Legislative Assembly of Alberta

The 27th Legislature
Second Session

Standing Committee
on
Public Accounts

Health and Wellness

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Legislative Assembly of Alberta
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Second Session

Standing Committee on Public Accounts

MacDonald, Hugh, Edmonton-Gold Bar (AL), Chair
Quest, Dave, Strathcona (PC), Deputy Chair

Benito, Carl, Edmonton-Mill Woods (PC)
Bhardwaj, Naresh, Edmonton-Ellerslie (PC)
Chase, Harry B., Calgary-Varsity (AL)
Dallas, Cal, Red Deer-South (PC)
Denis, Jonathan, Calgary-Egmont (PC)
Drysdale, Wayne, Grande Prairie-Wapiti (PC)
Fawcett, Kyle, Calgary-North Hill (PC)
Jacobs, Broyce, Cardston-Taber-Warner (PC)
Johnson, Jeff, Athabasca-Redwater (PC)
Kang, Darshan S., Calgary-McCall (AL)
Mason, Brian, Edmonton-Highlands-Norwood (ND)
Olson, Verlyn, QC, Wetaskiwin-Camrose (PC)
Sandhu, Peter, Edmonton-Manning (PC)
Vandermeer, Tony, Edmonton-Beverly-Clareview (PC)
Woo-Paw, Teresa, Calgary-Mackay (PC)

Department of Health and Wellness Participants

Hon. Ron Liepert	Minister
Linda Miller	Deputy Minister

Alberta Health Services Participants

Stephen Duckett	President and Chief Executive Officer
Robert Hawes	Vice-president, Financial Reporting
Ken Hughes	Board Chair
Chris Mazurkewich	Chief Financial Officer

Auditor General's Office Participants

Fred Dunn	Auditor General
Vivek Dharap	Assistant Auditor General
Ronda White	Assistant Auditor General

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Standing Committee on Public Accounts

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8:30 a.m. Monday, October 26, 2009

[Mr. MacDonald in the chair]

The Chair: Good morning, everyone. I would like to call the Standing Committee on Public Accounts to order, please. On behalf of the committee I would like to welcome everyone in attendance. If we could quickly go around the table and introduce ourselves before we get to the agenda. We'll start with the Member for Strathcona, please.

Mr. Quest: Good morning. Dave Quest, MLA, Strathcona.

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

Mr. Benito: Carl Benito, Edmonton-Mill Woods.

Mr. Jacobs: Good morning. Broyce Jacobs, Cardston-Taber-Warner.

Mr. Vandermeer: Good morning. Tony Vandermeer, Edmonton-Beverly-Clareview.

Mr. Dallas: Good morning. Cal Dallas, Red Deer-South.

Mr. Bhardwaj: Good morning. Naresh Bhardwaj, Edmonton-Ellerslie.

Mr. Denis: Good morning. Jonathan Denis, Calgary-Egmont.

Mr. Kang: Good morning. Darshan Kang, Calgary-McCall.

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

Mrs. Wong: Good morning. Charlene Wong, Health and Wellness.

Mrs. Miller: Good morning. Linda Miller, Health and Wellness.

Mr. Liepert: Ron Liepert, Health and Wellness.

Mr. Hughes: Ken Hughes.

Dr. Duckett: Stephen Duckett, Alberta Health Services.

Mr. Mazurkewich: Chris Mazurkewich, Alberta Health Services.

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

Mr. Dharap: Vivek Dharap, Auditor General's office.

Mr. Dunn: Fred Dunn, Auditor General.

Mr. Fawcett: Kyle Fawcett, Calgary-North Hill.

Ms Woo-Paw: Good morning. Teresa Woo-Paw, Calgary-Mackay.

Mr. Sandhu: Good morning. Peter Sandhu, MLA, Edmonton-Manning.

Mr. Drysdale: Wayne Drysdale, Grande Prairie-Wapiti.

Mr. Johnson: Jeff Johnson, Athabasca-Redwater.

Mr. Doerksen: Arno Doerksen, Strathmore-Brooks.

Ms Rempel: Jody Rempel, committee clerk with the Legislative Assembly Office.

The Chair: Hugh MacDonald, Edmonton-Gold Bar.

Item 2, the approval of our agenda as circulated. Are there any questions or any other issues you want to have moved to item 2 at this time? No? Moved by Mr. Drysdale that the agenda for the October 26, 2009, meeting be approved as distributed. All in favour? None opposed. Thank you.

Approval of minutes. There are three sets of minutes here, from June 3, October 6, and October 7, 2009. Are there any amendments to those minutes as distributed? Seeing none, may I have approval of those three sets of minutes? Moved by Mr. Chase that the minutes of the June 3, 2009, Standing Committee on Public Accounts as well as the minutes for the meetings of October 6, 2009, as well as October 7, 2009, be approved as distributed. All those in favour? None opposed. Thank you.

This comes, of course, to item 4 on our agenda, which is the meeting with officials from Alberta Health Services. We will be dealing with the Auditor General's reports from April and October of 2009, the annual report of the government of Alberta 2008-09 as well as the Health and Wellness annual report, two volumes, for 2008-09 as well as the 2008-09 Alberta Health Services annual report and the Alberta Health Services performance report from September of 2009. Everyone should have and hopefully did receive briefing material prepared for the committee by LAO research staff.

