Title: Wednesday, March 15, 2006 Public Accounts Committee
Date: 06/03/15
Time: 8:30 a.m.
[Mr. MacDonald in the chair]

The Chair: Good morning. I would like to call this meeting of the Public Accounts Committee to order, please.

I would like to welcome on behalf of all members of the committee everyone in attendance this morning from the department of health and the Auditor General's office.

Perhaps we should start again by quickly going around the room and introducing ourselves. If we could start with Mr. Prins, please.

[The following members introduced themselves: Ms Blakeman, Mr. Bonko, Mr. Chase, Mr. Danyluk, Mr. Eggen, Mr. Griffiths, Mr. Johnston, Mr. Lindsay, Mr. MacDonald, Dr. Morton, Mr. Prins, Mr. Rodney, Mr. VanderBurg, and Mr. Webber]

[The following staff of the Auditor General's office introduced themselves: Mr. Dunn, Mr. Hug, and Ms White]

Ms Evans: Iris Evans, Sherwood Park.

Dr. Swann: David Swann, Calgary-Mountain View.

Mr. Elsalhy: Good morning. Mo Elsalhy, Edmonton-McClung.

The Chair: Karen Sawchuk, our committee clerk.

Thank you.

Ms Evans: Mr. Chairman, with your pleasure, may my staff that also have come today, who wanted to be a part of this process and listen in, have an opportunity to introduce themselves?

The Chair: Oh, please. If they want to assist in answering questions later on, they're welcome to come to the microphone.

[The following departmental support staff introduced themselves: Mr. Butler, Mr. Debolt, Mr. Hegholz, Mr. Kastner, Mr. McKendrick, Ms Meade, Ms Miller, Mr. Perry, Ms Powell, and Ms Trimbee]

Ms Evans: It was my understanding – and I don't know if I'm misinterpreting it – that you would far prefer my staff to answer some of these questions, so they are delighted and ready to go.

The Chair: That's fine. Thank you.

Ms Evans: Those are our health staff, but there are other staff present or other people present, sir.

The Chair: It's a public meeting, Madam Minister, and they can feel free any time to introduce themselves.

Now, I would like to advise all members that the agendas were sent out on Friday, and I would ask approval of the agenda if there are no questions. Mr. Lindsay. All those in favour of the agenda for this meeting, please raise their hands. Opposed? None. Carried. Thank you.

Now, could I also, please, if there are no questions, have approval of the committee meeting minutes for March 1 and March 8, 2006, which were attached.

Ms Blakeman: I'll do that.

The Chair: Thank you, Ms Blakeman. Moved by Ms Blakeman that the minutes for the March 1 and March 8, 2006, committee meetings be adopted as circulated. Those in favour? Opposed? Carried. Thank you.

Now, this brings us to item 4 on our agenda, which is our meeting with the hon. Ms Iris Evans, Minister of Health and Wellness. I would remind the hon. minister that if she could keep her comments on the overview of her department from the year 2004-05 to 10 minutes, we would be very grateful. There are many questions already by hon. members. They indicate that they would have many questions for you and your staff, so if you could please proceed, and that will be followed by any comments that the Auditor General would like to make.

At this time I would like to remind members of the committee and visiting Members of the Legislative Assembly that we're dealing specifically with the annual report for 2004-05, the Auditor General's report, the Auditor General's report on seniors' care and programs, and the government of Alberta's annual report. This is not a policy committee. This is a committee that deals with how and why we spend tax money in a respective fiscal year. Thank you.

Ms Evans, please.

Ms Evans: Thank you, hon. chairs, hon. members, one and all. I'm pleased to see so many here today, and I'm pleased to have a number of ministry staff accompanying me to assist in answering questions.

I'd also like to reflect, with a great deal of pleasure, what our staff perceive, and that is a much better working relationship with the Auditor General and his staff. I believe there has been frequent communication. We've tried to resolve outstanding issues. We have very much appreciated, Auditor General, your co-operation and the collaborative intent of working with your staff members and the fact that we have been able to make some progress on some of the outstanding issues and work on yet other outstanding issues. We've also appreciated your due diligence in the follow-up on the work that we've done on the long-term care review and the work that we continue to do to follow up on those very valued observations that you made last year. I want to say that from my perspective as a minister, it has been not without comment and without sincere appreciation. I believe Mr. Perry has felt some degree of satisfaction in being able to mutually look after and address some of the issues that you've identified. It's a very great pleasure to see Mr. Hug here today because he has been, as I have known, a very wonderful and dedicated public servant. I don't think I've had the pleasure of you at many of these sessions lately, so I'm very pleased to see you here again.

Well, may I say that the government in the year 2004-05 had an investment of $700 million in new funding to expand capacity and improve access. It was one of the most remarkable injections of funds during the history of Alberta's health system, with half of the money allocated to reducing wait-lists and wait times and new initiatives for protecting and promoting the health of Albertans being launched.

In slightly more detail, in co-operation with Alberta Infrastructure we paid the remaining $350 million to a series of health facility capital projects entitled to develop new supportive living and facilities for low and moderate income seniors in rural Alberta. That year we reaffirmed our commitment to learn from the best health systems in the developed world and to explore a third way of developing Alberta's health system, so the seeds of the work that has been ongoing in the last year and a half have been developed through that particular year.

A number of public awareness campaigns were launched. The Keep Your Body in Check campaign educated Albertans on how to reduce the risk of developing type 2 diabetes. The Fight the Bite! campaign reminded Albertans about the serious consequences of

West Nile. The Healthy U Crew made 13 stops at summer rodeos to talk about the efforts to educate and help Albertans to choose well and make better choices for health care. Sixty-two communities accepted the Community Choose Well Challenge, and I'm pleased to say that that continues to grow.

First ministers of federal and provincial and territorial governments agreed on the fundamental principles of a national pharmaceutical strategy, and we're proud to lead that strategy and still provide leadership in looking for ways to fund expensive drugs for rare diseases.

In core business 1 we took as our first step the business of encouraging and supporting healthy living. I think we have become world-famous for the work we've done to increase awareness of type 2 diabetes and associated risk factors along with the work of the scientists in developing advanced ways of treating diabetes. The mobile diabetes screening initiative provided mobile screening for diabetes-related complications to the eight Métis settlements and four other remote off-reserve communities, and aboriginal people in outlying parts of Alberta are very pleased with that particular service.

8:40

On the influenza pandemic we procured and began stockpiling 1.6 million doses in preparation for the influenza pandemic. Those of you who listened to the radio this morning may have noted that Roche also have released once again their antiviral for public purchase, so we continue to accelerate the awareness not only of government staff generally but the corporate and Alberta communities for our pandemic influenza contingency plan.

Our immunization program was expanded to reduce transmission of disease and to increase disease protection. I think that on a national basis we are doing better than others, but we still have a way to go to educate people on this front. Grade 9 students are now provided with whooping cough vaccinations.

Our breast cancer screening program made advances on performance measures, encouraging women from 50 to 68 years of age to receive a mammogram every two years.

In our core business 2 we worked to ensure quality health services. Part of that was the $350 million, that I remarked about earlier, increasing bed capacity and reducing wait times for surgery. You know about our new centralized orthopedic intake clinics in Calgary, Red Deer, and Edmonton to reduce wait lists. The project's number of 1,200 was identified by orthopedic surgeons. You've heard already interim results on the effectiveness of that program, something that they should be congratulated on.

In our comparable health indicators in the 2004 report, the second report released by Alberta government since 2000 in agreement with all Canadian ministries to provide regular performance reports using comparable data, we are showing better results than ever. We've shown that Albertans have slightly better self-reported health status compared with the Canadian average and that waiting times are close to the national average.

