Title: Wednesday, September 12, 2007 Public Accounts Committee
Date: 07/09/12
Time: 10 a.m.
[Mr. MacDonald in the chair]

The Chair: Good morning, everyone. I would like to call this Standing Committee on Public Accounts to order, please. There was an agenda circulated to all members. May I have approval of that agenda first off?

Mr. Strang: So moved, Mr. Chairman.

The Chair: Thank you. All members received the link to the agenda and materials on August 31, and updates of course have followed. Now, it's moved by Ivan Strang that the agenda for today's meeting, September 12, be approved as circulated. All those in favour?

Hon. Members: Agreed.

The Chair: Seeing none opposed, thank you very much.

It is my pleasure to chair this meeting this morning, and of course it's with officials from our Capital health region. I would like to welcome on behalf of all the committee members the entire delegation from the Capital health authority. We look forward to discussing your 2005-06 and 2006-07 annual reports, and we thank you for getting that material to us in a timely fashion. The members and the researchers and the clerk: we all appreciate that.

Now, you do not need to touch your microphones. Our *Hansard* staff here will turn them on and off for you.

Perhaps we can now go around quickly and introduce ourselves, starting with the vice-chair.

Mr. Prins: Thank you very much, Mr. Chairman. Good morning. My name is Ray Prins. I'm the MLA for Lacombe-Ponoka.

Mr. Hlus: Hello. I'm Brian Hlus from Capital health. I'm just flipping slides.

Dr. Massolin: Good morning. Philip Massolin, committee research co-ordinator, Legislative Assembly Office.

Mr. Eggen: Good morning. My name is David Eggen, and I'm the MLA for Edmonton-Calder.

Mr. Rodney: Howdy, if I may say, from the southwest part of Calgary. Dave Rodney, Calgary-Lougheed.

Mr. Herard: Good morning. Denis Herard, Calgary-Egmont. Welcome.

Mr. Johnston: Good morning, and welcome. Art Johnston, Calgary-Hays.

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

Mr. Chase: Good morning. Harry Chase, Calgary-Varsity.

Mr. R. Miller: Good morning, and thank you for being here. Rick Miller, MLA, Edmonton-Rutherford.

Mr. Bonko: Good morning. Bill Bonko, MLA, Edmonton-Decore.

Dr. Predy: Gerry Predy, medical officer of health for Capital health.

Mr. Wilkinson: Neil Wilkinson, chair, Capital health.

Ms Weatherill: Sheila Weatherill, CEO, Capital health.

Mr. Merali: Allaudin Merali, executive vice-president and CFO, Capital health.

Mr. Mondor: Al Mondor, board member, audit chair and finance committee chair, Capital health.

Dr. Gardener: Ken Gardener, vice-president, medical affairs.

Ms Staples: Jane Staples, office of the Auditor General.

Mr. Dunn: Fred Dunn, Auditor General.

Ms White: Ronda White, office of the Auditor General.

Mr. Dunford: Good morning. Clint Dunford, Lethbridge-West.

Mr. Cenaiko: Good morning. Harvey Cenaiko, Calgary-Buffalo.

Mr. Webber: Hi. Len Webber, Calgary-Foothills.

Dr. Brown: I'm Neil Brown, Calgary-Nose Hill.

Mr. Strang: Good morning. Ivan Strang, West Yellowhead.

Mrs. Dacyshyn: Corinne Dacyshyn, committee clerk.

The Chair: Hugh MacDonald, Edmonton-Gold Bar.

At this time I would like to recognize the hon. Member for Edmonton-Castle Downs, Thomas Lukaszuk, who has joined us, as has Laurie Blakeman from the fabulous constituency of Edmonton-Centre.

Our Standing Orders in the Legislative Assembly allow any member to participate in a committee, but they cannot vote. So if Ms Blakeman or Mo Elsalhy or Thomas want to participate, they're quite welcome. They just cannot vote in a matter that's presented to this committee.

Now, I understand that you have a brief opening statement, Ms Weatherill, and after we're going to have a PowerPoint presentation. You can please proceed, and we're going to clear out of the way so everyone can see here at the front. Yesterday we had a little trouble with the PowerPoint presentation, and hopefully that will not occur this morning.

Ms Weatherill: I'll turn it over to our board chairman, Neil Wilkinson, who will begin.

Mr. Wilkinson: I don't have a PowerPoint, so you can leave the lights up if you want for my talk. Sheila, who speaks next, will have PowerPoint.

Thank you very much. Thank you, Mr. Chair and committee members. Let me say on behalf of all of us that it's certainly a pleasure to appear before the Public Accounts Committee, your committee. You know, we take our accountability to you and to the people that we serve very, very seriously.

Capital Health, as many of you know, plays a key role in the Alberta health system, serving people not just from within our own region itself but from across central and northern Alberta as well. The Capital health board works with many stakeholders to assist in our governance role, including nine community health councils,

municipalities, and others. Although much work remains for sure, we are somewhat proud, we must say, of the progress that we have achieved on your behalf, on behalf of all Albertans, and we take our work and our responsibility very, very seriously. We are hearing, and you probably are as well, fewer concerns from the public as our board and staff are working very hard to improve access and to build healthier communities.

We have some gains – and I want to talk just about three of them very, very briefly – on the public side. Number one, suicide rates. They have decreased in the last 10 years from approximately 18 per hundred thousand in 1996 to 13 per hundred thousand in 2005. Number two, heart disease death rate has decreased from 185 per hundred thousand in '96 to 138 per hundred thousand in 2005. It's interesting that the percentage of daily smokers in 2005 was 19 per cent, down from 23 per cent in 2001, but probably more important than anything else is the fact that over 90 per cent of people living in their own homes said that they were not exposed to second-hand smoke. Of course, these improvements have been achieved through co-operation with our partners and the public.

We also work hard to ensure value for the money for the resources we receive. Most of that money comes from the provincial government, so we'd like to recognize the provincial government of Alberta for their work in establishing and refining the regional health system. Regionalization, in our view, is working very well, and it's giving us the opportunity to work with other regions to build a co-ordinated health system.

Now I'd like to talk about our audit. In 2005-2006 we received recommendations from the Auditor General, and we've now implemented all of his recommendations. In 2006 in co-operation with the Auditor General we made a substantial structural change with the establishment of a separate board audit committee, allowing us to give greater focus to the audit process. During this year's audit the auditors noted progress with the actions taken by the board and management on the previous year's recommendations.

We have a copy of our annual report for 2006-07, which you have, and it includes our financial statements. You'll also know by looking at it that no major issues were identified by the Auditor General and Capital health. As we always have every year since our inception, we received a clean audit report without reservation or qualifications.

We want you to know, particularly the people gathered here today from Capital health, that we appreciate the relationship we have with the Auditor General and the ongoing advice provided to us and to our audit committee and to its chair, to myself, and to others.

Now, I'd like to ask Sheila Weatherill, our president/CEO, to discuss more of the highlights of the organization's performance for the year 2006. She will be using a PowerPoint presentation.

Thank you.

Ms Weatherill: Thank you, Neil, and good morning, everyone. Before I start with my comments, I'm sure you're wondering what this little bottle is. We thought about bringing flu vaccine and giving you your flu shot but decided that might be going too far. This is the latest thing in hand sanitizer. It costs about $1.50, and we wanted you to take it and keep it in your pocket for flu season. Also, we've given you a couple of handouts, one on the new way of treating stroke, especially for people that live outside major centres, and some success in tackling diabetes. Those are for you to take away.

In the next few minutes I'll give you a bit more detail on 2005-06 and '06-07, and I wanted to close with some comments on how we see the future. My first slide is a map of our region, of where Capital health sits in the province. I think this is a good slide to show the role we play in supporting our referral area, the 1.7 million people that we serve in addition to the 1 million people that live inside Capital health. We support other regions not for basic services or primary care services but for complex services, and increasingly we're putting in place technology and new services that allow people to remain in their own community and still get the care of a specialist living down here in Edmonton.

We also play a major role, in part because of our geography, working with the University of Alberta and other postsecondary organizations in training the health workforce and also in doing research. In this past year we've worked hard in helping the Northern Lights health region to become stabilized and more recently with East Central.

10:10

I wanted to give you some of the factors that we see as key elements in the cost of Alberta's health system. There are seven of them. Population growth is key. I know you hear a lot about that. It's not just affecting health; it's affecting all things in the province. Every store you go past has a help wanted sign in it. The population growth in this province is really having a major effect on the health system.

Also population aging. Sometimes I think the public thinks this means that we just must need more continuing care beds, but it means that we have a lot more people in their 50s and in their 60s, and people do need to see doctors about having early arthritis or high blood pressure. We're doing way more joint surgery, and this is all a part of the fact that we have more older people and the population is aging. Also, we have many more very old people, and we are able to do many more procedures on very old people. Somebody said to me yesterday: 90 is the new 80. New technology is allowing us to do procedures on people in their 90s when even a few years ago we would never have thought of it. A good example is a friend of mine. Her dad's family physician said that, really, heart surgery wouldn't work on him. When he went to the specialist, the specialist said: no, we can fix your heart. This very elderly man went home fully recovered, bought a new car, and is still golfing and curling.

I know that we've started to talk a lot about the increase in chronic disease, also a major factor in the cost of the health system. We'll have doubled the diabetics by 2016. Obesity, in my view, is really an epidemic, and this is one of the key areas where we have to focus. We have new drugs, new technology: very expensive. We can be circumspect about it, but if it's your child that needs a service or your relative, then cost becomes irrelevant. The public is very active in advocacy on this front.

On Friday we did our first prostate surgery with a robot. The robot cost $4 million – the Stollery family actually gave us quite a bit of the money towards that – but this robot did the surgery with very little blood loss, absolute precision, no big incision, no side effects, and the patient doesn't have to stay in the hospital very long. So, of course, everybody is going to want a robot. We've now got one clot-buster drug, $2,700 per dose, and those are drugs that are given to people in the ambulance now when they're having a heart attack. You'll read in your handout about clot-buster drugs in the use of stroke.

One of the problems we have is that we're short of people, and that's driving our labour costs up, so we were thrilled with yesterday's announcement. But we have a lot of Albertans that want to work in the health field, and we do need to train more. We are in Alberta; the public wants the best of everything here.

I wanted to move on to tell you what our resources are buying, and are there improvements. The answer is yes. We are making improvements. It's hard, it's slow, and people still talk to us about

wanting to receive services faster, but we are making progress. You can see that we are looking after more patients that come into hospital, but those patients are sicker. That's what we call acuity.

We've started to see a reduction. We started to see a reduction in 2005 in the wait time for joint surgery, and this has been something that we've been able to sustain into this year. We've seen an increase in our emergency room in the number of very, very ill patients, but we've also seen a decrease in the number of patients that can actually get their care from their family physician through a primary care network or who can call Capital Health Link. We're very pleased that the number of emergency visits is fairly stable.

So more of everything. We're trying to increase services to match this growing population. In the years '06-07 we had a banner year on new babies: 15,000 new little people became members of our population. Some people have called this a baby tsunami. Again we added beds, and again we improved our joint wait time and actually reduced the number of people waiting for joint surgery. Amazingly this year, even with the number of people who use the emergency room being sicker – that's an increase in acuity – we have actually virtually no growth in emergency departments.

Some other success stories. One that's not on here is that we've been able to slow the growth of dialysis from 12 per cent per year, which it was just a few years ago, to 4 per cent in this year. So we are seeing progress but are still very challenged by the growing population. How we see the future is, of course, that demand will continue to grow. This province is booming, and we are expecting even more babies this year, with a population continuing to age.

I wanted to reassure you and let you know that there is real change under way in Alberta. When I am in other provinces, I feel very proud to be here as part of the Alberta health system because we have a lot under way, a lot of change that is very fundamental: primary care networks – I know Ken will talk later about that – the electronic health record, which has been hard work, but we are making gains; starting to see improvement in how we're managing chronic disease; and much better collaboration among regions. We do need to do things differently, and we do need to make as much change as we can to ensure that this health system we have come to be so interested in and so dependent upon is something that we can sustain.

Those are my opening comments. Let me end, then, by saying six things that we need to do for the future. Find people at risk for chronic disease and intervene early, and it's the intervening early that's really key here. One of the things that has been just a really surprising success for us is that using our electronic records, we've been able to find all of the people that live in our region who are at risk for diabetes. That allows us, working with their family physicians, to actually get treatment under way and help people change their lifestyle so that this disease can be prevented.

The second thing we need to do is optimize the use of technology. A great example there is that rather than having ICU nurses enter all of the information from monitors using a pen on a paper chart, that now can happen all electronically right from the monitors themselves.

We need to expand and maximize the health workforce. For every training spot in the health workforce there are four Albertans who would like to enter a training program. We do a very good job of training people, and we need to maximize and expand this workforce. In one of our urgent care centres in Sherwood Park now almost 50 per cent of all patients that go there are not seen by a physician. They're seen by a nurse practitioner and never need to see the physician.

I'm a big believer in increasing personal responsibility and being more forceful in encouraging people to have mammograms, to be immunized, and to take responsibility for their own personal health. We'll see health costs impacted by that. Those of us administering the health system need to manage costs – recently we were able to get into a longer term software contract which allowed us to double the discount we received from the company – and, lastly, recognize health as an economic asset, a big trade advantage for companies and employers. It allows them to be very competitive with the Americans because we have a publicly funded health system and, of course, Alberta's big interest in growing the biotech industry.

Thank you very much, and I now look forward to your questions.

10:20

The Chair: Thank you very much for that.

Mr. Dunn, do you have any comments from your reports?

Mr. Dunn: Yes, I do. Thank you, Mr. Chairman. As mentioned by Chairman Wilkinson, we made a number of recommendations to the management of the Capital health authority following our March 31, 2006, financial statement audit. Those recommendations included that all program changes be processed through the change management system, a comprehensive review of the estimates and underlying assumptions used to calculate the allowance for doubtful accounts for patients, strengthening their cash count processes, and regarding management estimates in financial statements ensuring that accrued liabilities only include amounts meeting the criteria under generally accepted accounting principles.

The latter issue resulted in our recommendation 35 on page 126 of volume 2 of the Auditor General's annual report, that you have a copy of, wherein we recommended that management of CHA provide its audit and – at that time also – finance committee with complete and accurate financial information. I was particularly perturbed that our audits were finding significant errors, primarily in the accrued liabilities of CHA, and that we had reported that matter to management for the last three years. Management committed to me last year that this matter would be addressed, and you should ask management how they did address this matter in the current, 2007, fiscal year.

In addition, I took strong exception to the business case analysis supporting the early repayment of the authority's long-term debt, incurring an early repayment penalty of $880,000, which is described on pages 127 and 128 of our 2006 annual report.

In our management letter to CHA for the year ended March 31, 2007, we reported that the recommendations on the previously mentioned matters had been adequately implemented. In addition, a long outstanding recommendation regarding conflict-of-interest processes, which is described on pages 131 and 132 of our 2006 annual report, had also been implemented. You may want to ask them how they managed to implement all those last year.

You should be aware that our audit opinions on the financial statements for each of the years ended March 31, 2006 and 2007 are unqualified.

As the committee is aware, our 2006 annual report also includes several systems audits that affect all health authorities and those we discussed yesterday regarding food safety, RHA global funding, and seniors' care and programs.

Those, Mr. Chairman, are my comments. I and my staff will answer any questions addressed to us.

The Chair: Thank you very much, Mr. Dunn.

There's quite a list already from the members interested in asking questions, and we'll start with Mr. Bonko, followed by Mr. Strang.

Before Mr. Bonko gets started, it is the tradition of this committee

that there be a question from the opposition, then from the government, then back to the opposition, and they each have a follow-up question. If we could be brief in our questions and concise in our answers, it would be beneficial to the committee.

Please proceed, Mr. Bonko.

Mr. Bonko: Thank you, Mr. Chairman. I will acknowledge that you do have a difficult role. Everyone has an opinion on health care and how it should be managed, considering that it takes up probably 40 per cent of the provincial budget.

On page 3 of the Capital health region 2006-2007 annual report it states that "one of the key benefits of regionalization has been the coordination of health promotion and wellness with service delivery." How does the region co-ordinate the transfer of patients with the Calgary health region?

Ms Weatherill: Transfer of patients between ourselves and any region is most of the time done formally through a telephone line that's staffed 24/7 and has a critical care aspect to it, so if the patients are very ill, physicians are brought on the line, up to as many as 30 physicians. Sometimes transfer of patients is done by physician-to-physician contact, but typically when I'm thinking of our major referral area, which is northern Alberta, if there's somebody very ill in, say, Fort McMurray, the initial call goes in to the critical care line. The physician is on the line from Fort McMurray. Any number of specialists are brought on the line here in Edmonton. A decision is made about the appropriate method of transfer if the patient is to be transferred, or often support is given to the local physician to allow the patient to remain there.

Maybe I'll ask Ken if he has anything to add.

Dr. Gardener: All patient transfers between health regions, whether it's Edmonton and Calgary or other regions, are driven by physician-to-physician contact and referral. Once the decision is made to transfer, then we have the resources within our regional patient transport office, which is also where the urgent care line and critical care line are housed, to co-ordinate that transfer with either ground transfer or air transfer.

Mr. Bonko: Okay. My follow-up one: was Capital health contacted by the Calgary health region prior to transferring Karen Jepp? That was the woman who delivered the quadruplets in Montana.

Ms Weatherill: Yes. We had been in contact, and in fact senior administrative staff from Edmonton and Calgary and relevant physicians are meeting in the next short while to discuss the situation and what we might do differently and how other regions could be involved as well.

The Chair: Thank you.

Mr. Strang, followed by Mr. Chase.

Mr. Strang: Thanks, Mr. Chairman. First of all, I want to thank the Capital health authority very much for the co-operation that they give the two health regions in my area, Aspen and Peace Country health. It's certainly appreciated.

In your 2006-2007 annual plan on page 64 it shows that emergency visits have not really increased. Why are people waiting longer, and what is Capital health doing to reduce the time that patients are in the emergency department?

Ms Weatherill: Well, the good news is that we are making progress on the length of time people are waiting. Our emergency rooms are extremely busy. This is caused by a couple of things: a very rapidly growing population, and we are short of beds and putting in place beds as quickly as we can and are making progress in that area. In the last short while we've started a big initiative to try and completely re-engineer the emergency room processes, and I will ask Ken to talk about that in just a minute. But what I wanted to tell you was that our wait time for patients in emergency has actually dropped by about 20 per cent. Still lots of work to be done there, but we are making progress. This is the biggest single attempt, the broadest attempt, the most comprehensive attempt we've ever taken on to try and completely rethink how emergency departments are working.

I'll turn it over to Ken.

Dr. Gardener: The pressures that the emergency departments not only in Capital health but across the province and across the country face are primarily due to the flow of patients through the system. It is not fundamentally an emergency department problem, so what we had to do was look at this from a system throughput perspective. We have 15 different strategies that we have outlined. Some of them start before the patients get to the emergency department in partnership with our ambulance providers and end up going right through to continuing care and community placement to facilitate the move through.

We have implemented a number of these now. The most notable ones are that we now co-ordinate the management of our beds through single points. No longer do individual units manage their beds. We manage them centrally within the sites and regionally. We are implementing patient care case management to initiate discharge planning right from the day of admission so that we are improving our throughput. We have implemented a full-capacity protocol, which is a system whereby when the emergency departments reach a certain level of pressure with patients waiting to be admitted, these individuals are admitted to extra spaces within the units. These extra spaces are not in hallways, but they are extra capacity that the units have that allows the emergency department to decompress and ensure that we can get timely access to individuals who are coming in the door. We are also doing the same thing within our continuing care environment with that sort of full capacity process. So we have other implement strategies yet to develop, but we are making progress.

10:30

Mr. Strang: Okay. Thank you. I guess I've got a supplemental question. We're always talking about more staff, including physicians, that are required in our system. Why are we not using the international medical graduates to fulfill this need?

Ms Weatherill: It's a good question, a question we get frequently. We are making progress. Over the last few years we've started to bring international medical graduates into this system and give them roles that then allow them to become qualified to take the residency training here in Alberta.

I'll ask Ken to give you the details.