At this time I would like to invite Dr. Duckett to make a brief opening statement on behalf of Alberta Health Services. Dr. Duckett, please.

Dr. Duckett: I don't have any comment to make at this stage, but I think the minister does.

Mr. Liepert: Yeah, I will make a few opening comments. We're happy to be here this morning. I think it's important that we present an overall picture of health care delivery and policy in this province, and they work together. I know that there were some difficulties in trying to arrange appropriate times for both this committee and for the Alberta Health Services folks. I want to go on record to say that at no time was it ever refused that Alberta Health Services would attend this group, nor was there ever a meeting skipped.

We're delighted to be here today to answer any and all of your questions. For the most part I think that Dr. Duckett and Chairman Hughes will be quite prepared to provide the answers that you need, and if there are questions around policy, if there are questions around governance issues that I should answer, I am more than happy to do that and would probably just suggest that we move straight on to questions because typically in these sessions we run out of time for questions, so we want to allow as much time as we possibly can.

The Chair: Thank you.

Mr. Dunn: Ronda White will read in very brief comments from the office of the Auditor General.

Ms White: Our work in the Ministry of Health and Wellness last year included two large systems audits and the annual audits of the financial statements of both the department and Alberta Health Services.

The first project is electronic health records. The results of our audit on the ministry's systems for managing the implementation of

electronic health records starts on page 59 of our report. We made four recommendations to the ministry to improve its management of these systems. The department needs to work with AHS and the governance committee to improve the oversight of EHR. The department also needs to deliver its projects and initiatives in accordance with project management standards and proactively monitor access to the Netcare portal.

We also conducted our follow-up of our 2006 recommendations on food safety. That work starts on page 87 of our report. We followed up 10 recommendations, and we repeated five of the original recommendations. Specifically, we found that AHS needs to improve its food inspection systems and automated information systems and that the department, AHS, and Agriculture need to work together to improve food safety planning and accountability.

We've also included the results of the annual audits of the department and AHS on page 245. We made two recommendations to the department: to improve its compliance monitoring processes and to improve its practices for accountability for conditional grants. We made 11 recommendations to Alberta Health Services, that start on page 256 of the report. These recommendations relate primarily to executive compensation, information technology, capital project management and financial monitoring and reporting controls.

The last item that I'll highlight for the committee is on page 340 of the report. We list the recommendations that we've previously made to the ministry that are still outstanding. You may be interested in those that are outstanding for more than three years.

Mr. Chair, those are our comments. We'd be open to answering any questions about our report.

The Chair: Thank you very much.

We will proceed to questions here, starting with Mr. Chase, followed by Mr. Johnson.

Mr. Chase: Thank you. My first question reference is page 61 of the Auditor General's October 2009 report. Page 61 reports that $615 million has been spent on building components of the electronic health record systems but that "the Department has not calculated the total cost for all the EHR systems it funds." Page 61 also reports that there is no "combined business case for the EHR components." Now, how is the department monitoring the implementation, progress, problems, et cetera, of building the EHR system in the absence of a business case?

Mr. Liepert: Let me start. I'll give some overall comments and then ask Deputy Minister Miller to add to the comments. There's probably no initiative that's going to be more important to delivering quality health care in the future than the electronic health record. It will avoid duplication. It will improve safety. I believe it will substantially streamline costs. The difficulty you have with the electronic health record, however, is that the success of it is contingent on participation by the professionals. We continue to struggle to ensure that we have all of the health care providers on the electronic health record, but it's a constant challenge. I'm told consistently, however, when we meet with other provincial jurisdictions, that we're ahead of the rest of the country. That gives me some comfort but not enough because I think we need to be further than we are.

Maybe I'll ask my deputy to elaborate a bit more on the details as asked by the Member for Calgary-Varsity.

Mrs. Miller: Good morning. While it is true that we don't have one, single document called the business case for the electronic health record, because the electronic health record is a combination of hundreds of projects over the course of the last 10 years that we've been undertaking this initiative, what we do is embed the business case in each of what we call the project charters with each major initiative. In those charters we document the anticipated costs of achieving that broad-scale initiative. We track those costs and benefits with each major-scale initiative.

8:40

We will work toward an overarching business case; however, given that the journey started well over 10 years ago, quite frankly, much of what we know today we were not aware of 10 years ago. It is a learning journey as we go, and we have felt it was a better use of time and energy to embed those business cases in each of the subsequent subinitiatives achieving the total electronic health record.

Mr. Chase: Thank you very much. Obviously, the Auditor General didn't find the embedded plan nor a total overarching plan.

Why was the department not proactively monitoring access to the Netcare portal given how important it is?

Mrs. Miller: We do have proactive mechanisms, but given that there are over 22,000 providers that connect to the electronic health record, we have a system in place where we rely on the delivery organization, in this case Alberta Health Services, to have people identified that need to have access to the electronic health record, to provide that information to us, and then when they either leave the organization or have a change of responsibilities, it is up to the supervisor where that particular individual works in the organization to notify Alberta Health and Wellness that their user privileges either need to be disconnected or changed in some way.