In mental health we improved mental health with the motivation behind innovative funding for two new multidisciplinary programs in Calgary. You'll know that we have continued to expand collaborative mental health care projects for children under six at risk for mental health disorders. We look to the program of prevention through risk identification management and education, early identification and treatment for persons with schizophrenia. While we still have a way to go to integrate those persons and programs in our communities, we are far more advanced than we were in Alberta five years ago, with a province-wide service training program providing caring staff, who also support persons with Alzheimer's and other dementia. A total of 3,000 front-line workers were trained through this program in the 2004-05 fiscal year.

On telehealth there was an increase of 22 telehealth sites; 261 sites are available in Alberta with services for psychiatric counselling, pediatric care, physiotherapy, clinical discharge planning, case conferencing, and family visitation.

On international refugees our Calgary refugee health program launched a first point of contact for refugees in the health system. The team there provide initial assessments. If you've ever visited some of the work they've done on trying to integrate new Canadians and put them in touch with the services, it's quite touching. Their emotional joy at being part of Canada is something to behold.

Our rural health program continued to address a shortage of doctors in rural Alberta. It's interesting, Mr. Chairman, that when we look at our satisfaction surveys on access, rural Albertans, although the perception is that they might have more difficulty accessing services, are in fact more satisfied than other Albertans on their access to health care. Those are interesting statistics that are being demonstrated today. We have a bursary program for 10 new students. Actually, annually we are giving students this capacity to learn and return to rural Alberta under the rural physician action plan.

Now, just to keep within your time frame, I'll mention briefly that in core business 3 we further expanded our electronic health record, worked on the RSHIP program, worked to continue to enable physicians, pharmacists, hospitals, and home care to be involved. It's most noteworthy that the orthopedic surgeons, 100 per cent of which are connected with EHR and POSP, the physician office system records, have really made an effort on collaboration for hip and knee surgeries, and I think in large part because they are already connected to the EHR.

I'd like to just make a comment about performance measures, something the Auditor General has continued to remind us of as government. Albertans aged 12 and over who smoke decreased from 28 to 23 per cent. Youth aged 12 to 19 who smoke decreased from 18 to 14 per cent. Albertans who were active or moderately active grew from 52 per cent to 56 per cent. So many of these statistics that we have show that we are getting better results from some of our health promotions.

Now, finally, on financials. Looking at our picture in 2004-05, the ministry spent $8.4 billion, an increase of $1 billion or 13.6 per cent over expenditures in 2003-04. The $8.4 billion reflects an additional $359 million that the department received during the year. Almost two-thirds of this entire spending went to health authorities. The increased spending reflects $150 million for medical diagnostic equipment and $605 million to reduce wait times. The money also supported the delivery of acute care, continuing care, mental health, and cancer services, including very high-cost cancer treatments and new technologies in supportive care.

I'd like to just comment that there was $51 million spent on the continuing demand for nongroup drug benefits, primarily by seniors, and $32 million on promotion, protection, and prevention activities. That, added to some $172 million that was spent through health authorities, helped enhance our work on prevention.

I'm just going to say, finally, because I've just slightly run over, that I'm pleased that the Auditor General found no exception in auditing our ministry's performance measures and found satisfactory progress on all recommendations issued in last year's report. I would be remiss if I didn't comment that in our seniors' care and program we have made some significant strides, and we appreciate the Auditor General's program, which identified many areas which have indicated complete co-operation in endeavouring to increase personal care hours from 3.1 to 3.4 hours per day. We thank the

MLA task force for their help, and we note that within the next month we will be releasing our standards.

Oh, Mr. Chairman, I'm sorry to overrun, but I thank you for the opportunity to make this brief overview, and I look forward to answering your questions.

The Chair: Thank you very much.

Mr. Dunn, please.

Mr. Dunn: I'll be very brief here. Our comments are in two parts in our annual report 2004-2005. First, on pages 223 to 235 we note that we followed up and reported on the progress made on prior year's recommendations concerning that department, the Calgary health region, and the Alberta Cancer Board in addition to the report on the work done by the office last year for the first time to review the security and handling of high-illicit-value prescription drugs in 13 pharmacies operated by five regional health authorities.

Also, as mentioned by the minister, on pages 53 to 69 of our last year's annual report we summarize our recommendations and findings from our May 2005 report on seniors care and programs. Mr. Chairman, I believe each of you should have a copy of that report. It contains nine numbered recommendations, six of which include a reference to the Department of Health and Wellness.

In the letter from the Hon. Shirley McClellan, Deputy Premier and Minister of Finance, to this committee dated February 27, 2006, the government has provided its written acceptance of each of these six numbered recommendations in our report on seniors care and programs, which involved the Department of Health and Wellness. As well, that letter refers briefly to the actions taken to date by the department and future planned actions to address these recommendations.

Those are my brief comments, Mr. Chairman. I'll be pleased to answer any questions that the committee directs to us.

The Chair: Thank you very much.

Before we proceed with questions, the chair on behalf of the committee would also like to welcome this morning the hon. Member for Lethbridge-East, Bridget Pastoor, who has joined us. Welcome.

We will start questions this morning with Ms Blakeman, followed by Mr. Griffiths. I would remind all members that there's a long list. If you'd keep your questions to the minister as brief as possible, the chair would be grateful.

8:50

Ms Blakeman: Thank you very much. This department has worked hard, and you should take credit for that. This is a much better report from the Auditor General this year.

I did circulate some specific questions to the minister in advance so that you'd be prepared to answer some specific questions on numbered companies. This is springing from the contracting for consulting services that was noted on page 226 of the Auditor General's report, but this is actually coming out of the 2005 blue book. The corporate registry search on numbered company 911880, which appears on page 9 of the blue book – this is the information I did provide your ministry with – indicates that a grant was given to an organization that was struck from the corporate registry in 2003. It was not difficult for me to get that information. I'm concerned. Given the situation with the Applewood Park Community Association, I'm wondering: what is the Department of Health's explanation for having issued money, not a lot, under $10,000, to an organization that has been struck from the registry almost two years prior?

Ms Evans: First of all, before deferring to Peter to give a response to that question, I'd like to say thank you very much for the recognition of department staff, Ms Blakeman, for the work that they have done. They really have worked very hard.

Peter, I know that you are prepared to provide that answer, please.

Mr. Hegholz: Ms Blakeman, can you give me the number of that company again, please?

Ms Blakeman: 911880. It appears on page 9; $8,941.

Mr. VanderBurg: Minister.

Ms Evans: Yes.

Mr. VanderBurg: You know, if there are issues with answering certain questions, you can provide that in writing for us, and we will, through the clerk, get that to everybody. We don't expect you to know every single company, every single grant.

Ms Evans: Yeah. May I just thank Ms Blakeman for releasing that through her researcher to our department.

What has happened is that the number that was assumed to be the correct number was the one that there was preparation made to respond to. We will respond in writing. I apologize that we don't have that now, but that wasn't the numbered company that was assumed to be the one that you were seeking information about. So I'm sorry for that. We will provide that in writing, and I will be prepared to speak to Ms Blakeman later about that.

Ms Blakeman: Okay.

The Chair: Thank you. If you could provide that written answer through the clerk to all members.

Ms Evans: Absolutely.

The Chair: Yes, please.

Ms Blakeman: Oh, yes, excellent.

