Title: Thursday, September 23, 1993 Designated Subcommittee
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[Chairman: Mr. Lund]
Time: 6:32 p.m.

MR. CHAIRMAN: I think since we're already past the hour, we'll call this meeting to order. I want to welcome the minister and her staff.

There are just a couple of housecleaning matters that we have to deal with before we start. It's our intent tonight to start with an overview from the minister, a maximum of 20 minutes unless the committee decides otherwise. We would then go into questioning. We are proposing that we would go program by program. The chair is in the committee's hands as far as moving it along. We've got about – what is it? – six programs, plus one small estimate from the Alberta heritage savings trust fund capital projects division. The time frame, of course, is four hours. I would propose that the questioning be alternated between each side. We would allow the questioning to continue until everyone has asked what they wanted to on a particular program before we move on to the next program. Also, the chair will be lenient when it comes to moving from one program to another. It's not our intent tonight to get into any kind of a philosophical debate; we're hoping that we can stick with the programs as they're in the estimates.

The questioning. We would have one question with a fair preamble – not too long, but I recognize we have to have some latitude – and then two supplementaries. We would hope that the supplementaries would lead from the first question.

Is the committee agreed to the process? Any problems?

Grant Mitchell.

MR. MITCHELL: I just want to state for the record, Mr. Chairman, that while we're not entirely happy with the program-by-program restriction, we understand that you've allowed some flexibility in the past. We're willing to work within that, but I want it known for the record that we'd prefer to have more flexibility than that, given that many of the issues we have to deal with actually cut across programs.

MR. CHAIRMAN: Thank you.

Okay. Once the minister has made her presentation, we will start with the folks that are on my right-hand side. Madam Minister, if you would care to proceed, we would appreciate if you would introduce the folks you've brought with you and then just move straight into your presentation.

MRS. McCLELLAN: Thank you, Mr. Chairman. I'm pleased to have this opportunity to discuss the 1993-94 Health budget with the subcommittee. I don't intend to take up a great deal of time with introductory comments, but I do want to make a few points.

I would begin by introducing the staff members that are here. We have Don Philippon, acting deputy minister. Don, as many of you would know, assumed this role in March of this year and has served us well in those months of challenge. Frank Langer is down at the end. He's the acting assistant deputy minister in the acute and long-term care division. Immediately beside me to my left is Dave Kelly, the assistant deputy minister in the health care insurance division. Next to Frank is Steve Petz, the assistant deputy minister of community health. Sitting in for Bernie tonight is Denis Ostercamp, the executive director of the mental health division; our ADM is out of the province right now. As well, Rhonda Stevenson, with our communications area, is back there. Of course, I think most of you know my executive assistant, Maureen Osadchuk. If you don't, you should get to know her, a very knowledgeable lady in my office that's willing to help any and all of you. Yes, I almost forgot Aslam Bhatti. How could I do that? Aslam is with the finance part of our operation.

Just a couple of opening comments, Mr. Chairman. I'd just share with the committee that one thing I learned very quickly in this portfolio is that Albertans hold our health care system in very high regard. They believe, quite rightly I think, that our health system is among the best in the world, if indeed not the best. They also believe that we must work hard to sustain the system for the future. We have seen that commitment from the people in this province, from the people who access our system to the people who provide in the system.

Certainly our government shares this very deep commitment to the system, Mr. Chairman. I think living up to this commitment certainly means that we must ensure that we have the financial capacity to sustain the system and to ensure its viability. I believe that our 1993-94 budget takes significant steps in ensuring that viability. It's a budget that maintains our generous financial commitment to health, but it also recognizes that resources are finite. It recognizes that we do no one any favours jeopardizing the future of our system by spending irresponsibly today. In reviewing the 1993-94 budget, I would note that we have reduced overall spending by about $200 million. I believe that Health, spending about a third of our provincial budget, must be a part of our commitment to deficit reduction and, while doing that, maintain the high quality health services that we have in this province.

Mr. Chairman, I'm going to speak very briefly about each vote, and then we could certainly go to questions.

Program 1 is Departmental Support Services. I think if you observe the budget in that area, you will see that we are prepared to tighten up in our own administration, with a drop of over 10 per cent from our last year's estimates.

Program 2 funds the health care insurance plan. We now have an overall cap on physician services and also, you would recall, have committed to no increases in allied health services such as podiatry, optometry, chiropractic, and physiotherapy. In other words, we're going to maintain them at their level for this budget year.

Program 3 is acute care funding. This is the largest program. It is the area where we're seeing the greatest savings potential, for a number of reasons. Hospitals have certainly become more efficient, not only individually but collectively, as planning together a network progresses. Also, new techniques in medicine and diagnostics have reduced the need for numbers of inpatient services, and we see a great move to ambulatory care, to outpatient surgeries, et cetera.

Program 4 is long-term care. This is a major area of funding reform for Alberta Health. We've seen the introduction of a patient classification system and a single point of entry delivery system. I should say for your interest, committee members, that both of these systems have been seen as models across Canada.

Program 5 is Community Health Services, which comprises our funding to the 27 health units around the province. In this area we've continued our increased commitment to home care as a desired and appropriate alternative to institutional care, certainly encouraging a shift to community-based health.

Program 6 is community mental health. We've maintained funding in this very vital area and are working stakeholders through the mental health strategic plan to create a continuum of care for the mentally ill.

6:42

Program 7 is unspecified at this time. I would say that we've received excellent suggestions from the Red Deer roundtable on

where to achieve savings in 1993-94, and I hope that we will be able to announce specifics in the very near future.

Mr. Chairman, through the budget process and throughout the restructuring process that we've embarked on in Health, I've certainly been impressed by the willingness of health professionals to roll up their sleeves and get involved in the process. That's been evident through the roundtables, through informal discussions, head-to-head meetings. Through all of those, health professionals and government members have discussed, debated, argued, and planned, but all in the interest of making this system the best it can be. Equally important have been the ideas and suggestions of thousands of Albertans who have participated in these discussions or written to me as individuals. I appreciate that support and the constructive criticism I've received from Albertans. I think it's a clear indication of Albertans' desire to be a part of the decision-making process. I also would say that I appreciate the critical evaluation of our work provided by my government colleagues and by members of the Official Opposition. I know that regardless of what side of the House we sit on, all members of the Assembly share an honest desire to sustain our health system and prepare it for the new challenges and opportunities of the next century.

Mr. Chairman, one final note. Through these challenging times I've been very fortunate as minister to have received advice from many talented public servants in the Department of Health. Some of them have joined me tonight, but many others that you won't meet have worked very, very hard, and I want to acknowledge that.

Mr. Chairman, with those very brief comments, I look forward to questions from the members.

MR. CHAIRMAN: Thank you, Madam Minister, for the overview. It's not the chair's intent to direct the questions, so if members are wanting to ask a question of a specific person other than the minister, feel free to do that.

Howard Sapers.

MR. SAPERS: Thank you, Mr. Chairman. Thank you, Madam Minister, and appreciation to all the staff for coming out tonight. I'm really looking forward to this, actually. I'm hoping to learn quite a bit, much more than I know now.

A general comment in terms of program 1. I was expecting to see some detail in terms of health promotion, health prevention, so I would appreciate a general response about where those programs are funded from in Health and how they're funded and how those funds are allocated. I also have some specific questions in regard to the budgeting.

MRS. McCLELLAN: Can I help you on that one, first?

MR. SAPERS: Sure.

MRS. McCLELLAN: If you'd just look in program 5, it's dealt with mainly under public health.

MR. SAPERS: It's all in program 5?

MRS. McCLELLAN: There is some overlap, because obviously even in the other sectors there's some work done in health promotion and so on, but the main bulk that we support in health promotion and prevention is done through our public health.

MR. CHAIRMAN: The chair erred in not mentioning that program 1 is very broad, so there will be more latitude as you're discussing program 1.

MR. SAPERS: Thank you, Mr. Chairman.

My specific questions out of program 1 really have to do with the budgeting process, Finance and Administration. The present government is very committed to privatization. We've seen lots of moves recently in terms of privatization. We're also beginning to hear more and more evidence of moving away from the universally accessible health care system to a more two-tiered system; at least, there are fears about that. I'm wondering if we can expect more of the cost of health care as well to move towards the private sector, third-party insurance. Will these private insurance companies in the future be increasingly more responsible for covering the insured costs of health care?

MR. CHAIRMAN: If I could interject. You've got about three questions on the table already. Would you please tighten it up?

MR. SAPERS: Okay.

MRS. McCLELLAN: Do you want me to answer them?

MR. SAPERS: Thank you, Mr. Chairman. My question to the minister – I was hoping this would be a little less formal, but please.

MRS. McCLELLAN: Well, I think that what you're really doing is musing on the future of health care. We do not have per se a two-tiered system in health today. Obviously there are some inequities, and I suppose there always will be. For example, people in the urban areas have much more access to a greater variety of services. Our desire is to ensure that every Albertan in this province, wherever they are, has reasonable access to health service. That's our desire there. Under the Canada Health Act I think that is our responsibility. So what the role in the future would be – just thinking and thoughtful is fine, but it can't really be dealt with in the budget.

The other thing I would say on that is that I think those discussions are being held through the roundtable consultations. As I mentioned, the Red Deer roundtable was a start. It really dealt with some of the short-term objectives, but it was a building block to moving into the wider discussion. The reason we're holding them in the regions of this province rather than in just two or three places is to ensure that the people in those areas have an opportunity to make us aware of the health needs they have and ways that they can assist us in seeing that the health services are delivered. So I think a lot of that, Mr. Chairman, will evolve through the roundtable process, which is a start.

I should say that every province in Canada is in a similar situation. They are doing it in different ways, and in fact I think you were present in the room in Red Deer when the gentleman from Ottawa said that he applauded what was occurring in Alberta and thought it could well be used as a model for Canada to get public input into such an important area.

MR. SAPERS: The budget called for stakeholder savings in the order of about $122 million, and the roundtables were in part designed to accommodate that.

MRS. McCLELLAN: Yes.

MR. SAPERS: How was that amount determined? The budget actually is very specific: $122,903,000. I mean, on what basis was that determined to be the amount that could be achieved through savings based on roundtable consultations?

MRS. McCLELLAN: As I said in my opening comments, the delivery of health services in the province, how we provide them, has changed considerably. We believe we can achieve those savings in Health. I said in my opening comments that Health is about a third of our provincial budget, and I don't think it can be exempt from the discussions of reaching a balanced budget. I mentioned the changes in needs in inpatient beds in acute care. People are not spending the time in hospitals that they did even two years ago, and I think that's important, because we're able to provide a service to people and they can go home, which is most desirable. So we see a fair shift in that area. We know that long-term care is one where we are seeing a growth, a need, and we're trying to facilitate that through what people have told us they want, which is to be maintained in their home, in their own surroundings as long as they can, and then if it comes to institutionalize that we have those for them. So these are why we feel that the shifts can be made. You would notice that the acute care budget is the largest expenditure in the budget, almost $2 billion.

MR. CHAIRMAN: Your second supplementary.

MR. SAPERS: Thank you. I want to refocus that question, because it wasn't a question about whether cuts could be achieved or in what areas cuts could be achieved. I think there is general agreement that savings can be achieved, but it's how precisely was that figure arrived at and how can we expect to reasonably find $122 million in six months?

6:52

MRS. McCLELLAN: Well, again, you have a budgeting process and you have a minister of the department and department support that look at the total dollars and believe that we can deliver the health services for that amount.

MR. CHAIRMAN: Bonnie Laing.

MRS. LAING: Thank you, Mr. Chairman. Madam Minister, I'd like to also congratulate you on the fine job you're doing in very challenging times and support your efforts very much. Thank you very much also.

On program 1, looking at Human Resources, 1.1.4, how many positions were eliminated through the early volunteer option program?

MRS. McCLELLAN: Let me give you the exact dollars, and I do have the numbers here. There were 82 permanent positions.

MRS. LAING: Uh huh. How many positions were eliminated as a result of tightening up and administrative efficiencies?

MRS. McCLELLAN: Sixty-one full-time equivalents – we call them FTEs; you're all familiar with that – have been deleted due to the administrative efficiencies. I should also just inform members that transferring program delivery from the department to private-sector agencies has resulted in the removal of another 255 FTEs in addition to a net reduction of 175 FTEs through downsizing in the early voluntary options program. So it really takes a total of about 491 FTEs from government payroll in Health.

MRS. LAING: Okay. Thank you. Naturally this has resulted in some reorganization. What type of initiatives have you undertaken there in the department?

MRS. McCLELLAN: Well, one of the things that I heard early on in my tour as minister was that if we were going to restructure the system, then we have to look at restructuring the department that serves that system. That makes all kinds of sense. What we've tried to do is to co-ordinate, bring together services so that our support services operate in more of a continuum instead of in fragmentation and isolation. That was made very evident by the people who provide the services in the system. Whether they're in acute care, long-term care, public health, or mental health, they wanted to see more co-ordination and amalgamation. So we've done some of that in the department, and certainly I think what we want to do is move parallel with the restructuring in the system, with the restructuring in our department.

MRS. LAING: Thank you.

MR. CHAIRMAN: Colleen Soetaert.

MRS. SOETAERT: Yes. My concern is: on the one hand we build facilities and on the other hand we don't have appropriate funds to operate them. I'm thinking of the capital expenditures to the Cross Cancer Institute. They're near completion, and administration says that it won't have sufficient funds to operate. So I guess that's my question: how do you work that out?

MRS. McCLELLAN: Well, when we build, we build based on a capital budget to cost there, and we anticipate an operating cost. We have asked all of our institutions to ensure that they are operating them as efficiently as they can. I have not heard from the Cross Cancer that they are anticipating a shortage of funds, and I'm sure that if they have a serious concern in that area, they will contact me.

MRS. SOETAERT: Okay.

MR. CHAIRMAN: A supplementary?

MRS. SOETAERT: Why don't we put those two in the same budget? Like, were operating costs left to global budgeting for separate facilities, the capital costs aren't part of that global budgeting process.

MRS. McCLELLAN: Well, capital building is not in my budget at all.

MRS. SOETAERT: That's what I'm saying: those two should work together.

MRS. McCLELLAN: The decision was made some time ago for public works to build the infrastructure in the province. I think we've achieved actually some real savings by doing that as well. Health's role in this is to look at need and work with the communities and in the case of infrastructure say: this is the building that is required; these are what would be required through health standards and so on. We do not need to have the building expertise. So really we do have the planning, that part of it in Health, and the recommendations, and then the actual building of it occurs in another department. I see no value of having us build buildings.

MRS. SOETAERT: No, but the co-operation between the two departments . . .

MRS. McCLELLAN: Well, there is no problem there at all. Capital costs are onetime and operating costs are ongoing. I think it's very important that we are on the side of it where we talk about the need and the type of facility, the size to meet the needs, and the ongoing operating – that we are very conscious of that before we say yes, because as you indicate, it's important that once we have a facility, we can operate it.

MR. CHAIRMAN: A final supplementary.

MRS. SOETAERT: Okay. If you don't mind, I'll get specific on this one then. Specifically on the Royal Alex: are we going to be able to staff that new emergency department?

MRS. McCLELLAN: The new emergency department is up and running now and has been for a long time. I anticipate that they will continue, and a great improvement it is, if you've had an opportunity to visit it, particularly if you had an opportunity to visit the one that they were working with before.

MRS. SOETAERT: Oh, yes.

MR. CHAIRMAN: Ed Stelmach.

MR. STELMACH: Madam Minister, on program 1, item 1.2.3, rural physicians.

MRS. McCLELLAN: Do you have a page for that?

MR. CHAIRMAN: It's on page 47 in the supplementary estimates.

MRS. McCLELLAN: Anyway, go ahead.

MR. STELMACH: Okay. There's an approximate $500,000 increase there. Could you give us an idea of what the plan is or the reason?

MRS. McCLELLAN: Rural Physician Action Plan. As you know, this is a program that's in its, I think, second full year of operation. It's fairly complex in its total makeup. Don's going to give you something, and I can be a little bit more concise here. There are actually 16 initiatives in it. They're targeted at three groups: the students in residence, the existing rural physicians, and the rural communities. It's important in that to recognize that existing rural physicians' support was extremely important in this, because one of the reasons that we would lose physicians in rural areas was because of the lack of support. So that was an important part of it.

Part of the reduction that we have is really on the visiting specialists area. That may not be able to move ahead as fast. We felt it was very important to keep this program, and I should say to members – I'm sure you all have a great interest in this one – that even though it's only in its second year, it is showing some signs of success. I've had an opportunity to visit some facilities, the teaching side of it, where interns and residents spend time in the rural, out-of-city hospitals. It was interesting to me to hear the doctors who were there all the time say what a value it was to them to have the visiting interns and residents come. They had new ideas, fresh approaches, and indeed they were challenged as well. We are finding that with interns spending some of their internship there, they are much, much more comfortable about moving into a rural practice.

We can leave you a copy of the program.

7:02

MR. STELMACH: So the goal, then, would be to increase the number of doctors that would perhaps serve those small, sometimes isolated communities in Alberta.

MRS. McCLELLAN: Yes. I should just tell you that in 1992-93 the U of A would have had 60 undergraduates and 36 residents involved in the program. The U of C would have had 59 undergraduates and 32 residents. So I think those are fairly sound numbers for such a young program.

MR. CHAIRMAN: Do you have a final supplementary?

Grant Mitchell.

MR. MITCHELL: Thank you, Mr. Chairman. Madam Minister, I think to anybody but perhaps the most casual of observers it would seem that the effect of these initial health care cuts is really bearing largely on nurses and nursing-related kind of staffing. In fact, many of them have lost their jobs. I'm wondering whether the minister could tell us what labour force readjustment plan she has in place which is looking at how nursing resources, nursing people, could be redeployed within our health care system in a way that might in fact enhance health care services and reduce health care costs at the same time.