Dr. Gardener: Just for clarification, we have always recruited international medical graduates. "International medical graduates" means they are physicians who are trained outside Canada. There are two categories of IMGs. Some international medical graduates are eligible for full licensure by the College of Physicians and Surgeons. The determination of eligibility to get a licence to practise is under the purview of the college, not the regions. For those individuals we continue to and have always recruited them. A

large number of physicians working in our region were trained elsewhere.

The other group is international medical graduates who are not determined by the college to be eligible to get a licence. These are the individuals that we have, with the support of Alberta Health and Wellness, set up a training program for, that has now been running for several years, that allows them to enter the workforce and to work under the supervision of a licensed physician in providing care within our acute care system. So we have been successful in training these individuals. They are now working in the health system and providing care. As Sheila referenced, some of them we have actually trained well enough that they have become prime candidates for the Alberta international medical graduate program, which then provides them with postgraduate training through residency training, that is a route to full licensure. So I think the province wins that way because we get additional physicians, and obviously the international medical graduates benefit from that as well.

Mr. Strang: Thank you.

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

Mr. Chase: Thank you. As a former Alberta chair of Friends of Medicare I have concerns about the privatization/profitization of public health services. On page 41 it states that this region has "developed an innovative partnership with Pfizer Canada for expansion and delivery of our Chronic Disease Management Program," and page 34 states that "chronic disease is the new public health epidemic. Cardiovascular disease, cancer, diabetes, respiratory disease and arthritis continue to be major causes of illness, disability and death in the region." Referencing Auditor General Fred Dunn's opening remarks, is there a potential conflict of interest in having a major drug company work with a health region to combat an epidemic of diseases that have drug therapy as a major component of their treatment management?

Ms Weatherill: My simple answer is no. There is not a conflict of interest. We have very strict policies and guidelines to determine the type of relationship that we would enter into. I'll ask Allaudin Merali, who is lead for this area, to expand.

Mr. Merali: As Sheila mentioned, we are very careful in terms of endorsements that we get, and even when we get an endorsement, it is very contained in what their role would be. The role of Pfizer on this diabetes one was mostly to help us with some of the promotional stuff. All the strategy and all the health services decisions are made by our clinicians, and there's no involvement by the pharmaceutical company.

Having said that, there are a lot of clinical trials that are supported by pharmaceuticals that are done as part of the research program that exists in collaboration between us and the university. There is an ethics review done for each of those trials before they're implemented. It's a very rigid process to make sure that we and our clinicians are not in any conflict of interest.

The other side to it is that obviously we have a lot of relationship with a lot of vendors because of the scale for procurement. We do get a lot of a good value-adds from those vendors. So we try to squeeze as much as we can in trying to get as much other support from these companies without impacting our core services.

Mr. Chase: Thank you. I'm very aware that drug costs are one of the major contributors to the increased costs of health delivery.

My second question: what percentage of health services or delivery costs does Capital health contract out to private providers?

Ms Weatherill: Quite a small percentage, actually. We may have to get back to you on that. We have contracts with a number of continuing care providers and contracts with home care service agencies, laboratory services.

Mr. Chase: I'll look forward to the further details. Thank you to all members.

The Chair: Thank you.

The chair would like to remind the delegation from Capital health that if you have any additional information, if you could provide it in writing through the clerk to all members, we would be grateful.

Mr. Dunford, followed by Mr. Miller, please.

Mr. Dunford: Well, thank you, Mr. Chair. First, though, clarification. We're early on in the presentations and in the questioning, but already we see we've moved from 2006 to 2007. So my comment would be – and I would ask if I'm correct – that just because a presentation talks about the future or just because an annual report might make some reference to something, you know, that is in present rather than in the past, in my view that doesn't change the mandate of this committee. This committee, as I understand it, is structured so that we look at public accounts, not policy, and we look at what has happened in a previous year, not current year. Am I on the right track here?

The Chair: You are certainly correct. We were dealing with the Auditor General's annual report, and we're also dealing with the annual reports of 2005-06, 2006-07 of this health authority. We dealt with this yesterday. The chair was very lenient in giving mostly government members lots of scope. There were policy questions directed from Mr. Cardinal to representatives from the northern health region. There didn't seem to be any problem then, and I don't see any problem today. Mr. Strang, for instance: his second question made no reference to an annual report whatsoever. So please proceed with your question.

Mr. Dunford: Well, I'm okay as long as I know what the rules are. I don't have a problem.

The Chair: The chair has been very lenient, and it has worked to date. So please proceed.

Mr. Dunford: All right. Thanks.

What I'm curious about is wait times. Over the years that I've been around, it has been quite interesting how comments from the public, especially to MLA offices, have changed. But the one that seems to be most prominent and has been the most prominent for the longest period of time is, of course, the wait times. We all know that once you get into the system, it's a very good system in Alberta, but it's agonizing for a person that has been diagnosed and their families when they can't seem to get in. So when we're presented with information like services in 2006-2007 showing reduction in wait times, now, that's good. What I want to hear, though, is a comment: is that taking us from good to great, or is it from really bad to not so bad? How far are we away from what would be considered actual reasonable targets?

10:40

Ms Weatherill: In the case of the progress that's been made in Alberta – and I can speak to our own region – in wait time for joint surgery we've made real progress, and we benchmark very positively across Canada. In other areas we've made good progress with

CT scans, good progress with cataracts, but we're a growing population.

I just want to make a comment on the public. It's my view that the public has quite a bit of tolerance for waiting a reasonable period of time, but they need predictabilities. So we're working hard to be able to say to people that here's the range of time that you'll wait. We think that if people know that within the next three or four months they'll get in, then they can get on and plan their lives. It's when we are not able to give that certainty.

We've made progress in people waiting to get in to see their family physician. That's part of this primary care network change here in our region. We've made real progress in that area.

I hope that's answering your question. With the joint replacement surgery Alberta benchmarks very well across Canada.

Mr. Dunford: I want to with my supplemental focus on emergency times. I realize that we're short-staffed, but I would assume that a health authority would not short-staff an emergency room. You still hear – and it's anecdotal, again, because of either phone calls to an MLA office or I'm just sitting in conversation and people tell me things, recognizing that if they had a good experience, I'd probably never hear about it. You know, I realize that it would be like waves – there would be high times and low times – but on average has there been improvement in emergency wait times given the labour shortages that you might be experiencing?

Ms Weatherill: Well, summer was a challenge, for sure. We like to give people their vacation. As I said, overall we've seen about a 20 per cent drop in wait times in our four major centres, which are where we've started our big project, back to my earlier point about needing to train more people and get more of these people that want to work in the health system into the training programs, so they can support our workforce.

Something else we're doing that we're just trying right now is that when people are in emergency and they're waiting and they're not a trauma patient or critically ill, we're trying a new approach by giving people a pager and telling them that we'll page them. They can go away and wait somewhere else or go shopping, and we'll page them when their time comes up. Other organizations have tried that sort of thing with good success. Again, trying a variety of things.

The need for predictability for emergency wait times is there as well, and the real breakthrough will come when we are able to offer more alternatives to emergency care, like urgent care centres like the one we have in Strathcona and the one we'll be opening in Eastwood, also when family physicians are more able to offer care outside of their regulars hours, and that's starting to improve as well.

Ken, anything to add?

Dr. Gardener: The emergency departments clearly work on what we call a triage system, and that is that the acuity, the severity of the condition with which the individual presents, determines their place in the queue. So we have maintained very, very rapid response to individuals who come in as triage levels 1 and 2, who are the sickest individuals. Triage levels 4 and 5, the ones that are not as ill based upon their presentation, we have seen other avenues being taken by these patients. As a reference, we are seeing fewer and fewer of these individuals in the department. The triage level 3s are the ones that typically we focus on the most with concern. The number one cause for longer wait times in emergency is when the emergency capacity is negatively impacted by individuals who have been seen, and a decision to admit has been made, but they have nowhere to go. So this is where things like the full-capacity protocol, where we guarantee that 75 per cent of the capacity in the emergency department will be available for new patients coming in, allows us to improve the throughput and reduce the wait time.

We still have work to do. No jurisdiction that I'm aware of has actually solved this, but we are definitely making progress. We have seen significant improvement in those wait times since initiating our emergency services and system capacity project.

The Chair: Thank you.

Mr. Miller, please, followed by Mr. Webber.

Mr. R. Miller: Thank you, Mr. Chairman. As you folks are most likely aware, we had East Central health in front of us yesterday, and there were a number of questions regarding infection control and sterilization. I note on page 9 of appendix A in your most recent annual report, which you've conveniently numbered as page 90, for those of you who are wired – I might be the only one – you outline a key performance strategy to implement a multiyear strategic regional infection prevention and control plan. I'm wondering if you could tell us what supports were provided to East Central health after the infection control problems were revealed this spring.

Ms Weatherill: Yes. Thank you. Actually, through Dr. Gerry Predy's staff as well as our nursing staff we did work very closely with East Central in a variety of ways to support their ability to continue with sterilizing and providing adequate infection prevention and control services, but I would characterize it as really providing our staff to support them being able to get services in place to support themselves. For example, one of Dr. Predy's staff actually was on-site. Our staff provided advice on a daily basis. There were daily meetings that involved Dr. Gardener and Dr. Gardener's counterpart there. So very, very comprehensive. Where necessary, supplies were provided. So a broad range of supports.

Mr. R. Miller: My supplemental. It would probably be unfair to ask you to provide here today a breakdown of the cost to your region, but I'm wondering if you might be able to provide that in writing to the committee at some point.

Ms Weatherill: Yes.

Mr. R. Miller: Thank you.

The Chair: Thank you.

Mr. Webber, please, followed by David Eggen.

Mr. Webber: Thank you, Mr. Chairman, and thank you, Ms Weatherill, for your presentation. In your presentation you compared the health inspections from '05-06 to the '06-07 health inspections, which increased significantly, over 25 per cent, up to 50,000. What I'd like to know is: did these health inspections include food inspections? The reason I ask that is because of some findings that our Auditor General reported in his report from '05-06, where on page 4 he states: "8 of 9 RHAs haven't met inspection targets. Follow up and enforcement are lacking, so places with poor safety practices continue operating." So I guess my question, then, is: what actions have you taken at Capital following Mr. Dunn's report?

Ms Weatherill: Thank you. Actually, I'm happy to let you know that we did meet our targets, and I'll turn it over to Dr. Predy for some detail.

Dr. Predy: Yes. Even though we did meet our targets when the Auditor General did his review, we have taken all of the Auditor General's recommendations and implemented them. For example, one of the concerns that was cited was the fact that there are violations that the inspectors find that then aren't corrected. So we are not only meeting our targets on inspection, but one of the things that we've implemented is to be sure that our inspectors, when they do find a violation, go back and correct it within a reasonable period of time. Our information system is monitoring that, and our supervisors are monitoring that to ensure that these violations are corrected.

As well, even prior to the Auditor General's report we did recognize that food safety was a problem and did increase staff. So some of the increase in inspections was an increase in staff but also just looking at all the aspects of the AG's report and implementing them. We're working along with the other health authorities as well because we know that one of the issues was that there are not common inspection systems across the province. So we're working with all the health authorities to try and adopt a more common inspection system and, again, bring up the quality of all inspections across the province.

10:50

Mr. Webber: Great. Thank you. Well, you just answered my second supplemental. So thank you, Mr. Chair.

The Chair: Thank you.

Mr. Eggen, please, followed by Mr. Herard.

Mr. Eggen: Well, thanks, Mr. Chair, and thanks to all of the members of the Capital health delegation for coming this morning. My questions are to do with having private contracts with societies or businesses to provide services. I have a specific concern that I think we saw borne out in Monarch Place in Red Deer, where the Innovative Housing Society had a contract to provide assisted living accommodation in the city of Red Deer and then pulled out from under that responsibility and sold the building. I know that Capital health also has contractual arrangements with the Innovative Housing Society. In fact, I have a facility in my constituency, and it's causing a lot of concern.

The first question is: have you established protocols in the last few years to check on the financial health and viability of societies under businesses that Capital health enters into partnerships with so that we can ensure that what happened in Red Deer doesn't happen here?

Ms Weatherill: We were aware of the situation in Red Deer, and we do have protocols in place to monitor continuing care facilities, including their business health, their business viability.

Mr. Eggen: So could I be reassured to know that the Innovative Housing arrangement, private contract with this establishment is being monitored closely so that, as I say, we don't see this happen again, in Edmonton? I would be very concerned about that.

Ms Weatherill: Yes, it is.

Mr. Eggen: Thank you.

The Chair: Thank you.

Mr. Herard, followed by Mr. Bonko.

Mr. Herard: Thank you very much, Mr. Chairman. Just a note to begin. I've been trying to understand, you know, just exactly what contributes to cost escalation and cost drivers. I went to your website, and there are annual reports there from 2000 all the way to the present day, none of which have financial information in them. Any of the schedules that I could have used to determine or to learn something about what your particular cost drivers have been weren't there, so I had to resort to just what's here before us, which is really two annual reports.

One of the areas that, of course, influences cost is the salaries and benefits. I look at that from 2005 to current, and I see an 18.8 per cent increase there, which pretty much seems to be in line with what health care has been going up over the last number of years. But when I look at specific areas where those costs are being derived, there are two striking anomalies. One is other management persons reporting to those above, which is really your executive team. That has gone up by 37 per cent. Then when I look at the executive team itself, that has gone up by 58 per cent. I guess that I need to understand what the cost drivers were to make that happen.

Ms Weatherill: We will be putting our financial statements on the website, just to let you know that.

The challenge of remaining competitive for public-sector organizations is real with the boom in the Alberta economy. We do benchmark all salaries and do that twice a year. So we are trying to stay on top of what we need to do to keep our people. Our people are frequently headhunted away from us by private-sector companies. You would think that somebody who is a health professional may not be headhunted by a private company, a nonhealth company, but in fact they are. So the key reason for salary increases is retaining people and recruiting people. We are very careful in benchmarking not just with health organizations but with others.

Mr. Herard: Thank you. The second question is on page 167, which is schedule 2, continued. There's a table there that talks about accrued obligations, March 31, 2006, and March 31, 2007. There's $5.7 million worth of accrued obligations. Could you help me understand what that's about.

Ms Weatherill: I'm sorry. I wasn't able to hear.

Mr. Herard: Could you help me understand what that's about?

The Chair: The page number again?

Mr. Herard: Sorry. Page 167, schedule 2, continued, and it's talking about accrued obligations, '06 and 07.

Ms Weatherill: Okay. Yes.

Mr. Herard: There's $5.7 million there, and I'd like to understand how that happened.

Mr. Merali: Thank you for that question. It's page 167 of the annual report. This is in line with what the Auditor General had recommended, saying that on the pension obligations we need to make sure that there is disclosure of what the liabilities for pension are. We've broken it down between what is the current cost and for the prior year and so on. So this is in the interest of time to have full disclosure regarding what is going to happen on the pension liability.

Now, these are not cash payments to the individuals in the plan. They are actual estimates of what the liability is at that point in time.

Mr. Herard: Thank you very much.

The Chair: Thank you.

Mr. Dunn: Mr. Chairman, maybe I could just add to that.

The Chair: You certainly can.

Mr. Dunn: Mr. Herard has asked us a couple of times. Indeed, it's the reason why we made the recommendation, and we made it to Finance last year, about disclosure of the SRPs, these supplemental executive retirement plans.

Mr. Herard, really, part of the answer to your question is that the SRPs have come in over the last couple of years, and they are very, very expensive obligations. That's why we made an issue last year to make sure that you got all the costs on one schedule. You'll remember that there was a concern about the Calgary health region, and did people properly understand the compensation? The SRPs are a very expensive pension fund. What this is is the amount of the obligation owing, by individual, as at that point in time as explained. That's the amount that's owing to the plan for those individuals, which will be paid out. It's earned at this point but will be paid out postretirement.

Mr. Herard: Mr. Chairman, as a result of that, could the Auditor General please indicate how far back the service goes that amounts to these particular dollars?

Mr. Dunn: They'll go back to the time the accrued benefits will cover. So some will go back to a stage when it was started or the stage of the introduction of the plan. Each of the health authorities will be able to explain exactly when the service commenced to that date.

This is a disclosure which is new this year. That's why we were interested to have the March 31, '07, statements in front of you. You're now seeing the amount of these SRPs that are being created. It is getting to be a very large number across the public sector.

The Chair: Thank you.
Mr. Bonko, followed by Mr. Rodney.

Mr. Bonko: Thanks, Mr. Chair. Over the next 10 years I feel that our health care system will face its greatest test. How confident are you that the long-term plans at best will meet the ever-changing needs and costs?

Ms Weatherill: Thank you. As I said earlier, the key thing for us as our population grows and ages over the next 10 years is to consider sustainability in the context of changing how we do things. I have hope when I see us advancing primary care networks, groups of family physicians working together with the health authority, with other health professionals, with more emphasis on chronic disease, with more emphasis on prevention. I'm an optimistic person. If we continue making the changes that need to be made, I believe our health system will be sustainable.

11:00

Mr. Bonko: Okay. In follow-up, how does the region guarantee that residents in public/private nonprofit continuing care facilities are all receiving the same standard of care?

Ms Weatherill: Well, there are expectations and specific standards and requirements irrespective of the operator of a facility of deliverables, and that is monitored. We have new standards. The implementation of those standards is under way. We've assessed and evaluated a large portion of the existing facilities. So it's through the setting of standards and the ongoing monitoring.

Mr. Bonko: Thank you.

The Chair: Thank you.
Mr. Rodney, followed by Mr. Chase.

Mr. Rodney: Thank you, Chair. I have two questions. The first one is quite specific, the second one a little bit more general.

On page 40 of the '05-06 Capital health annual report the region indicates that it's committed to addressing population health priorities; specifically, healthy aging, injury prevention, obesity. I see you nodding your head. You know exactly what I'm probably getting at. I know from your opening comments that we can add smoking cessation successes to that list. My constituents and, I think, Alberta taxpayers would be served well if they knew some specifics of that. In other words, I think there is more good news that could be told. Can you give us some specifics related to those topics: healthy aging, injury prevention, obesity, and even smoking?

Ms Weatherill: I'm just going to turn that over to Gerry. That's his area.

Dr. Predy: Thank you. Yes. One of the things that we did early on in looking at population health was identify some priorities because there's such a broad array of things you can address, so we felt that we needed to really focus down on these things.

I can give you a couple of examples. For example, in injury prevention one of the things we looked at in our data was the fact that we have a high rate of injury and death from car crashes. When we looked at, "How do we prevent car crashes?" we recognized that it wasn't necessarily within our own jurisdiction; we had to work with some other partners. So we set up a partnership with our police departments and our municipalities as well as the Alberta Motor Association to look at some of the things we can do. One of the examples is that we looked at all the intersections in the region and identified the high-risk intersections and then worked with the municipalities to re-engineer those for the police to increase enforcement there and then worked with a social marketing campaign to educate people about needing to slow down at the intersections. So we've adopted that strategy and have actually seen a decrease in the rate of hospitalizations due to motor vehicle crashes over the last five years. In the last year it's kind of crept up a little bit, but we have had some success in that area.

Tobacco reduction is another one, where I think, as was mentioned earlier, we have seen a reduction in smoking rates and in large part by working through a comprehensive strategy, not just one thing that worked. We tried to work with our municipal partners to bring in bylaws to restrict smoking, to work with the schools to again advise kids about the dangers of smoking as well as to bring in cessation programs for adults who smoke so that they can get off tobacco. Again, a comprehensive approach in both of those areas has resulted in some success.

Mr. Rodney: Did you want to comment on the other two, healthy aging or obesity? We're hearing a lot about both these days.

Dr. Predy: Yes. Well, with obesity we've established a regional program called weight wise. It's a comprehensive set of interventions, everything from working with people who are overweight or obese and getting them into medical treatment or actually surgery, if they require it, to prevention. We have our nutritionists or

dietitians doing public education. As well, we're working at the policy level with some of our partners, like the municipalities, to look at community design to ensure that when new communities are designed or old communities are redesigned, they're designed in such a way that health activity is promoted. You don't have to get into your car to go to the grocery store; you can have something in the neighbourhood that you can walk to. So those kinds of things although those are longer term objectives, but we are looking at those issues. So far, I guess, our rate of growth in obesity and overweight has kind of leveled off. It's not going down, but it's not going up anymore. We're hopeful that we will see that rate come down.