My supplementary question on that is also coming from the blue book. I note that Health and Wellness provided two different governments with a sum of money: the government of British Columbia for almost $5,000, that appears on page 328 of the blue book, and the government of Ontario for $15,000, which appears on page 328 of the blue book. I was thinking this might be reimbursement for health services provided, but that's a fairly small amount, so they're just striking me as a bit odd. Could I get an explanation?

Ms Evans: Yes, you may. These relate to our federal/provincial/territorial commitments, and frequently these are cooperative and collaborative projects. I'd ask Peter to give a response to that, to both of those from the blue book.

Mr. Hegholz: Bear with me here, Ms Blakeman, until – what page was that? Sorry.

Ms Blakeman: Page 328. Both of them appear on 328.

Ms Evans: All right. To my deputy, please.

Ms Meade: Ontario was the co-lead during that year, and the larger payment goes for our portion of some of the subgroups that they

have to do. B.C. has been leading on some of the drug and the technology issues. We can get you a firm answer as to what that dollar amount was for. Each jurisdiction leads on certain initiatives done at a federal/provincial level. The rest put in our share of the money to support those initiatives.

Ms Blakeman: Okay. Thank you.

The Chair: Thank you.
Mr. Griffiths, followed by Mr. Chase, please.

Mr. Griffiths: Thank you. Minister, I ask pretty much every minister that comes before this committee the same question, the same concept. There are three types of measurements, each one more engaging than the previous. The first one is satisfaction surveys, which are meaningful but not as meaningful as measurements of outputs, and of course then the most important one is the third level, which is measuring outcomes to see if we're getting real bang for the buck on our dollars. So my question specifically is about the electronic health records and if your department – I might have missed it – has measurement criteria for evaluating the real good that electronic health records can do instead of just how many might be signing on to it.

Ms Evans: Thank you. I'm going to ask Linda Miller to respond to that. You'll note that during this year there was significant progress made to RSHIP for the program that relates to rural doctors. There was also over $40 million provided to the physician office system to expand that. But I'll ask her to comment, please.

Ms Miller: Thank you for the question. What we've done to date and particularly in the year 2004-2005 is that we continued to track the number of users and how frequently they were using the electronic health record as well as certain pieces of the EHR story; i.e., the physician office system program did surveys of users as well. However, our plan for this coming fiscal year is to do a provincial framework for what we call a benefits evaluation plan. So as we continue to roll out and as we continue to invest, our strategy here will be to introduce certain indicators that we would be expecting the various organizations and providers to track to demonstrate more quantitatively the progress we're making on the electronic health record.

Mr. Griffiths: Thank you. My second question. I saw quite a bit of information on MRI clinics. I'm wondering if your department did or plans on doing any measurements on private MRI clinics for satisfaction surveys, how many people went through private MRI clinics, and how much it saved the health care system by having them go through faster. I didn't see any measurements on that either.

Ms Evans: Go ahead, Paddy.

Ms Meade: If the privates are being utilized out of pocket, there's no tracking of that information. The other labs that we do know do the diagnostics we can track by the breakdown, so I'd be better off to send you the breakdown information. But if someone is using private anything, this province or another province or another country, that's not tracked.

The Chair: Thank you.
Mr. Chase, please, followed by Mr. Prins.

Mr. Chase: Thank you. My questions both have to do with value for money and, at the centre of my questions, the University of Calgary. Last spring the Ministry of Health and Wellness held a conference at the University of Calgary in the Calgary-Varsity constituency at a cost of approximately 1.3 million taxpayer dollars. Was this conference simply an expensive public relations event?

Ms Evans: At the University of Calgary, was that the one that related to some of the research and findings on the public health side of the equation?

Mr. Chase: This is where we brought in the world health experts at a considerable cost for their advice.

Ms Evans: Right. You're talking about the international symposium that was held.

Mr. Chase: That is correct.

Ms Evans: I'm sorry, Mr. Chair. I thought that it reflected on something that was held at the university, and that's what I was confused about.

Mr. Chase: It was just the location of the health symposium, the University of Calgary.

Ms Evans: No. The health symposium was held downtown at the Westin. That's the part that I'll just clarify. We did have representatives there from the university.

No, Mr. Chairman and to the hon. member. To my way of thinking that illuminated a number of things on a variety of fronts. There were several ideas, everything from dealing with pharmacare, dealing with the drug expenditures and consolidated drug expenditures, pointing out some of the things that related to access issues, to better treatments, and to better management. There were a number of topics at that particular conference. But I believe it was something that is reflected in our Getting On with Better Health Care that was released in July, where we have 13 strategies as a result. Many of them were reflective of information that we gleaned at the international symposium.

Mr. Chase: Thank you. My second question, and I'm in better shape with the location of this one, from the University of Calgary. The 2005 grant blue books indicate that the University of Alberta received $23,671,928 in grants compared to the University of Calgary, that received $2,998,500. This is on page 864 and page 865. What were the grants for, and why did the University of Calgary receive significantly less funding than the University of Alberta?

9:00

Ms Evans: If I may, I'll ask if we have that ready. If not, we would have to provide that in writing. I'm assuming that that might come in the area of the academic relationship plans. Sometimes those grants are for other kinds of either program delivery points or conferences. I'll just ask if Peter or Paddy can provide us with some information on that, please.

Ms Meade: I'd rather give you a written response, but you have differences in the size of the medical faculties and some of the research that's going on, so it goes back and forth between the different universities as to what they're actually dealing with or whether we're also involved with the RHA. We can give a breakdown of those grants.

The Chair: Thank you, and again, please, through the clerk to all committee members.

Mr. Prins, please, followed by Mr. Bonko.

Mr. Prins: Thank you, Mr. Chairman. On page 73 of your report, minister, there's a comment about the youth smoking and youth drinking. For youth smoking the number measures the rate for ages 12 to 19, and the heavy drinking group begins at age 15. I'm wondering why the discrepancy in the measurements between age 12 and age 15.

Ms Evans: Paddy, do you want to answer the discrepancy between 12 and 15, please? I think that's a worthy question because you'd wonder why the change.

Ms Meade: I'm sorry. If I understood the question, you're talking about the drinking rates and where they start at?

Mr. Prins: We're talking about the age of the problem smokers starting at age 12 and the age of problem drinking starting at age 15.

Ms Meade: It's access. So the difference actually starts at access. You can actually get cigarettes earlier. Also, on the surveys those are from the youths' disclosure in the school surveys that AADAC does. So it's not a discrepancy. It's actually age of onset where they would actually be into a category of being ranked in that area.

Mr. Prins: Okay. A further question is: the target is set at 16 per cent to reduce the amount of smoking, and you're actually already at 14. Why would you have a target at 16 when you had the amount of smokers at 14 per cent?

Ms Meade: Basically, the smoking rates across Canada for that particular age group have gone up and down. We were at 14, but we know we have to continue to address that. The longevity of keeping that group at a lower smoking rate requires AADAC and its partners to continue to address it, so we haven't reduced it. If, in fact, that is common, consistent over several years, then you drop the target.

Mr. Prins: Thanks.

The Chair: Thank you.

The chair is going to allow Mr. Rodney to make a comment on this question because he's the chair of AADAC, and he has some additional information. Briefly, please.

Mr. Rodney: Well, thank you very much, Mr. Chair. Just to answer that question directly, sir. The 2004-2005 target was based on results from statistics in 2000-2001, and they have been readjusted based on results from 2003.

I might add to the hon. member and to all others, including staff, that I think most people are well aware that on June 6 we will have an in-depth investigation into AADAC, so further questions can be detailed at that time if you care to dwell on other aspects of this incredible ministry.

The Chair: Thank you for that clarification.