MRS. McCLELLAN: Really in that area the Minister of Labour is working more directly, but certainly we are in discussions with all of the sectors, particularly the nursing sector, because the nursing sector has been very proactive, as you know, in establishing some future roles for nurses in the province and have indeed brought many ideas forward as to how their roles can change. Of course, the concern is that the proper training, education, and so on is there and available for those shifts in roles and responsibilities and to ensure that their members do have those opportunities to make the shift more to community-based, if that's the case, or to other roles. So we're working with them; I've met and talked with their associations on these issues. In our department we have a provincial nursing consultant, Sharon Snell, who works very directly with our nurses, if you're just talking about that one area, on a number of those initiatives. I would say that it's an area where we will have to spend much more time with them in discussions, because really to meet the needs, it has to be a consultative process where we work together. I don't think the department can say, "This is how it should be." I think it has to be working together.

MR. MITCHELL: It certainly seems like there's much more intensity and urgency driving the cuts than there is driving the redeployment plan. I wonder whether the minister could tell us: how many nurses does her planning predict will be required in our health care system in, say, five years and in 10 years? How would they be deployed amongst acute care facilities, amongst home care programs, and amongst long-term care facilities?

MRS. McCLELLAN: I think the question is a good one, but I think it's a little bit too soon, because through the roundtable process, which is the first stage of looking at the restructuring, we have eight roundtables left to go. They will be concluded. As you know, we have a very intense workload in the roundtables

because of the need for, I think, moving ahead as quickly as we can.

I wanted to ask the member if he'd had an opportunity to see the Provincial Nursing Action Plan before. It was distributed within the last month. If Maureen would make a note, I'll ensure you get one. I've had an opportunity to go through it fairly thoroughly, and a number of initiatives are discussed in that. So I'll share that with you.

MR. MITCHELL: I don't see how it can be too soon to say what the nursing staffing requirements will be in five or 10 years when we're already beginning to dramatically cut the number of people who have positions.

My third question. On the one hand, the system – the minister and certainly hospitals – are accepting that LPNs and nursing aide type positions will continue to encroach upon the work that has otherwise been done by nurses. If that is the case, and it is the case because it's occurring, could the minister tell us what steps she's taking on the other hand to bolster and utilize in broader ways nursing professionals by taking away things from doctors that doctors need not do and that nurses could better do, could perhaps do even more effectively but could certainly do less expensively?

MRS. McCLELLAN: Well, on the first comment, I don't accept that what has occurred to this point is changing the system. What you are really doing is taking the present system and taking some out of it. The important thing is the long-term restructuring. I think that has to be done with very careful planning, and it has to be done with all of the stakeholders: the labour associations and unions – in nursing, our health services – the physicians; all of the players in the system.

The RNs certainly in the Provincial Nursing Action Plan discuss in some of their recommendations ways to move the nursing role forward. They talk very much in that plan about the need for collaboration and co-operation between physicians, between support workers – I call them RNAs; I'm outdated – LPNs and nursing assistants. I guess what we all have to do – and we need two days to talk about the changes that are there, because the needs have changed within the institutions in long-term care as well. In long-term care, because people are staying longer in their communities, in lodges or in their own homes, the ages are different there. The ability to handle people in long-term care has changed. There is a function for RNAs and nursing assistants, obviously, and there is a very important function for RNs. We do have a guideline that we expect our long-term care, for example, to follow on RNs.

One of the new models that is emerging is midwifery, and that is another one that's discussed. As well, I should mention some ideas for remote communities, where nurse practitioners – I'm not sure whether this is an accepted term yet, but certainly there's a very, very important role for nurses in that area.

I think the important part of it is the desire by this minister and the desire by the nurses and the nursing profession and associations to work together. I'm most anxious for the roundtables to conclude their deliberations and we have the opportunity to move forward. I sense a very strong willingness from physicians, from nurses, from support workers, from all involved to come together and be a part of building the new – maybe "new" is the wrong word – the emerging health system. Change is going to continue to occur, and their desire and our desire is to ensure that we are ready to meet change as it comes and not have to have big swings in what we're doing. The professions want that; we want that.

MR. CHAIRMAN: Dave Coutts.

MR. COUTTS: Thank you, Mr. Chairman. I assume we're still on program 1. Am I correct? Thank you.

To the minister or anyone from her department. In your opening comments you mentioned that mental health wouldn't be cut at all, that you're keeping the same funding. I'm looking at item 1.2.2, Mental Health Patient Advocate's Office; it has taken some decrease. I wonder what the reasons are for that. Is that just administrative?

7:12

MRS. McCLELLAN: Yes, that is exactly what it is. There has been no change in the mandate or activities of the mental health advocate's office. It's an administrative position. It's not needed.

MR. COUTTS: What does the advocate, then, really do, and will that affect . . .

MRS. McCLELLAN: We fund the mental health advocate's office. The mental health advocate is at a distance from the minister. He is there in an advocacy role for formal patients, if you understand the terminology in mental health. If there is a concern or a complaint, I guess would be the word, from a formal patient, the mental health advocate is there to meet that need.

MR. COUTTS: Thank you.

DR. NICOL: You've been talking a lot about planning, how you've gone through the process of determining the cuts. In connection with your departmental planning part of the program, did you conduct studies? What basis did you use to ensure that the reductions you made – you know, the 5.6 per cent, say, in this current year – don't seriously affect or alter the relative health care services available to Albertans?

MRS. McCLELLAN: Well, I've outlined a few times in the House a number of the initiatives that have occurred. The planning is not starting today in Alberta Health. It's an ongoing thing, but it has, I would say, accelerated with The Rainbow Report. I used that as a starting point, although there have been other things since then: the government response to The Rainbow Report, I believe called Partners in Health; the development of role statements; health goals; and reviews that have occurred not just within the department but within institutions themselves. So there are a number of steps that have been taken.

There were a number of regional meetings held across the province last year in the May-June area. In January of this year I communicated with about 300 boards and associations and providers to talk to them about the planning process and how we could facilitate or assist in that and of course came to the roundtables that are now in place. So planning has been going on for some time. I should mention again the nursing – well, the action plan is one report from it, but we also had some responses in nursing initiatives that gave us some very good information.

I think the task now is to draw it all together and to look at the health system that will meet the needs of this province in these years and into the next century and also the importance of ongoing planning in a systematic way so that everybody is involved together: the providers, the people who provide the support, I suppose government, and the consumers.

DR. NICOL: You've indicated quite a bit of this planning that is going on, yet if we look at your 1.1.3 under program 1, there's

quite a significant $300,000-some reduction in planning costs. Yet all of this continual planning has to go on. What aspects of the planning process are being made more efficient that you can actually reduce the budget when planning requirements are accelerating?

MRS. McCLELLAN: Well, within those areas we looked at a number of ways to reduce some dollars without affecting the ongoing planning, and a number of initiatives, of course, complete as you go along and you move into others. We had an opportunity to reduce fairly significantly in our supplies and services in that area. We do that in every element as much as we can to have as little direct effect on the work that we're doing. Certainly through the early voluntary options program there were people who took that opportunity, and I have to say there are a lot of people in our department that are carrying a heavier load today. That's why I commented on my appreciation for that.

MR. CHAIRMAN: A final supplementary?

DR. NICOL: Yes, continuing on with the planning aspects of it. My own constituency is in southwest Alberta. They undertook one of the most detailed regional plans over the last three or four years in connection with the role of the hospitals that are there. How are you planning to deal with this kind of regional need that comes up in terms of planning to make sure that both facilities and access are maintained on a regional basis when you start dealing with issues of centralized hospital patient needs and then local hospitals in communities not too distant from a regional centre?

MRS. McCLELLAN: One of the things I have said repeatedly is that I think the best place to identify community needs in health or in many other things is in the community itself. That was very important in the planning process, and indeed the work that is done by those areas is what forms the basis for much of what will be our restructuring, I would say. What we ask communities to do in that process is to identify the health needs, not just health care but the health needs, because I believe we need to emphasize a little bit more preventative health, health promotion, education, and so on. So the community makes those decisions. In those cases such as in your area, they look at the infrastructure that is in place, look at the providers that are in place, and say, "Now, how does this fit with the needs of the community?" I think that's the important part of it.

I've said that I don't believe there is one model that is right for Alberta. Our geographic areas preclude just stamping out a model and saying, "This is it." We're too diverse culturally and demographically, and of course activity levels in an area change the health needs of an area. If you're heavily industrialized, you need something different than if you have a different type of community. So that's all very much a part of it.

We have heard through the roundtables the continued desire for whether you call it regional planning or community planning. When they talk about communities, you're talking about more than one town; you're talking about communities. It's important that communities have clearly defined in their areas where they receive the health services they do not provide – we know we will not provide the same health services in every community, so is it through a regional hospital, is it through an urban hospital, and if so, which one? – so that they can do their planning to meet the needs of all Albertans, which is really what they're there for.

I hope that's helpful.

MR. CHAIRMAN: Do we have any more on program 1? Lyle Oberg.

DR. OBERG: Mr. Chairman, I have a quick question. Thank you again for the comments. I'm actually asking about the rural physician action plan. Surprise, surprise.

Actually, I recognize the importance of the program, and I certainly applaud it. I especially think that the rural rotation for medical students and the rural experience during postgraduate training are extremely valuable. As you know, the hospital that I work at has been involved in that program for approximately 10 to 12 years. It's really been an effective program. One point as well that I draw your attention to is the rural regional visiting specialists programs. Basically what we're talking about is similar to the concept of itinerant surgery to, you know, become a bit more specific. Unfortunately – and I say "unfortunately," explaining my biases – the College of Physicians and Surgeons recently came out with a ruling against itinerant surgery. Does the Department of Health plan to rework this concept, or is it going to stay within the guidelines of the college, or are we going to ask the college to relook at it?

7:22

MRS. McCLELLAN: Well, I'm not sure whether it was really against it or whether it's something that needs more work.

DR. OBERG: I guess that's my question.

MRS. McCLELLAN: I think that's the case. When you look at the rural physician action plan, it's a very ambitious plan. It has 16 elements to it. As I say, it's only in year 2, and we've been able to implement a lot of them. That is probably one area and possibly one area where we need to do a little bit more work.

I think the other important part of the discussion when you're talking about the lack of speed moving forward with that is that we have gone and are going through this role-statement process, where the rural hospitals, the regional hospitals, and so on have been developing role statements. So I think that's one of the difficulties. The other thing is that in many cases the areas of the province that really require a lot of support are in northern Alberta, and distance is a challenge for us both in cost and in the time involved in traveling. I think that's one of the reasons for maybe the need to slow down a bit.

As we develop the role statements, we look at the regional hospitals. We look at their role and what services they could be providing, and we know they could be expanded to take more of the stress off the major, acute care hospitals in the urban areas. I think this may be more acceptable, but in that role-statement process we just need to do more work. For doctors the difficulty is working in isolation. Members would be interested, I'm sure, to look at the pilot that's occurring between the University of Calgary and Drumheller. I know that you're familiar with it. It's just more than a mentoring process; it's linking doctors at a distance to doctors with a speciality in acute care hospitals so they can have that link when they're a long way away from those specialists.

MR. CHAIRMAN: Do you have a supplementary?

DR. OBERG: Yes, I do. The Alberta Medical Association in the last couple of years came out with a rural physician action plan, and in it it laid out numerous topics about how to increase the recruitment of rural physicians, albeit both of us recognize, coming from rural constituencies, that there is a shortage of doctors in rural areas. One of the interesting things that I felt was deleted from it was incentives for rural students, not necessarily medical students but rural students to go into medicine. I thought this

would be an obvious location to get more doctors out into the rural areas, but unfortunately it wasn't included in that report. Does the minister have any plans for implementing something like this?

MRS. McCLELLAN: It's an interesting concept. One of the things that is interesting is that work-experience programs often are one of the most successful ways of interesting students in communities that don't have all the activities going on in them. We've seen a lot of interest and a lot of developing – veterinary students, many go obviously from the rural areas, and it may be because they have more interest. I was interested when the Heritage Foundation for Medical Research was talking the other day about their researcher-for-a-day program, where they were encouraging students to write essays or compositions about how they saw research in the year 2025 or something and the winners would become researchers for a day at a research facility. I thought, how exciting. If you want to promote that type of excitement – we've also had a lot of initiatives trying to interest more students in science and science related activities through the Premier's Council on Science and Technology, because we in the province I guess are a bit concerned that our students don't seem to be taking up those roles. So I think there are a number of initiatives, and if you've got ideas, tell us.

MR. CHAIRMAN: Thank you.
Final supplementary.

DR. OBERG: One final supplementary, and it's one you don't have to answer if you don't want to. As you know, in May the Alberta Medical Association announced a plan to basically limit the number of billing numbers that were allowed in Alberta. I realize this was a unilateral statement put forward by the Alberta Medical Association in response to things that were happening in the rest of the country. That statement and platform that they put out sort of got me musing, and I was wondering if there was any interest, for lack of a better term, in limiting the billing numbers in the city, allowing physicians to move out to the rural areas.

MRS. McCLELLAN: Well, that's a program, I guess, that has been put in place in Ontario, and that's really, I suppose, why the AMA responded when they did: because there was a fear that there would be a large influx of doctors from other provinces.

DR. OBERG: Actually – and no disrespect is meant here – in Ontario what they did was decrease the income to the physicians in the cities.

MRS. McCLELLAN: Well, you can only bill to 25 per cent . . .

DR. OBERG: Right; which is essentially limiting it.

MRS. McCLELLAN: . . . unless you went to practise in a rural area.

DR. OBERG: Right.

MRS. McCLELLAN: I would just say that we have, working with the AMA, a process where they are bringing a report on physician resource to me later this fall, probably early winter. We do have a system through the administrative council to work through these issues, and that is my preference: to do it in a thoughtful way with their advice and working with us. I think that's the way.

I think that for disbursement we have seen some of the challenges and responded through the rural physician action plan. It takes some time to work; you could not expect it to be overnight. One of the successful parts of it certainly beyond the interns and residency part of it is the locum area. We have doctors in rural communities who are tied to their practice 24 hours a day and indeed seven days a week. For professional upgrading, for holidays, for anything they did not have those opportunities. The locum program has been accessed a great deal, and I think it was very important. I live in a rural community, and I see my doctors at functions with their beepers. It's not very nice to not have even an evening off. I'm sure you recognize that even in a community where you do have other support, which all our communities don't have. Doctors in rural communities are working together to share responsibility, taking every other weekend or something for somebody else.

DR. OBERG: Thank you.

MR. CHAIRMAN: Thank you.

Before we move on, we've now spent 57 minutes. I'm getting a little bit concerned that we are getting into some philosophical things. A philosophical question leads to a philosophical answer. Of course, the chair is certainly in the committee's hands, but . . .

MR. MITCHELL: We didn't want the answers to be philosophical. It just got that way, Mr. Chairman.

MR. CHAIRMAN: . . . we're still on program 1.

MR. MITCHELL: We wanted them to be very, very specific.

MRS. McCLELLAN: I think they're pretty specific.

MR. CHAIRMAN: Howard Sapers.

MR. SAPERS: Thank you, Mr. Chairman. About 3.63 per cent of the almost 6 per cent, 5.65 per cent . . .

MRS. McCLELLAN: Are you in program 1?

MR. SAPERS: I'm still in program 1. Five point six five per cent of the overall budget reduction has been identified as savings through stakeholder consultations. That means that 64 per cent, if my math is right, of the cuts are yet to be identified, are not even identified as according to which of the six programs in the budget will be affected, and this in spite of all of the very careful planning that you've just spoken of. That doesn't suggest careful planning, even though we're aware that that planning has happened. How is that planning being applied to managing those cuts, and how long will it take before we know precisely where those cuts will be and which programs?

7:32

MRS. McCLELLAN: Well, as I've indicated, I hope to have those answers very soon.

MR. SAPERS: Okay.

MRS. McCLELLAN: You wanted specific and less philosophy.

MR. SAPERS: Okay.

MR. MITCHELL: Could you give us a date?

MRS. McCLELLAN: I wish I could.

MR. SAPERS: Sometime past tomorrow it will be. Okay.

What exact mechanism, Madam Minister, what precisely will be used to determine the priority of the issues raised and the suggestions offered during the roundtables?

MRS. McCLELLAN: One of the reasons it takes a bit of time to look at and assess all of the good advice that we got at the roundtables is that some are short-term, some are medium-term, some are long-term abilities to achieve. I think it's really important that we take the time to assess the impact on the system of what was suggested. That's the important part as we work through it.

MR. SAPERS: My last supplemental. I'm trying to get at what exactly you're going to do as Minister of Health when you get two equally strong, compelling suggestions or issues identified that are absolutely diametrically opposed. What are you going to do with these competing suggestions that are coming out of the roundtables?

MRS. McCLELLAN: Well, one, I think you have to look at overall health and health interests. As I said, in the short term you're dealing with the system we have today, but moving into the long term, we're looking at the system that we will have ongoing. The health system, aside from the fact that it is about $4 billion of the provincial expenditures, is a very complex system. It has a great number of people involved in it, and it affects the about 2.6 million people in this province. So you do not enter into decisions in this area lightly either in the short term or in the long term, and you have to look at the overall effect of whatever actions you take in it. So it may sound easy to make decisions, but it is not. It requires time, and it requires thought, and it requires consultation, and that is the way that it will occur.

MRS. FRITZ: Are we still on program 1, Mr. Chairman?

MR. CHAIRMAN: Yes, we are.

MRS. FRITZ: Thank you. I noticed that there are 1,644 employees in the ministry under the manpower authorization. My question was simply: how has that changed in the last, I don't know, three to five years? I'm certain that it's decreased significantly. Also, what do you see that as over the next two years?

MRS. McCLELLAN: Well, the harder part is to project over the next two years.