Healthy aging. We've got a number of initiatives there, a major one on falls prevention because, again, we know that one of the major issues for older people is falls. We've got an initiative looking at falls within our facilities – long-term care facilities, acute-care facilities – as well as working in the community. We've designed a program called steady as you go, that's implemented by volunteers in the community, again looking at that issue and working with the academic institutions to look at some other initiatives in healthy aging that we hope to bring into play in the next few years.

Mr. Rodney: Okay. Thanks.

The Chair: Thank you.

Mr. Chase, followed by Mr. Cenaiko, please.

Mr. Chase: Thank you. Just to follow up on the previous question. I'd like to read into the record my support and appreciation of Dr. Francescutti of the Capital health region and Dr. John O'Connor of Northern Lights, who have both been lobbying the government strongly on driver safety initiatives, both on the twinning of highway 63 and, Dr. Francescutti especially, on the contribution of cellphones towards accidents and their role in getting rid of them while driving.

I'd like to again reference accountability concerns raised by Auditor General Fred Dunn. On pages 127, 128 of volume 2 of the 2005-06 Auditor General report it states that Capital health borrowed $29 million: in 2000 for a parkade at the University of Alberta hospital and $19 million in 2005 for the Capital health centre. Capital then repaid the debt out of its cash in 2006 to reduce the accumulated surplus by $27 million. Since the debt was repaid before its maturity date, the region was on the hook for an early repayment cost of $880,000. According to the Auditor General, "the business case analysis supporting the debt repayment was superficial and flawed in its logic." My question: what was the benefit of repaying the mortgage early and accepting an $880,000 penalty?

Ms Weatherill: Thank you. Before I answer the question, I wanted to just let you know that there was a policy change so that loan repayments now at a certain threshold are approved by the board, both the threshold based on the size of the loan but also the size of the penalty. We did believe it was a good business decision, and our assessment of the business case saw us having a savings of about $2 million even after paying the penalty.

Mr. Chase: Thank you.

Mr. Dunn, please feel free to contribute to the answer to the next question.

Mr. R. Miller: He could also contribute to the answer to that question.

Mr. Chase: As well. I'm providing the spotlight transfer here.

My second question, then: was the Auditor General ever provided with an adequate business case analysis to explain the debt repayment?

Mr. Dunn: The business case analysis that we were provided with – and it took some time to acquire it – showed at the end of the day, if you'd strung out all the payments over the life of the debt, how much would be paid at the stipulated rates, which were generally, as quoted in here, around about the 5 per cent range. What it did was it compared it to what is the current rate of interest one would receive on a chequing account. Of course, if you have got a 2 per cent spread over 25 years, it would appear to be very large. The questions, though, that you're asking are very important: what are you doing with all the cash in your bank account, and why would you leave all that cash in your bank account for 25 years? You see?

You may also want to supplement your questions over to me, Mr. Chairman, at this point. What was the rate of interest you were receiving on your investment accounts? As we know from the heritage fund over the last five years, they've received over 8 per cent. So if the heritage fund and AIM can invest prudently and receive an 8 per cent return, what is the health authority investing in? You'll see from the financial statements that the health authority has very large investments, in excess of half a billion dollars, and they have large amounts in their bank account. What is their investment strategy and investment policy which would cause you to borrow – and it's for the 107th Street buildings – $20 million in one year and pay it back the next year? You always had the cash. You always had the amount.

If the analysis is simply a comparison of the stipulated rate which you agreed to one year earlier compared to the current bank account, I don't accept it because nobody would do that. Right? You don't borrow long-term debt to put into your current bank account. You borrow long-term debt to acquire long-term assets. The reason you borrowed the long-term assets is that you would receive a larger rate of return on those long-term assets than the rate of borrowing. Thus I still cannot get it through my head why one would borrow one year, repay it the next year, incur a large penalty, and try to support it by way of an explanation compared to what I might have received if I'd left it in my chequing account. It just is, as I've said here, superficial and fundamentally flawed logic. I'll leave it to the chief financial officer to explain the logic of your treasury management investment strategy.

11:10

Ms Weatherill: Al Mondor is going to respond.

Mr. Mondor: Yeah. Thank you, Mr. Chair. We don't dispute the recommendations of the Auditor General. We certainly have accepted them, and we've certainly implemented everything that he's recommended. We don't have any issues with respect to the analysis that he's done. Our analysis was different. As a result we've appreciated his input, and we've now modified our processes to approach this differently in the future.

The Chair: Thank you.

Mr. Cenaiko, please, followed by Rick Miller.

Mr. Cenaiko: Thank you very much, and again thank you very much for being here this morning. As the chair of AADAC the issues in the Capital region with relation to drug abuse, alcohol abuse, the issues related to approximately 2,500 individuals that are homeless here in the city of Edmonton and the surrounding area, and as well the issues related to mental health: I want to get some

feedback regarding programs that you have. I just want to ask you for the steps you've taken as Capital health regarding working with organizations and the health care of these individuals that do have diseases which are related to alcohol and drug addiction.

Ms Weatherill: Thank you. Well, we have a very good relationship with AADAC and work very closely with them. Capital Health Link actually provides support to people who are trying to quit smoking, so we have tobacco support there. But what I want to focus on is the fact that where we can, we try hard to collocate with AADAC staff. For example, in the new facility that's being opened in Eastwood, the primary care centre there, the health centre there will have AADAC staff on-site. There are many, many initiatives where we see AADAC as a full partner. I'll maybe turn to Gerry for more specifics.

Dr. Predy: Yeah. We've certainly built some relationships with our mental health staff and AADAC because we know that a lot of people with mental health problems have alcohol or drug addiction problems and vice versa, so recognizing that we need a joint approach to treating those people.

We deal with a lot of people with substance abuse problems, of course, on a day-to-day basis across a variety of our programs, so what we've tried to do is, again, build in some particular links to AADAC so that we can make those referrals easily. As an example, we've had AADAC counsellors in our hospitals and emergency departments to ensure that people get quick service if they decide they want treatment for their addiction, but also we have some more preventive type programs. We have something called health for two, that works with pregnant women, especially those who are more susceptible to substance abuse problems and try to, again, during the course of their pregnancy get them off the substance and get a healthier birth.

We also have programs that support children and families that are at risk of substance abuse. We have things like the Success by 6 early start kind of support program. Working as well on identifying kids with fetal alcohol spectrum disorder, there are some new initiatives there that our staff, our community nurses, and our mental health staff are involved with and, as well, supporting needle exchange for those people who are addicted to injection drugs. We don't just provide needle exchange, but we also provide other supports for people who are exchanging needles so that if they do need a medical treatment, we'll provide that to them and, again, try to encourage them to seek treatment for their addiction although many of them are not quite ready at that point.

So a number of areas where we have programs, some of which are aimed specifically at people with addictions, but some that are just trying to in the normal course of our provision of treatment get people into treatment programs. As well, we've tried to encourage a number of our physicians to get trained in methadone prescriptions so that, again, we can have a better capacity with addicts who want to get off the street drugs. So, again, lots of initiatives in this area.

The Chair: Thank you, Dr. Predy.

Mr. Cenaiko: My second question is related somewhat. As well, though, in yesterday's meetings with East Central I asked a question on how many regions we probably should have in the province, but we didn't get much of an answer there. I won't put Sheila or Neil on the spot, but what I would like to talk about is: with the regions that we have now, are there definitive standards and provincial standards in place regarding procedures and/or programs between Calgary and Edmonton, between Capital health and Chinook, for example, to ensure that we are complying with provincial standards and/or standards in the province so that we don't hear this issue related to "Well, we provide better health services in Chinook than they do in Capital"?

Ms Weatherill: Thank you. Let me start by saying that when I look back five years ago, I see a lot less of the type of point that you're raising about "We do something better in one region or another" because a lot of what happens in a region depends on what particular medical staff happen to be in the region. If you have a lot of orthopedic surgeons in a region, you're going to be doing more orthopedic surgery in your own region.

I would say that there has been a lot of maturing of the health regions and a lot more collaboration, good examples of working together, and this has been really fuelled and supported by us being able to be more electronic. There are frequently collective decisions made about which region is going to do what types of service, and there is much more benchmarking than there used to be. There's not a hard-and-fast place to go that says what services each region should provide because in part in the specialty area it's related to what physicians are there.

A couple of examples of where things are dramatically different are where we've been able to use telehealth and other electronic support to bring specialist physicians closer to remote areas, and this really does level access. It does very dramatically improve access for constituents and residents living in the rural areas. This new way of treating stroke: when you are having a stroke, you can stay in your own hospital and have your CAT scan read by a specialist in one of the large centres, and that specialist can tell your family physician in your home community how to give the clot-buster drug, you know, with full recovery. I mean, this is just amazing.

The collaboration is better. The decision about which region is going to be in or out of a particular business: those decisions are made collaboratively now, and there's much less sort of negative competitiveness.

The Chair: Thank you.

We'll move on now to Mr. Miller, followed by Mr. Johnston.

Mr. R. Miller: Thank you, Mr. Chairman. In 2001 your Capital region financial statements showed your noncurrent cash and temporary investments at the end of the year at approximately $105 million. In 2005-06 the annual report shows the same account, noncurrent cash and temporary investments, at $483.8 million despite the fact that over that time you were for the most part reporting deficit budgets and only recently started showing surpluses. I'm wondering if you can offer an explanation for the dramatic increase in that account.

Ms Weatherill: Yes. Thank you. In part it's related to changes in processes and rules, but I'll ask Allaudin to give you the detail.

Mr. Merali: Are you talking about the noncurrent cash?

Mr. R. Miller: Yes.

11:20

Mr. Merali: The noncurrent cash relates to money that we get primarily on capital projects. As we have many projects on the go right now, we'll get advances from the province. That money is then used to pay for all the construction projects that we have under way like the Mazankowski Heart Institute, the Robbins pavilion. So it really represents a growth mostly in the construction projects.

I just want to emphasize that the interest on the money that we get for the capital projects is kept in an account called a CCITF account, where the interest is earned by the province, so the interest does not flow through to any health authority. The interest is kept by government. It's just that the money is advanced to us to pay for the bills associated with those capital projects. It really represents the magnitude of the capital projects at that fiscal year-end compared to what was the case in 2001.

Mr. Dunn: Can I just help a little bit with Mr. Miller there? Just to pick up on your answer there, Allaudin, you showed investment and other income in 2007 at $110 million.

Mr. Merali: On the income side?

Mr. Dunn: Yes.

Mr. Merali: Investment and other income also represents not just purely investment income. It also includes WCB rebates. It includes payments that we get for the alternate payment plan for physicians. That's why the category is investment and other income. It's not just purely investment income. Having said that, we have also done a good job in getting more interest income on the accounts that are managed by the region.

Mr. Dunn: Note 16 breaks it down and shows investment income of $31 million. That's not a small amount. I think what Mr. Miller is asking: you've got sizable investments there, and it is returning some amount; $31 million is not a small amount.

Mr. Merali: No. Absolutely not.

Mr. R. Miller: My supplementary would be, then: in light of the Auditor General's earlier comments can you briefly outline for us what the investment strategy is, and how can you assure us that the residents of the region are not suffering, not doing without some services, based on the rather sizable amount of dollars that are currently sitting in the bank?

Ms Weatherill: The investment strategy is set by the Finance Committee and approved by the board and reviewed on a regular basis. I'll invite Al to respond to that question.

Mr. Mondor: I think it should be pointed out that the cash is not cash that's idle, sitting there. It's basically spoken for. It's not like we can take the cash and use it elsewhere. The cash is sort of there, waiting to be dealt with with respect to commitments that have been made under the capital projects, primarily an amount for the noncurrent cash and amounts that are eventually paid to suppliers. So it's not cash that's free, I guess, that's loose. It's basically already earmarked for ultimately being paid to the suppliers and the builders.

Mr. R. Miller: If I might, Mr. Chairman – and I know this is almost a third question – I am confused, then, because Mr. Merali just indicated that the interest earned goes back to government and we don't get it, yet you're telling us that you've got $31 million invested and that this is creating wealth for you although the money itself is seeming to be the same money that Mr. Merali indicated you don't earn money from. So I'm confused as to the investment income.

Ms Weatherill: I can clarify that. The money earned on the fund that we hold for capital projects, the interest earned on that, does flow back to government.

The Chair: Thank you.

Mr. Merali: If I can supplement that, when we talk about the money that we hold, there is one component that's for capital projects, and there's another component for paying the ongoing operating bills and so on. That's the one that generates interest. That is the reason why we say interest revenue in the financial statements: because they are different components of the cash that we hold. That's what I was talking about.

Mr. Mondor: Mr. Chair, there are two cash accounts on the balance sheet. There's one under current assets called cash and temporary assets, and then there's another account below called noncurrent cash and investments, and there's a reference in note 4 which explains the breakdown of that. The one that's explained in note 4 is the cash that's held for capital projects. Again, it's not cash that you can use elsewhere. Similarly, with the cash under current assets, that money will be required to make payments to suppliers that are yet to repay bills, or their payments aren't due yet. That doesn't represent any kind of surplus. I guess that's what I'm telling you.

The Chair: Thank you very much.

We'll move on to the next question, please. Mr. Johnston, followed by David Eggen.

Mr. Johnston: Thank you, Chair. Capital health treats people from out of province at the interprovincial in-patient per diem rate, and I'm looking at the recovery. Is it 100 per cent recovery? Is there a percentage? How do we recover for out-of-province patients?

Ms Weatherill: Thank you. The interprovincial rate is set through a process between the ministries of each province, so we're not involved in the setting of the rates. It's set at the ministry level, and it changes. I believe we're approaching full cost recovery or are at full cost recovery.

Mr. Johnston: How do we go about collecting that? I'm just curious. My own curiosity here.

Mr. Merali: Well, if it's a resident of another province, Alberta Health has done a good job in being the main vehicle. We can send our invoices to Alberta Health, and then they work with the other provinces to collect the money for their residents. This way it's a more streamlined process rather than us trying to bill each of the provinces directly. All of the health authorities co-ordinate with the ministry, and the ministry then collects it from the other provinces. This is where there'll be Albertans accessing services in other provinces as well, so they go through a process of transferring funds between provinces. But we work with the ministry to get our funding.

Mr. Johnston: Okay. So are they taken on on an emergency basis? How do they fit in our system? How do we get them in?

Ms Weatherill: I'd say both ways. Some people are visiting here from other provinces and need service here. In other cases there are arrangements between provinces for certain services to be delivered. For example, here in the Capital region we provide all of the pediatric heart surgery for the prairie provinces and all of the complex heart surgery for the prairies plus B.C. That's a formalized arrangement. So some of both.

The Chair: Thank you.

David Eggen, please, followed by Mr. Strang.

Mr. Eggen: Thanks, Mr. Chair. My questions are to do with the Auditor General's report concerning seniors' care. On page 191 of the Auditor General's report there was a range of deficiencies that were identified that wanted correcting. I just wanted to ask what steps Capital health was taking to deal with these issues. What measuring sticks did you have in place to recognize your success?

Ms Weatherill: Well, we support the recommendations and support the development of standards and are now in the process of implementing these standards. What we've done locally is that we've asked every site to develop an action plan to implement the new standards, and we are auditing compliance. So far we've audited 14 of our 28 sites. Those audits are completed. We've also developed two new information initiatives which link our cost to outcomes and quality and are developing scorecards. We've looked at every physical plant and had a look at them, but again the key area is implementing the recommendations, the provincial standards.

Mr. Eggen: Thanks. Further to that, I just wanted to ask how the program to move individuals from long-term care to daily assisted living fits into that. I'm having difficulty understanding the logic that's taking place across the province in view of the deficiencies that we're seeing in seniors' care. We are losing long-term care positions in favour of daily assisted living positions across the province, and while it's certainly admirable to look for innovative solutions such as daily assisted living to deal with the increased needs of seniors, certainly that shouldn't be done at the expense of losing long-term care spaces.

11:30

Ms Weatherill: In the Capital health region we've actually increased the number of continuing care beds that we have as well as assisted living spaces, and we are pausing this year and having an evaluation done of assisted living to make sure it's actually doing what we thought it was going to do. Many, many clients are very positive about it, but we see an increasing acuity, and we need to make sure we've got the right match, the right proportion of beds. Something that's key is that we keep adding continuing care capacity each and every year. It helps us make the best use of our hospital beds and helps us keep the system moving.

Mr. Eggen: Thanks so much.

The Chair: Thank you.

Mr. Strang, please, followed by Mr. Bonko.

Mr. Strang: Thank you, Mr. Chairman. I guess that where I want to come from this time is on mental health. As you realize, it goes through Children's Services, through Education, and of course you people have quite a significant amount. As I look at from 2005, '06, '07, I notice that your caseload in 2007 is down, and I'm just wondering: how are you co-ordinating with those other two departments I mentioned on this, especially with the young people?

Ms Weatherill: I'll try and answer your question. Mental health: a lot of demand in the area of mental health, and we've put in place a regional plan. We're just partway through implementing it. We've put a lot of effort into increasing community-based crisis intervention services. We've expanded our eating disorders program, with a lot of people needing that service. We're working very hard to co-ordinate with other agencies like AADAC because a lot of people with mental illness also have substance abuse problems. We have a large referral area that depends on us for mental health as well.

Maybe Ken can add something to this.

Dr. Gardener: I would appreciate, maybe, a repeat of the question to get the specific of what you're looking for.

Mr. Strang: Well, maybe what I'll do is go with my second supplemental, and it'll sort of bring it all into line. I guess what I'm looking at is the aspect of zero to six. You know, with young children about 50 per cent of the diagnosed problems are with the younger ones in that age group. Back in 2005 we had $25 million over three years for the mental health innovation fund, and of that, Capital health got $8 million. But we have one agency, CASA, the child adolescent services association, and basically they only got $85,000, only 1 per cent. I guess I'm wondering how we work with these different nonprofit organizations, for one, as well as the other two government agencies that I mentioned.

Ms Weatherill: We'll get back to you specifically on the question about CASA, but there's very good co-ordination with other agencies. A good example is that if you're a senior citizen, there's one single access point for all mental health services for seniors, so one place to call for a family physician or a family member.

But on the specific question of funding to CASA, we'll get back to you on that.

The Chair: Thank you very much.

Mr. Bonko, please, followed by Mr. Dunford.

Mr. Bonko: Thanks, Mr. Chairman. You somewhat touched on it, but I just want maybe a little bit more clarification. On page 50 of the '05-06 annual report it states that approval was given for $647 million in capital grant funding, which will add an additional 455 acute beds. How long will it take for these beds to be operational and fully staffed?

Ms Weatherill: Well, from the information I showed you at the beginning, we're adding beds every year, and just to be trite here, we're doing it as quickly as we can. We have experienced some delays in some of the construction, but we've had good success on our plan to free up all the space inside our hospitals that can be converted back to beds. I think this year we're adding about 150 more hospital beds. It's the same challenge of the growing population. We're thinking about how many more beds we'll need into the future. Good progress, but it's a challenge.

On the question of staffing, again, we would like to see more training spots for the large number of people in Alberta that want to work in the health workforce, and we were pleased with yesterday's announcement. We're moving as quickly as we can. It's a big concern to us, and it is one of the issues that causes us a backup in the emergency departments.

The orthopaedic centre at the Royal Alex is well under way. We've got Eastwood under way now. It doesn't have beds but will have an urgent care centre that will take pressure off the emergency room. A big expansion at the Royal Alex is under way. We will be moving patients into the Mazankowski Alberta Heart Institute in the first week of May. So we're moving.

Mr. Bonko: Okay. So ideally, then, these new acute beds would help reduce the emergency wait times.

Ms Weatherill: Yes.

Mr. Bonko: Okay.

The Chair: Thank you.

Mr. Dunford, following again by Mr. Chase.