Mr. Bonko, please, followed by Mr. Rodney.

Mr. Bonko: Thanks, Mr. Chairman. My question is with regard to how far in advance the Health and Wellness minister was looking to test the water with regard to the alternative to health care known as the third way. There was a grant contract to Ipsos-Reid for $188,500. That would have been in the blue book supplied, at page 1305. I suspect that perhaps that's what it was for, but I'd like to know from the minister what was the service provided, and when will you table the final report?

Ms Evans: My understanding, Mr. Chairman, is that Ipsos-Reid was not connected to the third way in the context that the hon. member might be implying. We can provide further information about the study itself or the polling and whatever research was undertaken and give you that back in print.

The Chair: Thank you.

Before you proceed with your second question, Mr. Bonko, for clarification that was on page . . .

Mr. Bonko: Page 1305.

The Chair: So that wouldn't be a grant.

Ms Evans: That would be a contract.

The Chair: That would be a contract, supplies, or services, so the chair would like to clarify that, please. That was not a grant.

Mr. Bonko: Thank you.

The Chair: Okay. Now, please proceed with your second question.

Mr. Bonko: The other one was mentioned in the Auditor General's report, 233-234 with regard to safeguarding the prescription drugs. Perhaps the Auditor General would like to maybe give a little bit more of an explanation as to the progress made in this department, perhaps followed up by the minister. We know that it's continuing to be a rising cost out there on the streets not only in the hospital, but as these prescription drugs make their way out there, they're becoming more and more addictive. We're just looking at how they are managing to safeguard the supplies.

Mr. Dunn: Okay. The member is talking about the matters we address on page 233 of our report. In there we do indicate that there was a fraud at one of the pharmacies in the year 2003, which had been identified and reported on previously. The OxyContin had been moved through the pharmacy out into the street through one of the gangs, and there was a fair amount of dollars that were involved.

That triggered us to go look at other pharmacies. We looked at, as it says in our report, 13 pharmacies at five of the regional health authorities. We found, generally, that the controls were in reasonable shape. However, we did note that there could be improvements in the purchasing of it, and there was an opportunity, we thought, within the pharmacies to make comparability because in the pharmacy where there was the fraud, there was three times as much OxyContin going out of that very small, rural pharmacy as there was for the Foothills hospital in Calgary, which would then say: why were they, obviously, purchasing that number? So there's an opportunity to use the data to look at the procurement, then the control over inventories, the safeguarding of those inventories, and then, eventually, the dispensing of that to appropriate prescriptions.

We do give a series of recommendations, and we've discussed those recommendations with each of the pharmacies that are involved, and we expect that each of those pharmacies will adopt those recommendations. The early indication that we have is that were was no question around the validity of our findings, and the recommendations have been accepted. We'll be following up with

those pharmacies subsequently just to make sure that those recommendations have been fully applied.

Ms Evans: To respond further, as the hon. member invited me to make an overarching comment, the Health Quality Council of Alberta is currently engaged in making sure that quality of delivery of the regional health authorities on this item is improved and enhanced. They have undertaken a more rigorous role. As you know, they were engaged in Calgary at the time of the adverse events to try and help us sort out what we could do to make sure these things did not occur in future. In terms of evaluating and monitoring the hospital's performance on behalf of the Department of Health and Wellness and the people of Alberta for that matter, they have been more engaged in the last year and a half to help us identify those areas where there may be gaps in that kind of management of medications and medical supplies in the hospitals and through the authorities.

The Chair: Thank you.

Mr. Rodney, followed by David Eggen.

Mr. Rodney: Thank you, Mr. Chair. I don't know about my hon. colleagues, but I often think that the toughest job in provincial politics is that of the health minister and her staff, and I'd like to commend you, minister. I have a question from my constituents. Constituents have asked questions about prevention versus treating after the fact, and they've asked me about AADAC. They've said, "What percentage is on information, prevention, and treatment," and I can tell them that it's a third, a third, and a third. But I haven't been able to answer this question after perusing both volumes here today and in the past. I haven't been able to find this number. I don't necessarily expect you to come up with it here today. Perhaps you could get it later if not. Is there any way to answer the question: what percentage of the budget is designated for sickness versus wellness? I guess I'm thinking prevention versus treatment. I don't know how you'd break that up. I just wonder if that number has ever been come up with, and if not, if we could see where that's at.

9:10

Ms Evans: I believe that was the context of a question or reference point the hon. Member for Edmonton-Centre made earlier this year. I think that in order to give you an accurate number, we really ought to talk about wellness budgets in various ministries.

Mr. Rodney: Right.

Ms Evans: There are dollars that are provided in a number of ministries. Family and community support services, for example, in Children's Services gives about $70 million, which constitutes about 80 per cent of what's spent with the 20 per cent or thereabouts coming from the municipalities. Human Resources and Employment make an investment in wellness. Economic Development to some degree has an investment in wellness in terms of the management of information to promote Alberta amenities to Albertans and to visitors. Community Development has a large investment in wellness. A significant amount of the dollars that are provided through the parks and recreation would be considered wellness dollars.

As I cited earlier, in the year 2004-05 about $172 million to $173 million was spent through the regional health authorities, with some $30 million spent departmentally. This comes through grants and through a number of program initiatives that broaden the horizon for aboriginal peoples, both on and off the reserve, as well as a number of other programs. Both advanced learning and education K to 12 have program delivery that support this.

I think if you added the dollars between all ministries for everything from staff programming, wellness programming for staff, Alberta government employees, as well as people that are recipient of that program delivery, it might be a very useful exercise to see what we are expending overall. At one time, when we looked at the establishment of a wellness account, it was thought that that might be about $500 million. When we did the math on that, we realized that we are probably spending more than that of the provincial budget today. So you'd have to look at the broad context.

One final point. When we looked at our drug expenditures to try and consolidate our drug expenditures to get some efficiencies of management, we noted that primarily four ministries spend on drugs, but actually six ministries overall in this government acquire drugs and purchase drugs. So under those circumstances, I would have to say that there are at least four core ministries, probably six and perhaps even eight, that should be contacted to give us some amounts of monies that they spend within the context of their budget to promote wellness.

I think, finally, Mr. Chairman, one hundred per cent of Alberta government budgets likely have some dollars for employee wellness and employee services within their own budgets. We could undertake to provide this to Executive Council to see what the appetite is of researching this more broadly to see what we have for wellness and benefit for Albertans.

The Chair: Thank you.

Mr. Rodney: No further questions. It's a good-news story, and I hope more Albertans find out how much is being spent on wellness in terms of percentage in your and other departments. Thanks.

The Chair: Mr. Eggen, please, followed by Mr. Danyluk.

Mr. Eggen: Thank you, Mr. Chairman, and thanks very much to the ministry for coming here in force. It's been a year since we've had Health and Wellness here, and certainly the report has improved considerably. I appreciate the hard work that everybody has done.

I've noticed down in the Calgary health region that there's quite an aggressive advertising campaign going on for fundraising. The fundraising seems to be for what some people may consider essential medical equipment such as heart monitors, for example. While the CEO of the Calgary health region has a remittance of more than half a million dollars per year, there seems to be a shortfall in the budget for the Calgary health authority. I'm just wondering what specific areas seem to be making up the shortfall in the Calgary health region if they have to do this fundraising to meet the needs of the budget.

Ms Evans: Mr. Chairman, I'm going to ask Mr. Perry to answer. Then following that, we will engage in a more detailed response through the Calgary health region itself so it can bring forward those initiatives.