MR. MITCHELL: A point of order, Mr. Chairman. The minister answered that in her opening comments.

MRS. McCLELLAN: Yeah, I did. I was just going to clarify.

MR. MITCHELL: It will be in *Hansard*.

MRS. FRITZ: Oh, thank you. I'm sorry. I missed that.

MRS. McCLELLAN: It was a total reduction of about 491 FTEs.

MRS. FRITZ: I appreciate that. That's fine.

MRS. McCLELLAN: On the long term it's more difficult to assess because, as I say, as we restructure the system and we do it in a parallel, the support for the system will depend on the system that we have.

MRS. FRITZ: I appreciate that. I was late by about three minutes, and I must have missed it.

Thank you.

MRS. McCLELLAN: Okay. I think it was about the first question.

Who's next?

MRS. SOETAERT: I am. Thank you. Mr. Chairman, I'm wondering what work is being done on identifying procedures that nurses in outlying posts in isolated areas do instead of doctors. Could they do them in centres here? You know, if they're allowed to do them out there, can we take those skills and use them here?

MRS. McCLELLAN: Well, again, Colleen, I just draw you back to – I think I discussed that. I'll share with you a copy as well. I'm sorry you don't have that, because it's a very good document on the nursing action plan.

MRS. SOETAERT: I guess it's not a specific plan.

MRS. McCLELLAN: Well, I don't know how you think that is not occurring. Oh, you're talking about the fact that we don't have nurse practitioners.

MRS. SOETAERT: The specific things they do up here, can they do that down here?

MRS. McCLELLAN: Do we fund it differently?

MRS. SOETAERT: Do you allow it?

MRS. McCLELLAN: Well, we have public health nurses in this province everywhere. We have public health nurses in my community that not too long ago were the first point of contact for anybody in a medical situation. We have 27 health units, but how many public health offices do we have in this province?

MR. PETZ: Two hundred and fifty-eight.

MRS. McCLELLAN: Two hundred and fifty-eight, and many people access that public health nurse as their first contact.

MR. CHAIRMAN: Supplementary.

MRS. SOETAERT: Thank you. What steps is the minister taking to implement nursing practitioner policies?

MRS. McCLELLAN: I am going to work with the nursing associations that presented the nursing action plan. I think what they asked for was that we work together, not the nurses and the ministry but the nurses, the physicians, the support workers, everybody. I wish I could remember the number of the recommendation – I don't have it with me – where they asked for that and they asked for the opportunity to identify ways of changing and expanding roles for registered nurses in the province. I think that's the proper venue to deal with that. It isn't the minister that should decide what the role of the nurse is; it should be decided with the nurses.

MRS. SOETAERT: There are steps being taken to do that?

MRS. McCLELLAN: They've presented it to me, yes.

MRS. SOETAERT: Okay.

My last one is, I guess, on numbers of nurses that we have now. No one can see the future, but I'd like to know: can we foresee how many nurses will be working in acute care facilities in the year 1998 and in the year 2003? Kind of a projection.

MRS. McCLELLAN: It's a good question, but it would be a tough one to answer. First of all, nurses will always be an integral part of primary care in this province – always, into the future. I know that two of your colleagues heard the comments in Red Deer from a panelist that talked about the changes that are occurring so fast in, first of all, procedures, in drug therapies, in technology that we can't, I don't think, anticipate anymore almost month to month what the changes will bring. So it's very hard to envision what an acute care facility might look like in 10 years or what services might be required.

I think what you are going to probably see in the future, if you want a philosophical musing from a minister who is observing this, is health centres; you're going to see integrated health centres. I think we're moving to that in many areas in the province today. It would appear – as I say, it's a musing – that that is the future in this province. You're going to see a stronger role played in health promotion, in preventative health, and much more in keeping people healthy. Nurses have always had a strong role in that, and I think we can strengthen it even further through the community health side. We have to be concerned about some of the statistics we have in the province. Some of you were there when we made our presentation to the standing policy committee and talked about the number of treatments that we have that are life-style related. It's of concern.

MR. CHAIRMAN: Do any members on this side have any questions on program 1?

Grant Mitchell.

7:42

MR. MITCHELL: Is the minister planning to negotiate wage rollbacks to nurses as part of a package that would see commensurate rollbacks to payments to doctors and that would see graduated rollbacks; for example, no cuts to people earning less than $30,000, with increasingly greater cuts to people earning more and more: $100,000, $150,000, or more?

MRS. McCLELLAN: The minister does not negotiate.

MR. MITCHELL: Is she planning any kind of approach to that?

MRS. McCLELLAN: The minister doesn't have a negotiating role. I have a consultative role.

MRS. LAING: Point of order, Mr. Chairman. We should be on the budget, just as we do in estimates.

MR. MITCHELL: How much of the minister's office expense is going to her time spent considering this kind of package?

MRS. McCLELLAN: As I say, I have a consultative role, and I don't negotiate. I mean, that's not my role, to negotiate.

MR. MITCHELL: In that consultative role . . .

MR. CHAIRMAN: You've had your final supplementary. I'm sorry.

MR. MITCHELL: No, no. No, I didn't.

MR. CHAIRMAN: Yes, you did.

MR. MITCHELL: Mr. Chairman, I did not have my supplemental. I didn't have one supplemental. The minister asked for clarification. I hId one question, and I have two more to go.

MR. CHAIRMAN: I'm sorry, but you've had three questions, Grant.

MR. MITCHELL: I can repeat the question, and I can show you that it was one question, Mr. Chairman.

MR. CHAIRMAN: Do the members on this side have any more questions on program 1? If not, Grant Mitchell.

MRS. FRITZ: Well, I'm sorry. Is it our side then? I do actually.

MR. CHAIRMAN: Yvonne.

MRS. FRITZ: Thank you. It's back to the full-time equivalent employment for the ministry manpower. Would you just share with me where the manpower is allocated, how it's allocated? I don't mean for each person or whatever, but just generally under the ministry, just the 1,644, please.

MRS. McCLELLAN: I have to figure out what exactly you want to know. How many permanent positions we have, how many . . .

MRS. FRITZ: No. I understand there are 1,644 and a half full-time equivalents, and I'm just wondering how those positions are allocated under the ministry.

MRS. McCLELLAN: Okay. The highest number of positions are in Health Care Insurance, and I suppose that's for obvious reasons, because of the program itself. I shouldn't say that. The second highest. The highest number are in Mental Health Services. In Departmental Support Services there are about 342. The Health Care Insurance that I started out with is 411. There are 580 in Mental Health Services. I should mention that Claresholm is in that area, so that would be a reason for significant numbers, obviously. Community Health Services: 205.

MRS. FRITZ: In community health.

MRS. McCLELLAN: Yes. Twenty-four point seven in long-term care. These are done in FTEs, you know, so you can have points. It's split out that way.

MRS. FRITZ: Thank you.

MR. CHAIRMAN: Supplementary?

MRS. FRITZ: No, thank you.

MR. CHAIRMAN: Grant Mitchell.

MR. MITCHELL: Yes. I wonder whether the minister could indicate: in her consulting role on the question of what nurses will be paid, what doctors will be paid, what exactly she is telling those people to whom she is consulting.

MRS. McCLELLAN: I am not telling those people anything. If there's consulting, they're telling me. The dealing has been with the roundtable process and the opportunities there. The nurses have a collective agreement, and it is not appropriate for this minister to discuss those issues with them unless they come and want to discuss them with me.

MR. MITCHELL: Has the minister developed a scope of practice criteria, a set of criteria for LPNs which distinguishes their role from the role of nurses?

MRS. McCLELLAN: Well, the scope of practice for LPNs I believe is in professions and occupations, and, again, it would not be in my venue.

MR. MITCHELL: What are the doctors saying to the ministes about relinquishing procedures and activities that could be done less expensively by nurses?

MRS. McCLELLAN: Discussion I don't believe has occurred between me and doctors on that particular issue. However, I'll go back to the desire that I see between all of the areas to work together on providing help towards health.

MR. CHAIRMAN: Lyle Oberg.

DR. OBERG: Thank you, Mr. Chairman. I just have one quick question on the role of nurses, as it comes up. One of the commonly held perceptions is that if nurses go out and become salaried and become primary gatekeepers, there will be a significant cost saving. Just adding up some quick figures, and this is purely off the top of my head: with expenses being approximately 50 per cent, which includes office expenses, staffing, billing, things like that, plus liability insurance, it seems to me that a salaried nurse would have to be salaried somewhere between $100,000 and $125,000. Does this sound about right, or is it . . .

MRS. McCLELLAN: I definitely haven't worked out the figures to the extent that you have obviously thought about them. It's a very interesting area of discussion, but again – and it's not to avoid the discussion at all – I have to tell you that I was very impressed with the work done by the profession in the nursing action plan. I was most impressed with the desire for co-operation, collaboration, and discussion with others in the health-providing area to advise appropriate roles, and the strong desire to work towards ensuring that we have a long-term sustainable health system in this province.

MR. CHAIRMAN: A supplementary?

DR. OBERG: No supplementary.

MR. CHAIRMAN: Ken Nicol.

DR. NICOL: Madam Minister, back to your planning part. Within the planning focus is there any activity funded that would allow for regional authority with power in the sense of co-ordination between a group of hospitals in a region or between the regional hospitals and health units, these kinds of things?

MRS. McCLELLAN: What I heard at the roundtables where it's been discussed to date is that there are three areas when you look at regionalization, or regional areas: one is in planning; the second, in fiscal; and the third, in governance. I think that was the concept that was discussed in Red Deer in particular. I think it carried through in other areas. There would probably – and Don could help me on this – have to be enabling legislation if you were going to look at governance changes, and I think it would be appropriate to say that if they emphasize that, if at the end of this process there is a strong desire for that, as I said earlier when we embarked on this, I am open to hearing from the health providers and working with them to provide what works best for their communities. We would need enabling legislation for changes.

MR. CHAIRMAN: A supplementary?
Ed Stelmach.

MR. STELMACH: In reviewing program 2, Health Care Insurance . . .

MR. CHAIRMAN: No. We're still on program 1.

MR. STELMACH: Well, we'll ask the same thing on program 1. [interjections]

AN HON. MEMBER: When do we move on?

MR. MITCHELL: Soon. I have one more set of questions.

MR. CHAIRMAN: As soon as the committee has exhausted their questions on program 1.

MR. STELMACH: Well, I'll ask the same question here. It's just that we've spent an hour on $26 million, and we've got $4 billion in here. Anyways . . . [interjections]

Information Technology and Finance and Administration. I can probably ask the same questions in the other departments. What is encompassed in Information Technology? What do we do for the $5 million, let's say?

7:52

MRS. McCLELLAN: We do a lot of things. I suppose one of the larger challenges in Health is in information technology. We have heard at a number of our roundtables and discussions on health the need for outcome measurements, better data, and certainly at the ministers' meetings that we've held, that's consistent as well. So some of the areas are definitely there. We're supporting data distribution, which is, as you know, in this province quite large, systems development for our hospitals and others – and obviously we want to continue to support systems that will enable us to be more efficient in our planning – the services to external facilities after treatment. So it's quite a large field because so much of the data we're moving to automated systems. I think that will add a fair amount of efficiency. One of the concerns I hear consistently from everywhere is the need for information and data, the need for filling out forms and charts, and if we can make it more efficient through systems so that the information can be useful to us in the long run, it will be a great help.

I should also say that we have a fair amount of work that we've had to do through development of financial systems as well in this department, and I'm sure you would understand that. If you want a little more information, Aslam might give you some more of what actually goes on in the depths of that department.

MR. BHATTI: We have a brochure that we can get, Madam Minister, that outlines all that.

MRS. McCLELLAN: Oh, that would be helpful. That would save some time.

AN HON. MEMBER: Can we have a copy of that too?

MRS. McCLELLAN: Sure.

MR. CHAIRMAN: A supplementary, Mr. Stelmach?

MR. STELMACH: The investments of $5.7 million in this particular program and then – God help me for mentioning program 2 – there's some $8 million in the other one. Is this leading us closer to some technology that may implement the concept of a smart card, let's say, leading to efficiency, better record keeping, and perhaps stopping or putting an end to some of the abuse in emergency rooms and doctors' offices, et cetera, et cetera?

MRS. McCLELLAN: I think the short answer is yes. There is a lot of work that needs to be done. A health card is one thing. A smart card is kind of a leap from that, but there is some very interesting work going on in that development.

MR. STELMACH: Thank you.

MR. CHAIRMAN: A final supplementary?
Grant Mitchell.

MR. MITCHELL: Thanks, Mr. Chairman. In the minister's planning . . .

AN HON. MEMBER: And consultation.

MR. MITCHELL: . . . and consultation, what has she determined will be the single greatest health care intervention required of acute care facilities in five years and in 10 years?

MRS. McCLELLAN: Intervention?

MR. MITCHELL: What will be the single greatest health care intervention – this is not the second question; this is just repeating the first one – required of acute care facilities in this province in five years and 10 years? It just seems to me that those kinds of projections are critical to knowing where this health care system will be and beginning to build to that point now.

MRS. McCLELLAN: I don't disagree with you, but I don't think I'd be prepared to place an answer on the table as to what it will be. I guess one of the areas that I think we can work on a national basis is on information exchange that will lead us to anticipate better in that. We've said that in our country, not just in our province, we do require much better data information, and as I indicated, I believe to you, in the House one day, we have entered into a health information system and so on, that we can have that.

I think it's fair to say that today it would appear that many more activities will be on an outpatient basis. However, we all know that things can change. Things come at us in this field that we can't anticipate. So that's one observation I would make. I think all of your questions point to the need for consistent and long-term planning, and although it's not in my budget or my vote, I would just mention the fact that the Premier has put in place the Health Planning Secretariat, whose role is to work on long-term planning.

MR. MITCHELL: One of the critical features of planning is to co-ordinate among other things these cuts.

MRS. McCLELLAN: That's right.

MR. MITCHELL: You get this sense that we have discrete institutional mandates. If every hospital in Edmonton, for example, runs its budget perfectly and meets the funding limits which you have imposed upon them, that still begs the question of whether all those institutions' services added up meet the level of demand that in fact exists. Who is taking the role? Is it not the role of the minister and of the department to ensure that somehow these cuts don't result in all kinds of demand for service falling between the cracks, as it were?

MRS. McCLELLAN: Well, I can give you statistics that tell you some things. For example, we have a higher number of acute care beds per thousand in Alberta than the national average. We have almost one per thousand higher than British Columbia, our sister province. In some areas we have higher inpatient days per procedure. However, I think statistics are important and I think you should use them to some extent, but there are always circumstances that surround those statistics. I haven't tended to talk about that a great deal tonight, but I could give you those statistics that show that, and you use them as only one measurement, one forum.

AN HON. MEMBER: Can we have those?

MRS. McCLELLAN: Yes; I think I've quoted them actually, maybe even in the House. There is a national average. The maritimes have a higher number of beds than we do. Saskatchewan did; I'm not sure they still will in a short time, because they've actually reduced a great number. That's only one measurement, though, because as I said before, geography, industry, demographics, many things enter into health in a province. If you're highly industrialized, I suppose you have different needs than if you have a different type of economic activity. So that's one of the things.

I think what we want to zero in on more is appropriate care rather than – I think the biggest danger to this system is that we don't change. I expect a number of you heard some comments from the address made in the U.S. last night. You've heard me say before that the U.S. is the highest privately funded system in the world, and it does not have the best health outcomes, anywhere near. We're the highest publicly funded, and unfortunately our health outcomes are not at the top either. So to sit back and say that what we've got is great – it is good, but let's look at how it can be better, and let's ensure that we are able to provide appropriate care to the people of this province in the future.

MR. CHAIRMAN: Final supplementary.

MR. MITCHELL: Thanks, Mr. Chairman. My third supplementary, again on this theme of planning to co-ordinate. Here's an example of where I think something falls between the cracks. On the one hand, acute care facilities will pay for intravenous when it's in the hospital. On the other hand, if they discharge somebody who needs intravenous, that isn't paid for outside the hospital. It just seems to me that that means people stay in hospitals when they shouldn't, when they don't need to. In fact, if they got out, it would save us money and it would probably enhance their health care and reduce some of the risk of infection and so on that goes

on in hospital. Why is it that that kind of inconsistency is allowed to prevail in this system?

8:02

MRS. McCLELLAN: Well, again you point out – and you've made the arguments I think consistently all night – the need for planning. These things happen very quickly. They are not funded today in that way. As I indicated earlier, I think we will be doing more outpatient, more home based, so I guess one of those things we need to do is look at these. We have introduced a partnership between facilities and our health units to address some of those areas of concern. Again I think it requires close co-operation and collaboration between our facilities that are community based and institutionally based. So those are areas that obviously we need to work on.

MR. CHAIRMAN: Are there any more questions on program 1? If not, Ed Stelmach on program 2.

MR. STELMACH: Madam Minister, Provincial Contribution to the Health Care Insurance Fund is $638 million. Out-of-Province Health Care Services constitutes about $31 million. Is that after the adjustments that were made to the snowbirds? Is that cut encompassed in there?

MRS. McCLELLAN: The adjustments that were made were not made to the snowbirds. The adjustments that were made were made to all Albertans. Even you, sir, would be under that. Yes, the answer is that those adjustments are included in the out-of-country health care services.

MR. CHAIRMAN: A supplementary? [interjection] Howard Sapers.

MR. SAPERS: Thank you for moving us along, hon. member and Mr. Chairman. Recently we've heard some musings – that seems to be our word – from the government side about nonessential medical services being billed by doctors. I believe the phrase "nontreatment" was even used, which suggests certain other problems being billed for by medical doctors.

MRS. McCLELLAN: Do you want to get more specific with that?

MR. SAPERS: The minister responsible for the Health Planning Secretariat was quoted . . .

MRS. McCLELLAN: That's not in my budget.