Mr. Dunford: One of my pets, as other members of the committee now know because this is the third time that I've talked about it, is farmers' markets. I love trade shows anyway, but I particularly like farmers' markets. What I've noticed is little signs starting to show up about organic. I've always had fun with black words on white paper, how neutral words can take a positive or a negative usage in the general language that we use. Discrimination, for example, is a neutral word, but if you said, "You're discriminating," that's negative. Prejudice would be another one. You know, you can show a positive bias to something.

I'm a little worried about organic. I'm a little worried that people are starting to associate the word "organic" with healthy and pure. I guess I'm almost saying exactly what I did yesterday, that those of us that have grown up in rural areas know that there are some really dangerous critters out there. So if somebody is not using pesticides or herbicides or whatever and these little fellows come in on a leaf of spinach or something like that, there are a lot of people that are going to get really, really sick.

I'm curious. How does Capital health deal with farmers' markets within your jurisdiction?

Ms Weatherill: I'm going to ask Dr. Predy to respond to your critter question.

Dr. Predy: Well, farmers' markets are treated like other food outlets. The operators of the market have a food permit, and we do inspect them regularly or go in on a complaint basis.

Your point is well taken. We know from what we've seen recently that there have been a number of outbreaks of disease on imported produce. Alberta Agriculture is also interested in this, so we're doing a little project now with them. We're going around to some of the farmers' markets and collecting, particularly, vegetables and fruits and actually testing them to see what the microbiologic quality is. Now, we're not focusing specifically on organic, but we do know that some of the producers at the farmers' markets do call themselves organic. So we'll have a better picture after we do this project. If there is any danger, where does it lie? Are the organic people putting us at risk because of more microbiologic contamination or not?

We know that the flip side of it is that people are concerned about the chemicals, as you said, pesticides. Again, we're trying to get some better information so that we can then provide better advice to consumers, but it is an area where I think we need to do more research.

11:40

Mr. Dunford: So my supplemental would be: is there anybody either now or in 2006 and 2007 working on an actual definition of organic?

Dr. Predy: We don't, but that would have to be referred back to the appropriate government agencies: agriculture, consumer affairs. It wouldn't be up to us to define that.

The Chair: Thank you very much. I hope you can both get together at the Strathcona farmers' market this Saturday and check it out.

Mr. Chase, please, followed by Len Webber.

Mr. Chase: Thank you. The 2005-06 annual report discusses several mental health program initiatives. When Dr. Sam Tsemberis of New York City came to Calgary last month, he indicated that providing 24/7 supported housing cost a third of a drop-in centre mat. Therefore, there is a fiscal as well as a moral argument for being proactive. My first question: how are mental health programs integrated with affordable housing initiatives in the Capital health region?

Ms Weatherill: We've agreed and will be involved in the design of any new affordable housing. We've asked to do that, so Dr. Predy's staff and others will be involved. We provide service within that environment or other environments for people with compromised accommodation. Maybe I'll ask Dr. Predy to add to that.

Dr. Predy: Yes. Our mental health staff do do assessments on people's needs, and for those who require some form of supportive housing, we work closely with the housing providers to ensure that the housing that is in place is safe. We look at it from a number of perspectives, including things like "Are the windows large enough?" and all those kinds of safety things. But it is a challenge at this point because there isn't a good supply of low-cost housing. What we've seen, unfortunately, over the summer is that a number of homeless people have had to live in tents. We've been working with our municipality as well as with the housing providers to try and place all these people in housing before the cold weather comes. We're making progress although we're not quite there yet. As Sheila said, as new housing is being built, we are involved in that, but right now we're sort of playing catch-up because there isn't enough affordable housing. Again, people with mental illness are the ones who often bear the brunt of not being able to get into the housing.

Mr. Chase: It's noted that just simply putting a roof over a person's head, especially if they have a mental illness or an addiction, isn't going to keep them under that roof, so the support is necessary.

When Capital health develops a new program, how does it analyze the costs and benefits?

Ms Weatherill: We work hard to do that on any new initiative. A high-level principle that we have is to look at what's working and what's not working. We do provide also to government information on something we call cost of health outputs, which helps us look at value for money and the services that are provided and what they're actually costing, et cetera. We do, as I say, have as a principle the need to evaluate services because the system is changing, and one of the main drivers of change is the value that a connected or electronic system can bring.

Mr. Chase: Thank you.

The Chair: Thank you very much.

Mr. Webber, please, followed by Mr. Miller.

Mr. Webber: Thank you, Mr. Chair. I want to go back to food safety. I asked a question earlier, and I've asked questions with previous health regions. I'm fixated on food. Again, it's more of a comment than a question. Mr. Dunn reported that eight of nine RHAs haven't met the inspection targets, as I mentioned earlier. I just wanted to congratulate the Capital health authority because of the fact that they have met the blue book targets for completing inspections. I think that's quite an accomplishment, so I congratulate you. Keep up the good work.

Mr. Dunn reported here that it is a lack of inspectors that is commonly blamed for not completing the targets. A very quick question to Dr. Predy. The number of health inspectors in the Capital health region: could you give me an idea of how many you do have?

Dr. Predy: I'd have to get back to you on that. It's in the order of 50, but I can't give you the exact number. Just in terms of a supply of health inspectors, again, a number of the rural regions have had difficulty recruiting, but we've worked with one of our local postsecondary institutions, Concordia University, to develop a training program. It's been very successful and has grown, so I think we're making some progress in getting a supply of people out there. I'll undertake to give you the exact number. I can't tell you off the top of my head how many staff we have.

Mr. Webber: Great. I just wanted an estimate, and that gives me an idea. I know that in your comment rural Alberta definitely is having difficulty with placing inspectors around the province. Fifty in the city: that's significant, I think. So thank you.

Thank you, Mr. Chair.

The Chair: Do you have another question?

Mr. Webber: No.

The Chair: Okay. Thank you.

We'll proceed, then, to Mr. Miller, followed by Mr. Strang.

Mr. R. Miller: Thank you, Mr. Chairman. My question is regarding electronic health records. Page 41 of the '06-07 annual report discusses electronic medical records and even claims that a report by PricewaterhouseCoopers "noted that a higher investment in information technology improves a hospital's business performance and creates a cost reducing effect." My question is: have any of these services for electronic health records been contracted out to foreign-owned companies, and what would be the cost of those contracts?

Ms Weatherill: Thank you. There's no foreign involvement in electronically reading any of our scans or X-rays or whatever, so there's none of that that we do. We do have competitive processes for when we're securing software or consulting advice or project advice, and several countries other than Canada do bid on that work.

Mr. R. Miller: "Have you contracted to them?" was the question.

Ms Weatherill: Yes. I think we have a contract with a New Zealand company and with Americans.

Mr. Merali: The portal, the viewer which displays the electronic information for the clinicians: our clinicians were quite involved in doing the search of what is available from a software perspective so that it meets their needs. Having gone through a competitive process, they agreed that the product from a New Zealand company, Orion, was the one that was best suitable in how the information was displayed to them. The actual data and all the health service aspect of it does not reside outside of our region. The software that we use is one that was produced in another jurisdiction, but the health services, all the clinical data, all the information about patients, lab results, and so on is maintained within our region within our data centres.

Mr. R. Miller: Thank you. My supplemental question would be: what risks has your region identified in moving from paper to electronic health records?

Ms Weatherill: Well, thank you. Very much on the minds of the public, of course, are privacy risks. We've worked very closely with the Privacy Commissioner and the staff of Alberta Health and Wellness. We're very contemporary in our approach to that and constantly upgrading and modernizing to reduce the risk. We have good policies in place and benchmark frequently to ensure that we've got the most comprehensive policies. I'd invite anyone on our team to add to that, but we obviously take it very seriously. We're committed to advancing the electronic agenda, and we have to do everything to minimize risk.

11:50

The Chair: Thank you very much.

Mr. Strang, please.

Mr. Strang: Thanks, Mr. Chairman. Reviewing your 2005-06 revenue stream, I see where your fees and charges accounted for 7.1 per cent. What I was wondering about: have you considered looking into additional charges? I guess an example I could use is charging for hospital meals.

Ms Weatherill: Yes. Thank you. Well, we actually had an idea given to us by a patient. We are looking into this one, so it's at the top of my mind; that is, for obstetrical patients wanting enhanced services like larger towels in their rooms, Internet access. As we're getting ideas from the public, we're looking at them. Again, based on advice and feedback from the public, who said that they think it would help them if they could not have to worry about parking their cars, we've introduced a parking service so that a patient can be dropped off at the front door, and someone else will park their car for them. So those are the sorts of things we're looking at.

Mr. Strang: Okay. It sort of follows into my supplementary. Are there any other areas where costs can be offset by charging a reasonable fee for services that are nonessential to the delivery of primary health services?

Ms Weatherill: Thank you. Some of that is definitely policy that we would follow if that was the direction of the ministry. For nonessential services we do look for opportunities, again primarily when good ideas have been brought forward. We work hard to ensure that our food services for the public are profitable and have looked at a variety of other ideas, again, when they've been suggested. A suggestion a few years ago was that a flat registration fee might be something that was of interest. But many of these things need to be done on a province-wide basis, and we look to government for direction on this.

Mr. Strang: Thank you very much.

The Chair: Thank you.

Mr. Eggen, please.

That will be the last question, and then we will read the rest of the questions. We still have a long list.

Mr. Eggen: Okay. I'll move very quickly.

The Chair: Go ahead.

Mr. Eggen: Okay. I'm a bit concerned about the system capacity program that you've put into place. I'm wondering: is this a temporary measure, or is it going to become standard procedure? I mean, logic tells me that if you're shifting patients from one place to another, you're going to put a strain on other systems and services in the wards where they have these extra people. Are you monitoring that? Is this going to become permanent policy, or is it just kind of a triage thing until you can increase your capacity?

Ms Weatherill: Thank you. We are evaluating full capacity protocol and very actively evaluating it and will do it on an ongoing basis to determine if it is something that we should leave in place. One of the key elements in having good throughput and timely care in emergency departments is having enough beds in the overall system, and we've talked this morning about the work that we're doing to add additional beds. It's still very early. We've only had full capacity protocol in place for a few months, so we need to get some more experience to it.

As Ken said earlier, the other factors are the many, many other initiatives that we have under way to support better throughput in our system to make the best possible use that we can of our beds so that when we know that somebody needs to go to continuing care, for example, there's not a delay of a couple of days while we're processing paper with that. So all of those connected changes we want to get in place.

Full capacity protocol: we're going to continue to look at it. It has made a big difference. It's made a big difference in the emergency department, and we are monitoring the impact very, very carefully.

Mr. Eggen: So could we see that analysis once it kind of emerges?

Ms Weatherill: We'll definitely look into that for you.

Mr. Eggen: Thanks.

The Chair: Thank you.

We'll proceed to questions, please, that are read into the record, and if you could respond in writing through the clerk to all members, we would again be grateful. We'll start with Mr. Herard, please.

Mr. Herard: Thank you, Mr. Chairman. On page 167 we've already discussed this liability thing in some detail. But I guess I need to know if these liabilities have resulted from a decision that a board may have made at some point in time, or in every case are these liabilities part of original contracts?

The Chair: Thank you, Mr. Herard.

Mr. Bonko, do you have a question?

Mr. Bonko: Yes, Mr. Chairman. Thank you. On page 38 of the '05-06 annual report it shows that there's been an increase in the infant mortality rate since 2000. How does the region explain this? Then on page 40 it talks about prevention of low birth weight listed as a priority, but there are no details. What specific action is being taken to target that?

Thank you.

The Chair: Thank you very much.

Mr. Chase, followed by Mr. Miller.

Mr. Chase: Thank you. On page 68 of the 2005-06 annual report it states that the opening of additional continuing care beds in new facilities was deferred due to construction delays. I would like to know first: how many patients are on lists waiting for space in a continuing care facility? How many of those patients who are on the waiting lists are currently having to be housed in acute-care hospital beds?

The Chair: Thank you.

Mr. Miller.

Mr. R. Miller: Thank you, Mr. Chairman. Further to the issue of seniors in continuing care, page 34 of the '05-06 report stated that redevelopment projects would "add over 800 new acute care beds and up to 1,000 continuing care and supportive living spaces to meet the long-term needs of our aging population." My question would be: over the last two years how many long-term care beds have been transitioned into assistive and/or supportive living beds, and what is the plan for the next five years? Secondly, has the region received any direction from the ministry regarding the affordability and availability of long-term care beds?

Thank you.

The Chair: Thank you very much.

That concludes this portion of the meeting if there are no other questions from members. Seeing none, I would like on behalf of the committee to thank all the officials from Capital health for their time this morning. You have been very gracious in providing us with detailed information regarding your annual reports. We appreciate that, and we wish you the very best in all your endeavours in providing public health care. In conclusion, I can only say to Mr. Wilkinson that we would like to be able to chair meetings in this Legislative Assembly like you chair your board meetings. You do a very good job.

Mr. Wilkinson: It was a pleasure to be here.

The Chair: Thank you. Now may I please have a motion to adjourn and reconvene at 1 p.m.? Mr. Rodney. All members in favour?

Hon. Members: Agreed.

The Chair: Okay. We will reconvene at 1. Thank you.

[The committee adjourned from 11:59 a.m. to 1 p.m.]

The Chair: Good afternoon, everyone. I would like to call the afternoon session of the Standing Committee on Public Accounts for Wednesday, September 12, to order, please. I would also on behalf of the entire committee like to welcome officials from the Calgary regional health authority.

We appreciate your time this afternoon. We look forward to discussing your 2005-06 and 2006-07 annual reports.

Now, I would remind you at this time that you do not need to touch the microphones. Our *Hansard* staff will turn them on and off for you.

I understand that you're going to have a brief opening statement, but before we do that, we can quickly go around the table and introduce ourselves. We'll start with the vice-chair.

Mr. Prins: Thank you very much. Good afternoon. My name is Ray Prins. I'm the MLA for Lacombe-Ponoka.

Dr. Massolin: Hi. I'm Philip Massolin. I'm the committee research co-ordinator for the Legislative Assembly Office.

Mr. Eggen: Good afternoon. My name is David Eggen, and I'm the MLA for Edmonton-Calder.

Mr. Rodney: Hello from Calgary-Lougheed, just down the road from where the new south Calgary health campus is going to be. With greetings, Dave Rodney.

Mr. Herard: Good afternoon. Denis Herard, Calgary-Egmont. Welcome.

Mr. Johnston: Good afternoon. Welcome. Art Johnston, Calgary-Hays.

Mr. Chase: Harry Chase, Calgary-Varsity, fortunate to have two hospitals extremely close and within his riding.

Mr. R. Miller: Good afternoon. Rick Miller, Edmonton-Rutherford MLA. Thank you for being here.

Mr. Bonko: Good afternoon. Bill Bonko, MLA for Edmonton-Decore.

Mr. Davis: Jack Davis, CEO.

Dr. Eagle: Chris Eagle, executive vice-president, chief clinical officer.

Mr. Tuer: David Tuer, chairman, Calgary health region.

Ms Best: I'm Kay Best. I'm the CFO for the Calgary health region.

Mr. Kastner: I'm Mark Kastner, communications, Calgary.

Ms Staples: Jane Staples, office of the Auditor General.

Mr. Dunn: Fred Dunn, Auditor General.

Ms White: Ronda White, Auditor General's office.

Mr. Dunford: Hi. Clint Dunford, Lethbridge-West.

Mr. Cenaiko: Hi there. Harvey Cenaiko, Calgary-Buffalo, and the MLA for the new Sheldon Chumir health clinic, that will be opening shortly.

Mr. Webber: Len Webber, Calgary-Foothills.

Dr. Brown: Welcome. I'm Neil Brown from Calgary-Nose Hill.

Mr. Strang: Good afternoon. Ivan Strang, West Yellowhead.

Mrs. Dacyshyn: Corinne Dacyshyn, committee clerk.

The Chair: Hugh MacDonald, Edmonton-Gold Bar.

Please feel free to proceed with your opening remarks. Thank you.

Mr. Tuer: Thank you, Mr. Chairman, and good afternoon. I'd like to thank you for the opportunity to meet with you here today. We do consider it to be an opportunity. We've already introduced the staff we have here today, and we'll be collectively answering whatever questions may be asked of us today.

I'd like to acknowledge the role that the Auditor General plays in our business and the role that we play in his business. We have a constructive partnership. I chair the audit committee at the Calgary health region, and I find that we have a very strong working relationship that results in the Auditor General working both as the financial auditor and as an internal management consultant for us. So I'd like to acknowledge that relationship.

We have provided a handout in advance which has most of the background material that we'll talk to in our statement here today. Just recognize that, of course, there's a lot more information in the annual reports that we're discussing here today.

I will in my comments, though, go over the Auditor General's findings and the steps that we've taken to deal with the concerns that he identified. I'll speak to the efforts that the Calgary health region has taken to ensure that we operate efficiently and effectively. Finally, I'd like to update the committee on the status of our electronic health record project, and I will speak to the issue of disclosure of executive compensation.

In 2005-2006 the Auditor General dealt with the monitoring of contract service providers' performance, using agreed service level standards and reporting timelines. The Auditor General did confirm in his report that service level standards had been appropriately established but that our procedures to monitor the service providers' compliance with standards should be improved. In 2006-2007 the Auditor General further indicated that satisfactory progress was being made in this area. What the Auditor General was primarily referring to in those comments is an outsourcing initiative the region had taken to move its human resources function outside of the health region and to a third-party service provider and the start-up pains that we had as we went through that process and the staffing that we had to leave within the region in order to monitor the performance.

In that same report the Auditor General reported that 12 of 86 internal control objectives had been met by the service provider and that the region and the service provider were working together to ensure that appropriate remedial action was in hand for the remaining. Again, in 2006-2007 the Auditor General advised that he was satisfied with our progress in this area.

In addition to the financial audit, the Auditor General reported on two systems audits, the first with respect to seniors' care. There were 22 provincial system-wide recommendations, some of which applied to the five facilities audited in the Calgary health region and five specific to the Calgary health region. The Auditor General raised key issues in respect to development and implementation of care and accommodation standards, and while we're straining at capacity, we believe – and the Auditor General supports that in his comments – that we're making good progress in collaboration with the Continuing Care Leaders' Council in ensuring that our long-term care facilities are in compliance.

The second systems audit was with respect to food safety, and the Auditor General raised two main issues. There were six provincial system-wide recommendations, of which four included the regional health authorities. None was specific to the Calgary health region. His recommendations were to improve food establishment inspection programs through recognition of the fact that we needed to increase the frequency to comply with the standards. We've added additional inspectors, standardized our approach, and certainly increased the frequency of our inspections on the high-risk facilities in the region.

The Auditor General also recommended that we improve the food safety information system. We do post orders on the region website, and we've improved the access to that information by improving software functionality.

Again, I want to point out that in a lot of organizations you'd rely on your own internal resources, primarily internal audit, to bring forth those issues so that you could deal with them. Here we have the Auditor General and his team doing that and performing the role of an internal auditor and internal management consultant for us. It's a valuable asset to the region. While we don't always agree on the conclusions, we always agree by the time we've discussed our way through them.

The region is undertaking an efficiency review, and we're undertaking the efficiency review in collaboration with the ministry and with Capital health. We're looking to review five major areas where opportunities exist to optimize our processes and outcomes.

The reason that that's an important initiative, driven again by the Auditor General's stimulus, is that health care going forward probably has to look quite different if for no other reason than we need to provide an increasing amount of health care as we all age, but we probably have access to fewer service providers. So we have to rely more on technology, and we have to change the processes in order to do that.

The areas that we're focusing on and looking at are optimization as work flow optimization for patient care, work force optimization, chronic disease management, data collection and reporting requirements so that we can analyze and perform continuous improvement, and interregional consolidation of support areas.

I'd also like to comment now on the region's performance with respect to the electronic health record and also talk about the executive compensation disclosure. In 2005-2006 we had disclosed the salary and benefit costs on a schedule separate from the retirement arrangements, or SRP costs, and that was in compliance with the standards that were provided by the department. So we were in full compliance with respect to our reporting standards. However, in 2006-2007, following some dialogue and earlier recommendations from the Auditor General, we had combined those salaries and benefits along with the SRP on the same schedule.