I might say that it should be remarked upon that at the health boards conference the ladies from the Alberta health auxiliaries came and spoke to me about the level at which they're providing supports for fundraising for amenities to improve, primarily in their case, long-term care and other things that can encourage patient comfort. There may be challenges at times when it appears that they're raising funds for core elements. You saw that in Fort McMurray this year, where for diagnostic equipment there was fundraising by the corporate sector.

I don't believe this is a bad thing. I would look at it as a good

thing where communities can get involved. Much of what we're seeing in capital funding for ambulances in rural regions and STARS ambulance have been funded there. What I remember thinking, as a reeve and as a member of a community council and school board, is that in many ways we did this to prompt senior levels of government to come forward and notice that they should be providing those things. We got the local satisfaction of kick-starting some of these projects because of local priorities, and it profiled it not only for the local board that was accountable but for senior levels of government.

I have learned since I've come into this ministry that the cancer fundraising that has gone on is something that people like to do, both by bequest and because they feel so very well served by those boards and services that they've been provided.

For more detail on that as it relates to Calgary, to Mr. Perry.

Mr. Perry: Okay. The minister has covered off the benefit of foundations and the mandates that they have about raising capital dollars, dollars for equipment to assist the facilities.

There are three parts to the equipment issue. In '04-05 the regions received essentially two amounts. One was the flow through of the federal medical equipment dollars. This is an annual amount that ends this year. It was roughly $50 million distributed. That was a boost, and the regions participated in purchasing equipment, everything from bed lifts to medical equipment.

The second part is that in the capital planning process the hospitals that come on stream, the new hospitals, are turnkey operations, so they're fully equipped. The regions may want to supplement, move equipment from other previous facilities, or they may want to buy some enriched equipment.

The third. In 2004-2005 on the financial side there was an infusion of about $350 million. There's also $350 million in capital dollars for new beds and construction. Calgary health was flowed $69 million in that year for capital medical equipment. So for that particular year in question, the region received two buckets of funding specifically for their medical equipment needs.

Now, the corollary of that, of course, is that, I mean, equipment ages and needs to be replaced, and it's a constant planning process that all the regions have to go in and plan for.

Mr. Eggen: Thank you.

The Chair: Before your second question, hon. member, if you could give the rest of the committee a reference number if you are referring to the Auditor General's report, we would appreciate that.

Mr. Eggen: Well, it's a perceived shortfall in the last year's budget that would precipitate the Calgary health board having to raise funds privately, so it would be the whole budget, really, of that specific health region.

I'm getting two messages here that perhaps you can help me clarify. Are you, then, gathering this information where there are specific areas of shortfall for equipment in these various health regions so that you can meet that funding next year in the budget, or are you specifically underfunding these health regions to encourage private investment or foundation investment? What's the rationale behind this? I don't understand.

Ms Evans: Mr. Chairman, one of the observations that the member has used is the terminology of shortfall. Are we deliberately shortfalling budgets in order to provoke or prompt fundraising? I think, being somewhat senior to the hon. member, I can remember fundraising by local constituencies for things before you were a gleam in your daddy's eye.

Mr. Eggen: We lived two blocks away from each other.

9:20

Ms Evans: For several decades people have had a history of funding things, amenities, for hospitals. I think the real question is: are we deliberately trying to short-circuit the funding for acute and long-term care so that people will have to fund raise almost as a desperate move? We are not.

If you look at the funding for the Calgary health region, the province-wide supports, the other kinds of funding envelopes that were provided for that authority and other authorities, we did the very best we could with the funding available. Where people in local regional health authorities make other choices or in-year spending might move beyond the scope of what we are funding, then those are things that are local choices and are their prerogative under the regional health authorities. You will note that although the bulk of the funding comes from the Alberta government for each of the health regions, each of the health regions has other sources of funding, other initiatives to gain the support of either foundation support, auxiliary support, or bequests from families.

I'd ask further for the comment from Mr. Perry on that.

Mr. Perry: One of the issues that has come up in Calgary is, for example, the new Children's hospital and the equipment in the old Children's hospital, whether or not you could actually transfer that in. Their decision was to in fact leave much of it behind. As they replace that facility with new activities, that wouldn't be part of their normal planning process, so in-year they will have to make decisions in terms of how they allocate.

In the capital plan that the regions are required to do, one of their primary accountability documents is to plan their capital and equipment and the operating costs that go with those facilities when they come on stream. That is all part of the requirement of the regions.

In their funding I spoke of the specifically dedicated flow-through funding from the federal government. In their other planning they do have the ability in their global funding to allocate to equipment. If they're shortchanging the equipment, then that really is a short-term approach, and we would certainly caution them against that. But they have this global funding that they need to allocate, and they are free to allocate it to equipment and salaries and everything else in their portfolio.

Mr. Eggen: So would it be . . .

The Chair: Excuse me. That's two questions, please.

Mr. Danyluk.

Mr. Danyluk: Thank you very much, Mr. Chair. Madam Minister, to you or to staff I'd like to refer you to the annual report, section I, page 33, and I guess my continuous topic about access of health services in rural Alberta and remote areas. In the statements on page 33 you talk about key performance measures, especially in rural Alberta, and you mention two initiatives, the first being a joint initiative with Alberta Advanced Education, the bursary program, the second one being a residency program under the Alberta rural family medicine network. Now, my question to you. You have those two initiatives, and I don't see the performance. I don't see the increase taking place from that position even till today because we still have that concern today when we go out into rural Alberta. Can you tell me what else you're doing to try to instigate professionals to come to rural Alberta?

Ms Evans: Not in this particular year but very recently, as you would be aware, hon. member, we have expanded our opportunity for international medical graduates to take posts at the universities and are looking forward to taking a further step with that now to other outlying facilities in Grande Prairie, Lethbridge, and Medicine Hat to institute a second insertion of graduate opportunities to come not once a year to universities but twice a year and to get co-operative residencies to provide them with tutorial, especially looking at graduates that would return from educating themselves out of country in either Ireland or Australia. I think that's an exciting new initiative that's on the horizon that may not have resulted in more supports for access to medical supports in this particular year.

Although they're supporting and providing more satisfaction in the surveys that were done on this year, I'm going to ask Annette Trimbee to just expand a little bit about some of the rural action program success and performance measures that she has seen.

Ms Trimbee: Okay. As the minister mentioned, the actual survey results show that rural residents are more satisfied than urban. What we have been doing as a department is working with the regional health authorities on specific local issues. We get quite involved, and we have been encouraging them to take a more provincial approach to collective workforce planning rather than to have a strategy that is basically to get your workforce from another region. We have been working with them on provincial access initiatives, for example, on the arthroplasty pilot. We're working on a breast cancer access initiative as well.

We think, in part, both to get them looking through a provincial lens at their workforce as a whole but to also work more collectively on providing new ways of delivering service, for example telehealth and the critical care line, that we can do a better job. Again, you will always see specific examples of places where they can't get the particular doctor that they want. I know that if you look at the web, you can actually see that there are a lot of physicians posted in different parts of the province.

So I agree with you. It does take a little bit of time, and we are working with them at a local scale, a regional scale, and on a provincial scale.

The Chair: Thank you.

Your second question, please.

Mr. Danyluk: Thank you very much, Mr. Chairman. My second question was partially answered but not to the extent that I need.

If you refer to page 40 and look at the rate of ease of access to health services and look at the second bullet, that says, "per cent rating . . . obtaining access to hospital services," we're basically stagnated at 71 to 72 per cent. My question is: is that adequate? The second part of it is: what is the comparison between rural and urban number-wise?