MR. SAPERS: Right. That's why I wasn't getting more specific.

MRS. McCLELLAN: I was hoping it wasn't me.

MR. SAPERS: No, just somebody from the government side.

MR. CHAIRMAN: Order. Time is quickly running out.

MR. SAPERS: My question is this. The Canadian classification, diagnostic, therapeutic, and surgical procedures system and the claims redevelopment project, both slated for implementation later on this fall, I believe October 1, are really geared to changing the way doctors bill, doctors access health care dollars through this program. Has the utilization monitoring committee chaired by Dr. Watanabe uncovered evidence of widespread and/or growing misuse or abuse of the Alberta health care insurance plan through either inappropriate doctor visits, inappropriate use of diagnostic services, or billing? If that has been uncovered, what are you doing about it?

MRS. McCLELLAN: Well, the utilization committee really looks at procedures. They look at trends, and when they see something – in particular I would mention a high number of thyroid testings that occurred. When they raised that, the incidence did drop. Remember, though, that in Alberta we have a capped pool of dollars for physician services. Obviously, the physicians themselves are, you know, very conscious of how this is used.

Dave may want to elaborate on the health care insurance. We have a monitoring system where we do random audits, periodic checks, as you would in any insurance system. Those things are in place to look at that area.

Dave, I don't know if you want to comment any further on that.

MR. KELLY: The utilization monitoring committee has certainly noted increasing visits, increasing diagnostic services. Discussions have taken place with the medical community as to what the reasons behind that might be. Basically, there have been two responses to date. One is the hard cap, so that increasing services would no longer mean increasing costs, although they still remain a concern if they are necessary. Second is the identification of clinical practice guidelines as a way of getting at the problem and the beginning of the development of clinical practice guidelines within Alberta.

MR. SAPERS: Thank you. How is the department ensuring, Madam Minister, that the relative value guide being developed by the Alberta Medical Association will result in a fair distribution of the budget as it is available for physician services and will not result, in fact, in higher billings or claims for service?

MRS. McCLELLAN: We work very closely with our Medical Association. We have an administrative council that we work through on those issues. Certainly Mr. Kelly has ongoing discussions with the Medical Association in those areas at all times.

Dave.

MR. KELLY: We're very much involved in the development of the relative value guide. Dr. Platt, the medical director of the health care insurance plan, sits on the Relative Value Guide Committee and has been an active contributor to the process. The Alberta Medical Association is using methodology to develop a relative value guide. It's very similar to that developed by Dr. Hsiao at Harvard, who is the world's leading expert in the area. We're satisfied with the work that's been done to date, and we're monitoring it very closely. Again, because we have a hard cap, if they got it wrong, it wouldn't result in an increase in cost; it would result in a misallocation among physicians within a fixed provincial allocation. So the physicians themselves as an association have a very real interest in getting it right, and we think they're trying.

MR. SAPERS: In making a choice between a hard cap on billing and, I suppose, not even a choice but working in concert with the development of clinical practice guidelines, is the department also contemplating developing similar practice guidelines for the allied health professions?

MRS. McCLELLAN: I'm trying to sort out the scope of practice in my own mind. Don, you might have to help me. Some are

under the Health Disciplines Act; some have their own Acts. I'm trying to sort out in my mind just which one, because there's podiatry, chiropractic, physiotherapy, and optometry. Some of them have their own Acts, and they have their own guidelines.

MR. CHAIRMAN: Bonnie Laing.

MRS. LAING: Thank you, Mr. Chairman. Madam Minister, you mentioned in your opening remarks about all the steps that are being taken to contain the rising pharmaceutical costs, such as the Alberta Health drug benefit list. If we look at 2.2.3, who decides what drugs should be added to the drug benefit list?

MRS. McCLELLAN: We have an external expert committee comprised of physicians, pharmacists, and pharmacologists. They assess the therapeutic and economic benefits of the drugs over all products, and they make the recommendations to the minister. So that is the committee that does the review and makes the recommendations to the minister.

MRS. LAING: How many products are on this list?

8:12

MRS. McCLELLAN: The drug benefit list has 3,470 listed on it, but there are a number of different areas. It might be of interest to members to know that there are about 1,477 of those that are single source, noninterchangeable, and 1,993 that are considered interchangeable.

MRS. LAING: What impact does this list have on the cost of drugs?

MRS. McCLELLAN: For a period of time about five years prior to 1991 drug costs were increasing by about 13 to 15 per cent a year, which is really quite a lot. After we implemented the drug benefit list, in 1991-92 they decreased by 5.4 per cent and again by 3.7 per cent in 1992-93. So I would say quite a significant effect.

MRS. LAING: Thank you.

MR. CHAIRMAN: Colleen Soetaert.

MRS. SOETAERT: Thank you, Mr. Chairman. My question is about how the department makes decisions about which services are covered and which are not.

MRS. McCLELLAN: I'll get Dave or Don to comment a little bit more on this. Insured services are medically required services. I'm giving you the short answer and then I'm going to let Dave give you the long answer, because I'm losing my voice. I have a bit of a cold.

DR. PHILIPPON: We're a part of the Canada Health Act. We're required by the Canada Health Act to insure all medically required services – all medically required services – and we believe we do. The specific identification of the procedures and the rules that surround those procedures, the circumstances under which they're provided arise from a consultation process between ourselves and the medical profession. Every year we sit down with the medical profession. They identify to us the services they believe should be added or deleted or changed, and we ourselves, through our own medical staff, identify what changes we believe are appropriate. We consult over a fairly lengthy period of time and make changes to a schedule of medical benefits.

MR. CHAIRMAN: Folks, the acoustics in this room are not that good, so I would appreciate if you'd just speak up a little bit, please.

Supplementary.

MRS. SOETAERT: Specifically, I'm asking about the medical condition – I've called it anodontia before, but I know there are other names for it as well – where children do not develop permanent teeth. I guess I compare that with someone who was in an accident and they were badly injured and had to have restructuring and teeth. That would be medically covered, yet kids who never have teeth is not considered a medical condition and it's not covered. So I'm questioning specifically that condition. Why isn't it covered?

DR. PHILIPPON: Because it's a dental procedure. It's not covered in the schedule of medical benefits because it's a dental procedure.

MRS. SOETAERT: But it has medical repercussions. You know, a kid can't eat, and mush when you're 15, you know, you can't take a lunch to school. To me it's medically if not emotionally a medical – it is physically.

My next question. You meet with the other doctors every year. Could this be seriously considered? I realize there is partial anodontia and complete anodontia, and that could even be defined within that. People are really hurting on this one. It's very costly; it's financially breaking families. I think deep down we all know it is medical. An orthodontist or whatever has to fix it, yes, but it is a medical condition. So I guess my question is: will you consider taking that to the list next year?

MRS. McCLELLAN: I think it's fair to say that you consider these things at all times. You consider them in consultation with dentists, with physicians. I don't know what I can say beyond that except that we are aware of it. I've made a commitment to look at it. Again, the decision is on medically required services that we insure. It has been considered a dental procedure, and we're working through that with the Dental Association.

MR. CHAIRMAN: Yvonne Fritz.

MRS. FRITZ: Actually that was my question: basic health services. Thanks.

MR. STELMACH: Madam Minister, during the election there was a fair amount of lobbying by, I guess, some of the people from allied health services. I understand that you worked out some arrangement where their fees are capped. Doctors too, I guess, in a way are capped, a 1 per cent reduction, I think, or whatever. There's some concern out there that some of the services may not be offered or that people will not get the same level of service as before from the allied health professionals. Would you be able to comment on that for us, please?

MRS. McCLELLAN: Well, it would depend. I suppose one of the things you should maybe identify is in which of them, because in a number of them they're allowed to extra bill, and we pay a portion of the fee.

MR. STELMACH: So that would be like the chiropractors.

MRS. McCLELLAN: Yes.

MR. CHAIRMAN: Do you have a supplementary?

MR. STELMACH: No.

MR. CHAIRMAN: Grant Mitchell.

MR. MITCHELL: Thanks, Mr. Chairman. User fees.

MRS. McCLELLAN: They're not in my budget.

MR. MITCHELL: Well, they're under program 2.2, health care premiums or something like that, I guess. The Premier kept saying the other day in the House that he's got user fees on the table because somehow they're going to reduce that abuse. That's all that much more interesting because of course a member of his own caucus, a very learned doctor, is saying there isn't any such abuse. I'm willing to think that the Premier probably has some basis for his statement. Could the minister please tell us what studies her department has undertaken to determine the level of abuse, quote, unquote, that exists at all in our system, and whether the implementation of user fees would reduce this abuse of health care services?

MR. CHAIRMAN: I think we're getting off onto just what we said we didn't want to do tonight, and that is getting into a big philosophical discussion. The chair has been very lenient, and I'm certainly in the committee's hands if the committee wants to continue with this. It's good information, but it was not the chair's understanding that that was the purpose of these meetings.

MR. MITCHELL: Mr. Chairman.

MR. CHAIRMAN: Yes.

MR. MITCHELL: If we cannot discuss user fees under a Minister of Health's budget when the Premier of this province has been saying that user fees are a possibility, it seems to me this subcommittee would absolutely be dysfunctional.

MR. CHAIRMAN: I believe that discussion is more appropriate in the Legislature, but I'd tell you that I'm in the hands of the committee, and if the committee wants to continue on this line of questioning, I will certainly not interfere. I think I would have to have direction from the committee.

MR. MITCHELL: Well, then let me point out, Mr. Chairman, that in the estimates book itself it refers to revenue under the summary of the Health Care Insurance Fund. It seems to me that user fees would be revenue related, that they would be related to the Canada Health Act, and that they would be related to health care premiums. It seems to me it is absolutely, perfectly applicable that I should be able to ask that question and expect an answer under this particular program.

MR. CHAIRMAN: Well, perhaps if you would cut the rhetoric and cut the preamble, the chair would find it much more acceptable.

MRS. LAING: Mr. Chairman, it was my understanding – and I've already been in one of these subcommittees – that this was to be similar to estimates and supply, where you dealt with the budget and you didn't go off into what ifs and wherefors and philosophical debate. I mean, that place is in the Legislature. This is for the budget of Health, and that's what I came prepared to see.

MR. MITCHELL: How much of the general administration budget . . .

8:22

MR. CHAIRMAN: Order please. Order. Is the committee prepared to continue on this line of questioning, or would you prefer that we stick more to the direct estimates as they are printed in the estimates book? How many would prefer . . .

AN HON. MEMBER: To continue this?

AN HON. MEMBER: To continue with the list?

MR. CHAIRMAN: Yes, to the budget as we've got it listed.

MR. MITCHELL: So we win. We want to continue with this.

AN HON. MEMBER: What is the question?

MR. SAPERS: Could I suggest that this time not be included in our four hours?

MR. MITCHELL: No, I think it's over. I think we won.

MR. CHAIRMAN: Go ahead.

MR. MITCHELL: Thanks, Mr. Chairman.

Back to the user fees. Could the minister tell us what studies her department has undertaken to see what the level of abuse is in the system and whether user fees reduce this abuse?

MRS. McCLELLAN: Well, first, I'm not going to comment on comments that are made of people that are not in the room. User fees, when they're raised, are usually raised in two contexts. One is a perceived or real concern: the concern is real or a perceived misuse or inappropriate use of the system. The second context is on a revenue side.

I would suggest that we have done in Alberta very little in actual study of user fees. I think the more important discussion is: why would you consider them? So I think what I would say is that in the spirit of consultation I am willing to discuss any issue and any suggestion anyone has. However, I believe that what we should be doing is looking at the dollars we have in our budget and ensuring that we are spending those in the most appropriate manner. To my knowledge – and I could be wrong – we do not have actual studies that we could present to you on the yeas or nays of user fees.

MR. MITCHELL: To follow up the minister's I think appropriate and rhetorical question about how this issue comes up in the context of how you reduce use or abuse of the system, does the minister have any expectations that user fees could reduce abuse, when it is always said that user fees wouldn't be charged to people who couldn't afford them, so it wouldn't reduce their abuse, and if you could afford them, I suppose it wouldn't reduce that abuse either. So my point is: how would they ever reduce abuse?

MRS. McCLELLAN: Well, I never did say they would. I think that more appropriately we should look at ways of making people aware of the system we have and giving them more information to make choices as to how they access the system. You might

know that I have endeavoured through a couple of columns that I've shared with anybody who wished to print them some just plain facts on our health system. It is an important system, and it is important that people know what the system can provide and what the cost of that system is. I've had very good feedback on that. So I think that is an area we should continue: looking at public education as to the health system that we have and how you can access it for prevention as well as for treatment. I think that's a consideration we've heard – and I think you would agree – through our discussions in the roundtables and others: that people want to look at it in a whole system and to look at wellness as well as illness.

MR. MITCHELL: Final supplemental: has the minister done any studies, given any thought to exactly what the administrative costs of implementing a system of user fees would be and how that would be structured? For example, would doctors remit the fees and be paid the same amount, or would they keep the fees and be paid less? How would they be compensated for the accounting burden that would place on their already pressured office operations?

MRS. McCLELLAN: No, the minister has not done that. Under the Canada Health Act today user fees are not permitted, and the minister has not done any studies on the administrative costs.

MR. CHAIRMAN: Dave Coutts.

MR. COUTTS: Thank you, Mr. Chairman. I'd like to get an explanation from the minister regarding drugs and drug costs. I understand from a constituent of mine that some of the drugs are not covered under the benefit list. What is the policy on these least-cost drugs?

MRS. McCLELLAN: Well, the least-cost alternative policy, which will come into effect on October 1, 1993, will allow us to pay only for the lowest priced product where interchangeable products can be used to fill a prescription. That is really the policy. Clients who request or prefer a higher priced alternative when there is an interchangeable product available would be responsible for paying the difference in the price.

MR. COUTTS: A supplementary. If there's not an interchangeable drug, then they bear the entire cost of that also?

MRS. McCLELLAN: That is correct.

MR. COUTTS: My third question then. Does this compare with other provinces across Canada equally, or are we . . .

MRS. McCLELLAN: I'll ask Dave how many provinces might have this type of program if any.

MR. KELLY: All provinces except British Columbia and Quebec have least-cost alternative policies in place, and we understand that Quebec is about to implement a type of least-cost alternative policy.

MR. COUTTS: Thank you.

MR. CHAIRMAN: Ken Nicol.

DR. NICOL: Madam Minister, under your Basic Health Services component there's been a significant drop of about $14 million. You've accomplished some of that by putting caps on certain services; for example, on the physiotherapy services that are provided. Physiotherapists have got together and provided an alternative approach. At what point are you in considering their proposal? How would that impact in terms of the budget?

MRS. McCLELLAN: Again I don't have an answer for you on the date I will have a decision on that except to say that you're entirely correct: they have presented a proposal and I am considering it.

DR. NICOL: In that area, also, you discussed earlier the basic health care services and the shift, the continual emphasis on home care concentration, trying to get people to the lower cost programs. Again, I had a constituency example of a person who went to the hospital after suffering a severe fall down some stairs. The doctor looked at her and did an X-ray – there were no broken bones – and suggested that she return home. The doctor told her not to walk, not to use her hip. They had to take an ambulance back home. The ambulance attendants carried her to her bed, put her in her bed, and left her. Because of her income situation, she was in a position where couldn't get full-time long-term care under health, but had she stayed in the hospital, she would have been covered. It seems to me that some inequity exists in terms of the practices and how they're covered. Here's a person totally incapable of looking after herself, and she's shifted to a home care situation as opposed to being allowed to recover in a health care situation. Are these kinds of things being considered as the cuts are made in basic services, and how they are interpreted?

MRS. McCLELLAN: Well, first of all, I'm sure you would not want me to comment on a doctor's decision.

DR. NICOL: No. It was just an example.

MRS. McCLELLAN: That would be highly inappropriate.

DR. NICOL: Yes.

8:32

MRS. McCLELLAN: The changes to community based and to home care are not all fiscally driven. In some cases it may not be less expensive. One of the concerns is for the person's well-being and quality of life. In many cases that can be quite enhanced by them being able to be at home. We have increased our home care budget again, as you would see through our elements, and we have increased the home care to people who are under the age of 65 – I think that was a move in the right direction – and support community-based care as a more appropriate care for people and look at it on quality of life and as the most appropriate way to serve their needs, rather than just a shift because of dollars.

MR. CHAIRMAN: Final supplementary.

DR. NICOL: Yes. Still under Basic Health Services and issues of provision of services. As an example, if you go to a doctor's office now, you can get acupuncture service provided. They're allowed to bill at a standard office visit charge, whereas if you go to a professional, many of them with years of successful experience with acupuncture, this is not covered because of their lack of contact with an institution or the medical degree to support it. Are these kinds of things being looked at in terms of practitioner certification as part of your methods of dealing with service provision?

MRS. McCLELLAN: Well, I think you would have to talk to the College of Physicians and Surgeons, one, on qualifications and abilities in that area. Again, we do have certain procedures that have to be performed by professionals. Those are the services that we pay for; we do not fund all. The broader discussion is: should you and could you? I guess that's a discussion we can have down the road, but I can tell you that in this budget we do not. I can't tell you whether we will at some point in time.

MR. CHAIRMAN: Committee, we are at the midpoint. If it's agreeable with the committee, I would propose that we recess for 10 minutes, and we could fill up our coffee cups and do whatever.

MR. MITCHELL: Do we add that on, Mr. Chairman?

MR. CHAIRMAN: Oh, yes.

MRS. McCLELLAN: Well, let's just not recess. Does anybody want a recess?

MR. CHAIRMAN: You don't want a recess?

HON. MEMBERS: No.

MRS. McCLELLAN: I don't want a recess. Let's just go. I'm like everybody else at this table; I had an awfully early morning and it's a very late night.

MR. CHAIRMAN: Okay.
Bonnie Laing.