1:10

The region's executive compensation disclosure now adheres to – well, it's way beyond best practices. The securities administrators now have backed away from recommending going as far as we have with respect to the disclosure because of the confusion that it caused. However, the region has exceeded the required disclosure requirements as outlined by Alberta Health and Wellness financial directives for the 2006-2007 reporting year. We have additional CEO compensation slides that we can put up and discuss if it becomes something that we want to discuss further.

With respect to the region's performance on the electronic health record I should point out that the electronic health record, in our view and in our strategic plan, is the single most important initiative being undertaken by health regions today. It offers the greatest promise for changing the way we supply health services to residents of Alberta. It's a concern for every health organization today, and it performs a role in managing quality, safety, and the enormous amount of data that's associated with health care. It prevents redundancy and has a direct impact on costs.

I would like to say that the region is a recognized leader in implementing the processes, the tools, and the knowledge management necessary to implement a successful electronic health record. Today we have 15,000 staff and 2,000 physicians using our system 24/7 in our three major hospitals. It's a way of life; it's integrated into the way we do business today. The system directly supports 22,000 clinical decisions and orders that are made every day. As of March 31st of this year we've spent $109 million to develop that system: $80 million was funded externally, and $29 million was funded as internally funded capital by the region. The electronic health record that the Calgary health region has today is, I think, recognized across North America as a standard and is actually being sought after by other health regions or hospitals throughout North America.

Unless there are areas that the committee would like me to expand on, that will conclude my remarks. We are available to take whatever questions the committee may have.

The Chair: Thank you very much.

Do you have any comments or suggestions at this time, Mr. Dunn?

Mr. Dunn: I'll be very brief, Mr. Chairman, if I may, and I'll pick up from what the chair's comments have been. Quite rightly, we did have a number of recommendations that followed our March 31, 2006, financial statement audit, and as mentioned, the recommendations dealt primarily around the oversight and controls on the outsourced payroll service provider together with the controls in their own in-house computer systems. Those recommendations made their way into our 2006 annual report. If you look at volume 2, page 128, it includes our recommendation 36 regarding the monitoring of its contracted service provider's compliance and performance. So the recommendations from the management letter made their way into the 2006 annual report.

The material that was provided to you beforehand, the various slides, also dealt with our 2007 management letter for the region, and I believe you have a copy of that now. That included several recommendations relating to improving the computer change management and access controls; segregation of duties in the purchases, payables, and payments system; removing inappropriate user access privileges; approval of executive expense reports; and contracting for consulting services.

However, in addition, we also provided a status report on the progress being made in improving the controls over the outsourced payroll service provider. We note the testing carried out at the region on the procedures and controls associated with the initiation, authorization, recording, and monitoring of its payroll transactions. Those are all summarized there. I can confirm that over the last two years a great deal of audit time has been focused on the payroll function and processing at the region.

You are aware that our audit opinions on the financial statements for the region for each of the years ended March 31, 2006 and 2007, are unqualified, and of course, as the committee is aware, our 2006 annual report includes the systems audits referred to by the chair, which affect all health authorities; that's the food safety, global funding, and the seniors' care and programs. Those are my opening remarks, Mr. Chairman. Certainly I and my staff will take any questions directed to us.

The Chair: Thank you very much, Mr. Dunn.

We'll proceed. Again, we have a long list of members interested in asking questions. We will start with Mr. Chase, followed by Mr. Strang.

Mr. Chase: Thank you very much. The Auditor General's recommendation 1.7 in the June 27, 2007, letter that was addressed to Jack Davis states that in 2005 Charlebois Consulting received a $12,600 sole-source contract. As background, it's important to note that Kelley Charlebois billed the province for almost a half million dollars of verbal advice. Also, Rod Love's company, 13 strategies incorporated, received a $42,000 contract, the latter without the required accompanying documentation that would justify the decision to sole-source the contract. I would like to know what the deliverables of these contracts were, such as written reports, performance measures, something tangible, accountable.

Mr. Davis: Okay. Thank you. Those were two very small contracts, so we'd have to go back and look at them again. But in those cases the work to be delivered would have either been reports or advice, and we would have a record of that. We have since – and I'm going to ask Kay Best, our chief financial officer, to help me out here – amended our policy on contracting. I believe we've strengthened it considerably, thanks to some of the work of the Auditor General, and aligned it very closely with the internal trade barrier policy on procurement. Kay, I might ask you to comment.

Ms Best: I can speak to the specific deliverable for Mr. Charlebois. It was assistance with speech writing for public communications around our annual report to the community, part of our accountability process with the community we serve. Again, our policies. I think that, you know, we appreciate the comments that the Auditor General made. We had some documentation supporting the decisions, but we hadn't addressed specifically the points in our criteria, so we've agreed to make sure that our documentation in future covers the specific points in our policies.

Mr. Chase: My second question, then, has to do with asking the region to provide documentation to show taxpayers that they got value for their money on these contracts. I'm pleased to note that greater transparency and accountability now exist. Hopefully this is the beginning.

Mr. Tuer: Well, we'll undertake to do so.

Mr. Chase: Thank you.

The Chair: If you could do that through the clerk to all members, we would be grateful.

Mr. Strang, followed by Mr. Miller, please.

Mr. Strang: Thank you, Mr. Chairman. I guess I was intrigued with Mr. Tuer's speech there at the start with electronic health records. As I was going through this, I couldn't find any notation where you've got it expensed out, but I guess I'm interested now where you said that since March 31 of 2007 you're looking at $109 million. You know, you had $80 million from external funds and $29 million funded out of the region, so I'm just wondering: what are your capital costs going to be on this project?

Mr. Tuer: Just to clarify before we answer the question: it's as of March 31. Those were the amounts that we had spent to that point in time, not the amount that we were proposing to spend. So over the previous number of years that's the amount that would have been either capitalized or expensed against that project. With respect to the total cost of the project I'm not sure. You never know when a computer system is going to be finished, but maybe I can ask Dr. Eagle.

Dr. Eagle: The principal cost in the electronic health record project relates to a contract signed with a U.S. software vendor, which is about $40 million spread over a number of years. The major cost, however, is the staff training and the support required for configuration of that software. The bulk of the costs are training of staff, figuring out how to get the software to work effectively in a clinical environment, and for a successful implementation of a system that is absolutely critical. So the bulk of the costs are human costs within the Calgary health region.

1:20

Mr. Strang: Okay. Thank you. I guess just to follow up with that, being especially in Alberta, how much of a transient society we are, are we going to have connectivity with Alberta Health and the rest of our health regions in the province of Alberta?

Dr. Eagle: The Calgary health region is working very closely not only with the Department of Health and Wellness but also with the other health regions on projects such as the provincial Netcare portal and the health information exchange to allow that information to flow to qualified people with appropriate security so that the information may be seen from our system through that portal by a physician in Fort McMurray, for example.

Mr. Strang: Okay. Thank you very much.

The Chair: Thank you.

Mr. Miller, followed by Mr. Dunford.

Mr. R. Miller: Thank you very much, Mr. Chairman. Further on the issue of medical health records, as it has been pointed out, the Auditor General raised several concerns in his letter to Mr. Davis on July 27 regarding the inadequate controls and monitoring of financial or other information that is stored in your various computer systems. I guess my question would be: what measures have you taken to address the concerns and recommendations raised by the Auditor General? You said that you've met them, but I'm wondering what exactly you've done to address those concerns that he raised in his letter to you.

Mr. Tuer: The audit committee, subsequent to the Auditor General's comments, requested that management present to the audit committee exactly what the weaknesses were in our control system and what proposals we were putting forward to strengthen the system. As it turns out, the development of the computer systems had probably gotten somewhat ahead of existing controls, and it was simply a matter of making sure that those controls were carried out. We do that now. We've had a discussion, certainly, with management, and internal audit is taking maybe an increased focus as they look at that in the coming years.

Mr. R. Miller: Thank you. Further to that, then, I guess I was a little incorrect in the way that I worded the question because the Auditor General's comments really were about financial and data records, and my concern, then, is whether or not you've done an evaluation to ensure that other records, as in medical health records, wouldn't be exposed in the same fashion as those financial and data records were.

Ms Best: Thank you for the question. When we were discussing the results of these procedures with the Auditor General, we had exactly the same thought and then undertook discussions with our IT people to ensure that the kinds of issues that were being raised here around access and control were dealt with in the implementation of the electronic health record. We're satisfied that there weren't any issues there.

Mr. R. Miller: Thank you.

The Chair: Thank you very much.

Mr. Dunford, followed, please, by David Eggen.

Mr. Dunford: Yes. First of all, thank you for coming. This is not only, in my view, a great opportunity for members of the Legislature to get a chance to understand better the operation, administration, and governance of the health system, but I suspect, from your point of view, it's probably a great opportunity as well to get things on the record. *Hansard* is here, and sometimes it's difficult for entities to get the word out to the public through normal mass media. This is a way in which you can do that. I know that MLAs circulate *Hansard* to their constituents. You might consider wanting to do the same thing.

My interest today is in terms of workplace safety. We're in an era of tight labour markets, and we all talk about recruitment and

retention. Of course, part of the retention, then, of a productive employee is having them at work. I'm curious: in the time frames that we're looking at here, either '05-06 or '06-07, what was the safety record of the Calgary health region in terms of its employees over that period of time?

Mr. Davis: Thank you. As you know, health care, generally speaking, has a less than satisfactory record compared to other industry sectors on safety partly because of the nature of the work, with there being so many individual transactions by health care providers with patients involving lifting and carrying. Having said that, in the Calgary health region our record is a little better than most, and we've in fact received two rebates, I believe, from Workers' Comp for our record. We absolutely agree with you that the health care workforce is by far the biggest issue facing health care. It's critical to us. Retention of the workforce is probably the biggest issue within the set of issues around the health care workforce.

We have invested heavily in technology, lifting apparatus – I know that health regions across the province are looking at that – lifting teams, and various ways of trying to move some of that more difficult work that does cause injuries onto either technology or people that are in a better position to actually do that work. It's an ongoing issue though, and it is a challenge because it's remarkable now that we have our EMS providers buying ambulances that are oversized to deal with heavier patients. As we're designing and building the new south health campus, we are looking at capacity and some specialized facilities and technology to deal with very heavy patients as well.

So there are a lot of issues here that are not easily dealt with, but we're definitely focused on them and making some progress.

Mr. Dunford: Okay. It might be unlikely that you have the numbers in front of you, but a rebate from WCB is excellent news. It's good news, and it needs to be publicized. What were the rebates, then, that you received for the particular years that I'm questioning?

Mr. Davis: Fortunately, we have our chief financial officer here, who, I'm sure, would know what those numbers are.

Ms Best: That's because we have lots of discussion as to where the money should be applied. I believe that last year the rebate amount was around a million dollars, and the year before that it was about $800,000, sort of order-of-magnitude numbers. It was significant.

Mr. Dunford: Congratulations.

Ms Best: Thank you.

The Chair: Thank you very much.

Before we proceed with David Eggen's question, Mr. Tuer, could you clarify for us. You talked about your audit committee. The 2006-07 annual report, which you put on the Internet late last week at least so I could find it: I could not find the list of who was on that audit committee. Could you provide that to us, please, for the interest of the members?

Mr. Tuer: We'll just point to it in the annual report. It'll just take us a second to pull that list up. I'm sorry. The names are not in the annual report. I thought they were. We could either provide that to you in writing, or we can just name them here today.

The Chair: Oh. Name them, please. Yes.

Ms Best: The audit committee is made up of David Tuer as the board chair, Myron Kanik as the chair of the people and finance committee, George Pinchbeck as the chair of the quality and access committee, and Loreen Gilmour as an ad hoc member of the committee.

The Chair: Thank you very much.

Mr. Eggen, please, followed by Neil Brown.

Mr. Eggen: Well, thanks, Mr. Chair, and thank you for appearing before us here this afternoon. I hope it's worthwhile for you. I wanted to ask about an incident that took place in 2005. Your health region intervened in a new EUB application to drill for sour gas within the Calgary city limits. I was interested to know always what the details were of why you considered this to be a necessary intervention and what the health concerns were around that that precipitated your concerns and intervention.

1:30

Mr. Davis: Our medical officer of health has a mandate, of course, to look at any issues which may affect public health within the region. When it comes to sour gas or any other noxious material that may be in the atmosphere, there's actually a fairly rigorous and scientific approach regarding the concentration of the noxious material, its dispersion rates over a geographical radius against the time required to notify and evacuate people from that radius. The process that that group went through was simply to apply those principles to the proposed sour gas drilling that was adjacent to the city. They had concerns primarily with the ability to notify all of the residents and evacuate them in a way that would sync up with the dispersion rates of the gas.

Another complicating factor, of course, was the proposal to build the south health campus within one of the evacuation zones. That was a complicating factor in terms of how you would notify and evacuate that type of population. That was really the basis and methodology under which they intervened.

Mr. Eggen: Well, thank you, and certainly I thank you for your intervention. It's very helpful. I would like to ask, then: are there other scenarios or potential contaminated sites or what have you that Calgary health monitors on an ongoing basis or has similar concerns about in and around the city that would give rise to similar concerns?

Mr. Davis: Well, there are numerous sites, issues that come up, some of which we intervene directly in and some of which we intervene in through the appropriate regulatory body. We've had everything from creosote sites out in Cochrane to the Lynnview Ridge issue. Sour gas is something that we look at on a regular basis. There's still quite a bit of drilling in and around the Calgary area, so it's monitored, and again, it's monitored against those criteria that I indicated.

Our public health group are given quite a bit of freedom within their mandate to do what they think is right based on the scientific principles, the best practices of the day. We work with them and support them in that.

Mr. Eggen: Thanks so much.

The Chair: Dr. Brown, please, followed by Mr. Bonko.

Dr. Brown: Thank you, Mr. Chairman. My first question is

regarding the allocation and the use of staff. Particularly, I'd like to refer to the staff in your emergency department and the ultrasound staff. My understanding is that service is not provided after 5 p.m. for ultrasound. If patients come in after that who require an assessment by ultrasound, they have to come back the next day, which results in considerable inefficiencies. It's my understanding that those patients will have to come back and see another physician. They have to have a new hospital chart prepared. I'd like to know what the additional costs – billings for an assessment by a new physician the following day, a new hospital chart, and so on – are as compared to what the cost would be of having an extra ultrasound staff on duty after 5 p.m. So I'll let you go with that one.

Dr. Eagle: Thanks for the question. You know, access to emergency services in a number of different domains is a challenge. The services for ultrasound are a particular concern largely because of the shortage of providers, and that's a shortage of technologists not only in the public sector but also the private sector. Simply put, we cannot find sufficient ultrasound technologists to provide this service after hours. We are short a number of ultrasound technologists. We certainly looked with interest at the announcements made yesterday in terms of increasing the number of training positions, I think, at NAIT for ultrasound technologists, but this is not a financially driven issue. It's a lack of human resource issue. We would very much like to employ additional ultrasound technologists. A year ago as part of our primary care networks the physicians in Strathmore wanted to have an ultrasound sonographer help them. We were unable in the course of a year to find that person, so it's a major issue for us.

Dr. Brown: Just a follow-up question stemming from your answer there. You mentioned that an announcement had been made regarding additional training positions at NAIT. I'm wondering what your experience is with respect to the recruitment of individuals from a northern institution like NAIT as compared to those who do their training in the city where they are going to be hired?

Dr. Eagle: We have a bias. We would like people to be trained close to home. We find that people stay where they train, so, you know, it is an issue. We have to provide a much more attractive approach to bringing people to Calgary for those areas such as pharmacy and MRI technology, ultrasound, where the training program is located in one place only. We would be working with our institute of technology in Calgary to try and broaden some of the training programs to allow more people to be trained in Calgary, but it is an ongoing issue for us.

Dr. Brown: Do you have any idea of what the ratios would be with respect to the training versus the deficiencies in terms of those technological trades that you mentioned as opposed to, you know, the north and the south?

Dr. Eagle: I can't give you a numerical answer to that, but if you look at MRI technologists, we have a shortage of probably about 10 people at present. That is, you know, considerable given the size of the program at NAIT.

The Chair: Thank you.

Mr. Bonko, please, followed by David Rodney.

Mr. Bonko: Thank you, Mr. Chair. On page 3 of the Capital health region's '06-07 annual report it states that "one of the key benefits of regionalization has been the coordination of health promotion and wellness with service delivery." I asked Capital health, who was in here this morning, so I'm asking you the same thing: over the past year how many of the five women who were sent to Great Falls, Montana, could have been transferred to Capital health, and what would have been the resultant savings?

Dr. Eagle: The staff of the Calgary health region work closely with staff from Capital health, with staff from across western Canada to look at the allocation of these ladies when they come for delivery. It's a very dynamic situation. If you go back and look at the Friday afternoon when the decision was made to transfer the quads to Montana, there were three or four phone calls made to Capital health that afternoon. There were phone calls made to other places across western Canada – Vancouver, Winnipeg – to try and find a place in Canada for this delivery to occur. So it's a very tight integration. It's a tight network of providers who work with really, you know, looking at the best interest of the patients, recognizing that it's a dynamic environment.

The patients' conditions can change quite quickly. Often in these situations clinically you need to make a decision about the best place for this patient to go now. On the particular Friday afternoon when these decisions were made, the providers made the best decision they could. Subsequently it was found that there was space in Capital health, but that had not been the case in the previous conversations. After the decision had been made, then a space was found.

I just want to really underscore the amount of work that goes on between the health regions across western Canada to try and avoid transfers to the United States. I don't have the financial numbers for, you know, how much those deliveries cost are, but I'm sure we could get them.

Mr. Bonko: Okay. My follow-up. On page 8 of the annual report it says that Calgary health region "ensures that patients receive the right care at the right time in the right place." Then how do the patients who were transferred to Montana fit into that statement when there was space?

Dr. Eagle: The transfers are made to provide the best care that's available at the time. The staff who were making those decisions, you know, were in constant phone call contact. They talked to the staff in Capital health three times that afternoon. When the space became available in Edmonton, transport had already been arranged. The family had already accepted care in the United States. They knew fully the situation. It was at that point very, very difficult to go back and change that. The situation in Capital health could change even in the space of a few hours. I mean, every facility in western Canada had challenges with capacity, and we work with that dynamic situation.

Mr. Davis: I think the key thing: these decisions are made with the best interests of the patient in mind, not with the best interests of the health region or health authority. Budget is not the bottom line.

This was potentially a very high-risk situation. We were looking for four high-risk beds in one location. None was available when we did the initial checking. None was available when we did subsequent checking. As Dr. Eagle has indicated, the beds did become available but didn't become available until after all of the arrangements had been made: the family had accepted care; the transition process with Montana had begun. Because of the potential high acuteness of these newborns, the decision, I think, was appropriately made clinically not to disrupt that flow.

1:40

Now, subsequently and happily it turned out that the newborns didn't require that level of care. If we'd known that and if we'd gambled not in favour of patient safety but had gambled on efficiency, or the bottom line, we could have kept the newborns in Calgary because we had enough beds at that level for them. But in some of these cases and especially when you're talking about multiple births involving four – and we know that the frequency of that is 1 in 13 million – you simply can't take any risks. At the end of the day this is not a situation that we want to get politics into. This situation was made by health care providers – by physicians, by nurses – not by Jack Davis, and it was made absolutely one hundred per cent in the best interests of that family, and the family recognizes that.

Mr. Bonko: Thank you.

The Chair: Thank you very much.

Mr. Rodney, please, followed by Harry Chase.

Mr. Rodney: Thank you, Mr. Chair. On the heels of this last question I think it's fair to say that all Albertans are very concerned about addressing service gaps, and I hope you don't take that as an offensive term. We can't be everything to everybody all the time for no fee at all. But I'm wondering what you can tell us about procedures for assessing any sorts of mismatches between supply and demand, if I can put it that way, in the CHR. I'm just looking for details such as: if there is a gap that's identified, what's the process that you use to determine the best course of action? Is it on an individual basis, or are there specific strategies for, you know, different sorts? I mean, you gave one example with the newborns. Can you tell us about whether it would be paramedics or shortage of beds or, you know, because of the whole code burgundies and that sort of thing? I guess what I'm looking for is: what's the good news that we could be sharing with our constituents about the fact that you have plans in place for whatever the gaps might be?