It is true that Alberta Health and Wellness was not notified on some of the user privileges; however, it is important to acknowledge that, by far, 95 per cent of them were accurate and modified accordingly given current job descriptions. We will work to improve that relationship and the monitoring of responsibilities and who should have access to what. It is a recommendation that we have accepted, that we need to do a better job and produce a standard of user access privileges that needs to be followed throughout the organization, be it at Alberta Health and Wellness, be it within the physician community, the pharmacist community, or, indeed, within the ministry itself.

Mr. Chase: Thank you.

The Chair: Mr. Johnson, followed by Mr. Kang, please.

Mr. Johnson: Thank you, Mr. Chair, and thank you to all the folks from Health and Wellness and Alberta Health Services for being here today. We appreciate your time.

My question I believe I'll address to Mr. Hughes, and whoever wants to respond can respond. It's with respect to the sensitive issue of severances, coming out of the '08-09 annual reports. After the large payments we saw to executives from the former boards, the expectation would be that these kind of payouts wouldn't happen any longer, yet we saw some again with AHS executive Paddy Meade and others, as indicated at page 267 of the annual report. I guess I'll ask two questions and just leave them with you. My constituents, of course, would like to know why this happened, and we'd like some kind of assurance that these kinds of payouts, or severances, are not going to be standard operating procedure or continue to happen in Alberta.

Mr. Hughes: Thank you, Mr. Chair. I'm pleased to take those two questions. It is quite clear that historically there were compensation practices. From the perspective that I have as a person deeply experienced in governance, compensation is often one of the most difficult aspects of governance to get right. It's quite clear that there were practices which do not meet the current expectations in governance. The severances that were undertaken last July related to contracts that had been written over several years prior to that. Those were more common practices in the public sector during those years. The contract that was written for Paddy Meade as the executive vice-president was a contract that was, first of all, very early in the term of the interim board.

If you think about last year, the year that we're looking at here, it's important to keep in mind that there were really three phases from a governance perspective. There was the first phase, under which the existing 12 entities had their own individual boards. That was from the 1st of April to the middle of May. From the middle of May to the 1st of December there was an interim board in place comprised of seven Albertans. From the 1st of December to the end of March there was a board of a full 15 appointed on a longer term appointment basis. The agreement with Paddy Meade was struck very early in the second phase with the interim board. The practices were still being followed based upon historical practices within the organization, and I can assure all constituents, all Albertans, that this is a practice that we will no longer follow in Alberta Health Services. Starting with the contract with Dr. Duckett, we have established the practice and it's a clear practice that severances in senior executive contracts will not exceed one year for new contracts written.

The Chair: Thank you.

Mr. Kang, please, followed by Mr. Dallas.

Mr. Kang: Thank you, Mr. Chair. On page 259 of the Auditor General's October report it states that one terminated CEO will continue to be in an AHS SERP until March 2011 and will continue to accumulate pensionable service for a total cost of $290,000. Was this a previously decided arrangement for this individual in the contract, and why is it being done?

Dr. Duckett: As Mr. Hughes indicated, we were bound by the contracts entered into by the previous regional health authorities and the pre-existing provincial organizations. All of those contracts which are referred to on those pages 258, 259 and in particular that one are related to the decisions of the previous organizations. That's what their contract provided for, and unfortunately that's what we are bound to do.

Mr. Kang: My supplementary questions, sir. Who is the CEO who will continue to have their SERP contributed to by AHS two years after being terminated, and how many other such cases are there that you're aware of?

Dr. Duckett: I'm not precisely aware of who that individual was.

Mr. Hughes: It's at the Cancer Board. No, I'm not aware of any other examples like that. It was an exception.

The Chair: Thank you.

Mr. Dallas please, followed by Mr. Chase.

Mr. Dallas: Thank you, Mr. Chair. My question is for Mr. Hughes. In late 2008 the Alberta Health Services Board received increased compensation over the pre-existing board compensation level. My constituents have expressed their interest and concern with this. To Mr. Hughes: why did the board decide on these raises?

Mr. Hughes: Well, Mr. Chair, actually the board didn't decide on raises. The board itself can't compensate itself. The board is appointed by the minister, and compensation is set by the minister.

Going back to the three phases, the first phase was an interim phase. The board was established with a relatively short-term perspective to establish Alberta Health Services, and a level of compensation was established by the minister at that time, in May of 2008. Subsequent to that we went through a process, the minister and I, of casting and looking for and finding some very talented Albertans to take on this assignment. The minister appointed the full board on December 1, 2008, and he established a compensation level at that point.

Having said that, in the context of the belt-tightening that all Albertans are facing today, those of us in the private sector and those who serve in the public sector are facing similar constraints. Our board has a meeting this week in Red Deer, and I'll be recommending to our board that we consider recommending to the minister that he establish new compensation levels; i.e., reduce compensation levels for board members back to something similar to what the interim board compensation levels were.