MRS. LAING: Thank you, Mr. Chairman. Talking again about drugs, under 2.2.3, when we're talking about the least cost alternative – I supposed we'd have to kind of guess at this point – approximately how much could be saved by implementing this policy? What would be the savings to the system?

MRS. McCLELLAN: Well, we have to estimate on those savings, but we have made some estimates. As you know, we have two Blue Cross plans, group 1 and group 66 and 66A plans. We estimate the savings there could be about $13.8 million. In savings to Alberta Health itself we're looking at close to $11 million anticipated – and these are estimated again – and probably close to $3 million before that. So the anticipated savings are fairly significant, and they are just anticipated.

MRS. LAING: There would be no danger to the patient? The patient's care would not be jeopardized by this savings?

MRS. McCLELLAN: No. I would say we wouldn't see any reason that it would be. Lower cost alternatives have been used by hospitals in Alberta and other provinces for a number of years without any therapeutic problems. Least cost alternatives are manufactured to the same standards, set by Health and Welfare Canada, as their corresponding drug names, so I think the benefit is in direct savings. I don't see any concern.

MRS. LAING: The last one: would the low-cost alternative policy impact research and development initiatives in Alberta?

MRS. McCLELLAN: Well, we have maintained in Alberta that there's a need for a balance between research and development investment and cost containment, and we'll continue to work very hard to make sure that we can provide that type of environment in Alberta. We think at this point that the balance is there for the protection on the patented drugs and still able to obtain the cost containment available to us.

MR. CHAIRMAN: Howard Sapers.

MR. SAPERS: Thank you. Does the expert committee that reviews the insured drug list have the power to add breakthrough drugs as they are identified and have their utility proven?

MRS. McCLELLAN: I guess one of the difficulties we have is ensuring that we can maintain the viability of our drug program. In order to do that, I think we have to make very careful decisions when we look at covering new and expensive drugs. The minister receives recommendations from an expert committee, but the minister makes the final decision as to additions of new drugs to the drug list.

MR. SAPERS: I see.

MR. CHAIRMAN: Supplementary.

MR. SAPERS: Thank you. Why is Proscar, a drug used for the treatment of enlarged prostates, excluded from the drug list when we know that its use can eliminate the need for expensive surgery?

MRS. McCLELLAN: You know that for sure?

MR. SAPERS: Yes, I think we can say that. [interjections] Three out of five doctors.

MRS. McCLELLAN: Again, I have to say that I am very concerned about the viability of our drug program. We have to really look very carefully at new drugs, especially that are very expensive, before we add them. We will consider that and others. There are some others that we would like to add, but again we have to ensure that we can continue this program, and to do that, we have to make some pretty careful decisions. You have to look at the broad use of product and availability. They're very expensive.

MR. SAPERS: As I understand it, the viability of the program would be both cost to Alberta Health but also cost throughout the rest of the system and potentially cost to users.

A composite drug I believe called Timpilo is a new drug that's used in certain treatments. The two drugs that it replaces are presently insured. When those drugs are prescribed in tandem, of course, it requires two dispensing fees. It requires the patient to medicate themselves twice. When that drug is prescribed as a single drug, it's only one fee, it's a lower cost drug, and it's easier for the patient to use. But the new drug is not insured. That does not seem to make sense. Why is that?

MRS. McCLELLAN: Dave may want to comment on it. Again, the one thing I want to say is that we do have an expert committee. It's made up of physicians, pharmacists, and pharmacologists that look at our drug benefit list and make recommendations from that to the minister. As I say, Dave will perhaps want to comment on that specific, but I do think that we have to take that expert advice, and then finally we have to make the decision in the best interests of the viability of the program.

8:42

MR. KELLY: The drug benefit list is updated twice a year. I'm not sure about that particular product. There is a new edition of

the list effective October 1, and I know that there is one product in precisely the same situation which has been added, effective October 1.

MRS. McCLELLAN: It's February and October, isn't it?

MR. KELLY: Yes.

MR. CHAIRMAN: Yvonne Fritz.

MRS. FRITZ: Thank you, Mr. Chairman. Walk-in clinics are often seen as a duplication of service, and my question is whether or not you see them as either being limited in any way or changing in any way.

MRS. McCLELLAN: I'm sorry; I didn't really get the drift of the question.

MRS. FRITZ: Walk-in clinics: I don't know if they track patients that go to walk-in clinics and then on to the doctor's office, over to the urgent care centre, maybe on to trauma or emerg, maybe back home. I don't know if there's any tracking done in that way, but they can be very costly, and many people view them as being a duplication of service, although they're expedient for the client. I don't know if that's being looked at at all in any way. My question is whether or not, if it is, they're going to be limited or if that service is going to be changed in some of these re-evaluations by your department.

MRS. McCLELLAN: Well, I certainly understand the discussion you're having, but I think we come back to the whole issue of physician services and fees. We have to remember that in Alberta we have a hard cap on the pool of dollars, so there is a strong incentive on that side for the disciple by the physicians as well. So while it will not add dollars to our system, it will not add costs because we have top limit of costs. I think if there seemed to be an inappropriate use of it, then it would be looked at.

MRS. FRITZ: Thank you. Just a sup. Are they tracked in any way now? Often we hear emergency staff saying, "You know, we get so many patients that come from the walk-in clinic, and they could have skipped that clinic and just gone straight to emerg." Is that tracked in any way now?

MRS. McCLELLAN: Hospitals keep statistics on their emergencies. Through our systems development and so on we would have better information if we had a better system of collecting data and so on. We have a monitoring system; Dave may want to comment on it. As I said earlier, we do audits and random monitoring and auditing, I suppose, of facilities as well as individuals.

You go ahead.

MR. KELLY: We know through our payment system what services were received by what people where and who provided them. So for any particular clinic we know how frequently it's utilized and by whom.

MRS. FRITZ: But do you know where that patient then went to, that they showed up in emerg? I guess that's the next.

MR. KELLY: If the patient was seen in an emergency department and treated by a physician there who billed us on a fee-for-service basis, then we could look at what services the patient received and see that there was a clinic service and then an emergency service. That wouldn't enable us to know whether the walk-in clinic told the patient to go to the emergency department.

MRS. FRITZ: Okay. That's good.

Thank you, Mr. Chairman.

MR. CHAIRMAN: Do we have any more on program 2 on this side?

Lyle Oberg.

DR. OBERG: Thank you, Mr. Chairman. I've had two very interesting conversations in the last two days. One of them was with a member of the pharmacy committee of one of the local hospitals, in which case he stated that the projected drug costs as a per centage of overall acute care hospital budgets in Edmonton are presently 5 per cent and are predicted to rise to 20 per cent by the year 2000. I also had the opportunity of a talk yesterday by a lady by the name of Mary Katherine Lindberg, who is a director of the Ontario drug plan. She stated that Ontario recently put in a freeze on all the drug costs effective 1994. She also stated, interestingly, that with regard to the generic drugs, they will not let any generic drug come on the market unless it's priced at 75 per cent of the regular drug or less. Is there any plan to implement a program such as this?

MRS. McCLELLAN: Well, one, I should say that we do have the Patent Medicine Prices Review Board in Canada that is in place to monitor drug prices and to ensure that they are not out of line and excessive. Unquestionably we're all concerned about rising costs of pharmaceuticals. However, I would say that another concern is the appropriate use of pharmaceuticals as well. Those are some areas that I believe would require certainly further work and discussion. Ontario is implementing – in effect, I think, just the end of this week – some changes to theirs. Saskatchewan changed their program very significantly in February, March of this year, and other provinces are facing a similar thing.

I suppose one of the things I would like to see us do a bit better at is working harder on people's knowledge of their use. I would say I have to commend the pharmaceutical industry for the program that they have out right now where they have for one month TV and newspaper ads making people aware of the proper use of pharmaceuticals and encouraging people to question the use of them. We've had some studies and are concerned. We've heard recently about superbugs that are overpowering the antibiotics, so I think it's an area that really requires a lot more attention.

DR. OBERG: One more question. There's a new area of pharmaceuticals and pharmapsychology coming out called pharmacoeconomics. To give you an overall approach to it is something like Proscar, a drug mentioned recently. As we know, 20 per cent of all people with benign prostatic hypertrophy have a focus of cancer of the prostate which is missed by using Proscar. So there are a lot of different nuances to each drug. It's something that is not a simple topic by any means, but is there any indication from the department that a new drug coming on would have to put forward a pharmacoeconomic or a cost/benefit study prior to having that drug implemented?

DR. PHILIPPON: I'll comment on that to start with. This is very timely. Just last week at the health ministers' conference the deputies approved a new addition to what's called the co-ordinating office of health technology assessment, which is based

in Ottawa. It's an organization that all the provinces participate in. Up to now they've been looking at mainly equipment technology. Now they're going to start looking at drugs and precisely at this area. Up to this point in time new drugs have come on the market largely if they satisfied the safety criterion, but the cost-effectiveness aspect has not been looked at thoroughly. This group will now start doing that.

DR. OBERG: Super. That's good news.

MR. CHAIRMAN: I don't have any other people on my speaking list, so we'll move to program 3. Colleen Soetaert.

MRS. SOETAERT: Thank you, Mr. Chairman. I'd like to ask the hon. minister what studies have been done to determine how and where to allocate capital dollars.

8:52

MRS. McCLELLAN: We have very exhaustive criteria for establishing when facilities should be rebuilt or upgraded. We are not generally building new facilities in this province and haven't for some time. We are in many cases replacing facilities. There are a number of criteria that are used in developing a priority list, if you want to call it that, or what is most needed to be done now, and there are a number of things that enter into that. Certainly one of the things we want to be concerned about, I think, is the safety of the workers in our facilities, the safety of the patients our facilities, so in that we're looking at the age and the condition, which is very important. We have to look at what health service capability there is in the community. Those are a number of things that we look at as criteria. It's not like building a house. When you're building a health facility, many times the cost of upgrading can equal or indeed be over the cost of replacement, because we have very strict fire codes, health codes that we have to meet; the kitchen in the hospital is a very expensive thing. As I say, I think one thing we want to be very concerned about is the health and safety of not only the people who are patients but the people who work in our facilities. So those are very important criteria when we look at replacing or upgrading facilities.

MR. CHAIRMAN: A supplementary.

MRS. SOETAERT: Thank you. I want to get a little specific here. Can you tell me the current status of the project that's been approved in Westlock? Is the hospital being built?

MRS. McCLELLAN: I believe it was tendered. That is not in my budget. I'm sorry. It's in Mr. Thurber's budget.

MRS. SOETAERT: Okay. Then I guess you can't tell me what's happening in Stony Plain either.

MRS. McCLELLAN: I can discuss the facility, but, no, I can't tell you what the status is.

MR. CHAIRMAN: Do you have a supplementary?
Ed Stelmach.

MR. STELMACH: Under Program Support, 3.1, there's a budgeted figure of $6.2 million above the comparable '92-93 estimates, I believe. Why the increase?

MRS. McCLELLAN: You're right; the variance is there. One is in Ambulance Services, an increase there. Equity Interest: there is somewhat of an increase there. There was a decrease in Program Support in that area but also an increase in Operational Commissioning. The Ambulance Services side of it: I think if I'm right, if you're in 3.1, we're expecting a continued heavy use of the air ambulance system, so we've increased that. The expenditures in that were $10.7 million in 1992-93, which exceeded our estimates. Those are the areas where the increase came.

MR. CHAIRMAN: A supplementary?

MR. STELMACH: She just answered my next question, the increase in the air ambulance. That's okay. Thank you.

DR. NICOL: Again planning. This is my favourite area. You've suggested in there that basically no change much in the amount of budget that you're spending on planning. Is it feasible to assume that within that you do the planning for capital projects, where they're going to be located, and the funding for the actual construction is done by public works? Am I correct in this?

MRS. McCLELLAN: Yes.

DR. NICOL: In terms of a reference to the public works budget also, the St. Mike's health care centre in Lethbridge has been reduced from $6.9 million to $1.7 million. What process in your planning justified or was used to make that change in your recommendations to public works?

MRS. McCLELLAN: Well, you would know that there is a discussion going on in Lethbridge between the Lethbridge regional and the St. Mike's hospital boards on their roles. That is the reason the project hasn't been finalized. The community asked for a review. This is really the best way to put it. I suggested to the two boards that they were the most appropriate. They are elected and/or appointed to represent the health interests of that community, and I think they're the most knowledgeable to know what best meets the needs of that. So I asked the boards to sit down together and ensure that what was developed best met the needs of that community. That's where they are. Obviously, if they had gone into construction, they would need more dollars.

DR. NICOL: As they deal with the planning and the allocation of funding between the long-term care and the acute care, again falling back on the Lethbridge example right now where the 60 beds in the regional acute care facility are being occupied by long-term patients, at what point is this being dealt with in terms of this planning process and the delay?

MRS. McCLELLAN: Well, the boards are meeting. I believe they're acting in the best interests of the community, and when they come to me with a decision or a request or a proposal, I'll entertain a look at it. As I say, I think they're acting in the most responsible way in taking the time to ensure what occurs in Lethbridge meets both the acute care and the long-term needs of the community into the future. They're doing that, and the time frame is in their hands frankly.

DR. NICOL: If I might follow up on that just a little bit. It seems that when you ask boards that have a mandate to look after their own institution to suddenly expand that mandate to look at a regional concept, you're putting them actually in conflict of mandate, and they're no longer serving their function to look after their institution. These board members are either elected or

appointed to look out for the best interests of their institution. What we have here is a very definite conflict between institutions.

MRS. McCLELLAN: I don't think so. I don't find that the boards – and I've sat down with them – feel that they're in conflict. I think they feel that they are responsible for more of a co-ordinated approach than maybe was thought of some years ago when this project was first initiated. Lethbridge is a regional hospital, and it has a regional mandate. St. Michael's, on the long-term side, was not seen simply as a long-term care facility for Lethbridge. It is being developed as a regional, serving much of southern Alberta, geriatric centre, and a very important part of it. So I believe, as I said, the right thing is occurring now. They're sitting down; they're looking at those facilities. They're looking at the use of both of them.

Projections aren't always correct. I mean, we'd all be wonderful experts if we could sit here today and say what we should have done 10 years ago. Things are changing, but I believe that they're looking at it in the best way. They're looking at St. Michael's in that whole context, and the two are saying, "How can we co-operate?" You are sitting down with different people than I am, if that's' the case, because they are, at least from my perspective.

9:02

MR. CHAIRMAN: Bonnie Laing.

MRS. LAING: Thank you, Mr. Chairman. Madam Minister, what is the government doing currently to ensure accountability to Albertans for the funding spent in acute care facilities?

MRS. McCLELLAN: One of the things that we've heard throughout the discussions of health reform not just in the recent weeks or months but in past time is that accountability has to be a cornerstone of our process. All of the acute care facilities have now developed their role statements – I would call them preliminary role statements – identifying the inventory of services that they provide. While this was occurring, we developed what we would call generic, for lack of a better word, role statements for urban hospitals, specifically specialty centres, regional hospitals, and teaching hospitals, because that's really the range that we have in the urban hospitals. I think those role statements will be the basis for a contractual document, or whatever you wish to call it, between the department and the facility. That will help us ensure that the facility is discharging their agreed upon responsibility within the level of funding that is available to them. That's a very important part of this process, and accountability is very much a part of it.

MRS. LAING: How has the HPI calculation helped in achieving accountability?

MRS. McCLELLAN: Well, although I would say it's been with its little hiccups, as with anything new that you do, it certainly has done much to ensure more equitable distribution of funds: funding reallocation of targeted hospitals who do require additional assistance in meeting their operating commitments, and funding has been recovered from hospitals where their activity in patient severity levels hasn't kept pace with their spending patterns. So I think it has been a much more equitable distribution of funds, and that will enhance accountability. Again, it's a new formula, and we're working into it. The committee is working hard to ensure that it works well.

MRS. LAING: Okay; thank you. We're talking now about making additional cuts to the hospital acute care system. Will the quality of service and level of patient care deteriorate, and will there be now waiting lists? This seems to be what people fear at this point in time.

MRS. McCLELLAN: Well, I believe that services don't have to deteriorate. I think we can make better use of our dollars. I think that physicians, our hospitals, and our patients all need to look seriously at this, and I believe they are. I think we have to recognize that our health system perhaps can't be all things to all people, and personal responsibility is going to have to be a part of it.

However, on waiting lists, I think that with earlier discharges, with new and faster, less intrusive medical procedures – my doctor colleague here might comment on that – we're going to see the programs being able to be managed. In many institutions, in fact, the waiting lists have decreased significantly, even though there have been less dollars. We're going to continue to monitor the impact of reductions. Certainly there is a possibility of longer waiting lists for elective surgery, but medically required or emergent services today are occurring as they have. The other thing is that waiting lists are not always budget driven, and that's a part of educating the consumer. Surgeons have waiting lists, and if you want a particular doctor, in some cases you have to wait for their schedule. They operate on certain days. They indeed, as others, have to take a break once in a while, too, and may not be operating every day.

Generally, as I say, our indications are that waiting lists are being managed quite well other than some waiting lists for elective surgery.

MRS. LAING: Thank you.

MR. MITCHELL: I'm interested in how the minister came to the conclusion that she would cut all rural hospitals 1.5 per cent, thereby somehow, it seems to me, concluding that they are all equally inefficient.

MRS. McCLELLAN: No, I wasn't assuming that any of them were inefficient in any way. What we did was ask them all to take that much of a reduction and to look for it in areas of supplies and services and administrative dollars as much as they could rather than affecting direct patient services. What we're seeing now is really a tightening of the system that we have in place. I think, frankly, that they responded very well.

MR. MITCHELL: I think we'd all be really fearful of any kind of rural/urban split in the consideration of health care delivery. Understanding that as many as 50 per cent of the patients of some urban hospitals are from rural areas, why was it that the minister decided on a 4 per cent across-the-board cut to urban acute care facilities as opposed to a 1 and a half per cent across-the-board cut to rural acute care facilities?