Mr. Davis: Maybe I'll start. I think there's lots of good news in Alberta because I think that all of the health regions in Alberta along with the ministry have been focused on looking at how to both expand our systems to meet the growing populations and make some changes to be more aligned with the kind of service needs that the public has. The difficulty in health care and one of the things that I think that governments and opposition parties need to keep in mind is: the time gap now, if I can call it a gap, between identifying a gap or strategic initiative that you need to implement in health care and actually being able to deliver on it is many, many years. If you're talking about constructing a facility, we know the length of time involved in that as well as the cost. Dr. Eagle, I'm sure, will talk in a minute about the difficulty in acquiring the human resources to adequately staff and operate the program maybe even becoming a larger issue than the capital infrastructure.

We've got cost issues, infrastructure issues, and human resource issues, and we need to be very, very strategic in our planning. We need to be much longer term. We are now starting to talk about a north health campus for Calgary. It may not be under construction until 2017, '18, '19, or '20, but those are kind of the time frames we're starting to work with now. Even on less capital intensive initiatives that still require specially trained health care providers, we may now have to put in place training programs in order to ensure that we've got the human resources available to operate these programs.

We're getting much better at health human resource planning, much better at planning on the infrastructure side with the timelines. Some of these issues that are on us now have developed over a number of years. Some of them weren't foreseen. You know, the population growth had not been foreseen. Some of the shifts in some of the disease states, some of our abilities to treat were not foreseen. So the ability to get that stuff into play certainly has a timeline associated with it.

Chris, let me defer to you.

Dr. Eagle: Just to give some examples of how we try and deal with program issues and try and improve performance, a particular one that you are very familiar with was the pilot project by the Alberta Bone & Joint Health Institute to try and bring down waiting times for hips and knees by re-engineering the intake part of the system, the processing done by the surgeons, and the rehab that occurs after surgery. Initiatives like that, where teams of providers come and look and say, "We can do this business differently," we're very open to that. We continue to look to use that model in different clinical areas.

The other area that obviously is of critical concern to us is the functioning of our emergency departments. We've monitored the performance there with the providers of emergency services on an hourly basis, if not more frequently. When we see trends that we don't like – for example, earlier this year we were noticing an increase in people leaving the emergency departments at the Foothills and the Rockyview without being seen by a physician – we put in very, you know, dramatic changes in how we do business and try and keep up with that. We've talked about the use of overcapacity beds in hospitals. We were doing that two years ago, but based on what was happening this year, we changed all of the thresholds for that. We brought on additional porters; we brought on additional other support staff, additional shifts of physicians to be able to cover emergency departments. So where the staff is available, we're able to make substantial change in the system with very strong provider support in order to achieve better patient flow and better patient outcome.

I think the emergency department shows that. You know, we were having a problem earlier this year. The changes that came in in February had an immediate effect. We were looking at improvements in patients: less patients leaving without being seen, shorter processing time in the emergency department. That occurred by April. So the system can change, and it can improve. The key is getting providers, really, to work with us in coming up with better ways of doing business.

Mr. Rodney: On the heels of that question, I wasn't able to find it: in the years that we're discussing here today, can you tell me how much money was spent on communications with Calgarians specifically having to do with updates in terms of efficiencies? I'm wondering if I missed – I really enjoy and I get a lot of feedback from constituents saying, "Hey, this is great that I found out from the CHR that they offer this service and this one, and this is new, and now there's telehealth" and so on and so on. But has there ever been a list saying, "Listen, we do this to save money here; we do this to save money there," whether it's infrastructure services, resources, pharmaceuticals? In the last couple of years has there been a publication? If so, what would that have cost? I'm just suggesting that it would be a great return on investment.

Ms Best: It's a good question, Mr. Rodney. We have not itemized the nature of the efficiencies we've derived or the changes we've made of that nature other than in a sort of ad hoc way when we talk

about our budget and we talk about the efficiencies that we're including from a financial perspective. If we could, with the chair's permission, get back to you with details as to what some of those might be and the cost of any communication materials we've used around that, that would be helpful.

Mr. Rodney: Yeah. I'd appreciate that, Mr. Chair. It might cost a little bit of money, but it certainly sets the record straight. They get attacked, and we get attacked, but there's so much good news. We should be sharing it.

Thank you.

The Chair: Thank you very much.

Mr. Chase, followed by Mr. Webber.

Mr. Chase: Thank you, Mr. Chair. Before proceeding with my second question set, I would like to table five copies of the June 27, 2007, letter that Auditor General Fred Dunn wrote to CHR CEO Jack Davis. Tabling documents in committee is an extension of the legislative process.

My first of the second set. In the 2005-2006 year former Premier Klein pledged a billion dollars to combat cancer. Apparently, that money hasn't arrived yet as the CHR is leasing more space at the former public, now unfortunately private Holy Cross facility. Have you been given any firm financial commitment from the province to address the needed expansion of the Tom Baker cancer facility?

Mr. Davis: Of course, the funding for that nature of cancer care in Calgary does not come to the Calgary health region. It goes to the Alberta Cancer Board. The contracts that you spoke of for space at the Holy Cross are between the Cancer Board and the Holy Cross, not with the Calgary health region.

I might, though – and I think it would be instructive for the committee – ask Dr. Eagle if he could just outline the types of cancer care provided by the Calgary health region, the types provided by the Alberta Cancer Board in Calgary, and where he thinks we're at in terms of resources, capacity, and issues.

1:50

Dr. Eagle: As the population grows and ages, the ability to provide appropriate cancer treatment is a major issue for all health regions in Alberta, and certainly, you know, the Cancer Board will draw full attention to that. In Calgary we have a complex but very efficient embedding of Cancer Board services into many of our health region facilities.

If you look at the Tom Baker facility at the Foothills site, which is run by the Cancer Board, it provides high-intensity chemotherapeutic treatments. It provides radiation treatment. But when it comes to sort of the initial assessment of patients, when it comes to surgery, when it comes to ongoing care, many of those types of procedures are taking place in hospitals in the health region. For example, a patient with a lung tumour may be seen initially in the Calgary health region, have surgery in the Calgary health region, and then be transferred from the thoracic surgeon's care to the oncologist's care for the ongoing treatment of that disease. That all occurs within the Foothills site. Many people are unaware that there are two organizations involved in the care of that patient, but that tight integration between the region and the Cancer Board is highly effective and highly cost effective.

Mr. Chase: I'm very thankful that that collaborative process is taking place and would like to see a larger funding support for both institutions in cancer care.

My second question. As a fellow member of the south Shaganappi advisory planning group Bob Holmes of the CHR provides monthly updates on progress and problems beyond the Children's hospital, in Varsity, and the Foothills hospital, bordering the constituency. When the projects – including expansions of the Rockyview, Lougheed, Foothills as well as the much anticipated, decade-delayed southeast replacement hospital – come online, will Calgary, given its rapid growth in population, finally meet the 1.9 staff beds per thousand population average?

Mr. Davis: The short answer is yes. Hopefully, with the way we're going to be constructing the south health campus and its future expandability, we'll not only get caught up in 2010-11, but we'll be able to stay caught up by continuing to expand the site at the south health campus. Then we're talking about a north health campus. At the same time, there's no question that the major part of our strategy is all about moving care more into the community, trying to support people either with chronic illnesses or support them, hopefully before they get ill, with strong wellness programming to avoid acute-care hospitalization.

The south health campus itself is going to be much different than a normal hospital. It's going to be not a centre of care but a hub of care, and we anticipate supporting hospital beds at home out of the south health campus and doing many things around chronic disease management and wellness there. Our model in Calgary will have to be different because we lack a lot of the infrastructure that other health systems of similar size cities have. We have no dedicated mental hospitals. We don't have a dedicated cancer facility. We don't have a dedicated rehabilitation facility. We have a smaller medical school. So we in a way are going to be forced to be much more innovative – and that might be a good thing – than many other systems that have, you know, much stronger infrastructure and essentially larger systems that have grown up over time. That's our plan.

As I always say, we're in a race. We're in a race against population growth and aging, and we're also trying to catch up. The good news is that by 2010-11, if we can execute this program that's in front of us – and we're well on our way to doing it – we will finally be caught up, and then the name of the game will be innovation to stay caught up.

Mr. Chase: Thank you.

The Chair: Mr. Webber, please, followed by Mr. Miller.

Mr. Webber: Thank you, Mr. Chair. First of all, I'd like to apologize to my colleagues for sounding like a broken record. I've asked this question to, I think, all the other health regions that have been before us, but I am fixated on this food safety issue and the comments that the Auditor General had back in his report from 2005-06 regarding the RHAs who have not met the inspection targets.

Now, Chairman Tuer, you were quite thorough in your presentation with respect to what the Calgary health region has been doing with respect to food safety and the inspections, and it sounds impressive. I applaud you for that. One thing that I read here in the Auditor General's report is that the RHAs and Alberta Health have not really formally endorsed any type of standards, any type of targets. The blue book, for example, which is a book that I'm sure you're very well aware of, has frequency of inspections described in there. Have you adopted these targets from the blue book? That's one question.

I'll quickly ask my supplemental also, and that is: can you maybe

give me an idea of how many health inspectors you do have in the Calgary area, and are there any opportunities to improve their capacity and the effectiveness of the food inspection program?

Thank you.

Mr. Tuer: Maybe I can ask Dr. Eagle to respond to those questions.

Dr. Eagle: Certainly. On the advice of our medical officer of health we are moving towards achieving the blue book standards. The issue that is of concern to us is, again, the human resource one. We have attempted to hire food inspectors, and we have increased the number of food inspectors on our roster. However, the efficiency of deployment of those food inspectors while we're in a catch-up phase and while we're dealing with very basic issues like many people going on maternity leave is a substantial issue.

What we have done over the years is try and triage the use of the health inspectors to what we believe are the highest risk establishments. In moving towards blue book standards, we are trying to make that triage cover a wider spectrum of those standards in those establishments as we close the gap. So we are in a position of closing the gap. We do look at this mainly now as a human resource issue in terms of the food inspectors. I think we'll close that gap.

Mr. Webber: Great. Thank you.

The Chair: Thank you very much.

Mr. Miller, please, followed by Mr. Johnston.

Mr. R. Miller: Thank you very much. Page 39 of your annual report discusses hip and knee replacement times, and page 40 describes wait times and volumes for adult emergency department waiting room time, ACH ultrasound access, and PET/CT access. The results for hip and knee seem to have met or exceeded your expectations, whereas the other areas did not meet the expected achievements. My question is: has the Alberta hip and knee joint replacement pilot project been a factor in the lower-than-expected achievements of wait times and access in other key areas?

Dr. Eagle: Really you're asking us for an opportunity cost, as far as I can understand. Is that correct?

Mr. R. Miller: Well, I'm wondering whether or not other areas may have suffered at the expense of the decrease in wait times as a result of the pilot project.

Dr. Eagle: No. I understand. There was no substitution or sort of beggar-your-neighbour type of approach to this. The changes in processes within orthopaedic care were funded directly by Alberta Health and Wellness and using resources already committed by the Calgary health region. So there was not a situation where we were substituting, you know, performance in one area for performance in another. The bone and joint program was effective in its own right.

Mr. R. Miller: My supplemental question would be: where would you like to see that program go next? What should we concentrate on next, after hip and knee and the success in the hip and knee?

Dr. Eagle: The providers are looking at back surgery, for example. Back care has a very large waiting list, and I'm sure everybody in the room has letters of concern around access for chronic back conditions. It's a significant workforce issue and a significant cost for the Workers' Compensation Board, so that's one that the providers have chosen within the orthopaedic domain. We're looking at rolling out that type of model into many areas, not only surgical but medical access, and we're looking at central intake for many of our specialty medical clinics right now. That type of innovation is actually funded through the support given for innovation by the alternate payment plans in the province of Alberta, so actually the alternate payment plans are allowing us to change our way of doing business.

Mr. R. Miller: Thank you.

Mr. Tuer: That is somewhat akin to asking us which of our children we love the best, though.

The Chair: Thank you.

Mr. Johnston, please, followed by David Eggen.

2:00

Mr. Johnston: Thank you, Chair. The Auditor General recommended last year that the region ensure that the process for computer access terminations be consistently followed, and there were a number of areas that were obviously not followed. One is the several instances of terminated users – I assume employees that have been terminated – still having access to the network applications, then a review of the user account system by the systems administrator, and password complexity requirements where applications are not implemented. Can you tell me what's happened there and what improvements have been made?

Ms Best: We were in the course of looking at the kinds of issues that the Auditor General raised. One of the challenges that we have is, in part, working in our rural areas, and again we keep coming back to the same theme about workforce issues. We don't always have enough people on hand that we get the right segregation of duties all the time, but we have compensating controls to ensure that where there was a potential weakness like that, other procedures might have picked up issues that could have arisen. So one thing to look at is our compensating controls, and the other is that we are working at making sure we implement the recommendations that the Auditor General has made to us. As Mr. Tuer said, we have plans in place or completed on all of those areas, and we will be reporting again to our Governance and Audit Committee at the beginning of October as to our progress in meeting those recommendations.

The Chair: Thank you.

Mr. Dunn, do you have something to add?

Mr. Dunn: Maybe I can help Mr. Johnston here. Hopefully, you understood the term "compensating control." Certainly, the controls that we are addressing here, as one would expect, are the front-end, preventive controls. If you don't get an inappropriate user on there, they can't hack in and provide a virus. A compensating control is quite often described as a back-end control. Therefore, if I could assist, could I ask Kay Best: could you describe your compensating controls for the member?

Ms Best: For example, if we had a segregation of duties area where one person could initiate and approve a transaction, we would have a compensating control to look at a transaction log to make sure that all transactions were to appropriate, recognized vendors and at reasonable amounts approved by the right authorities within finance. So we would have other checks and balances to catch the initial condition that could have created a problem.

Mr. Dunn: Just to supplement, is a compensating control more effective and less expensive than a preventive control?

Ms Best: Well, Mr. Dunn, it's been a long time since I was in public practice. I actually think the preventive control is the better one to be in place, which is why the recommendations and our actions are to implement the controls up front rather than after the fact.

Mr. Johnston: Thank you.

The Chair: You have no further questions at this time? Okay. Thank you.

David Eggen, please, followed by Mr. Herard.

Mr. Eggen: Well, thanks, Mr. Chair. I'd like to ask a question about a recommendation made by the Auditor General from 2005-2006, recommendation 17. The Auditor General was asking to clarify goals and performance measures for global funding methodology and to improve the data used in calculations and for timeliness of information. I know that this is a tall order, but at the same time I think it's a precondition by which we can realize efficiencies in very large budgets such as Calgary health. I just wanted to ask: what steps are you taking to cost all services in the region, and how long do you think that would take to achieve?

Ms Best: I suspect that that's a question that I will be able to answer. We do participate with Alberta Health and Wellness and under the department's sponsorship in a costing process. We have spent a lot of time and effort with our colleagues in other regions making sure that we have similar definitions of costs, similar methods of allocation because we need to allocate costs, obviously: people costs, equipment costs, diagnostic costs, all those kinds of things. Are we making similar assumptions about those allocations?

How are we ensuring that we have timely access to this information? That's a challenge to us, and that's why our electronic health record project is also particularly important. We have a number of feeder systems now that come into our costing system, and our front-line staff priority is clearly on serving their patients, so the extra step of inputting information to costing does add a little bit of time.

We have got a process now where by sort of the third to fourth quarters of the fiscal year we are able to prepare what we call a schedule of health services that covers our costs for the fiscal year that ended in March of the same year. We look at all our acute care procedures, all our community services and are actually able to identify those expenses based on different service indicators and different volumes depending on the nature of the service.

I think that we are in Calgary making good progress in that area. We need to make sure that our system's functionality is assisting us in that. I think we are certainly making progress over the last couple of years. That is, as well, a performance measure that has been established by Health and Wellness, so we do report quarterly on our progress on that through the ministry.

Dr. Eagle: I would just like to add one comment to that. Within clinical programs we have a rotation called sustainability reviews, where we ask each program to build up its budget from basically a zero-based budget. Recognizing the size of some of these programs, it can take quite a while for programs like renal, cardiac sciences, operating rooms, and so on. We've gone through that approach, and we've looked at how we buy equipment, how we utilize staff, and we get a much better idea of the things that drive costs within individual programs.

Mr. Eggen: Sounds like a very tall order, time consuming. Would you have any idea how much it costs to cost all of those costs?

Ms Best: We have three or four people who work full time in that area.

Mr. Eggen: Thanks.

The Chair: Thank you very much.

Mr. Herard, followed by Mr. Bonko.

Mr. Herard: Thank you very much, Mr. Chairman. In an effort to try and understand cost escalations and cost drivers, I went to your website to see if I could get a little more historical information because a couple of years is not a great deal of time in the life of a health region. The earliest information I could find was 2004-05, an annual report that you have on your website, so I'm using '05 as sort of my base. I note that since 2005 there has been a 36 per cent overall increase in expenditures, which is a little more than the 10 per cent or so that we're being told it's costing. You know, our health care system is going up at about a rate of 10 per cent a year. I note that you've had a 21 per cent increase in staffing, but that staff is costing you 37 per cent more, so it must be more expensive to get staff nowadays and to recruit them and so on.

As an MLA I can tell you that the comment I get the most, you know, from constituents is that: well, they're short of nurses, but they've sure got lots of supervisors. So I've looked at that, and I see that while we've had an overall staff increase of 21 per cent, there's been a 40 per cent increase in management staff, and that management staff is costing us 56 per cent more than it was before.

But the one that really kind of screams out for an explanation is that in the executive team there's been an 83.4 per cent increase in costs since 2005. I just don't know how that can happen, so I'd like someone to try and help me understand that.

Mr. Davis: To understand all of it or just the last question?

Mr. Herard: As much as you'd like to enlighten me on.

Mr. Davis: The executive team number you're looking at is largely a function of the number of direct reports to the CEO. If there's a reorganization that adds reports to the CEO or subtracts them, that'll impact, you know, that number fairly dramatically. I'd have to have a little closer look at where you're drawing your data from, but it could very well be related to that.

In terms of us having a lot of supervisors and not a lot of front-line people, one of the concerns, actually, that we have is that our spans of control for our front-line supervisors or patient care managers are much, much too large. In fact, when you look at the management costs for a large health region as a ratio of its total expenditures, we're way below any other similarly sized organization, and with increased accountability pressures from the Auditor General, public expectation, it's very, very difficult to manage these large, complicated organizations with very little management. Also, again, when you look at our historically low investment in information technology, we don't have the systems we can rely on as we're building them up.

2:10

So we look very carefully – and I'm going to let Chris talk as well because he really oversees on the clinical side, which is the biggest chunk of our business and of our management, the priority-setting every year. We look very carefully at what goes into management,

what goes into supervision, what goes into front line. We have to be very, very careful as we go forward that we don't do what we did in the early '90s, and I guess I can say that because I was here in the early '90s and maybe part of the problem. We really thought for some reason that we could kind of run these large, complicated systems with no management. Management was the enemy; administration was the enemy. Let's clean it out. Let's get rid of it. But the fact of the matter is that no successful organization can be run without good leadership, without good management, without good systems, and we have to show stable career paths for people that are going to lead them into these jobs so that they can be the future leaders of these systems that we're going to have to rely on pretty carefully.

I would ask you, Chris, to maybe talk briefly.

Dr. Eagle: I think that just where we have the greatest number of managers is in the management to front-line units, and the way the workforce works, each one of those front-line managers has approximately a hundred and sometimes quite a lot more than a hundred people reporting to them. The gross number of managers is at that front-line level, and the size of their responsibilities is daunting, so that's, you know, a real pressure in our system. It's a real issue in terms of recruitment and retention of those people because of the pressures that they feel.

That doesn't speak to growth as much as what's appropriate, but where we have had growth over the last couple of years, not ascribing all of the numbers that you have quoted towards growth in these areas – we've put a lot more money into safety, and that requires people to be trained. It requires people to bring in new systems of safety. Those are classified as management positions. We've done a lot in terms of quality. Again, good things to do but management positions. The growth of our electronic health record has required additional management support. So there are factors within the way health care is changing that have driven some of those numbers that you're talking about.

