been treated at Drayton Valley, the cost then fell back on the individual as if they were continuously in the ambulance all the way to Edmonton. So this is definitely designed to eliminate that extra cost to the patient.

MR. THURBER: Thank you. Just as a follow-up to that, if I may, Mr. Minister. You know, we hear urban people talking about an eight- or a 10-minute lag time to get someplace in an ambulance. In a lot of cases out in our country there the minimum that you can look at is half an hour to an hour, and you incur an initial expense of $600 to $800 to get to the nearest health care centre. I guess I'm getting back on to some of the stuff that my hon. colleague was talking about in the Peace River area, where there's such an additional cost for the customer, the consumer, in the rural areas of this province. Is there any way that we can balance that somehow through this additional funding at some point in time so that, you know, the individual isn't hit with this $900 ambulance fee to get to the closest hospital, have that amortized over the province somehow? It's probably more of a policy thing.

MR. JONSON: Madam Chairman, quite frankly that's not one of the things we're looking at right now. We are still dealing with the overall ambulance review that is chaired by Judy Gordon, MLA for Lacombe-Stettler. Even in their interim report, as I recall, they did not suggest any change in the current payment for the initial ambulance trip, leaving it there to the individual or to their private insurance. It's just not in the mix right now.

MR. THURBER: Yeah, but it is a concern, you know, to people out there when they see people in the urban areas complaining about a 10-minute lag time and maybe a $200 bill to get to the hospital, whereas we have to go sometimes 50 or 100 miles to get to the nearest hospitals.

Thank you.

MR. CLEGG: Just to follow up on that question, because that's also a concern of mine with ambulance service. You know, if you go around – and I guess I'm lax in that I didn't study it well enough – we have so many ambulance boards in the province of Alberta, and every one of them without exception thinks that they are the best ambulance board in the province of Alberta. The fact is that that is not true. They are doing their very best, but when you have an ambulance service that in fact – and I'm going to give you specific examples.

The Fairview Ambulance Board, which comprises about four municipalities, takes patients to the Grande Prairie hospital and then they unload the patient. The fact is that when the ambulance board or whatever system they have there drops the patient off, they go back to Fairview, and the ambulance from Grande Prairie follows our ambulance back into Fairview. Now, if there's anything that wastes money, it is that system. If you talk to any of those boards, they'll say, "We're doing a wonderful job" but at the expense of the people of Alberta. So I think it's extremely important that we somehow co-ordinate this.

I really don't think ambulance needs a franchise to operate. I personally wrote to the mayor of Grande Prairie and told him that. I guess he's still figuring out his response. That's about a year and a half ago, and he hasn't got back to me yet. It's something like some other comments I've heard: you know, it does take time to study these.

I know there is a lot of improvement that can save dollars. Dollars can be saved by – I'm not suggesting getting rid of the boards, but to have some co-ordination within those boards or something. It just burns me every time I see our ambulance go to Grande Prairie, drop a patient, bring one back to Fairview or Grimshaw or wherever. There are dollars being wasted in that system. Just a comment.

THE CHAIRMAN: Mr. Minister, I've had a note passed to me from the opposition just asking for a clarification, so briefly, Gary, because this is government time.

11:54

MR. DICKSON: I always like to treat that carefully.

Thanks, Madam Chairman. I understand that the minister had said that he felt he'd answered most of the questions, and I was just hoping that he would understand that if there were specific questions asked of him – and there certainly have been some this morning – we'd ask that he respond to those specific questions. Of course, from our perspective the ideal would be before we're in a position where to vote on the appropriation.

Thanks, Madam Chairman.

THE CHAIRMAN: We have till 12:04. Are there any other questions from the government side or comments? Go ahead, Gary.

MR. SEVERTSON: It's 12:04? I thought this meeting was supposed to close at 12 o'clock.

THE CHAIRMAN: No. We started at 8:04, so that's the four hours. So we have till 12:04.

MR. SEVERTSON: I just want to make more of a comment with reference to midwifery. I recall sitting in this room when the midwives' association came to the government and wanted to be certified, and they basically at that time stated that they didn't want any funding from Alberta Health for their services. They stipulated time and time again that what they wanted was to have the right to practise in the province.