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

8:50

Mr. Chase: Thank you. I'm referencing page 42 of the government of Alberta 2008-09 annual report. Given the backdrop of over a billion dollar health ministry deficit, the elimination of chiropractic services and podiatry funding, the cutbacks to eye surgery, tripling of individual Blue Cross premiums, hiring freezes, hundreds of bed closures, on page 42 the report shows that there is $1.7 billion held in a trust fund for the regional health authorities and various health institutions' construction accounts. This is an increase of $892 million, double the amount from the previous year. What is the reason for this increase?

Mr. Liepert: Well, I think we need to make it clear that there was no cutback in podiatry services. There was no cutback in eye surgery as alleged by the member. If he's got statistical evidence that I don't have, I'd ask him to bring it forward. There were no bed closures. There are no acute bed closures in this province, so, again, if he has information in that area, please bring it forward.

Could I get the last part of the question repeated?

Mr. Chase: I'd be glad to repeat it. It had to do with the $1.7 billion held in a trust fund, which is an increase of $892 million, double the amount from the previous year.

Mr. Liepert: I don't know what trust fund the member is referring to. I sure wish I had that $1.7 billion.

Mr. Chase: Page 42 of your report.

Mr. Liepert: Okay. Good. If we can have somebody at Alberta Health Services answer it, I'd appreciate that.

Mr. Mazurkewich: Those trust accounts are the construction and capital projects cash advancements from Alberta Health and Wellness to Alberta Health Services.

Mr. Liepert: Now I know what he's talking about. Annually Alberta Health and Wellness in its budget that is approved by the Legislature has a capital plan. In our case almost all of it flows to what used to be the regions, now Alberta Health Services, for capital projects. There was a combination of things, but I think probably the major one was the inability to proceed as quickly in the buoyant economy that we had. There was an inability to expend those dollars as quickly as we were advancing them. So when we hit, I guess, the end of '08-09, Alberta Health Services was left with something like about a billion and a half dollars in their capital account. For projects that had been approved, it would be expended, but we weren't able to expend it in that current year. Now I know what you're referring to.

Mr. Chase: Thank you. The cuts concern me when you're sitting on $1.7 billion. Can you provide a detailed list of how these funds will be allocated and how it was determined where the funding would be directed?

Mr. Liepert: Well, as I said earlier, our capital plans are public, and I'm going to take a shot at the shot that was taken. There are no cuts. Alberta Health Services received a 6 per cent increase in funding over the previous year. That may not be what the member would like to have, which is continued double-digit expenditures, annual increases, but there was not a cut in funding. No one is sitting on any money. If you want to suggest that we redirect, as an example, the billion dollars out of that capital fund for continued operating expenditures and stop construction of the south Calgary hospital, then I want you to make that comment in Calgary, Mr. Member.

The Chair: Thank you.

Mr. Quest, followed by Mr. Kang, please.

Mr. Quest: Thank you, Mr. Chair, and, again, thank you, everybody here. Thank you to all of you for being with us here this morning. I was looking at page 44 of the annual report. The ending financial positions for the different health regions vary quite a bit from a deficit of $219 million for the Calgary health region to a surplus of $30 million for the Northern Lights health region. So it's quite a range in performance and practices. My question for either Dr. Duckett or Mr. Hughes: was there a process in place for identifying and documenting best practices amongst the various health regions as they were amalgamated?

Dr. Duckett: Thanks very much. Indeed, there was significant variation in the performance of the former entities in terms of their adherence to budget. Although I wasn't here, I guess that might have been one of the reasons which led to the amalgamation.

But going forward, we are certainly trying to ensure that the ideas in one part of the province are able to be accessed by everybody else in the province, and there are a couple of ways in which we are doing that. For example, if I take Chris Mazurkewich's area of responsibility, he is amongst other things the chief finance officer for the organization, and what we're doing is that we're integrating the finance function. So the best practices of each of the regions are able to be brought to bear through a single accountability. Chris also has responsibility for metropolitan hospitals, so the vice-presidents of Rockyview hospital in Calgary and Royal Alexandra hospital in Edmonton report to the same person in the organizational structure. So we are able to honestly compare the performance of those two hospitals without the previous territoriality that inhibited honest and fair benchmarking.

We've also brought together the zone vice-presidents, the vice-presidents in charge of the Calgary region and Edmonton and central and northern and southern, so that they can share their ideas. As you know, we're facing a significant budget challenge, and what we want to do is make sure that the ideas from one part of the province, that the bright ideas anywhere in the province can be used elsewhere in the province. It's certainly one of the things we are doing.

Mr. Liepert: I'd just like to supplement that very briefly if I could. One of the things that I was probably the most shocked about when meeting with regional health authorities prior to the amalgamation in the first month or so in this portfolio was the fact that there was almost developed an inherent – if a good idea happens somewhere in one of the regions, there was almost a standoffish attitude in many of the other regions to take that good idea and run with it. It was kind of like: well, if they thought of it first, then it can't be any good. It was that kind of thinking that led ultimately to the decision that we made last May.

Mr. Quest: Very good. Thank you.

The Chair: Anything else?

Mr. Quest: No.