Mr. Herard: Thank you. My second question relates to page 130, schedule 2, and that's the accrued benefit obligations under SRP. I think I understand what that means, but I'd like to know if these are as a result of a decision made by the board or contracts that created the obligation from day one with respect to each one of these people. In other words, is this something that came in after the fact, or was it part of the contracts all along?

Mr. Tuer: If I understand your question, it's really looking at when the health region introduced the SRP program and whether we were required to establish it because of contractual commitments in hiring people. Employees in the Calgary health region participate in the local authorities pension plan, but the Income Tax Act limits the level of employment income that can be recognized in a pension formula for the LAPP. So as compensation has risen above that level, corporations – the Calgary health region is certainly one, the government civil service another – have looked at how they can continue to provide pensionability for the income for those employees. That limit is slightly in excess of $112,000 a year for 2005, and the limit increases at the same rate as average Canadian wages thereafter.

The issue gets exacerbated when we have executive employees, where their compensation level is significantly above that, and when they transfer in from one organization to another, they may lose pensionability in the organization they're with in making that move. So, again, organizations – and the Calgary health region is one – have looked at how they can accommodate that.

The Calgary health region put in place their supplementary executive retirement plan in 2001 in order to continue to provide pensionability to the executive and to employees whose salaries were above that $112,000 threshold, or at a lower threshold at that point, and in order to continue to provide attractive recruitment for our employees. So in answer to your question, the need for the supplementary plan wasn't driven by any particular contract, but it certainly did allow us to continue to recruit. As people were contracted in, they certainly asked to be included or certainly asked for that benefit.

The Chair: Thank you.

Mr. Herard: So this was a board decision to go with that kind of a program in 2001. Is that correct?

Mr. Tuer: That's correct. Thank you.

The Chair: Okay.

Mr. Bonko, followed by Mr. Cenaiko, please.

Mr. Bonko: Thanks, Mr. Chairman. I'm going to be a little bit more specific. We've kind of come close to the answer, but not really the answer that I'm looking for here on some of the questions. Given the problems that have occurred in Calgary's emergency rooms like public miscarriages, the long waiting lines that we've talked about, the mothers going to Montana, how does the board defend a million dollar salary for a CEO when a region also has bed shortages and front-line staff who provide care to Albertans?

Mr. Davis: I'd better get my boss to answer that. Not me.

Mr. Tuer: Let me start by making sure that we're using a common language here. Mr. Davis certainly doesn't have a million dollar salary. His total compensation reaches that kind of a level, but his salary is, I think, somewhere in the order of – we should get the actual numbers. In the previous year his salary was $614,000, and that was a combination of both the annual salary and the bonus. Mr. Davis has a contract with the region which allows for us to pay him a certain amount per year, and we can give him a bonus of up to 50 per cent of that salary based on specific performance targets that he's challenged with at the beginning of that year. In the previous fiscal year that amount, that salary and the bonus, amounted to the $614,000, and that included the benefits.

Any amount beyond that related to a charge on the balance sheet for the supplementary executive retirement plan, which is being amortized for Mr. Davis' pension. Just to explain the supplementary plan so that we all understand it, the supplementary plan is an investment that the region makes, or any employer makes, so that we can amortize the pension costs that we've promised all of our employees. In Mr. Davis' case we have to amortize it over a shorter period of time because he hasn't spent his entire career with the region. He has spent a much shorter period of time. So we amortize that cost over a much shorter period of time so that it can be paid out once he does retire.

There are a number of ways of doing that. We can use an RCA, where we actually pay the money out, invest it with the federal government for instance, in I'll say a non tax-effected vehicle, but we're actually using cash to do it, or we can do it on an accounting basis, where we accrue the number on our balance sheet so that we show the liability going forward. Because cash is king in the health care world, we much prefer to use the supplementary executive retirement plan because it's really just a future liability that we're

talking about, and we preserve the cash to use at the bedside. When you look at adding those numbers together, you tend to distort what the actual numbers are.

2:20

To put Mr. Davis' total compensation into perspective, his cash compensation is roughly equivalent to that of the CEO of the Capital health region. In fact, it's just slightly under that. When Mr. Davis retires, he'll get a pension which is slightly less than the CEO of the Capital health region. His pension isn't indexed, so over time that gap will widen. Because of the way that we account for it and because of the fact that some of the Capital health region's CEO's pension is covered under the LAPP whereas all of ours is covered under the SRP, the numbers don't add up quite the same way. So it's easy to become confused.

It's one of the issues that the Canadian securities administrators have been barraged by when they proposed that we disclose compensation in a way where we just sum these numbers up. It makes it very difficult. Unless you have me sitting here telling you that the Capital health region's CEO's total compensation is roughly the same as the total compensation of the CEO of the Calgary health region, you can't go to the financial statements of the organization and see that. It's just another area where financial statements tend to confuse the issue. I had this problem with the Auditor General and, actually, the auditors of a lot of the public companies that I'm involved in where over time the accounting standards have changed to a point where you almost have to be some form of savant in order to understand what those financial statements are trying to tell you.

The Chair: Thank you.

Mr. Dunn, do you have some comments in regard to Mr. Bonko's first question?

Mr. Dunn: Yeah. I just want to clarify and be on record that in my opinion total compensation must include all amounts which are currently paid and payable, no different than base salary, incentive comp, vacation pay, all that are paid and payable currently, together with anything which is deferred to subsequent years. That is total compensation because you can only earn your compensation while you work for an entity. Subsequent to your retirement you are no longer providing any service. Thus all amounts that have been earned must be accounted for and recorded at the time of employment.

So as much as Mr. Tuer and I have disagreed on this on a number of occasions, I still confirm to you that in my opinion total compensation must include all base, variable, together with any other benefits, together with any amounts which are deferred to future periods.

The Chair: Thank you.

Mr. Tuer: The Auditor General and I actually don't disagree on that. I actually believe that we should disclose as well. I just believe that we have to do it in such a way that it's consistent so that what we're disclosing in one set of financial statements can be read the same way on another set of financial statements. Again, the Canadian securities administrators, who tend to provide the rules by which we'll report these things going forward, have recently retracted their position draft on it for exactly this reason. We need to figure out how to do it. No one is questioning the fact that we want to get to that point. It's just that we have to do it in such a way that it's meaningful to people.

The Chair: Thank you.

Mr. Bonko, your second question, please.

Mr. Bonko: Thank you, Mr. Chairman. You somewhat touched on it. What would be the performance measures and goals that the board uses to evaluate the CEO?

Mr. Tuer: As with every organization the performance measures are different. Specific to the Calgary health region we developed an accountability agreement with our CEO some years back. That accountability agreement makes it clear what we hold the CEO accountable for, and within that agreement is a section that we negotiate annually which says: these are the specific goals that we want you to achieve in the coming year. The vast majority of the bonus that's awarded to Mr. Davis is based on his performance relative to those goals, and a small portion of his bonus relates to the achievement of goals by the corporation, using a balanced scorecard.

Mr. Bonko: But you've still not told me any of the specifics. You've generalized, but even one or two specifics of the goals.

Mr. Tuer: They change on an annual basis, and I didn't bring the accountability agreement up. Jack probably carries them close to his heart, so why don't I ask you?

Mr. Davis: Yeah. I could go over some of them. For example, they generally fall under four main categories. One of the main categories has been delivery of key elements of our capital program. In the year you're talking about, of course, the opening and commissioning of the Alberta Children's hospital on time and on budget was a key performance goal of mine that was met when the Alberta Children's hospital was opened last August, successfully commissioned, and generally, I think everybody thought, a job well done now. Obviously, I was only a very small part of it, but I was part of the leadership providing leadership to that team. There are other elements of the capital plan that are in there. With respect to the electronic health record, the Sunrise Clinical system that Dr. Eagle has spoken about, again, successful implementation of that system was a key element of our strategy going forward. So that was important.

The Chair: Thank you very much, Mr. Davis.

I don't mean to be disrespectful and interrupt, Mr. Bonko, but that was a third question. There is a long list of members here, and we only have half an hour left. We're going to proceed, please, on to Mr. Cenaiko, followed by Mr. Chase.

Mr. Cenaiko: Thank you very much for being here today. Mr. Tuer, David, the huge commitment you take by being a volunteer in chairing the board is a tremendous commitment to the community. I just want to say that I enjoyed the six and a half years that I spent on the board of the Calgary health region in the late '90s and the tremendous job that all of the volunteers do but as well the staff, the president and CEO, as well as the senior staff and all of the 15,000 employees in the Calgary health region. I know the tremendous commitment they have to providing health care for the citizens in our region.

What I wanted to ask was a couple of questions around innovation. Those are regarding issues that I think every corporation has in the province of Alberta at this time, including, I think, the government of Alberta, in looking at employment of and/or the issues related to employing trained staff that you need in the Calgary health region, specifically in the aboriginal community. What have

you done regarding that? As well, looking at – I believe I read something recently regarding foreign staff. The third component of that would be that of interns. Obviously, you're working with Health and Wellness and the University of Calgary to try to allocate the additional space you need in emergency settings for those interns. Is there an opportunity to increase that, and are you, I guess, working collaboratively with other regions to provide the emergency space that they have to learn in, regarding becoming a physician?

Mr. Davis: I'd like to just respond to the one on the aboriginal recruitment and let Dr. Eagle talk about the other two issues. We've recently entered into an agreement with both the federal and provincial governments on recruitment of aboriginal staff – recruitment, training, and placement – and we're very hopeful that's going to produce some results. We've hired an aboriginal individual who's going to be heading that up.

Now, I've been involved in many, many aboriginal recruitment and training programs over the years during my time in government and other ministries, the Solicitor General certainly being one of them. What's different now is that the aboriginal community offers something that we're very much in need of, which is young people. They're going to have to take a much stronger role. We need them to take a stronger role in many, many industry and government sectors in the future because of the high numbers of young people. They are a major part of the workforce of the future, so there's even more reason to solve this problem than there has been in the past. I mean, there were important reasons to solve it in the past due to social equity injustice, but now there really is an economic imperative as well. So we're very, very hopeful, and we see lots of opportunity and promise here.

2:30

Dr. Eagle: We've certainly been very interested in recruiting staff from offshore, outside the borders of Canada. We've done that in a way where we have not been impacting Third World countries, which is obviously an ethical issue. We've looked to areas such as the U.K., somewhat into the Middle East, where there's a surplus of nurses available from those places, and have very successful recruitment fairs there.

One of the issues of bringing staff from offshore is the issue of accreditation. We've had a number of sessions with the people from CARNA, the registration association for nurses, and made some progress with them in terms of revising internal processes to allow more speedy accreditation of foreign workers. I think you'll see more of that type of effort going on in the future. I think that as Alberta continues to grow and if it continues to grow at the rate we're growing, we'll definitely need those people coming here to provide the services that our population requires.

In terms of interns and residents we have an interesting situation, an opportunity perhaps, and one we've discussed internally. As the number of medical school slots increases, five years later there's a commensurate increase in the number of training slots for interns and residents, absorbing the people into those residency training positions. We've speculated that it might be useful to advance in time those increases in slots, so instead of being five years out, it might be this year or next year.

What that would allow would be for Canadians who have trained in accredited medical schools in Australia, New Zealand, U.K., Ireland to come back to Canada and take up those positions. We know that there's a cadre of people out there who would like to come back to Alberta, and we hear about them on a daily basis. We have ways of accommodating them, but the ways they're accommodated tend to be very custom crafted, very individual. A focused period of time where we're able to repatriate Canadian graduates of foreign medical schools would actually, I think, be of benefit. I think it would be a low-cost way of adding graduates to this system.

So we do have the capacity to train more people.

Mr. Cenaiko: Excellent. Thank you very much. I don't have a second question.

The Chair: Thank you, Mr. Cenaiko.

Mr. Chase, followed by Ivan Strang, please.

Mr. Chase: Thank you very much. As a former Alberta chair of Friends of Medicare I continue to be concerned about lingering remnants of Alberta third-way privatization such as the delisting of services and the ongoing extra billing in the form of Alberta health premiums. Money shouldn't dictate one's health care accessibility. On page 92 the fees and charges for "uninsured medical services" doubled from 2005 to 2006. For my first question I would like to know: what are the top five uninsured medical services?

[Mr. Prins in the chair]

Ms Best: Could you tell me which document you're referring to page 92 of, please?

Mr. Chase: I believe it's your year-end report 2005-2006.

Mr. Davis: I would think that in any event we would need to undertake to get that list back to you. What I can say is that we have not ourselves delisted or deinsured anything, so these would likely be hospital-based procedures. For example, as you are well aware, dermatologists who are on call to do emergency work in our hospitals will perform some uninsured services there, and there's a charge to patients for that as there would be in their office, but because we want to keep them on site – we'll have to get you that list, I would think, unless you have it at the top of your head there, Kay.

[Mr. MacDonald in the chair]

Mr. Chase: And possibly even without having that list present, which I look forward to receiving, is this part of the region's policy and plan, looking to increase revenue from this source?

Mr. Davis: It's actually – Chris can speak to it too – a problem for us because our facilities are constrained already doing the publicly funded work. Where facilities are used, it's only as a way of ensuring that we've got physician coverage for trauma cases requiring those types of services on site. Most of what physicians would normally do on a cost-recovery basis, an uninsured service, would be done in their offices or in a clinic.

You may have a sense of this, Chris.

Dr. Eagle: I think just one example is the need to have plastic surgeons on call for a trauma centre because of burns, because of facial injuries. In order for them to find it attractive to work in our sites and do that type of work, they want to have access to do their regular types of cosmetic procedures, so we are doing some cosmetic procedures. Now, I have to say that because of the pressure of the publicly funded work and the growth in the population that's becoming increasingly difficult for us to use that as an inducement. We're looking at other ways that we can maintain that 24/7 coverage by plastic surgeons in our facilities.

Mr. Chase: Thank you.

Mr. Dunn: Just to help Mr. Chase, it's note 15 to the 2006, and the doubling is what you've identified here: uninsured medical, $700,000 to $1.4 million. So it's your note 15 to the 2006 financial statement. It's not as clear or as descriptive as the previous year, but it's note 14 to your 2007 financial statements.

Thank you, Mr. Chair.

The Chair: Thank you very much.

Mr. Strang, please, followed by Rick Miller.

Mr. Strang: Thanks, Mr. Chairman. What I'd like to know is: what initiatives does the Calgary health authority pursue to improve the quality of care it provides to the patients?

Dr. Eagle: There's a multifaceted approach to that. We have a department called quality, safety, and health information that is tasked with a number of different things. One is reporting on performance data such as infection rates, such as people returning to hospital after discharge or readmission to ICU after discharge within hospital and coming back. We have a large amount of performance data that's reported. Part of their role is to educate staff in ways of using quality tools for improvement of programs.

We have a number of issues related to safety. After 2004 and the potassium deaths that have been well documented, we undertook a major organizational direction under Mr. Tuer's and Mr. Davis' leadership to try and bring Calgary health region up to the front of the pack in terms of safety initiatives and safety programs. That involves involving families in the management of these safety programs. It involves taking every potential safety issue apart and figuring out what actually happened in that situation. It involves doing prospective analysis of clinical situations, looking at what the safety risks are. They're called health themas, which is a health safety management technique to look at what you plan to do versus how it will turn out. So many of our new program designs actually go through a safety analysis before we ever institute them, which sounds very simple, but it hasn't been something that's been traditional in health care.

Mr. Strang: Thank you. I guess my supplemental would be, then: do you feel that the constituents within your region would support more privatization services if it would enhance their ability to access better health safety services? [interjection] You didn't ask your question yet, so I put this one in.

Mr. Tuer: We haven't asked them, and I'd be reluctant to speak for them.

Earlier this year I committed to the community that we would be putting our senior management and board out into the community this fall to ask them what their view of health care might be over the next decade. What should health care cover, what shouldn't it cover, and how do we go about addressing that gap? So we're committed to starting that process this fall, but it actually is right to the question that you're asking. So we don't have the answer today.

Mr. Strang: Okay. Thank you.

The Chair: Thank you very much.

Mr. Miller, followed by Mr. Dunford.

Mr. R. Miller: Thank you very much, Mr. Chairman. Only one question for Mr. Tuer. Alberta taxpayers, I'm sure, would like to know regarding the supplementary executive retirement plan: do those executive members make a contribution from their compensation package, or is that cost borne entirely by the health authority?

Mr. Tuer: The contribution to the SRP is entirely by the Calgary health region. If we were to increase the liability by allowing them to make a contribution, we run into tax issues. It isn't that the employees would prefer not to make a contribution the same way they do in any registered retirement plan; it's just that the system isn't set up to allow that to happen.

2:40

Mr. R. Miller: Thank you.

The Chair: Thank you very much.

Mr. Dunford: My question is going to be regarding the electronic health record, but I want to preamble it by just indicating that our attitude and our view of things is based, of course, on our experiences. After a major government reorganization in 1999 as a minister I was touring facilities and was pleased to note that at one area we had one person out doing basically what three had been doing previously, which, given the time that we were in, was good news. The bad news was, David, that the two computers that these three people used to use couldn't talk to each other. So my question would be: if the Alberta SuperNet, that we've just built and which I'm quite proud that this government has done, is a highway, is the Calgary regional health authority's involvement now in the electronic health record travelling on that highway, or do you have to build a highway of your own?

Mr. Tuer: Well, I can say first of all that we haven't built our own highway, but the ways in which data transfer takes place even from 1999 until today, of course, have changed dramatically. SuperNet by itself probably doesn't provide all of the resources that are necessary for something like an electronic health record, certainly not within the hospitals themselves. But maybe I'll ask Dr. Eagle to comment further on it.

Dr. Eagle: I think that in a hospital setting there is an electronic health record. That's sort of the writing of what happened about these people, about the patients, about the families, about what the staff do, but what it is actually is a way of managing transactions. A record is far too passive a description of what this is. It's basically: how do physicians and nurses manage their workflow on a daily, hourly, right down to the minute basis, and how do they communicate with the other professionals, for example in pharmacy, for example in DI? It's actually a system of transactions as much as a record. You've got to have that work engine, you know, working for the clinicians, and that they can use that work engine can be very effective in how they do their daily work.

The record that falls out of that, of the transactions, of the orders, of the lab results, of the diagnostic imaging results, is available, as I mentioned some time ago, through the Alberta Netcare project. Physicians across the province can see results in Calgary if they're in Fort McMurray, for example. So there are different systems across the province, but the backbone is similar enough. The tools of communication are there to allow those systems to work effectively together.

Mr. Dunford: Okay. Well, I'm clearly a layman in this, and I'm excited about electronics like I'm excited about electricity, but I don't understand either one. You know, I just want the results from it.

My question would be, though: within the Calgary health region, because you go beyond the Calgary city limits, you would have electronic data that would have to go from – well, is High River in your area, by the way?

Dr. Eagle: Yeah.

Mr. Dunford: Okay. So if you had to send information from Calgary to High River, is that information actually going on the fibre optic that we provided in the SuperNet, or did somebody else have to put something else in the ground besides that?

Mr. Davis: It's not going on anything we've constructed or paid to be constructed. In fact, between High River and Calgary we have a CT scanner in High River that is read by radiologists in Calgary, so there's a high volume of data that, you know, is moving back and forth between Calgary and High River. I'm assuming that SuperNet is a player in this, but as you know, SuperNet has to compete with other highways on a pricing basis for volume. That's always been our position. We don't build highways. We don't lock in where we don't get best price. I think SuperNet is a player but may not be the only one because on some of those corridors there's more than one highway.

Mr. Dunford: As a supplement, though, to my question, to fully answer my question, might you provide us with the information that, yes, we are using the SuperNet or that, no, we are not using the SuperNet?

Dr. Eagle: We could even provide you with an invitation to come and look at the physicians using this electronic system that we have or to anybody in the room, for that matter.

The Chair: Okay. Thank you very much.
Mr. Bonko, followed by Neil Brown.