Ms Evans: First of all, that's a very valid observation that has been made. One of the things that I think that we're doing with our bone and joint project, that was initiated in the planning stages during the 2004-05 year, is looking at ways that we can use existing resources to improve access. Another thing: in the recently released policy framework we've talked about different utilization and the role of hospitals and the role of community facilities to improve access, including the subacute capacity. In rural Alberta there is actually better access to hospitals than in urban Alberta, with about 80 per cent satisfaction in rural Alberta and 66 per cent in urban Alberta.

If I was going to look at how we manage this in future, I'm going to look and lean heavily on the Health Quality Council of Alberta to give us some evaluation. I think recent code reds and code burgundies have pointed to the need to use the rural facilities for subacute procedures and that better management of patients in outlying hospitals in the immediate vicinity, the 'rurban' area, if you will, around the large urban centres, is necessary. Also, in outlying areas we can hopefully find program delivery that accommodates that.

You point out clearly that with our growth in population and with the aging population and sometimes with things like we've experienced this past winter in a fairly significant flu season, access to hospital services – even the recent Leger survey, which we will be releasing this morning, talks about the level of concern among Albertans about accessing health care services in facilities.

The Chair: Thank you.

Mr. Danyluk: Thank you, Minister. Thank you, Chair.

The Chair: Ms Blakeman, please, followed by Mr. Lindsay.

Ms Blakeman: May I give way to my colleague?

The Chair: If you want to.

Ms Blakeman: There are so many questions to ask.

The Chair: Which colleague?

Ms Blakeman: Dr. Swann.

The Chair: Dr. Swann, please proceed.

Ms Blakeman: Thank you.

Dr. Swann: Thank you very much. Hon. minister, I'm recognizing it's about a decade since regionalization began in the province, and I gather the main indicators for that were to reduce administrative costs and to reduce overall costs. Can you tell us whether that's been the case?

9:30

Ms Evans: Well, that's a very astute question. I'd like to defer to my deputy in part, but I want to just reflect back on the fact that when the Rainbow Report was first released, when I read it as an outlying regional official, I wondered about the move to regionalization. At the time I was on a hospital board, and every hospital and facility seemed to have a board attached. We did at that time a great deal more conferencing and development of ourselves.

I'm going to point out that at the time I was on a school board, a hospital board, and I was a municipal councillor. I can assure you of one thing I discovered there at the local level: it was a pure pleasure to serve on hospital boards because it seemed like there was more flexibility in their budgets to serve myself in the light of serving others. That might be a fairly damning comment, but I saw that there was much more attention to detail and expenditure at the municipal side in those years from the administration. It was much harder to get away to a municipal-related meeting at the AMD and C, for example. The dollars were much tighter. They were similarly quite a lot tighter at the school board level

Where you had every facility with a board, the move then to regional health facilities started to consolidate that administration. Now, you know that in the interval in the last couple of years, the move from 18 authorities to nine authorities has not appreciably

reduced our expenditure. We're still between 3 per cent and 4 per cent for administration, but I would say that that in part has been consumed with the growth of the population. The costs have been absorbed with growth of population, aging of population, and to some degree, especially in the pressures of northern Alberta, the influx of the high industrial, fast-paced economy that seems to have necessitated quite a different mix of health force individuals.

It's very hard at times to get the administrators that one would want. An overarching comment would be that I think regionalization has worked in the attempt to consolidate policy direction in like-minded individuals within regions. Overall, when I look at the comments of Dr. Fraser Mustard, he believes that we have done much better in Alberta to implement regionalization than anywhere else with community health centres, for example in Ontario.

The Chair: Thank you, please.

Ms Evans: Was it too long? I'm loving this topic.

The Chair: Yes, but unfortunately the chair has to remind the member Dr. Swann and the hon. minister that in this committee our mandate is not to deal with policy, as interesting as this issue is. We're dealing specifically with the fiscal year 2004-05.

Please proceed, Dr. Swann, with your second question.

In fairness to all members of the committee the fiscal year 2004-05 is our mandate this morning not the historical reasons for regionalization.

Dr. Swann: In the year 2004-2005 what impact has regionalization made in terms of the proportion of administrative budgets to total costs and the overall costing of our health care services?

Ms Evans: I'm so tempted to respond, but I'll give it to Bruce Perry. I would look forward to a more detailed discussion with you later, Dr. Swann.

Dr. Swann: Has there been some research on it I guess would be the other question.

Mr. Perry: There's a national database with CIHI, the Canadian Institute for Health Information. I'll be very brief. They track that those provinces that have gone to regionalized structure over a period of time do avoid a lot of duplication, so there is research done. As Ontario goes to its new LHINs model in their mission mandate, they believe that it is a tool to save money.

In terms of '04-05, this is the year following the consolidation of regions from the 17 to the 9, so there were a lot of upfront investment costs. We expected that it would spike because they had to collapse all these different systems and all these different staff. They actually held the administrative costs at a 3 per cent to 4 per cent range, which the minister said, so we believe that was a very successful conversion considering all of the effort the regions had to do in that particular year. We would expect that that would have a very nominal increase over the years because everyone watches administration costs.

Dr. Swann: Has it reduced the progressive costs per year?

Mr. Perry: In terms of the cost increase, if the health inflation is at 10 and they're at four, yes. Now, you'd say that the base is adjusting, too, but industry-wide if you compared it to the private side, I think that would be very ideal, to have admin. costs at that range. So we believe it's a satisfactory benchmark.

The Chair: Thank you.

Mr. Lindsay, please, followed by Mr. Chase.

Mr. Lindsay: Thank you, Mr. Chairman. First of all, I want to thank the minister and her staff again for the excellent annual report. My question arises from pages 29 and 30 of that report. I would ask the minister to comment on why the regional health authorities did not achieve the set targets for immunization.

Ms Evans: Good question. The Alberta target for childhood immunization coverage at age 2 is 98 per cent. It's a standard coverage target agreed to by public health officials nationally. The regional health authorities, too, have the responsibility of delivering childhood immunization programs through the public health system. High immunization coverage rates depend primarily on parents voluntarily bringing their children in for immunization. Where we have difficulty, primarily it exists where people live in remote centres of the province or where, for one reason or another, parents have chosen not to get their children immunized, some fearing circumstances which may not be reality but may have had experiences or concerns about the immunization process itself. I believe that there's a need for public education to improve the awareness of the need. The work that we're doing with our early child development in both our ministry and in Children's Services we believe will help.

I'd like to also indicate that we're going to continue refining our reporting on meningococcal and pneumococcal conjugate vaccines. Data on the new vaccine programs from health regions is obtained by hard copy, and progress toward electronic submissions on this should help us track better. We're slow with that, but we are making some advancements.

All health regions currently do not report their immunization events. I think that we're going to accelerate that reporting so that we can profile the importance of childhood immunization, which in our performance ratings in this year's budget, obviously, points to the need to do even more.

The rate for seniors during this period was 69 per cent, which was 7 per cent below our provincial target. We believe that the reason for this is because seniors may be housebound and not able to go to the clinic. The number of seniors immunized each year has increased by 2 to 3 per cent, but the number turning 65 years of age and over has also increased by 2 to 3 per cent, so it's about a wash.

I'd just make one other observation. Capital health has instituted in some of their seniors' facilities, through Dr. Predy, the medical officer of health, a preventive, therapeutic administration of Cold-fX in order to try and help cover those seniors that are not taking advantage of immunization or getting flu shots, because they believe that that might entice people to think about wellness, to think about prevention. It's my understanding that we haven't received the final results yet, but we're hopeful, indeed, that in seniors' and long-term care facilities, they will be healthier as a result of it.