The Chair: Mr. Kang, please, followed by Mr. Denis.

Mr. Kang: Thank you, Mr. Chair. On page 276 of the Auditor General's report it says that $63 million was granted to East Central for capital projects in other former health authorities. Which specific project was the $63 million allocated for?

Mr. Liepert: I would have to have someone take a look. In a budget of a couple of billion dollars I couldn't tell you specifically what it was. I know there were several capital projects that had been approved for East Central as with a whole bunch of others. Does someone have that information? We'll have to get that answer for you. I don't have a specific project that I can refer to.

Mr. Kang: Thank you, sir. My supplementary question is that it states that East Central was not even aware of this grant. Does that mean that East Central didn't know what the grant was for or that it was given the money and didn't know about it? Can the board clarify how this is even possible?

Dr. Duckett: I think it is possible this way. The way the merger effectively took place was that East Central became the principal management entity. I wasn't here at the time, but the board had been previously dismissed, so the interim board was first appointed as the East Central board and then as the board of each of the other entities, and East Central became the management entity. My salary, for example, when I was first appointed, was paid through East Central. That's how they did it. In turn that meant that some of the decisions were made corporately in Edmonton and charged against the East Central health authority accounts. So it would not necessarily be surprising that the people who were managing the old East Central were not aware of what was happening for Alberta as a whole. You see, for example, on page 276 that "East Central Health . . . received an $80 million grant from the Department of Health and Wellness . . . for transition expenses." That was part of the use of East Central as the management entity before Alberta Health Services came into effect. My salary is still paid through an East Central payroll code.

Mr. Kang: So that $63 million was included in that $80 million, or was that on top of that?

Dr. Duckett: That was on top.

Mr. Kang: Thank you, Mr. Chair.

9:00

The Chair: Thank you.

Mr. Denis, please, followed by Mr. Chase.

Mr. Denis: Thank you very much, Mr. Chair. I do want to ask a couple questions to Dr. Duckett about the south Calgary hospital that's being constructed right now. I get a lot of calls on this in my office, representing a constituency in south Calgary. I notice in the report it's very difficult to tell what exactly is going on. I wonder if you could comment on the progress, where we're at.

I'll have a supplemental as well, Mr. Chair.

Dr. Duckett: I haven't actually visited the south health campus, but I've driven past, and there it is, rising up above the ground as you drive past along that freeway. The progress changes on a daily basis. At the current stage we're at, the program design work on south health campus is well under way, and the construction is about 40 per cent, I think, complete at this stage. At the moment we expect south health campus to be complete on schedule. It is currently running to schedule and to budget, and we expect it to open on the scheduled date in 2011.

Mr. Denis: Opening on the scheduled date in 2011.

Over the last year could you comment as to where we're at on the budgetary estimate, over or under budget for construction?

Dr. Duckett: In terms of the original allocated budget we are under budget. We have proposed a variation to the budget of a hundred million dollars to reduce our budget expenditure because of the success of the – well, the economic situation is quite different in terms of tendering and the like.

Mr. Denis: Thank you very much.

The Chair: Thank you.

Mr. Chase, please, followed by Mr. Benito.

Mr. Chase: Thank you. I'm referencing page 267 of the Auditor General's October 2009 report. In response to the minister, had the southeast hospital in Calgary been built in a timely manner – before, for example, the General was blown up – a billion dollars could have been saved. You are currently building shells and playing musical beds without providing the operational funds to staff them.

Referencing page 267, can the board provide a detailed breakdown of the $887 million deficit for '08-09 with a budgeted operating deficit of $392 million?

Mr. Liepert: I'll let Dr. Duckett or Ken Hughes answer the second part of the question, but the first part of the question reminds me of a country music song, *No Future in the Past*. We can dwell on the past all we want, but our focus is going to be on the future, providing an accessible, sustainable health care future for all of our grandchildren. We can spend a lot of time revisiting whether we should have blown up a hospital or not, but that ain't going to get us anywhere.

I'll ask the officials to answer the second part of the question.

Dr. Duckett: I'm just trying to hunt through this voluminous paper that I've got in front of me. Page 44 of the Alberta Health Services report indicated that the accumulated budget deficit was $343 million. I think part of the difference in the Auditor General's statements was Alberta drug and alcohol commission, which is sort of integrated into Alberta Health and Wellness. Page 44 of our annual report indicates the situation by each of the former entities.

Now, maybe if I could ask for the other part of the question again?

Mr. Chase: It had to do with the $887 million and, of that, the budgeted operating deficit of $392 million. It was part of the same question.

Dr. Duckett: Yeah. Well, the operating deficits are there on page 44. In terms of the accumulated deficit of $887 million, I presume that – Ronda.

Ms White: Maybe I can help out here. The amounts that we refer to in our report are the budgeted amounts, which actually would appear in each of the financial statements for each of the regions in the Alberta Health Services annual report. Then what Dr. Duckett has referred to on pages 43, 44 are the actuals that occurred. I think the detail is all in terms of each financial statement. The budget is provided.

Mr. Chase: Thank you. With regard to the minister, if you don't learn from mistakes of the past, you're doomed to repeat them.