MRS. McCLELLAN: Well, first of all, we have an excess of acute care beds in the urban centres.

MR. MITCHELL: And we don't in the rural?

MRS. McCLELLAN: Yes, we do, but there are fixed costs. I could tell you that the smaller rural hospitals are about 7 per cent of my health care budget.

MR. MITCHELL: They're $400 million.

MRS. McCLELLAN: Well, that's getting into the larger ones. I agree with you that there is absolutely no need for a rural/urban split in this, and I won't even discuss it, because health care and health interests are important to people in this province wherever they live. That's why I said you can use statistics but you also have to use other things with statistics. There are reasons that you have a facility. It could be distance from anything else. Many rural communities are half an hour to three-quarters of an hour from an ambulance. That's for the ambulance to get there; it's not to get them to a facility. So there are a number of things that enter into this. I think that what we want to do is concentrate on ensuring that the appropriate care is available for our citizens, not zero in on ifs and wheres.

MR. MITCHELL: We've been trying to get from the department what we thought to be public information on utilization rates of all hospitals in Alberta. I wonder whether the minister could commit to deliver that to us.

MRS. McCLELLAN: I don't know why you wouldn't have got that. I'm puzzled.

MR. MITCHELL: Well, we're being told that it's coming.

MRS. McCLELLAN: By whom?

MR. MITCHELL: A staff member.

MRS. McCLELLAN: Have you sent for it through my office, Mr. Mitchell?

MR. MITCHELL: We've been told it was coming.

MRS. McCLELLAN: But did you request it through my office?

MR. MITCHELL: I think so. Yes, we did.

MRS. McCLELLAN: Through my office?

MR. MITCHELL: We had to. We were directed to do that.

MRS. McCLELLAN: I don't recall it; I'm sorry. Anyway, we'll straighten it out. It's public information. I'll slide it in in the House.

MR. MITCHELL: Well, if it's public information, I want it when I ask for it.

MRS. McCLELLAN: Yeah; I'm sorry.

MR. MITCHELL: I'm sure you don't know about it . . .

MR. CHAIRMAN: The minister has committed that you are going to get it.

MR. MITCHELL: . . . but for the benefit of other people, that's very, very frustrating.

MR. CHAIRMAN: Yvonne Fritz.

MRS. FRITZ: Thank you. I understand . . .

MRS. McCLELLAN: Maybe you could send me a copy of whatever you sent us, and I'll straighten it out.

MR. MITCHELL: Sure, but if it's public information, why do I have to put it in writing? I mean, why don't I just get it?

MR. CHAIRMAN: Order please. Let's move on. There's another whole list of questioners.

Yvonne Fritz.

9:12

MRS. FRITZ: Thank you. I understand that there's a consultation report being gathered or whatever, in Calgary anyway, on the allocation of acute care services. My question is: when are you expecting the report, and will you be waiting for the results of that report prior to initiating further cuts?

MRS. McCLELLAN: I think the report you're talking about is an initiative by the acute care hospitals in Calgary. It is not ministerially driven; the acute care facilities there have commissioned that study and report themselves. As I recall, they anticipated having it sometime in late November, and it will be up to them whether they share that information with me. I would expect that they would.

MR. CHAIRMAN: A supplementary?

MRS. FRITZ: No, that's fine. Thanks.

MR. CHAIRMAN: Howard Sapers.

MR. SAPERS: Thank you. Many of the people I've talked to that operate acute care facilities have told me that while the HPI is an improvement over the way things used to be, it's far from perfect, and in fact the more they are involved with receiving funding based on the HPI, the more trouble they're becoming by the way the formula was arrived at. What adjustments in the HPI are you making, based on complaints received from these hospitals, to get rid of those problems that they've identified?

MRS. McCLELLAN: Well, first of all, let me clarify one thing: I did not develop the HPI, nor did the Department of Health. The HPI formula was developed in full consultation with a steering committee called the Acute Care Funding Plan Steering Committee. That steering committee is made up of persons from hospitals in this province. Now, I've met with the committee twice, I believe, in my short tenure and discussed a number of issues. This is a new formula, and I suppose it's like anything else: if you waited till it was perfect, you would never implement anything. In fact, until you implement it, I don't think you know entirely how it works. The Acute Care Funding Plan Steering Committee meets on a regular basis. It is people from those hospitals. I would suggest that if you're talking to people who have a problem with it, you ask them to contact the steering committee directly, because it's made up of hospitals, it's made up of doctors, it's made up of nurses and many others that are involved in this. So I want you to be very clear: the Department of Health did not develop the HPI, although we're in a supportive role to the process and adjusting it as we can.

The other thing that you should know is that it's also being phased in, and it was not implemented fully in one year. To be fair to hospitals, it was phased in. Certainly there have been some institutions that have had a little bit more difficulty, perhaps, in adjusting to it than others, but the department has worked with

them. In extraordinary circumstances we've offered support, and all I can tell you is that it's being refined every year. The committee is meeting often, and I just commend them for the initiative and for the work they've done on it.

MR. CHAIRMAN: A supplementary.

MR. SAPERS: Thank you. I am aware of the history of the development of the HPI. The thrust of my question was the specific adjustments that are being made based on your meetings and the feedback you've had.

I'll try to approach it in a different way. A hospital like the Glenrose is considered a specialty hospital and not funded under the HPI, whereas the rehabilitation clinic within the Calgary General is not excluded, and the Calgary General is funded under the HPI. That doesn't seem to be fair. Why are specialty hospitals excluded from that funding formula? What are you doing specifically to address the funding inequities that are experienced by the hospitals in that situation?

MRS. McCLELLAN: Well, two things. One, there is a very good reason, and with respect, I think it's obvious as to why specialty hospitals are excluded. By the very nature of the name they are specialty hospitals, and they would not fit under an acute care funding formula. I would venture to say that nobody in this room would attempt to take something that was designed for acute care institutions that have a number of commonalities and implement that onto one specialty hospital. Secondly, I would tell you that the chairman of the acute care funding committee is the chief executive officer of the Calgary General hospital . . . [interjection] The chair of the specialty hospital group.

MR. SAPERS: That doesn't answer my question.

MR. CHAIRMAN: The final supplementary.

MRS. McCLELLAN: He didn't feel he got an answer to the first one, Mr. Chairman.

MR. SAPERS: With respect, I'd like to pursue the second question, if that's okay.

MRS. McCLELLAN: Go ahead.

MR. SAPERS: The question is not trying to force fit; in fact, that's the point of my question. You've got units of acute care hospitals being funded in an inappropriate way, and that seems to be unfair.

MRS. McCLELLAN: Well, I'll ask Don to get into the specifics of that one, because there's more than one area in that hospital that is unique.

DR. PHILIPPON: When we initiated the acute care funding plan, the decision was made to exclude the specialty hospitals because there wasn't enough of a reference point to develop a good funding methodology. However, there is a special programs committee working on that, and we intend to develop a formula that will be applied to them in the future.

MRS. McCLELLAN: Excuse me. That's the committee that Mrs. Meyers is the chairman of.

DR. PHILIPPON: Now, if you take your argument the full distance, every general hospital in this province has some specialty type patients, whether they're cancer patients or children or whatever. So you have to make a decision at some point. The decision that was made is that if it's totally specialty, they're excluded. If there's some specialty as part of an acute care hospital, as there is in every hospital, then it was left that they're primarily a general hospital and therefore fit within the acute care funding. If you applied your argument all the way, you'd take all the kids out of every hospital, you'd take all the mental health out, all the psychiatric wards out. I mean, you'd have no formula left, which is exactly where we started.

MR. LANGER: Might I supplement briefly on that? The Acute Care Funding Plan Steering Committee is very sensitive to this and has recently undertaken a survey of all the hospitals involved in treating rehab patients to determine how they are different among those various hospitals in terms of the specialty program at the Calgary General versus the Glenrose hospital versus the rural hospitals. Once that data comes back, then we'll have a sense of how those patients are being dealt with. That'll be dealt with by the committee that Marlene chairs, to which the minister referred, and that'll help us come up with a funding formula.

MR. SAPERS: Thank you. Now the question has been dealt with.

My last supplemental. With the call for very widespread reform
including moving away from a procedure-based system to an outcome or a health promotion based system, it seems to me – and I've often heard the criticism voiced – that the HPI itself reinforces procedure-based health care instead of promoting the need for integration and the other changes that we're all hearing about. Is your department planning to change this system to help both fuel and accommodate the other widespread overall changes?

MRS. McCLELLAN: I have to go back to the other comment I made earlier. We have a committee. The committee is made up of the broad-based partnership in devising this formula. I look to that committee for the advice and recommendations that should be changed and accommodated. Again I would have to say that as we go through this, we learn a number of things and adjust as we go along. I think we will continue to do that, and the steering committee will continue to bring those issues to the table. So I guess the answer is yes, we will continue to adjust as we go along. It's relatively new. We've had two years' experience with a program, and I think overall if you look at the two years' experience, it probably has been fairly positive although it has not been without its challenges in a few areas.

DR. PHILIPPON: I have just one brief comment to add to what the minister said before on: are you going to tie it to this? We're moving down the road where each hospital has a role statement. So the role statement is how you determine who does what. Once you've determined who does what, then the formula is applied to what they're supposed to be doing.

MRS. McCLELLAN: That's right.

DR. PHILIPPON: So you have to put the two things together to, you know, sort out where we're heading.

MR. CHAIRMAN: Lyle Oberg.

DR. OBERG: Thank you, Mr. Chairman. Section 3.1.5 relates to Equity Interest. If I may add my supplemental at the same time, what is the equity interest, and why did it increase from 1 and a half million dollars to $4.3 million?

9:22

MRS. McCLELLAN: Does everybody understand equity interest agreements?

DR. OBERG: No; I don't. That's why I was asking.

MRS. McCLELLAN: Okay. Why don't I let Don explain equity interest agreements, because that is exactly what this is: a buy-out of equity interest agreements. He'll explain the concept and those two while I get some more coffee.

DR. PHILIPPON: I'll try and make this simple. In the late 1960s when public funding of hospitals came in in Alberta, there were a number of voluntary facilities, primarily run by religious organizations although not all, that had already built facilities and ran them. At that time the government said: "For the investment you've got in place, we will recognize an equity on the books. We will pay you from here on 3 per cent on that equity." There are certain clauses in those equity agreements, and I think there are all together 23 of these equity agreements in place. We pay 3 per cent on that balance each year, and there are certain ways that they can add to their equity. We're now in the process in some of these cases of actually buying out the equity agreements under new arrangements and entering into a new operating agreement. So what you see in the budget here are some additional funds that will go the Grey Nuns corporation for the equity agreement they had on the Edmonton General, the downtown site on Jasper Avenue, which is now part of the new Caritas organization.

DR. OBERG: Great. Thanks.

MR. CHAIRMAN: Colleen Soetaert.

MRS. SOETAERT: Thank you. These are a little more specific, but I am concerned with hip replacements and that surgery. It appears that because of these cuts and before the cuts, that because it is an expensive operation, the waiting lists for these are longer. I'm wondering if this can be addressed within these cuts. These people suffer for a long time before they get in, because it's expensive. So I'm wondering how that can be addressed within these cuts so that these people don't wait for months or years.

MRS. McCLELLAN: Well, again there is more than one reason for waiting lists, even for hip replacements. One is surgeons. In some cases that is the reason: the particular surgeon has a long list. Some of it is fiscal. I have said that there may be waiting lists for elective surgeries, and there may be. You know, if you would give me some suggestions as to where we would shift the dollars that we're trying to shift to the community – we're trying to deal with the specialty hospitals; we're trying to make sure that we have good promotion, that we have additional dollars in home care. I'm sincere; I really would welcome suggestions.

MR. CHAIRMAN: Supplementary.

MRS. SOETAERT: Yes; another one specific to the cuts. Now, this is based on a phone call, so we'll take it with a grain of salt. In a ward situation with four beds to a room there were three women and one man. Now, dignity is taken away anyway once you walk through that hospital, from my experience, but we won't even talk about that one. I think that's just one step too far. If that ends up being something that is actually going to happen, I guess I want some reassurance from you that we just can't have that kind of thing.

MRS. McCLELLAN: I wouldn't comment on that specific, because I am not aware of that occurring. Hospitals are responsible to manage their facilities and to provide the services in them. That is not the role of the minister. If there is a concern from a person, a patient about care or treatment, the first appropriate move is to talk to the board. These are board-governed institutions, autonomous to a great degree. Secondly, if they do not feel they have been dealt with in an adequate manner, they can write and request the Health Facilities Review Committee to investigate their concern. So I would suggest you do that.

MR. CHAIRMAN: Final supplementary.

MRS. SOETAERT: Yes. Has the department recognized categories of home care which need to be addressed in order to determine the appropriate level of care which is most efficiently given in acute care facilities as compared to the level of care which is appropriately given at home? Do you see what I'm getting at?

MRS. McCLELLAN: I think I do. I'm not sure.

MRS. SOETAERT: The different levels: for example, an IV at home as compared to maybe long term at home. Are we looking at those different levels now?

MRS. McCLELLAN: One of the things I mentioned to you earlier was the health unit/facility partnership program, where they look at these things. Certainly with IVs – that's one in particular. I think that was in reference to one of Grant's questions.

Health units assess home care. I'm not sure whether you're suggesting we should have home care in hospitals or home care in the community.

MRS. SOETAERT: Are they jointly . . .

MRS. McCLELLAN: Well, as I say, we encourage that, and we do have the health unit facilities partnership as well. The indications that I have are that there's a great degree of co-operation occurring in most cases between the facilities and the community to ensure that the needs are met. If there are areas where you feel there is a concern, if you would let me know, I could see what they have.

MR. CHAIRMAN: Dave Coutts.

MR. COUTTS: Thank you, Mr. Chairman. I realize, hon. minister, that building doesn't come out of your budget, but with the grant cutbacks and the $122 million that you're going to be cutting back and all of the things that are happening in being efficient, why don't we just simply stop the capital expenditures?

MRS. McCLELLAN: Well, that's a very good question. First of all, you have to understand, I suppose, capital expenditures. There are capital expenditures that occur on an ongoing basis. Those are upgrading and so on.

As I mentioned earlier, we have, I think, a responsibility to provide health services in this province to Albertans, and we have a responsibility to ensure that we provide those services in a safe manner as well as in an efficient and cost-effective manner. We don't always have the opportunity to just stop everything. So when there is a decision made to either replace or upgrade a facility, it is made with a great deal of care. It can be the age, it can be the condition of the facility, and certainly it's based on need.

It's easy to just say, "Well, there's another one 30 miles away." If you understand the geography and the transportation links and so on and look at the distance on the other side of that one as well, sometimes you come up with quite a different answer. As I indicated earlier, while we do have good ambulance service in Alberta, it is not within 10 minutes of every person in this province. Again, I just have to say that we have to make the decisions on the basis of need and immediacy. I assure you we are looking at all those things very carefully before we advance any building.

9:32

MR. COUTTS: So if we have inefficient existing facilities – and that's been recognized – and you say some of them have been scheduled for upgrading, I assume those would be done on a priority basis. With the restraints, do you think any of these would be put on hold, or would they be put back a year or so at this point in time?

MRS. McCLELLAN: Well, we have a lot of projects on hold, some 60-odd that are on a list and have been for some time. As I say, on an annual and ongoing basis we do review those projects and try and meet the most emergent needs while we have the opportunity to look at the restructuring, the reforming of how we deliver health services and the changing technologies that are out there. We are doing that, and it's a difficult process.

MR. COUTTS: Thank you.

MR. CHAIRMAN: Grant Mitchell.

MR. MITCHELL: Thanks. Under hospital computer systems, I wonder, Shirley, whether you could give us copies of the audited financial statements for UniCare as a separate entity from 1988 through to 1993.

MRS. McCLELLAN: One of the difficulties with your request is that as I indicated – maybe it wasn't in the House – the board of directors of UniCare and the University hospital board made a decision to, one, scale down UniCare and consider selling it or winding it up. While they're doing that review and considering disposing of the company, I think it would not be in the best interests of that, if they are in a negotiating period, to provide that right now. I would suggest when that is completed, there would be absolutely no thought about that.

MR. MITCHELL: Do you want me to phone you and remind you?

MRS. McCLELLAN: You won't have to.

MR. MITCHELL: Do you still diarize it?

MRS. McCLELLAN: No.

MR. CHAIRMAN: Do you have a supplementary?

MR. MITCHELL: That was my first supplementary. Thank you, Shirley.

With reference to an answer that you gave just moments ago, could you give us a list of the 60 projects that are on hold?

MRS. McCLELLAN: We can make a list for you.

MR. MITCHELL: Good. Thanks. That's it.

MR. CHAIRMAN: Are there any other questions on program 3? Ken Nicol.

DR. NICOL: Again, in terms of your co-ordination – and this possibly skips over a couple of the programs here – are you looking at any kind of efficiencies that could be obtained by communities getting together and buying supplies, buying products? How are you dealing with that kind of effectiveness that could be pulled together from, instead of acute care and long-term care and the extended care type of thing, all working together to co-ordinate?

MRS. McCLELLAN: It's occurring now, and I think it probably will continue to occur to a larger extent. For example, in the major acute care hospitals in our larger urban areas, they do that and in many cases have centralized management systems for dispensing supplies and drugs and so on. Frank could give you a little bit more detail in that area, but it is occurring now.

MR. LANGER: There's actually an increasing incidence of shared services throughout the province; shared lab services, for example, where urban hospitals have been working very closely with rural hospitals and that service is being done on a share basis. Waste management would be another example where there's a very strong shared service arrangement. In the area of materials, management purchasing: again a very strong link. This varies throughout the province. Foothills, for example, has had a long-term relationship with Banff in terms of materials and supplies to the benefit of both. Again, this is something we're seeing throughout and very much encouraging, because it is more cost-effective.