Immunization is an important part of the answer, but there are also other innovative ways to try and cover off people who are deliberately making choices to decline this important initiative.

The Chair: Thank you.

Your second question, please, Mr. Lindsay.

Mr. Lindsay: Thank you, Mr. Chairman. Actually, the hon. minister answered my second question with her first answer, so I'll pass.

The Chair: Mr. Chase, please, followed by Mr. VanderBurg.

Mr. Chase: Thank you. My question has to do with beds, basically staff beds. I've noted that we're at 1.7 beds per thousand patients, and the North American average is 1.9 beds per thousand patients. The completion date of the southeast hospital keeps being put further into the future so my questions have to do with that. Have the construction delays of the southeast hospital caused the approximate projected $500 million cost of the hospital to increase substantially?

9:40

Ms Evans: Not that I'm aware of. We can get more data, but I'm not aware of that at all.

The Chair: That hospital is in Calgary, correct?

Mr. Chase: That's the southeast, the long-awaited replacement southeast hospital in Calgary.

Will cost overruns, if they occur, result in a reduced facility as was the case with the Calgary courthouse?

Mr. Perry: I can't really comment on the Calgary courthouse. I'm not familiar with that. The traditional planning for the southeast hospital was approved in the previous budget as well as in the midterm. This second quarter we approved new projects in Calgary, about $1.4 billion worth of projects split evenly between Calgary and Edmonton.

In terms of the capital planning process we look at the escalation. We work with our partners, Infrastructure and Transportation. Calgary health has profiled the other projects – the Peter Lougheed, the east, the Rocky View, and the others – to go first. They have a resourcing issue. They just can't have more than a couple of projects going on at the same time.

As the programming studies and the construction and the architect's plans come in in the government's capital planning process, those costs are evaluated. If the price of steel has gone up 15 per cent, that would have to be factored in the eventual dig and build. At this point there's no indication that any of the functional program would change, but because it's still a couple of years away, Calgary health may come back to the province and say: we would like to reposition some of the other facilities and the other hospitals, and this is what we'd like to do differently. Until they get a crane on site, they still have the opportunity to adjust, perhaps, to what happens in the community, what is new, and what is more of a priority.

At this point there's no indication that, one, the price tag hasn't changed, and it would change through studies at this stage.

The Chair: Thank you.

Mr. VanderBurg: I want to refer to the annual report of the Auditor General, page 234. My first question is to the Auditor General with regard to financial accountability of health regions. Your audit findings talk about weaknesses in controls including bank reconciliation. I remember my wife and I teaching our sons how to balance their bank books. Then when we were in business, you know, we got a nice little computer program, and it was always done for us. What kind of staff did you run into that had troubles balancing the bank book of these health regions?

Mr. Dunn: You are referring to the three regional health authorities which we do not directly audit.

Mr. VanderBurg: I know that, but there's a comment here.

Mr. Dunn: We do look at the auditor's work. The staff that are contained in those regions, obviously, require the support and training that you're talking about. Indeed, I'm not going to dismiss this. These were serious observations of basic controls that should be addressed, and we would expect those health authorities to address those in a fairly short order. It should not take very long to correct those weaknesses because those are fundamental to any control system.

Mr. VanderBurg: Mr. Chairman, my second question, then, is to the minister. Minister, would it be helpful if the Public Accounts Committee invited those health regions that had trouble balancing their bank books to come in front of this committee to be accountable?

Ms Evans: Mr. Chair, for the first time this year I brought the health regions in to express some of their issues in budget when I came to the standing policy committee, to give them an opportunity to represent their own views. I think we could discuss that. Certainly, there were many members that appreciated it. Some of the members weren't so sure that it was a good idea because they felt that it was our arena to talk about it from a global perspective.

I think it raises the clear point, though, about the role of the accountability of the regional health authorities to Public Accounts vis-à-vis the way that Health and Wellness is accountable for its role in administration, overall, of the overall budget. It might be a discussion you could engage in with the Auditor General, and we would certainly be interested in that response. If we move the regional health authorities to this level of accountability, as the minister is as well, it may talk to a different configuration of accountability. While I'm not loathe to have it, while I think it's a wonderful idea to make sure that the regional health authorities can be held accountable for what they're doing, their current capacity or their current line of authority, if you will, in accountability is to their own regional health authority boards as audited statements are monitored and viewed here.

But I have noted today, Chairmen, both, that there have been significant questions about the management of the regional health authority boards, references to Calgary, references to fundraising in Calgary, things that may not be contained within the context of the Health and Wellness annual reports. We await the pleasure of the offices here to advise us what the outcomes would be in terms of how we look to the future about our accountability. I have no difficulty in instituting new methods of accountability.

Mr. VanderBurg: Thank you. The chair reminded me that health regions received over $2 billion in funding, more than 21 of our ministries here.

The Chair: Yes, that's correct. Both the Calgary regional health authority and the Capital regional health authority get $2 billion in the fiscal year ended March 31, 2005.

Ms Evans: Precisely why I brought them in to explain their budgets when they came into the standing policy committee.

The Chair: Yes.

Mr. Elsalhy, please, followed by Mr. Prins.

Mr. Elsalhy: Thank you, Mr. Chair, and thank you, Madam Minister. My first question is with regard to the different health regions and the way they report. I noticed that they're not all consistent, or they don't appear to be following the same methodol-

ogy; for example, the way they report salaries and the way they report disbursements and benefits and so on.

One observation I made is, for example, that in the Capital health region – I'm looking at page 125 of section 2 of your annual report – there has been an increase from $457,000 to $538,000 from 2004 to 2005 for the CEO. Actually, most of the other regions reflect similar increases. It's like a 17 per cent increase, and I would say that this money looks like it's more than the aggregate amount for all the other front-line health care workers. How is this explained?

Ms Evans: I'm going to ask for some support from my deputy minister here on this. But may I just indicate that salaries for senior executives in hospitals – I'm sure that Dr. Swann would be able to help me on this as well. Historically, administrators in hospitals positioned themselves to be held accountable in the context of the professionals that they were in charge of monitoring and evaluating and their financial purposes. So there was a period of time when the competition was quite fierce. My understanding is that because of the global marketplace and even because of what's happened in Canada, many of the places, including a hospital in Toronto, offered a million dollars for a CEO in one hospital. A top CEO to administer health districts, health regions, and health services in communities has been paid at a level much higher than what administrators or deputies would be in government, for example.

The marketplace for these individuals recognizes the high risk of both the circumstances – they're dealing with acuity of illness, the potential for risk – and also the fact that they're dealing with the very human element in a highly multidisciplined and potentially volatile environment. You look at the circumstances in management with the potential for things like SARS and so on. I think that in the marketplace of health CEOs across the country if we went to any other province, you would probably see very similar circumstances in terms of the payment scale. That's what we have found. We may be seeing a 17 per cent increase here, but it may in fact relate to overall merit bonuses.

I'll ask my deputy to add to my response.

Ms Meade: Not much to add. It was thorough. But, yes, it's beyond just actual take-home pay; it's the full package and certainly not out of line. When the boards address CEO compensation, they do take into consideration North American averages.

The Chair: Thank you.

Mr. Dunn to supplement, please.

Mr. Dunn: It's a very good question. Just briefly, if you'll make a comparison to page 59 of the same report – page 125 talks about Capital; page 59 talks about Calgary – you'll see that in the year 2004 there's quite a difference between the Calgary and the Capital remuneration, and you'll see that they've basically disappeared by the year 2005, so there's been alignment. The budgets are essentially the same between Capital and Calgary, so they have really aligned themselves between the two authorities.