Mr. Bonko: Thanks, Mr. Chairman. On page 83 of your 2006-07 annual report it states that in 2007 inventories increased as a result of the increase in the pandemic inventories. It states that $6.1 million was put towards pandemic inventories. What specific co-ordination procedures are in place with local facilities, hospitals, clinics, municipalities, and the province when it comes to pandemic planning?

Dr. Eagle: There are a number of working committees that go right from the provincial level that involve the medical officers of health from across the province to our local medical officer of health working on what he would see the needs of Calgary to be in terms of things like IV supplies, antibiotic supplies, and things like that that would be required in a pandemic, where communications were affected and where transportation was absolutely affected. That goes right down to having working committees across all of our hospitals, urban and rural, and involving community care facilities as well. So it's kind of a layered approach to planning for this, and it's co-ordinated provincially. It's taking some time to get there, but I think the fact that we are co-ordinated that way in Alberta is actually a plus. Other provinces have not reached that level of co-ordination.

You can never be well enough prepared for a pandemic, but I think that with the investments that have been made in terms of process and in terms of, you know, having the right supplies available, we're in better shape than we were three years ago. That's absolutely sure.

The Chair: Your second question, please, Mr. Bonko.

Mr. Bonko: Yes. Thank you, Mr. Chairman. How close are we to getting done, and what needs to be completed?

Mr. Davis: I'm not sure we ever get done, but we've just commissioned a warehouse, opened it, a fairly substantial one that is going to be our area where we stockpile our supplies. So we're well along the way to getting our stock in place. As Dr. Eagle mentioned, we work closely with municipal EMS and other partners. They have a large warehouse as well where they have stockpiled many of their supplies now.

You're always somewhat hampered by not knowing exactly what the pandemic is going to be. If we knew exactly what it would be, we'd have exactly the right stuff. But as Dr. Eagle says, we're well along the way, and I think that from this point forward it's really just trying to stay current and use our health surveillance systems, on which globally we're in much better shape than we were, obviously, years ago, to get a sense as to disease trends and issues, what's moving around the globe, and what the likely threats are at any given time. They do change and have changed over the last couple of years.

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

Dr. Brown: Thank you, Mr. Chairman. One of the emerging major issues in a big city like Calgary is the safety and security of staff and patients in hospital. I know that in the Foothills hospital there have been instances where the police have locked down the facilities because of the fact that perpetrators of violence have attempted or at least have threatened to come and finish off the job. In the Foothills hospital there are, as I understand it, four security persons for the entire hospital on night staff, and some of the comments that I've received are that that is not an adequate number. I'd like to know what is being done to improve the security at the hospitals and why the region has not implemented electronic swipe cards for security purposes, which have been the norm in industry for many, many years.

Mr. Davis: Well, we have invested extensively in security upgrades during the last couple of years. That has included hiring significant numbers of new security officers at higher rates of pay, so we're getting better trained and more capable individuals. We also are putting electronic surveillance into place in our hospitals, and I won't go into the details of that because everything I say is on the public record here. But we'll have a much more electronically based system complemented by better trained staff.

2:50

A swipe card system is virtually impossible, at this stage at least, because our facilities are wide open to the public, and we want them to be wide open to the public so that anybody can walk in the front door. We do not yet in this country have a comprehensive identification card system where you could swipe one card. It's been talked about from time to time when privacy issues come up, but we're a long way away from that.

As we build new facilities, we're looking at much more sophisticated ways of building in security as well that are less obtrusive, where really the facility helps you with security. So we're going to have that. We've got electronic security, and we've got an enhanced security staff: better trained, better qualified individuals. It's an unfortunate part of the world in major cities that trouble walks in the

front door from time to time. If you want to lock trouble out of the front door, you're going to lock a lot of other things out of the front door that we shouldn't be locking out.

The Chair: Thank you.

Dr. Brown: My supplemental question, regarding the electronic health card. You mentioned that this would enhance quality, safety, and avoid redundancy, Mr. Tuer. I wondered what analysis has been done with respect to the costs and benefits of the implementation of the card for various aspects. I know that in the U.K. the National Health Service experienced massive cost overruns with respect to implementation of that program with very limited returns.

Dr. Eagle: The system actually has been implemented, unlike some of the systems in the U.K., so we have something that's actually working. The ways that systems like this enhance safety are through a series of tools called clinical decision support, where basically medical logic has been designed by practitioners in the Calgary health region on the best ways of delivering care; for example, for pneumonia, for bone marrow transplant. All of that is put in as a series of preset care paths for practitioners, so that's all available to them electronically. It points them to other choices that they might make. It says what best practice is. It gives them access to what's available in the peer review literature if they want to go look at, you know, what's current in these areas. These care pathways are actually kept up to date by the people who use them on a day-to-day basis, so the software is really easily changed by the practitioners.

Just to give you an idea of how interested some other regions are, we had a call from the Sloan-Kettering Institute in New York in the United States looking to borrow our bone marrow transplant protocol. They hadn't ever seen one like that before, and they hadn't developed one themselves. So, you know, getting that degree of professional expertise embedded into an electronic health record has not only patient value and safety value; it has significant commercial value perhaps, too, because of the intellectual property involved.

The Chair: Thank you.

Mr. Chase, followed by Denis Herard, time permitting.

Mr. Chase: Thank you. My final questions have to do with recruitment and retention. On page 66 of the 2005-06 annual report under Outlook 2006-07 it states that the Calgary health region "is challenged with balancing a shortage of skilled labour and physical capacity constraints with the demands for services resulting from a rapidly growing and aging population." The latest government of Alberta announcement indicated single-digit and low double-digit university seat funding for specialist training. From 1994 through 1999 health care service providers were driven from Calgary with the premature government closing of half our hospitals, producing a negative rippling effect on supporting lab services, physio, et cetera. Currently front-line care providers are overextended. Therefore, given our current in-province training and external recruiting, can the regional health authority meet its recruiting targets?

I'll give you the second, which is basically a summation of the first, and that is that currently we have mothballed or yet to be opened operating theatres in our existing facilities. How will the region be in a position to fill all the positions required to operate new, updated, and expanded facilities? Simply stated, if we build it, will they come?

The Chair: Mr. Tuer, if you and your organization could be kind enough to look at *Hansard* and provide in writing an answer to Mr. Chase's lengthy question, if you don't mind, we would be grateful. We're going to run out of time, I'm afraid, before the other members get an opportunity to have their questions on the record and ask for a written answer.

Mr. Tuer: We'll do that.

The Chair: Mr. Herard, please, followed by Mr. Miller.

Mr. Herard: Mine was really just a clarification just so that nobody thinks I'm making this up. You know, Mr. Davis indicated that he would have to know what I was looking at in order to answer the question, so I just want to tell him what I was looking at. In schedule 2, which is the consolidated schedule of salaries and benefits, from the very first line, which is the CEO, to the line that says, "Other management reporting to above," everything above that is where those numbers come from that resulted in an 83.4 per cent increase. That's what I need to know about.

Thank you.

Mr. Davis: We will get you a written response to that.

The Chair: Thank you very much.

Mr. Miller, followed by Mr. Dunford.

Mr. R. Miller: Thank you, Mr. Chairman. Before I read my question into the record, I'm wondering: can I have two sets of questions read into the record?

The Chair: Do go ahead, but be quick, and don't follow the example of Mr. Chase.

Mr. R. Miller: I will attempt to dispense with the preamble that Mr. Chase uses.

The first set of questions would be regarding seniors and continuing care. I'm wondering if you could provide the committee with information as to how many long-term care beds have been transitioned into assisted or supportive living beds over the past two years and what the plan would be for the next five years. The supplementary to that would be whether or not the region has received any direction from the ministry regarding the affordability and availability of long-term care beds. That would be the first set.

The second set, in relation to electronic health records. I'm wondering whether or not any of the services related to electronic health records have been contracted out to foreign-owned companies, and if in fact they have, whether or not those contracts and those companies would be subject to the same privacy laws as other health care professionals.

Thank you.

The Chair: Thank you, Mr. Miller.

Mr. Dunford, please.

Mr. Dunford: Yes. Regarding food safety, I'd like to know how many inspections were held at farmers' markets and what the result of those inspections might have been.

The Chair: Thank you very much.

Mr. Bonko, followed by Dr. Brown.

Mr. Bonko: Mr. Chairman, my questions have been answered. Thank you.

The Chair: Okay. Dr. Brown, please.

Dr. Brown: Thank you, Mr. Chairman. I've got two questions, one relating to the maintenance and replacement of infrastructure and equipment. Some comments have been made by staff at the Foothills hospital that maintenance of computers and printers is almost nonexistent and that upgrades of hardware don't happen until they actually die. I'm wondering if you could advise what the protocol is and what plan there is for maintenance and upgrading of computer and printing equipment. Also, with respect to the Foothills CAT scanner, the Siemens brand of CAT scanner reportedly has a very poor maintenance record, and I'm wondering what methodology is used to assess the quality and durability of your equipment before purchase.

Also, with respect to the recruitment of personnel, you are actively pursuing the recruitment of nurses from abroad. I'm wondering: what programs are being implemented to retain your existing nurses and prevent burnout of staff due to overwork and overtime and so on? Also, with respect to the nonhealth staff there are instances where you have nonmedical support staff who have been there for 15 years, who have good performance reports, and who have upgraded their skills, yet they're still stuck in an entry-level position equivalent to the people that are being hired on a summer session basis. I'm wondering what programs you have with respect to advancing your support staff.

The Chair: Thank you.

Ray Prins, please.

Mr. Prins: Thank you very much, Mr. Chairman. I just want to make a couple of comments, and that is that I've been very happy to be able to co-chair this with Hugh.

I want to thank all the members of this delegation from Calgary health as well as the delegations from Capital health, Northern Lights, and East Central for their information, for their patience, and for their diligence in answering questions succinctly and clearly, giving us a lot of answers and information.

3:00

I want to thank also Mr. Dunn for his work, Philip Massolin for his work as well. He produced the Global Funding and Alberta's Regional Health Authorities report, which you might find very interesting, as well as the health regions. You might want to ask him for that. There's a lot of good information.

Your answers and your comments have been enlightening and informative for us as MLAs as well as for all Albertans because this is on the record. The media has been here, and anybody can check out what has been said. Typically we would be asking these questions of the Ministry of Health and Wellness, and they would try to answer all these questions without having the knowledge that you have. So I think it's been very good to have you here and answering these questions for us. It has been a good exercise.

I want to wish you the very best as you go back to your respective regions and provide that very important and essential care to our people in health and wellness. Thank you very much, and God bless you all.

Mr. Tuer: If I could just make a concluding remark. We do appreciate the opportunity to be here today. We have appreciated the questions. Just the insight as to where your interest may be has been useful for us. I also particularly want to thank you for the comments that have been made around the staff of the health region and the fact that they are, you know, very dedicated, hard-working, possibly underpaid, possibly overstressed. The truth is that the only reason that health is working as well as it is today in the province of Alberta and certainly in the Calgary health region is because of the calibre of people we have there, and they probably don't have the opportunity to hear that often enough. So I appreciate those comments here.

The Chair: Thank you very much.

I would like to remind the members at this time that we have other business to attend to, but certainly the delegation is free to exit or talk to the media or talk to your people at the back. Again, thank you very much for your time with us.

If we could move to item 5 on our agenda, Other Business, I would first like to thank Corinne for her hard work in getting these meetings organized and her patience with the chair and everyone else. We appreciate that. On Monday Corinne mailed out the 2005-2006 annual reports from the next group, who is going to appear before us in October, the colleges and universities. So you can have a look at that, and the chair would like direction from you, please, on which, if any, research projects you would like Philip and his staff to work on in the next few weeks to give us some additional information regarding the October 16th and 17th visits.

Mr. Dunford.

Mr. Dunford: I would be appreciative if – it's a complex problem, Philip, so I don't know how far you can get into it. Every institution that comes forward looking for funding talks about how they don't have space and about all the people that they have to reject, but we know that those rejections aren't rejects. They just went to a different school and probably didn't bother to inform them. If we could have some sort of feel, you know, for how many Albertans weren't able to get into particular institutions, real or imagined. That's a helluva complex thing I've just handed you, but whatever you can do would be great.

Dr. Massolin: I think I know what your question is and why it's complex. But barring the ability to track the persons rejected and where they go and get accepted, can I just give you statistics on the rejections and the rates of rejections? Would that be a good second best?

Mr. Dunford: We'd have to see. But that's the game they play.

Dr. Massolin: Right.

Mr. Dunford: I don't want you buying into that.

Dr. Massolin: No. No.

Mr. Dunford: I want the other side: how many thousands of students out of grade 12 graduated, and were there spots for them?

Dr. Massolin: Okay.

Mr. Dunford: Calgary is infamous, by the way, for this game that's played. We've got two institutions coming, so I think we need to have that information.

Dr. Massolin: Okay. Fair enough.

Dr. Brown: I think there's an ancillary piece of information that I would like to have at our disposal. It relates to the question that I asked earlier, and that is the ultimate destination of graduates,

particularly in the health care field, the health care professionals that we're graduating. I think that there is some statistical evidence to show that people who graduate in a particular area or region or city tend to seek employment there, so I'm wondering whether or not we could get any data with respect to that because it doesn't do a lot of good to graduate practical nurses in Edmonton if they're required in the city of Calgary or in Lethbridge. I'm wondering whether or not we could get some analysis of where we need that additional capacity, not just the fact that it's on a province-wide basis – we're trying to expand capacity – but where that is required and where those graduates end up going.

The Chair: Thank you.
Ivan.

Mr. Strang: Thanks, Mr. Chairman. I guess one area that I would like him to investigate is the aspect of transferability from one institution to the other because they've got all different levels. You know, if somebody happens to be operating in Edmonton and then their family gets transferred to Calgary, sometimes they can't transfer into the same course. I want to see if we can get some connectivity there.

The Chair: Okay.

Mr. Chase: If you could please examine the top three funding priorities of the institutions we're examining. Looking at a five-year plan, what government financial commitment to these projects has occurred at this point? In other words, are we providing the institutions with the necessary support to postsecondary education?

The Chair: Okay. Now, in preparation for this meeting Philip did excellent work in going back five years and seeing how much money went to each respective health authority. Before that there were 17, and we decided to cut it off at nine and proceed to this fiscal year. Do you want something like that on the four institutions?

Mr. Chase: Yes, because we have to look at the past. That would probably be the way to do it. To what extent were the priorities, say, from 2005 through 2007 – restrict it to those years – met?

The Chair: Okay.

Mr. Chase: That might be a safer way, then, because we're a historical organization.

The Chair: Is that enough general direction?

Dr. Massolin: I think so. Yeah. "Enough" being the operative word.

Mr. Herard: I find it interesting how former ministers think, because I had charged him with that same thing about two or three days ago. You know what he's going to find: exactly what you said they would find. You know, we'll get stats, and we won't be able to do anything with them.

I wonder if he could maybe look into whether or not the department could request a database from the institutions that has recognizable identifiers of some sort, student numbers or whatever, so that we can actually come down to an answer to that question sooner than later. In other words, it's not good enough to just get the same answer – as you've said, you know, not buying into that because it's been going on for so many years – but is there something that could be done? Obviously, it can't be just, you know, a mark on a sheet of paper. There has to be a response sent, a rejection letter of some sort sent to somebody. Quite frankly, in my view, if all of those rejection letters went to one place and there was an alternate path for that individual to get into whatever it is that he couldn't get into, then we'd have a handle on it. Perhaps he could look into whether or not the department would actually go ahead and do that for once so that we know what the answer is.

The Chair: Thank you. Okay. We got some direction, and we appreciate that. Philip also works with the four policy field committees. If you could have some patience, there's a lot of work to do. The meeting is four and a half weeks away, five weeks. He's got lots of time.

3:10

Mr. Chase: So as well as Dr. Phil we've got Dr. Super Phil.

The Chair: We've got Dr. Super Phil.

Since we're plowing new ground here, is his report that he prepared for us and circulated to us a public document now?

Mr. Prins: We're in a public meeting.

The Chair: Yeah. Someone mentioned that it was available.

Mr. Prins: I mentioned that.

The Chair: Ray did. Okay.

Mrs. Dacyshyn: Well, generally we don't deem committee documents to be public information until the committee has met again to approve the minutes of this meeting, so from my perspective I can't release any of that information until the committee has approved it at its next meeting.

Mr. Prins: I would like to make a motion that

> we would make Phil's document public so that anybody that wants access to it could access that.

Mr. Bonko: Is that for debate at the next meeting, then?

The Chair: No. That would be now.

Mr. Strang: We don't have all the people here.

The Chair: But we have a quorum, so we can have a vote. If you guys would like to vote on his motion, all those in favour? Opposed? The motion is carried. So that is now a public document at the will of the committee.

Now, we have one other item of business, and that's that I received verbal notice from Mr. Bonko, and I believe I've received written notice at some point. I forget. You would like to present a notice of motion for the next meeting in October, correct?

Mr. Bonko: October 16, Mr. Chairman. This is verbal notice, and I will give all members in written form as well my intent to bring forward CDI College. Obviously, it's up for discussion by the committee before we can proceed to that, but I would like the discussion to be at the October 16 meeting.

The Chair: That would be to bring CDI College before the committee to examine their financial statements?

Mr. Bonko: Correct, and just to be able to question them openly like we have the other members or departments as well.

The Chair: Okay. Thank you very much.

Is there any other business?

Mr. Herard: Well, I guess that at the same time we'll have to have some, I suppose, opinion as to whether or not a public body such as this can ask or compel private entities to come and present to this committee. I really don't know what the answer is. I'm just thinking out loud that maybe we ought to have some sort of an opinion next time to know whether or not this is an issue.

The Chair: Well, I believe we've had direction in the past, but I could certainly approach Parliamentary Counsel and get an opinion. Is that fair enough?

Mr. Herard: Yeah. It's just that it's a question that popped into my mind as soon as I heard it.

The Chair: I'm certain we can invite anyone that we wish. We've gone through this before. We've asked similar questions before we arranged these meetings, and this standing committee has considerable power, providing that the members want to use it.

Mr. Dunford: Well, it'll be a motion, and it'll be debated, and then we'll decide.

The Chair: It'll be debated. Exactly. Certainly, I will if you would like get information for you from Parliamentary Counsel because I believe that before you were on this committee, we had the same question, and you'll have to forgive me.

Yes. Corinne can have the floor, please.

Mrs. Dacyshyn: Our practical guide to committees says on page 32:

> A committee of the Legislative Assembly may invite any person to appear before it as a witness. A committee may not, however, summon any person to appear as a witness without an order of the committee or the Assembly . . . A witness cannot be summoned or brought before the committee by a Member on a Member's own initiative.
>
> Power to compel a witness to appear before a committee, to give evidence on oath orally or in writing, as well as producing papers, documents, or things required by the committee is provided in section 14 of the Legislative Assembly Act reproduced below.

Mr. Herard: Does that apply to public bodies or private bodies?

Mrs. Dacyshyn: Any person.

The Chair: Any person, yeah.

Mr. Herard: It's just that I wouldn't want to be making a decision without knowing the ramifications in terms of the law. That's all.

The Chair: No. That's fair enough.

Okay. Is there any other business? Seeing none, I would like to remind the members that the date of our next meeting is Tuesday, October 16, with Mount Royal College and Grant MacEwan. I believe we're going to have an organizational meeting at 9 o'clock Tuesday morning to review with the Auditor General and Philip and his research team the information that will be provided regarding the meeting.

Mr. Miller.

Mr. R. Miller: Yes. Thank you, Mr. Chairman. I was just going to first of all acknowledge the Auditor General's office for providing us their suggested questions this afternoon. That was something that, unfortunately, didn't happen yesterday. I appreciated having it in front of us this afternoon, and I would ask if we could have your suggested questions in writing at that organizational meeting next month.

Mr. Dunn: We'll do that. Obviously, we were just trying to see how these things were going to work out. We will do that in the future, and we'll do all four institutions at the one meeting. Yesterday we only did the two, and we really should have done the four.

The Chair: Absolutely. Again, I would like to thank you for your patience as this process progresses.

If there is nothing else, can we have a motion to adjourn, please? A motion by Mr. Harry Chase that the meeting be adjourned. All those in favour? Thank you very much.

[The committee adjourned at 3:16 p.m.]