So I totally agree with the minister's comments. If the regional health authorities want to fund midwifery within their budget, that's the way it should be coming if they're saving money. I would think that at least two or three times they've met with our

group and stated emphatically that they weren't looking for health care funding from the Department of Health.

THE CHAIRMAN: Mr. Minister.

MR. JONSON: Yes. With the few minutes remaining, I therefore could respond, and there were three or four other issues here the answers to which might be of interest to the total committee. One was the question with respect to the key performance measures, specifically with respect to injury and deaths in the province. One of the points, I think, that was made was about our data and our statistics. That is something that we want to improve in terms of our records in that area.

The other thing I wanted to mention is that we do have an initiative under way this year. Dr. Francescutti, who is very energetic and very expert in this area and very committed to an overall injury prevention program, is directly involved in the design of this overall effort. So that is a new initiative this year in the whole area of injury prevention and one which fits in with the type of effort that Rick Hansen is making across Canada and so forth in terms of everything from injury prevention to neuro-trauma treatment.

Also, Madam Chairman, the one statistic, though, that we have that doesn't cover everybody but does give us a good indication of the trend as far as injuries are concerned is the statistics provided through the Workers' Compensation Board. Their records would indicate that injuries in the workplace, at least, have been coming down. I will, however, certainly take the specific question and direct it to Alberta Labour and WCB for an answer, and that is whether recently there have been any spikes with respect to certain industries in actual injury rates. I don't know the answer to that.

There was a number of questions with respect to Calgary. The Member for Calgary-Buffalo raised a number of them. With respect to the Grace hospital and the other proposals that have been generally talked about in this area, including in Edmonton, no, I do not have a sort of final assessment and report in this particular area. It is something we are certainly monitoring.

To this point in time I have been assured as far as the Edmonton situation is concerned that there are established medical criteria for access to surgical procedures. This is being applied with respect to the population waiting for these surgeries with no discrimination of one person against another in terms of who gets attention for orthopedic surgery.

The proposals in Calgary are still just proposals. It is something we were following up on and monitoring. It is hard to say that you're monitoring something which isn't yet operating, but it's a proposal in that particular part of the world. We are certainly endeavouring to keep abreast of developments.

With respect to the disposition of the Holy Cross site and buildings this is something being handled through the regional health authority. They established a process involving a two-stage procedure for submitting proposals. I'm not completely up to date on where they're at with that, but it's my understanding that they're ranking their shortlist with respect to these proposals, and we will be hearing in the fairly near future as to what their plan is.

With respect to the Bow Valley site it's my understanding that the regional health authority has no plans to maintain a smaller hospital entity on that site. However, they are looking to the appropriate planning and future role for the overall land on which the hospital is located. That, of course, involves, as the Member for Calgary-Buffalo knows, work between the regional health authority, the city of Calgary, and ourselves and in an associated way the federal government in terms of working out the future use and disposition of that particular site.

A question was raised about psychiatric beds in Calgary. It's my understanding that a section of the Peter Lougheed hospital, a hospital that was never fully utilized, is now under the regional health authority's plan and is going to be the site of acute care psychiatric beds. I would have to check the information, but the number of beds is certainly being maintained and, I believe, increased, modestly, mind you, but increased, in terms of capacity in Calgary.

Reference is made quite often, not particularly focusing on the Member for Calgary-Buffalo – in Calgary they now have three full service hospitals, one very modern and up-to-date trauma centre, and with the exception perhaps of the one in the south, the Rockyview, both of those by most standards in most cities are pretty close to the downtown, maybe not in the geographic centre, but they serve Calgary pretty well.

Thank you, Madam Chairman.

THE CHAIRMAN: Thank you. Our time is up. If I could have a motion, please, from the floor.

MR. BRODA: Madam Chairman, I'd like to move that under Standing Order 56(8)(b) the designated supply subcommittee on Health conclude discussion on the 1997-98 estimates of the Department of Health and rise and report.

THE CHAIRMAN: All those in favour?

HON. MEMBERS: Agreed.

THE CHAIRMAN: Opposed? It's carried. Thank you for your patience and for being here so early.

[The committee adjourned at 12:04 p.m.]