We're seeing some of the barriers. You mentioned earlier the conflict of interest on the part of hospital boards, but in fact we're seeing groups of hospitals getting together and talking. In some cases this is now going beyond hospitals so that hospitals and long-term care facilities or hospitals and health units are getting together to look at how they can manage effectively. We're seeing shared administration where previously each service had its own administrator. Now we're seeing shared administration between several facilities. That's really increasing, and we're very pleased with that.

DR. NICOL: This is co-ordinated under local initiative, or is there a program put in place from the minister's office or from Alberta Health that deals with it?

MR. LANGER: The AHA co-ordinates in terms of their group purchase and group tendering program, and we're very happy that they're doing that. That's a multimillion dollar program that they're co-ordinating, and we're supporting that. Whenever we see the opportunity for a shared-service arrangement, we certainly bring that to the attention of the hospital administration and the board of the long-term care facility, whatever the case may be.

We're very pleased with the local initiative that's been taken. From our point of view, boards are being very responsible, in many cases coming up with these arrangements to their mutual benefit.

DR. NICOL: Can you give us an idea of approximately how much savings is being received on this, even on a per centage basis?

MR. LANGER: That's really an ongoing, running total depending on circumstances. We're seeing, for an example, recently in the area of Leduc and Breton, where again hospital administration is being shared, or between Red Deer and Bentley, where again that's being shared, Hardisty and Stettler, again through one administration. So just in the area of administration we've seen some initiatives very recently. That's ongoing – shared laundry service or shared dietary service – so that's not something we track in that sense. It's an ongoing development that we're encouraging, and we're very pleased with how rapidly it's developing.

MRS. McCLELLAN: You know, we don't tend to hear the good things that are happening out there, and I think it's another evidence of pointing to co-ordination and co-operation and a sincere desire on everybody's side that we ensure that we continue to have a very high-quality health system. I just see it everywhere I go in this province.

MR. CHAIRMAN: Are there any other questions on program 3? If not, Bonnie Laing on 4.

MRS. LAING: Thank you, Mr. Chairman. Number 4 on long-term care. This is a simple question. I suppose it's one I'm curious about. Could you tell me what the difference is between district, private, and voluntary nursing homes is?

MRS. McCLELLAN: Sure I could, but we're going to let Don do it, because it's a long answer.

DR. PHILIPPON: There are really three ownership groups for nursing homes in the province. The district ones are really the ones formed by boards, like hospital district boards, where the municipalities elect people to serve on the boards that are publicly funded. At the other end is the private, the extended care operations, and places like that that are for profit. They receive the same level of funding as the district under our formula, and they also have to abide by the standards. Then the third one is the voluntary. It's primarily a religious organization such as the Good Samaritan, groups like that that basically form organizations to provide nursing home care. They're not-for-profit organizations in that case.

MRS. LAING: Both District Nursing Homes and Private Nursing Homes took a small decrease, I notice, in Operating Support under program 4, but I notice that Voluntary Nursing Homes had an increase of approximately $4 million. Could you explain why?

DR. PHILIPPON: Okay, I think we'll dig up the details for that, but what happens is that when you open new beds in the system, of course you have to put more money into it. As well, with both the private and voluntary we have an upgrading program that they fund, and when it's finished, we pay them back through the operating grants. So we've probably had some upgrading going on in the past year, and some money went in for that purpose.

MRS. LAING: Have there been any long-term care beds closed this year?

MRS. McCLELLAN: No. Well, let me qualify that. The answer is really no, we haven't closed long-term care beds.

DR. PHILIPPON: What's happened in some cases is that under the formula there's a certain tolerance allowed for how much occupancy you have. You can drop from 100 down to 96, 94 per cent, in that range. Some facilities have reduced their bed occupancy. The beds are not technically closed forever, but they're not using all their beds at a point in time. We haven't reduced the size of that nursing home from 30 to 29 beds or whatever, but they may not be operating them all at 100 per cent occupancy.

9:42

MR. CHAIRMAN: Howard Sapers.

MR. SAPERS: Thank you. There are guidelines established by your department for the numbers of RNs, LPNs, aides to be present in a long-term care setting. In the past, funding for long-term care facilities was tied at least in part to their meeting those guidelines. Is that still the case? Is fvnding still tied to meeting those guidelines for the staffing, distribution of LPNs and RNs?

MRS. McCLELLAN: The guideline is on RNs, and it's 22 per cent RNs. We do not have a guideline on LPNs or NAs or whatever. We would expect that the management would make the appropriate staffing, but we do have a guideline on RNs.

MR. SAPERS: Is that guideline currently under review, or is it part of the plans within your department to lower that guideline?

MRS. McCLELLAN: Our department, to the best of my knowledge, has not looked at a change. We have a steering committee on long-term care. On an ongoing basis they look at all those issues and bring recommendations to the minister, but to the best of my knowledge, I haven't had a recommendation brought to me directly.

MR. LANGER: It's on its way, I think.

MRS. McCLELLAN: Yeah, but I don't think we should talk about that.

MR. SAPERS: I'm sorry; I didn't hear any of that.

MRS. McCLELLAN: We were discussing the committee, and I was just checking with Frank because I might be a day or two behind in my mail. I do not have any recommendation. I was just confirming with him that I had not received a report from the committee.

MR. SAPERS: So there may be recommendations in that regard, but . . .

MRS. McCLELLAN: Yeah. As I say, they meet on an ongoing basis, and they do bring those to me.

MR. SAPERS: Is it that committee's responsibility, or are there other mechanisms present within your department that continue to monitor and guarantee the quality of health care provided in long-term care facilities, particularly in reference to the de-skilling

that's going on right now within that particular part of the industry?

MRS. McCLELLAN: Well, as I said, we have a guideline for the RN component. We also have the patient consultant area and the Health Facilities Review Committee. I should explain about the Health Facilities Review Committee. While they do review a facility if they have a legitimate complaint, they also review facilities on an ad hoc basis. The intention is that they visit most of our facilities at some point. So there are those monitoring effects in place, and certainly if there are concerns, generally from individual patients, many of them would contact either through the minister's office or through the board or management area of the facility. Usually it's to the facility management first; then it would be to me.

MR. STELMACH: In long-term care I know there were some new facilities built, one in Edmonton, St. Joe's, and then in Strathcona there was the one in Sherwood Park. Are they going to be commissioning dollars to go to the operation of those facilities?

MRS. McCLELLAN: We will have to address that when they are closer to opening. They are under construction now, and that will be an area that we'll be looking at, as to whether they can operate within their existing budget or whether there will be any requirement for extra funding.

MR. CHAIRMAN: Do you have a supplementary?
Ken Nicol.

DR. NICOL: On your four different programs that you have on the different types of facilities, they had decreases that ranged from 22.5 per cent all the way up to – you've already addressed Voluntary Nursing Homes with a 10.3 per cent increase. What are the characteristics that bring about this difference, and what kind of rationale did you use for that?

MRS. McCLELLAN: Have you got the page, or is it just in the . . .

DR. NICOL: Oh, I'm sorry. It's page 49.

MRS. McCLELLAN: Are you looking at just the . . .

DR. NICOL: It's the operating expenditures for auxiliary versus district nursing versus private nursing versus voluntary nursing homes. As an example, Voluntary Nursing Homes increased by 10.3 per cent, Private Nursing Homes decreased 1.5, District Nursing Homes decreased 22.5, and then the auxiliary hospitals decreased 2.7 per cent. Why the difference? What services are provided at these different institutions?

MRS. LAING: Mr. Chairman, I believe I asked that question, just in a different way.

MRS. McCLELLAN: Yeah.

DR. NICOL: In the last part – wasn't it? – just in terms of the voluntary ones?

MRS. LAING: But it indicated in the question that the others had decreased as well.

DR. NICOL: But the rationale for the decreases . . .

MRS. McCLELLAN: Some of it was on the nursing issues.

DR. PHILIPPON: I think maybe the answer here, the reasons for those numbers going up and down: if all the nursing homes would not have changed in terms of beds, the increases would be exactly the same. In fact, we wouldn't have had any increase in beds at all. They all would have gotten a slight decrease because we increased the residence charge.

DR. NICOL: Okay; it's capacity based.

DR. PHILIPPON: The residence charge has changed, so that tended to bring everybody down a little bit in terms of money. But then some places had new beds put in, so they get more money, and there's money, as the minister mentioned before, for patient classification, a higher case mix index. Some of these facilities one year over the other have a heavier care resident type, so they get more money. It's a reallocation.

MRS. McCLELLAN: Do you want to talk about the case mix index, the CMI?

DR. NICOL: Thanks. Well, you answered my second question as well, so I'll go on to the third part.

In terms of the changes that were made in rates charged, you've increased rates to the standard accommodation by 17 per cent while the private rooms increased only 3.6 per cent. What was the rationale that differentiated between the rate changes for the two different classifications of rooms?

MRS. McCLELLAN: Okay. One, on private we're already higher. On the multiple-bed rooms, of which we have very few in this province – that's four beds in a room, very few of them and becoming less all the time – you may see what seem to be reductions because we've perhaps gone from four to three in a renovation and put in better bathrooms that are more wheelchair accessible. You have to remember that in our long-term facilities the needs have changed as well because there are different care types. On the decision to raise it – so it went from 60 to 70 per cent. I ought to make sure I have that right. Do you have the per centages here? That's the one I wanted, the four-bed rooms – it's getting too late for me to think of the right terms – and there are very few of those. Then there was a change on the doubles and a lesser change because the privates were at 80 and went to 82.50. We would not want to see somebody excluded from having a private room if they required one or indeed strongly desired one because of excessive costs. So it wasn't a matter of just raising everything 10 per cent.

Secondly, the formula is on a per centage of three factors: the guaranteed income supplement, the old age security, and the Canada pension plan. So there are three things, and we have the – what do you call it? There are three.

9:52

DR. PHILIPPON: Yeah; it's the old age security, guaranteed income supplement, and Alberta assured income. Those are the three.

MRS. McCLELLAN: That's it; not Canada pension. They are on a per centage of that, so you ensure that people have dollars if they're on all of those. What it amounts to on a standard – that's the right word for a four-bed – is $21.40 a day. On semiprivate

it's $22.95, and on private it's $26.75. So that gives you an idea of the spread right there. Obviously, you could work it out, but per month it's $650, $698, and $814. What we looked at is ensuring that people had disposable income after. In Alberta your minimum is $650; your maximum is $814. For example, British Columbia, which is next to us – we'll give you that because it's close – is $709 minimum, $1,304 maximum. In Prince Edward Island – and this is the 1991 figure; I don't have a really recent one – it was $1,643 minimum and $2,525 maximum. I tell you that to give you an idea of what the range is. Alberta, to the best of my knowledge today, has the lowest priced accommodation in these facilities that there is in Canada. We've tried to maintain that, and obviously you are aware that we do have some extra assistance in the income supplements for people who are of pensionable age if they require it.

MR. COUTTS: I just might follow up with a third one that I skipped on my second.

MR. CHAIRMAN: Go ahead.

MR. COUTTS: Is it the intention to move away from the ward type structure to semiprivate and private?

MRS. McCLELLAN: Well, I think it's a matter of what's appropriate. Some people obviously like shared accommodation; some do and some don't. Where we've looked at renovations, a great deal is because many of the rooms – it depends on when your facility was built – that were built years ago weren't built for wheelchairs. People in there weren't in wheelchairs generally. In some of those cases it's a real marvel to try and get a wheelchair into the washrooms and so on. So we've looked at the most appropriate use. I think the facilities themselves have generally done a very good job in saying we can change this, but I would suggest we would not be building anything today with the standard room. The new ones that are built are with semiprivate and/or private.

MR. CHAIRMAN: Dave Coutts.

MR. COUTTS: Thank you, Mr. Chairman. Again with the reduction in the major grants program, how will these reductions affect the long-term care beds?

MRS. McCLELLAN: Well, we certainly hope and encourage that any of those reductions again – and remember it was .5 per cent on long-term care – be deducted from the support and services funding rather than from direct patient care. That certainly was our strong recommendation to ensure that it didn't in any way jeopardize resident care.

MR. COUTTS: You've mentioned that we have too many acute care beds and not enough long-term beds. In my short tenure looking at this, would it not be effective to take some of the acute care beds and turn them into long-term facilities? I'm thinking of instances like in the Foothills and the General where they have months to wait for beds.

MRS. McCLELLAN: Well, that's an ongoing review. In some cases it does make sense both practically and economically to do conversions; in some it doesn't. As I said, sometimes your renovations can become more costly than just building a facility, especially in those areas, depending on the year it was built and how the facility is. That has definitely been a part of the recommendations from the roundtable: a review of all the facilities that we have in the province. I guess I come back to what I said. I believe the community should look at their health needs today and as much as they can into the future, look at the infrastructure that is available, look at the service providers and the service that is available, and draw their plans for meeting the health needs of those communities through that. I support that very strongly. You don't read much about this, but we see communities that really have health centres now. They may house the physicians' clinic, perhaps even a dental clinic. They may have some ambulatory beds to handle emergencies and some long-term care. Some of our facilities lend themselves very well to that, and some of them may not. So you have to look at that too.

MR. COUTTS: Not including the renovation in a facility, is it cheaper to have those acute care beds occupied by long-term people than to keep it open and empty?

MRS. McCLELLAN: It wouldn't be cheaper. It would be cheaper to keep it open and empty than it would be to keep it open and full. I guess what you really need to look at is the need and if the facility itself could meet the need too, because not all of our acute care facilities by design can function well for long-term care. In some cases that adjustment can be made, and when it can be made with reasonable cost, then we would look at it strongly. If it's going to incur a great deal of capital expenditure, then I think you would want to look at it very closely.

MR. COUTTS: Thank you.

MRS. SOETAERT: Mine is a follow-up from Dave's, as always specific. Because our population is aging and we're going to have to look at more long-term facilities and care, I'm wondering if the old Sturgeon hospital has been addressed or looked at or any considerations in that way for long-term care. I personally have had a lot of concerns expressed about that one. People feel it's just sitting there, a terrible waste of a building that's only 20 years old. It's one of those empties and heated for . . .

MRS. McCLELLAN: One of the difficulties that you do have – I have to come back to it – is: does the physical plant lend itself to long-term care? I know it's difficult for the public to drive by a building and say, "It's empty; it should be used," but I think you have to do it in the full consideration of the people who would occupy it as residents and the people who would staff it as workers, and you would have to ensure that it could happen. There has to be that looked at. Now, I would not say an outright no, but I would suggest to you that from a preliminary look at it, it would be unlikely. You know, we've looked at it.

MRS. SOETAERT: There have been studies done.

MRS. McCLELLAN: Yeah. Wheelchair accessibility, what we mentioned before, is very, very difficult in the building.

MRS. SOETAERT: They have done a feasibility study. You must be aware of that.

MRS. McCLELLAN: As I just said, the indications are that it's very unlikely that it would be practical.

MRS. SOETAERT: Okay.

MRS. McCLELLAN: I think it's important that we do that complete review within the communities and that the communities

have those answers, because it is hard for people who maybe have not even been in the facility to understand why we just wouldn't do that.

10:02

MRS. SOETAERT: Well, the study has been done, and I guess it is feasible.

DR. PHILIPPON: The studies and have been done, and we've seen at least two options out there. It is feasible to do it, but I think what you have to look at is the quality of life for the people that will be in there and also the cost-effectiveness of the operating efficiency of the building afterwards. If you're going to start making ramps for wheelchairs and putting bathrooms in each room, you might end up with a really spread-out building and maybe only have 50 or 80 beds in it. So the operational efficiency may not be there. Our conclusion is that it's not really an efficient way to provide extra long-term care beds in the Edmonton area.

MRS. McCLELLAN: There are probably better ways.

MRS. SOETAERT: Okay.

MR. CHAIRMAN: This will be the final one.

MRS. SOETAERT: Yeah, I know. So do we look at buildings in the term of, like, one floor being long term, one floor being maybe a seniors lodge situation, which I know is under municipalities, the bottom floor being actually shops and things that could bring in income? Can we start looking at those kinds of plans that may make that building work? Because it isn't a drudgery place to be. I've been there. You know, it isn't a terrible place to be. I hate to see that waste, and maybe not right now but long term I'd like to see those buildings become feasible somehow, maybe working with the municipality.

MRS. McCLELLAN: I think it's quite appropriate for the community to bring forward ideas for the utilization of any of our buildings that may be there, and I know that we are going to see changes in care models as we go along. It is happening now, and I think that's really important because, as you say, our population is not only aging; they're living much longer, and they're living independently much longer. So the needs in the facilities are different than they were a very few years ago. I believe – was it in the last five years? – the age in our lodges has increased 10 years, from 75 to 85. This is incredible. So we're going to see a number of different models suggested, and we are very open to seeing that, where we can have more community assisted living, a longer time for people to spend in the community setting and less necessity for moving, because I think that's very disruptive to our older people.

MR. CHAIRMAN: Lyle Oberg.

DR. OBERG: Thank you, Mr. Chairman. I just have one quick question. I recently read that there is a waiting list of about 400 in Edmonton for long-term care beds. With that, considering that the long-term care list in Brooks is somewhere between 50 and 60 at any one time, I'm just wondering if there is a plan to redistribute the beds to rural Alberta where they're needed. [interjections]

MRS. McCLELLAN: We do watch waiting lists, and we do have, I think, a fairly good, accurate way because of the single point of entry. In my recollection the waiting list is estimated at 300 in this area. I guess the difficulty in moving people is that when you move a person out of their community, you also move them away in many cases from their family and from their friends, who probably are not able to travel and visit. I think it's fair to say that our desire, particularly in long-term care, is that as many people can be accommodated in their communities as possible. I think that's a very important part of quality of life, maybe more important than some of the programs that we think are important, if they can have their families visit and their children and grandchildren.