Did the department of health give specific instructions regarding where cost savings were to come from or where funding it provided AHS should be prioritized?

Mr. Liepert: Well, clearly, we provide the funding to Alberta Health Services. We meet on a fairly regular basis to discuss the delivery of health care in this province, but at the end of the day the services that are delivered by Alberta Health Services are the decision of the CEO, the management team, and approval of that board. I don't know if there is anything specific the member might have in mind, but I don't know how to answer the question any other way than that.

The Chair: Thank you.

We'll move on. Mr. Benito, followed by Mr. Kang, please.

Mr. Benito: Thank you very much, Mr. Chair. My question is to our board chair, Mr. Hughes. It is well known that the former Capital health region was an international leader in the delivery of our health care. My constituents of Edmonton-Mill Woods are very concerned that due to the actions taken in 2008 to merge the health regions into Alberta Health Services, we have lost that edge. Mr. Hughes, how can we be sure that the capital area will continue to be a leader in health care?

Mr. Hughes: Very good question. Thank you. There is no question that the capital region was a strong region that had a deep commitment to innovation and to excellence, and the opportunities that we're building on now build on those strengths. One of the challenges that the former structure led to, which the minister has spoken of as well here this morning, is the difficulty in ensuring that that innovation and those best practices get delivered right across the province as well. We've got some fabulous programs in this province on stroke recovery and management, cardiac issue management for patients across Alberta. It's as good as anywhere in the country. We're exceptionally well served, and we're well

served because of the leadership of those centres of intensive medical leadership that you would find in larger centres like Calgary and Edmonton. We're building on that. We're deeply committed to it. The head office of Alberta Health Services is here in Edmonton, and actually Albertans currently rate their own perceived health at the highest rate of Canadians when asked the same question.

Mr. Liepert: I just want to add very briefly. Ken mentioned that the head office of Alberta Health Services is located in this city. I need to correct some misinformation that was reported a couple of weeks ago by a certain member in this room that somehow the senior executives of Alberta Health Services are from Calgary and not from Edmonton, and that is absolutely incorrect. Maybe Dr. Duckett can clarify that, but I think that out of the senior management team the majority live in this city. I'll ask Stephen if he can add to that.

Dr. Duckett: That's absolutely right, Minister, although I would have to say that I am very intolerant within the organization of the continuation of the Edmonton and Calgary rivalry. My view is that the Edmonton-Calgary rivalry is good in hockey. I went to the Oilers and Flames game and saw the Oilers lose by one goal at 30 seconds before the bell, or whatever you call it, in that game, but what's good in hockey is not necessarily good in health care. As I said, I've made it clear within the organization that we are here for the whole province, that we should pay as much attention to Calgary as to Edmonton as to Westlock as to Red Deer as to Lethbridge and so on.

In terms of where the executives live, I live here in Edmonton – you can't quite see my house from here, but it's within five or seven minutes of where we're sitting – as do the majority of the executives. Obviously, some of the executives live outside Edmonton. One lives in Westlock for example. One or two live in Calgary, so we're certainly a provincial organization.

9:10

Mr. Benito: My follow-up question, Mr. Chair, is about the emergency department snapshot for Grey Nuns hospital for quarter 4, 2008-2009, which is 23.8 per cent. Are there any measures that we are taking or are we placing some things so that only emergency activities are done in the emergency department of any hospital so the less urgent and nonurgent are not being delivered at the emergency departments of hospitals?

Dr. Duckett: We're addressing that in all sorts of ways. One of the most interesting is that we've established the Northeast health centre and Strathcona first clinic. I forget what the name of it is, but it's up in Strathcona. The clinic there is only open a limited number of hours, staffed by a nurse practitioner and an emergency physician, and during the opening hours of that clinic it had an impact that reduced the number of people turning up at the Grey Nuns by 20 per cent coming from Strathcona.

There are lots of things we can do to reduce the pressure on emergency departments, and we are doing more of them. We would be looking to see more urgent care clinics, more strengthening primary care, strengthening our ability to keep people out of the emergency departments and hopefully, thus, improve the performance in those areas.

Mr. Benito: Thank you very much, Mr. Chair.

Mr. Hughes: Mr. Chair, can I just augment that answer?

The Chair: No. We're going to move on, please. There's a long list.

Mr. Kang, please, followed by Ms Woo-Paw.

Mr. Kang: Sure. Thanks, Mr. Chair. My concerns are about the Peter Lougheed hospital. We were building a new wing in the hospital. We are going to open up new beds, maybe I think it was 140, and then we are going to close the same amount of beds on the other side. With all those bed closures happening, how is it going to improve the situation? How is it going to improve the wait times in the emergency rooms if you are going to close the same amount of beds, you know, opening the new ones?

Dr. Duckett: Thank you very much. I visited Peter Lougheed Centre a couple of weeks ago to actually look at that, look at the beds, look at the facilities in that hospital. I'm very proud of what we've done. Yes, we've actually not increased the net amount of beds. We had to make a priority choice about that. But if you just look at the new facilities, they are fantastic facilities, much better facilities, much more space, much safer facilities, so it is actually a quality improvement in terms of the accommodation that each of those patients is having. Regardless of the fact that we haven't actually increased the number of beds, we've certainly improved the care for every one of those people who are now able to be in that new block.