9:50

The Chair: Thank you.

Mr. Elsalhy: Thank you, Mr. Dunn.

My second question, very briefly: on page 85 of the annual report liabilities have increased from $670 million in 2004 to about $1.1 billion in 2005, so I'm wondering why this increase and what we're going to do to try to eliminate or address this liability?

Ms Evans: I'm sorry, Mr. Chairman; I didn't hear the first part of that. Was that page 85 in section 1?

Mr. Elsalhy: Yes.

Ms Evans: Yes. I'm going to ask Bruce Perry to give a response to this, please. I apologize for not hearing all of that question.

Mr. Perry: Okay. I'm just looking at page 85 of section 1, our financial statements. Is there a particular line there? Liabilities?

Mr. Elsalhy: Yes, liabilities: from $670 million to $1.1 billion.

Mr. Perry: Okay. This is driven primarily by the federal transfer payments. For example, when there's a five-year, 10-year health accord, the federal government will say that we're going to take so many billion. Our share is roughly 10 per cent. We are not permitted to use that in any one year. We have to actually marry up to the accord, so unearned revenue in this case – and there's a footnote, note 7 – is that we recognize it in the year that follows. This is basically a provision saying that you can't use all those funds. Maybe, Mr. Dunn, you can assist on that, but it's basically an accounting treatment.

Ms Evans: If you look at note 7, the wait times reduction transfer of $367,354,000 was included and would be part of the increase in that unearned revenue as well. Could I validate that?

Mr. Perry: Yes, that's right, Minister.

Ms Evans: So that would be an extra inclusion to that.

The Chair: Thank you. There are four members who have indicated that they have questions for the minister at this time. If we could read them into the record, hon. minister, and you and your staff could provide written answers to the committee through the clerk, we would be very grateful.

Ms Evans: We'd agree.

The Chair: Okay. Thank you.

Mr. Danyluk, please.

Mr. Danyluk: Okay. Thank you. I appreciate having the opportunity to be afforded another question. In the same report, pages 32 to 40, in goal 3, improving access to health services, I have two questions. I'll put them together, one of them being: we have dealt with the physicianal aspect of the delivery of health care in rural and remote Alberta; we have not dealt with the professional, being the speech therapy and the physiotherapists and the concerns of advancement in that stage.

The second part of the question, also to do with rural Alberta, is one point on page 33 where you talk about: "Five clinical telehealth projects were extended to provide medical services to several First Nations communities." There's not much explanation or comment on the advancement of that and how successful it has been.

Thank you.

The Chair: Thank you.

Mr. Eggen, please.

Mr. Eggen: Yes; very quickly. The recommendation from page 226 of the Auditor General's report to look for contracting for consulting

services: I'm glad to see there was some progress there. You set up a contract review committee to review proposals of greater than $25,000. I just wanted to ask how that's going, and did you have Aon Consulting go before that board? Could we see what the deliberations were? If you could pass that on to us, that would be great.

The Chair: Thank you.
Ms Blakeman, please.

Ms Blakeman: Thank you. I'm referencing the report of the Auditor General on seniors' care and programs. On pages 18 and 19, particularly, it's talking about housing and long-term care facilities. My question is: has there been any work done in this fiscal year to examine the housing stock? In particular I'm thinking about the age of it. I'm thinking about plumbing pipes. What kind of insulation is in the walls? What work has been done to identify the age and the status of the housing stock that includes the lodge program and long-term care facilities? I'm mindful that the government does not own all of these facilities, but I'm assuming that there is work that happened to monitor them. What are the results of that? I'm looking for what risk factors have been identified here.

Ms Evans: Could we actually just flag that for, perhaps, Seniors' response as well? It's the view of my staff that we might have to co-operate on this response, on the lodge piece.

Ms Blakeman: It shouldn't have been in the year we're looking at, but okay. Yes, certainly.

The Chair: A cross-ministry initiative. Certainly.
Seeing no other questions, Dr. Morton.

Dr. Morton: Thank you. Several of my constituents in Foothills-Rocky View have travelled to private clinics in Montreal, Vancouver, and London, England, to purchase needed surgery in a timely manner. Some of them have told me that they've been reimbursed by Alberta Health for the cost of these surgeries, and others tell me that they've requested reimbursement but been turned down. My question is: during the year in question, 2004-05, did Alberta Health reimburse any Albertans for surgical procedures done in private clinics outside of Alberta, and if so, how many and how much money in total?

The Chair: Thank you very much. We will await those answers.
That concludes this portion of the meeting with the Hon. Iris Evans. On behalf of all committee members, I would like to thank her and her staff for their commitment to the committee this morning. We appreciate it.

Ms Evans: We would thank you for your patience and attentiveness. We'll get those comments back as soon as possible.

The Chair: Okay. Thank you. Please, while we're winding up the rest of the meeting, feel free to leave. Okay?
Now we have item 5 on the agenda, Other Business, and Mr. Dunn. We're going to circulate some information that has been provided to us by the Auditor General. Mr. Dunn, please proceed.

Mr. Dunn: If I could just hold the committee's attention for a moment. Two pieces of information are being circulated. One is on training for Public Accounts members and MLAs regarding the use of performance measures. You are making use of performance measures as you refer to the annual reports of various ministries, and it picks up on the questions that you're asking about what outcome measures versus input measures are.
I'm handing out a publication on a seminar which does take place while the House is sitting, on May 8 and 9 in Victoria. Five different jurisdictions, representatives of Public Accounts Committee members, will be there. Should Alberta wish to attend or have any people attend this, this is an opportunity for something which is very near and very close, and it will discuss the uses of performance reporting. Alberta is more advanced than other jurisdictions, but you might benefit from the interaction with others, both federal and provincial jurisdictions, around that performance reporting. A representative of my office, Ronda White, will be making a presentation on behalf of our office regarding how this is being used and explained to MLAs.
The second piece of information is an extract from a report that's going to come out that some of you are familiar with, and that's again around uses and users of performance reporting. It does provide to legislators 13 basic questions you can ask. I've taken the liberty to circulate that extract, but we'll bring it to your attention when that publication is officially produced. I understand that it will be produced in the month of April, and we'll make sure copies of that come to all of the members here. It is a follow-up by that group that some of you know, CCAF. It is now being translated in both official languages and should be available for your use in the month of April. We'll want to get a copy to each of the members on this committee through the clerk.

The Chair: Thank you.
Mr. VanderBurg, you have a brief comment?

Mr. VanderBurg: Mr. Dunn, you're saying that it would be valuable for a couple of members of this committee to head to that?

Mr. Dunn: To the conference in Victoria? Yes, I believe it will be valuable.

10:00

Mr. VanderBurg: So if there were a couple of members, I'm imagining that that would come through your budget. You'd sponsor us. Is that what you're saying?

Mr. Dunn: I would like to think it will come through the committee's budget. This is not a very expensive conference.
Picking up on what the minister just mentioned about the use of public-sector dollars on conferences, we don't want to misuse them. However, this is a relatively modest cost, and the out-of-pockets should be very, very simple and very low also.

The Chair: Thank you.
Is there any other business for the committee this morning? No?
I would like to remind members that the date of the next meeting is next Wednesday, of course, March 22. We will be hearing from the Minister of Environment, Mr. Guy Boutilier.
If there are no other items, may I please have a motion to adjourn? Mr. Lindsay. Moved by Mr. Lindsay that the meeting be adjourned. All in favour? Opposed?
Thank you very much.

[The committee adjourned at 10:01 a.m.]