DR. OBERG: Thank you.

MR. CHAIRMAN: Do you have a supplementary?

DR. OBERG: No.

MR. CHAIRMAN: I don't have anyone else on my speaking list for program 4, so if the committee agrees, we'll move on to program 5 and Howard Sapers.

MR. SAPERS: No, actually . . .

MR. CHAIRMAN: Oh. Grant Mitchell.

MR. MITCHELL: Thanks, Mr. Chairman.

MRS. McCLELLAN: Are you on 4 or 5?

MR. MITCHELL: I'm on 5. We're getting there, Shirley. How are you holding up?

MRS. McCLELLAN: I'm all right.

MR. MITCHELL: I'm interested in asking a little bit about the co-ordination of home care services. This has many facets, of course, one of which is the problem – again, it relates to a governance problem. Well, here it is: acute care facilities are telling me that they would discharge some people earlier than they can now because they can't get home care services to facilitate the early discharge. It isn't so much that eventually it isn't there, but it takes as much as four days to get an assessment. They're saying, "We don't have the mandate to provide those kinds of services." Home care, on the other side, says, "Well, I guess we have the mandate, but we also have other priorities or we set priorities independently, and we don't want to be driven by acute care driven priorities." I guess my question is: has the minister given some thought to how she would solve this problem? Is it giving some of the mandate to acute care facilities or directing home care operations to be more cognizant of this problem?

MRS. McCLELLAN: I have always felt that you shouldn't start to address this problem with where the funding is. I think we should address it from where the service is required and the need is and establish that. I think that's the most important part. I'm going to ask Don to comment just a little bit more on the funding side of it, and I will also explain. I apologize that Steve had to leave; he had to catch an airbus. He asked if he could, and we thought we could handle this. The test is now.

DR. PHILIPPON: Certainly there's no question that the pressure is on hospitals to discharge earlier, and they have to have access to good community support out there. Home care is taking that on. You'll notice in the budget that the home care budget has been

increased quite significantly, given the fiscal pressures that we're under this year. Some of that additional money, of course, is intended to help them deal with early discharge from hospitals. As the minister said before, we're trying to encourage a good dialogue between hospitals and health units, the boards of health, to work out arrangements as to how this can best be done. I think we're starting to see in Edmonton and Calgary a much closer working relationship between the hospitals and home care. Certainly some of those problems are still there, but I think they're being reduced. There is some additional funding on the home care side to help with that.

MR. MITCHELL: Don said that the funding's been increased, and it has, of course. Have you got some system of monitoring, though, how much more demand has been placed on home care because of the cuts to acute care, and is this funding increase somehow reconciled with that increased demand? I mean, how do you come up with that particular figure?

DR. PHILIPPON: Well, we have an information system on home care. We know the client load each month. We can break down the client load into the types of clients out there, and we're trying as best we can to match dollars to those increasing pressures. You know, we want to say that there's enough money there to meet every possible need. Home care very much works on a priorized type of system. It looks at each individual client in relation to their needs and also in relation to the supports they already have in the community. If they've got good family supports and so forth, they can really do things more on their own. It's very much an individual assessment. That's really the strength that home care holds on the assessment aspect. As well we have put in place this health facility partnership program to try and encourage a few very specific programs to be developed to put more from hospitals into the community.

10:12

MR. MITCHELL: Could we get copies, say, of that monthly utilization of . . .

DR. PHILIPPON: We'll give you the statistics.

MR. MITCHELL: Could you show us that sometime? Like, I'd have to see this time last year and this year at least.

DR. PHILIPPON: Yes.

MR. CHAIRMAN: Do you have a final supplementary?

MR. MITCHELL: Yeah, sure. Could you tell me what guidelines the department has developed to address the issue of the required level of qualifications for home care providers?

DR. PHILIPPON: If they're providing a nursing service, obviously it would be a qualified registered nurse. Some of the other things like the homemaking service and so forth, some of which are contracted out to FCSS, who certainly provide those kinds of services – you know, there's not the same kind of rigid qualification requirement in those areas, but if they are providing a treatment service, they have to be as they would be in a hospital: a registered nurse.

MR. CHAIRMAN: Lyle Oberg.

DR. OBERG: Thank you, Mr. Chairman. My question is about the breast cancer screening project that you have. As you know, there have been studies showing that really the cost-efficacy or, even a different term, the difference in morbidity or mortality is not significantly changed from women having a mammogram I believe definitely under 50 and some people say under 45. Are there any plans to limit mammography to people in this age group?

MRS. McCLELLAN: As you know, we put the breast screening program in two years ago, and the objective was to ensure that we had this available for people all over the province, because the fact was very widely known that there was a real lack of opportunity for rural women in particular to have this opportunity. So the program was put in place. You rightly stated that there are studies that challenge the value of breast screening under the age of 50. So what I have done is reactivate the committee that recommended the initial program to do an evaluation of the program and come back and give us some advice as to how we should proceed with breast screening or diagnostics in that area. It's a major area of concern to us. Breast cancer is actually one of the highest death rates in women in Canada. That is one of the concerns we have. You know that the federal government has provided some dollars for research in this area. I forget the exact dollars that are coming to Alberta that we will be a partnership in, but I guess what we have to try to ascertain is that the dollars that we have available for this are spent in the best way. That will be the information that I will look for from that expert committee which is made up of radiologists from the women's health area and so on.

MR. CHAIRMAN: Do you have a supplementary?

DR. OBERG: Yes, I do, and you did touch on it, which was the access for rural women to mammography. As we turn on the stations – not that I watch anything but Canadian stations, but I turn on American stations, and they have things like mobile mammography units. Are there any plans on anything like that?

MRS. McCLELLAN: That's part of the breast screening program. There are two equipped vans. The areas of the province that were involved in it were the north, west-central – I don't know my directions, so I shouldn't even point in this room. Five areas?

DR. PHILIPPON: There were two main areas, but they're pretty broad.

MRS. McCLELLAN: They were mostly in the north part of the province. The question now is: should we expand the program? Well, I guess before you decide should you expand it, you look at – so we do have the two mobile units, and any person of any age who would request a screening opportunity would indeed not be refused.

DR. OBERG: Thank you.

MR. CHAIRMAN: Ken Nicol.

DR. NICOL: Thank you. I'd like to deal a little bit with Communicable Diseases Control, 5.2.5, AIDS prevention. How do you judge what activities to undertake here and determine how you're directing the programs toward different groups with different risk susceptibilities?

MRS. McCLELLAN: The communicable disease program: are you talking about the immunization side of it?

DR. NICOL: No. Just whatever programs you're dealing with, in terms of AIDS particularly.

MRS. McCLELLAN: Yes. I guess I'm struggling a little bit to know what the question is. How do we decide which allocation . . .

DR. NICOL: Like on the AIDS prevention. That's what I was specifically dealing with.

MRS. McCLELLAN: We have in Alberta the AIDS – committee is not the right word. It's Dr. Larke. Help me; what's the name?

DR. PHILIPPON: The AIDS Network. There's also the provincial committee.

MRS. McCLELLAN: Yes; it's the provincial committee I'm trying to talk about – it is getting late; I'm not a night person – with Dr. Larke, who gives us a great deal of advice in this area. There is a great deal of collaboration between the community-based organizations as well as the provincial organization to ensure that the dollars that are available are used most effectively. That's really where we get the advice on that particular program.

DR. NICOL: Have you had any studies done or looked at any information that would show the trade-off between prevention of AIDS as opposed to the long-term cost of looking after individuals once they're infected?

MRS. McCLELLAN: That is one of the areas they are concentrating the most on, obviously, because that is the concern. You would be aware of some of the programs that are available now and that we are funding: the needle exchange, education, many things in the preventative side, a number of areas of co-operating with the community-based organizations to ensure that we have a good education program.

DR. NICOL: Just a final then. With the settlements we've heard about with the hemophiliacs that were contaminated with blood products prior to the permanent testing of blood supplies, whereabouts in the budget is that going to show up and how much do you expect it to be?

MRS. McCLELLAN: If you're talking about the assistance program that was announced, it would not be expected that there would be an impact on this direct budget this year. It will be in our budget but not in the one you're examining today.

DR. NICOL: But it will show up under this area in the future.

MRS. McCLELLAN: Yes.

DR. NICOL: Thank you.

MR. CHAIRMAN: Ed Stelmach.

MR. STELMACH: Thank you. Madam Minister, looking at item 5.5, Environmental Health Services, we see an increase of $150,000 for this year. However, all health units in Alberta have to deal with the fact that more and more people are being exposed to the risk of food-borne illness in restaurants. I'm quite sure the rate of inspections has decreased in some areas because that part of the budget hasn't been expanded. From what's granted here, how are we going to deal with that?

10:22

MRS. McCLELLAN: Well, there are a number of things that have occurred in restaurant inspections or in food establishments, and certainly one of them is education and training for workers who handle food in public places. I think that's been one of the strategies we want to concentrate on as well. There are a number of voluntary programs on sanitation, on safety and hygiene, and in many cases maybe these could be less costly and more effective. I think we want to do that. Not that we are eliminating restaurant inspections; we have not eliminated them. But we certainly are concentrating – and I believe the industry itself is taking a very proactive and responsible role – on that side of the education and sanitation hygiene area, which I am pleased to see.

MR. STELMACH: I know that in the time I spent with the health units, there was the suggestion by some, especially the Edmonton board of health, that their inspectors be permitted to charge a fee for inspecting restaurants. Do you feel that's a good idea? What's the opinion of the department?

MRS. McCLELLAN: To this point it has been seen as a part of the public health responsibilities of the department, and I think I would want to hear more from the health community and the public before I make any decision in that way. That would be my feeling.

MR. STELMACH: There is one other area I'd like to cover, and it's a fairly complex subject because it deals with risk to public health. It deals with transferring a tax burden from, let's say, the average income tax of all Albertans on to one jurisdiction. What I'm speaking about is that we have had for years this continuing saga in the city of Edmonton where they have been unable to site a landfill. They have, quite frankly, increased costs to neighbouring jurisdictions, especially health units, because they say, "Well, we're going to find a site in Sturgeon" and "We're going find one in Tofield" or "We're going to look for one in Lamont." Every time you do that, the health unit has to respond. The residents of that jurisdiction actually face a risk in many ways because we have to then as a health unit transfer and ensure that there are enough funds to evaluate the siting of that particular location. What's happened is that for years this has been going on, and various health units have spent a considerable amount of money.

The point I'm trying to make is that I happen to know the individual very well that initiated some discussion on section 17 of the public waste management regulations, so that we will be able to assess a fee for those municipalities that want to encroach on the neighbouring municipality and site a landfill and in many ways put those people at risk in that particular jurisdiction because of that. Now, there was some argument that it would be unfair to charge a fee because then some municipalities would have to pay for a site of their own.

MR. MITCHELL: Could we get to the question? We still have program 6 to go. If you want to get into a debate about that, I'd be happy to engage in it, because if the minister would step in and make a decision, then . . .

MR. CHAIRMAN: Order please. Order.

If we could get to the question , it would be good.

MR. STELMACH: What happens is that the jurisdiction then has to face the extra costs. What we're looking for is a change in section 17 of the public waste regulations, and I'm looking forward to a decision in that particular area.

MR. MITCHELL: Is that a question?

MR. STELMACH: Yup.

MRS. McCLELLAN: Well, the issue is, as you say, very complex. I have asked the waste management regulation committee to bring a recommendation to me on that. I would expect that recommendation to come quite soon, and we will address it, because I have had, certainly, letters from a variety of municipalities suggesting the burden. You can tell by looking at our budget what environmental health increases have been, especially if you go back over the years.

MR. CHAIRMAN: Howard Sapers, are you on program 5?

MR. SAPERS: I'd like to move on to program 6, if that's possible, for two reasons, Mr. Chairman. One is that we are rapidly running out of time, and the second is that we do have an observer from the Canadian Mental Health Association, and in deference to him, I know he would be interested in hearing the minister respond to these questions.

MR. CHAIRMAN: I have two people that wanted to ask questions on program 5. If they concur, we could move on to 6.

MRS. FRITZ: I concur.

MRS. LAING: In light of the fact that you invited a guest, yes I will.

MR. CHAIRMAN: Okay. We're on program 6. Proceed then, Howard Sapers.

MR. SAPERS: Thank you. Here we go. The Children's Advocate report, the FCSS review, and the community and social services review on programs for 16- and 17-year-olds all outline the severe lack of mental health services for children in Alberta. What is this minister doing to ensure that Alberta's youth can receive mental health services, particularly community-based mental health services?

MRS. McCLELLAN: I think you would be aware and your guest would be aware that we are looking at certainly the co-ordination of services to ensure that we can assist in the community-based side. We are spending about $1 million dollars annually for 16 programs that are located throughout the province to assess and treat children and their families. That's in addition to two major programs that we have in Edmonton. For the one in Edmonton the expenditure is about $2.386 million, and in Calgary a program expends a little bit in excess of $1.7 million. We also have in our base budget $450,000, which funds 25 community agency programs that are specifically for the prevention and treatment of family violence. So we're looking at those. I mentioned in my first comments that we're also looking at the co-ordination of services. I think it's a very important area. Alberta Health, Alberta Education, Alberta Justice, and Alberta Family and Social Services ministers have committed to the co-ordination of services between those departments, and I think that is a very important move. We have begun a project that will work to improve the co-ordination of services for children. Now, that's perhaps a bit broader, but that's part of it.

We've chosen five communities to test new ways of improving services for children and their families. We're trying to look at ways that will streamline the process, minimize intrusion into the children's lives, increase access to services, make better use of existing services – we have many services out there; we need to use them better – increase what I think is maybe one of the most important things, local decision-making, and truly ensure that these are community-based. So we have those communities that were carefully selected, and that's on the co-ordination side of it: Calgary and Edmonton – I suppose the reasons for that are obvious; they are the large urban centres – Lethbridge, which is a regional program; Wetaskiwin; and Wabasca-Desmarais. I think you would know the reasons for those choices. I think it's a very responsible way to start that process on the co-ordination of services for children to ensure that it will work before you try and expand it.

That's just a bit.

10:32

MR. SAPERS: The majority of program 6 is spent in the community, but the bulk of mental health services actually lies in other areas: long-term care, acute care. This split in spending in the community actually works out to 11 per cent versus 89 per cent, still focused on institutional care. Are plans under way to increase this per centage split in a specific way so that more money will be increasingly allocated to community-based services?

MRS. McCLELLAN: Again I would mention that we've increased the budget a million dollars for community-based, looking more at the community-based. I want to point out to you a collaborative project that is under way in mental health, and that's the community services pilot project. It's a co-operative project with Alberta Hospital Ponoka and Alberta Health. It's a two-year project. The delivery of community services is shared between the hospital and the community clinics, and it's in four sites in central Alberta: Rocky Mountain House, Wainwright, Stettler, and Wetaskiwin. It is a new initiative. It's a collaborative approach, and we'll be looking at the results of that now. It's just in its first year. In fact, it began April 1 of this year.

MR. SAPERS: So an increase would be contemplated after the results of this? That's not my supplementary; I just want to make sure I understand the answer.

MRS. McCLELLAN: It's a bit hypothetical, Mr. Sapers, because first we want to see if this works. I should just mention that we had nine regional meetings around the province this spring to ensure that we do develop a collaborative approach and that we do have the best strategies for meeting the mental health needs in this province everywhere.

MR. SAPERS: My final supplemental. With the shift that's going on right now in acute care and the changes that are happening and all of the thrust which community-based care has meant to health services, have there been studies done that have precisely indicated the number of psychiatric beds that we are going to need in this province to meet the demand in facilities both now and in the future?

MRS. McCLELLAN: I don't know of an actual study.

MR. OSTERCAMP: There isn't an actual study that has been done for that purpose. Strategic planning addressed the shift.

MRS. McCLELLAN: Yeah. I guess I have to come back to the work that has been done in the strategic plan. Definitely, I think the . . .

MR. SAPERS: Alberta Health's strategic plan?

MRS. McCLELLAN: No; the mental health strategic plan, the desire to move to as much community-based as we can in that area.

I've just received the final report of that advisory committee. I'll just say that I'm very impressed with the quality of the work and certainly the dedication of the people that put it together, but I think you would understand – well, maybe you couldn't, but I will tell you that I have not had the opportunity to give it the fullest attention that it requires, to really look at the recommendations, or to make any comment on the recommendations yet.

MR. CHAIRMAN: The time has expired. I would like to take this opportunity before we adjourn to thank the minister and her staff. There certainly was a lot of very good information tonight, good dialogue. I want to thank the committee members for their questions. With that, I would entertain a motion.

MR. MITCHELL: Mr. Chairman, could I just make a comment? I'd like to say on behalf of the Liberal contingent that we, too, thank the minister very much. She's worked hard this evening. She was in the position of having to do most of the talking, and we appreciate it greatly. Thanks to her staff. This was a long evening for them and very much appreciated. Thanks to the Conservative members who forfeited their questions on 5 so we could get to 6, and thanks to the Conservative members who brought pizza. We really do appreciate this evening.

Just one final thing. We do have some further questions we haven't been able to get to, and we'd like to submit them to you in writing just so you have those.

MRS. McCLELLAN: Certainly, and there will be an opportunity again, I'm sure, to question this minister before we're finished the process. The other commitment, Mr. Chairman, that I will make, as I make in all instances, is that we will very carefully review the *Hansard* copies of this meeting tonight. On a couple of occasions I have offered some further information and will ensure that if there are reports or information we can give to you, to all of our members, we'd be happy to do that.

I appreciated the meeting. You've been good inquisitors.

MR. CHAIRMAN: Do we have a motion? Bonnie Laing moves adjournment. Thank you. The meeting is adjourned.

[The committee adjourned at 10:40 p.m.]