Mr. Kang: My concern: we should be improving the quality and the quantity at the same time because that's the fastest growing quadrant of the city, and we should be keeping the future growth in mind as well. We are not even keeping up with the present population. If we start to go after quality, then quantity is going to lag behind, and then we're going to have a much worse situation on our hands than we have now.

Mr. Liepert: You know, I'd like to answer that question if I could, Mr. Chairman. There's a belief by some people that if you continue to do things the same way, you're going to get different results. I'm a big believer that if we build them, they'll fill them. I think we've got to look at ways that we keep people out of hospitals and not build more beds so we can put people in them. Our whole mission around what we're doing in health care is to try and treat in urgent care settings, in increased home care, the development of PCN models that have team-based care.

You know, we've got to get away from this thought that somehow the only avenue to treating health care is through a doctor's office, emergency room, and then stick them in a hospital bed. We're never going to get a healthier society, we're never going to have a sustainable health care system if we just keep building facilities, building more beds, and filling them up. I think that what Dr. Duckett talked about is the quality that we need to be ensuring that patients are receiving, and we need to start to change the culture so that we can provide care in facilities and in places outside of hospitals.

The Chair: Thank you.

Ms Woo-Paw: First of all, I'd like to say that I agree with what the minister just said, and I wish that your ministry would work with some of us to convince people like my three Canadian-born children about the potential of alternative medicine like Chinese herbal medicine. Anyway, I'd also like to begin by saying that I'm very pleased to say that Albertans continue to receive high-quality care

despite some of the challenges our health sector faces, just like health sectors across the globe.

I would appreciate your response to the Auditor General's recommendation on page 253. This recommendation is a repeated recommendation that has been there since 2001 to 2007-08. The Auditor General has identified the need to implement a monitoring process to ensure that program areas receive and review reports on grants, conditional grants, so that we know whether the recipients use these funds as agreed to and unused funds remain available for future funding decisions. That's my first question.

Mr. Liepert: I think it's a valid recommendation that we probably have to acknowledge needs to be done better. One of the purposes behind merging into one health region is that it's much easier to work and ensure that with the unconditional grants we're achieving common objectives. All I can say is that we will make the commitment that for the next Auditor General's report you're not going to see that one in there again.

Ms Woo-Paw: Thank you. My supplemental is: could you remind us approximately what percentage of the overall expenditure is allocated to conditional grants?

Mr. Liepert: I'm not sure I can answer that. We could certainly get that answer, though, for the member.

Ms Woo-Paw: Thank you.

The Chair: Thank you.

Mr. Chase, please, followed by Mr. Bhardwaj.

Mr. Chase: Thank you. I have a who's-in-charge question resulting from the Auditor General's October 2009 report. In a letter from the minister of health the minister states: "Having the Chief Executive Officers and senior executive team contracts approved by the Minister of Health and Wellness . . . ensures that elected officials are accountable to Alberta taxpayers for future contracts." Can either the board or the minister clarify what involvement the minister of health has during the approval process of CEO and senior executive team contracts?

Mr. Liepert: Under the new model that the board chair outlined earlier, the board is responsible for hiring, but the final sign-off comes through my office. So I guess it's joint, but the final signature is mine.

Mr. Chase: Thank you, and you personally answered my second supplemental.

If there is a disagreement between Alberta Health Services and the minister of health regarding specific aspects of a contract, from what you've just said, you're the boss; the buck stops or starts at your door.

Mr. Liepert: I think that when it comes to health care, the buck stops at the minister's door on everything, so the answer to that is yes. I feel very strongly that one of the reasons why we moved to one health region was the lack of accountability that existed under the previous model. That's not necessarily anybody's fault; it's just the way it evolved. What we've seen through some of the severance packages that we were obligated to pay when the minister did not have final approval is the kind of thing that we are absolutely going to avoid in the future.

9:20

The Chair: Thank you.

Mr. Bhardwaj, please, followed by Mr. Kang.

Mr. Bhardwaj: Thank you very much, Mr. Chairman. Dr. Duckett, according to the '08-09 annual report on page 44 Alberta Health Services has been left with an accumulated deficit of $343 million from the previous health region boards with 7 out of 9 posting a deficit. Could you tell us what measures you have taken thus far to reduce that deficit, please?

Dr. Duckett: Thank you very much. Well, you'll appreciate that there's a huge range of activity, a huge range of measures we've had to do. The first thing: as you know, when you're in a deep hole, you stop digging, so what we implemented about three or four months ago, maybe five months ago now, was a tight vacancy management process. We said that if a position wasn't filled in the last quarter of the last financial year – that is, basically, if it wasn't already incorporated in the spend of last year – then we would have to look at it very, very, very carefully before we'd fill it again. That vacancy management process has started to bring down the trend of our spending.

Secondly, we then looked at specific initiatives for us to save money which wouldn't impact on our other goals of access and quality. About two months ago we announced the Edmonton and Calgary strategies, which are designed to save further monies.

We're looking across the province at ideas that have been generated by the leadership. We're comparing, benchmarking zone to zone, benchmarking hospital to hospital to try and find savings to bring our level of spending down to the 6 per cent increase that the province gave us.

Just last week we announced that we're looking to our own staff to generate further ideas to help us come within budget.

Mr. Bhardwaj: No supplemental. Thank you.

The Chair: Okay. Thank you very much.

Mr. Kang, please, followed by Mr. Jacobs.

Mr. Kang: Thank you, Mr. Chair. In the financial statements there are five references to internally restricted funds that total over a hundred million dollars. The minister of health has advised us that the allocations of these funds is the responsibility of AHS. What plans or decisions have been made as to how these funds will be allocated?

Mr. Hughes: Let me start, and then I'll ask Dr. Duckett to augment. Internally restricted funds are allocated. Usually they're dedicated capital funds or specific programs that have been announced and provided for by the department, with the money going to Alberta Health Services. Those are dedicated resources that are to be allocated and used only for that purpose. So we put them aside, and they're used for that when they're needed. We make sure that we have them there when we need them.

Dr. Duckett: For example, externally restricted funds might be a research grant that has been awarded and is managed by Alberta Health Services. It might be some other form of grant from Health Canada via Alberta Health and Wellness.

Internally restricted: one of the previous entities might have restricted the use of the funds. Basically, we are now going through each of those internal restrictions to analyze on what basis that

internal restriction was made by the previous entity to see whether we could free up that fund for use for health services delivery. I would expect that the vast bulk of those internal restrictions will have disappeared by the end of this financial year.

Mr. Hughes: That has nothing to do with foundation funds, which are restricted separately.

Mr. Kang: My supplemental: given that more than half of the proceeds, you know, will come from Capital health alone, will this money be made available to hospitals in the capital region to restore the region's budget cuts made to operating rooms and MRIs, or will it be spread around in Calgary or any other areas?

Dr. Duckett: Well, as I said, we are looking at the internal restrictions as we speak to see what was the basis for those internal restrictions. Bearing in mind that, say, the former Capital region came in at a budget deficit last year of $103 million, I think from memory, they actually didn't have the money to restrict it. So the money wasn't there because they were running in deficit. We are looking at all of those restrictions, as I said, as we speak.

Mr. Kang: Thank you.

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

Mr. Jacobs: Thank you, Mr. Chairman. Dr. Duckett, I was pleased a few minutes ago to hear your comment that you're concerned about health care delivery in all of Alberta, not just Edmonton and Calgary and Lethbridge, so I'd like to comment from the perspective of really rural Alberta, where people live 70, 80, 90 miles from the nearest hospital or health care centre. With what has been going on in the discussion around the delivery of health care in the past year and with the consolidation of the regions, there is a real concern in rural Alberta about how health care delivery will be accomplished in the future. One of the concerns that goes around is that we are planning to close more rural hospitals. Directly to you, Dr. Duckett: are there plans in place to close more rural hospitals?

Dr. Duckett: Thank you for raising that. I have said time and time again and I think the minister has said time and time again that those rumours, those documents – I think there was one from the David Thompson health region, which had this long list of hospitals we were going to close – aren't the policy of Alberta Health Services.

I met with mayors and reeves in Red Deer a few months ago, and I said two things: first, we've got no list of hospitals, and we're not going to be closing any hospitals, and we're not going to be repurposing any hospitals unless we have some sort of consultation with the local community. The other thing I said is this: health care isn't standing still. We've got to recognize that the world moves on, the world changes, and what might have been right in 1950, what might have been right in 1980 isn't going to be right in 2009, so we need to adapt, and we need to change.

We have said that we don't have a list. We're not going out there specifically trying to change these hospitals. This David Thompson list: I've never seen it; I don't care about it; it's not our policy. But what I have said is that we need to move forward, and we need to think about what is right for those rural communities. We've got to recognize, as you pointed out, the distances that people have to travel. Just recently I was up in the north, the Northern Lights hospital, right up in High Level and Fort Vermilion. I went up there on a plane, and we couldn't land because of the fog. We've got to recognize that there are issues up there, that there are issues all over Alberta. Transport is an issue. Distance is an issue. When the roads are iced over, it's an issue. So we've got to be putting first and foremost the delivery of care in those communities, but we've also got to recognize that things change over time, that health care doesn't stand still.

Mr. Jacobs: Thank you. One supplementary if I may, Mr Chair. Dr. Duckett, could you please explain for the committee the rationale – it's apparently happening now – where DALs are being constructed to a certain level of capacity and then being open to operate at a significant reduction in level of capacity; for example, build them to 90 beds and open them for 50 beds.

Dr. Duckett: Yes. There's one in my mind as we speak, and I read a briefing note about that on the weekend, as a matter of fact. Obviously, we need to be expanding age care in this province. Every month an extra thousand Albertans turn 65, and we need to be preparing for that. We need to be putting in more facilities, whether they're nursing homes, whether they're designated assisted living, or whatever. But the reality also is that this growth occurs on a continuous basis. Every month there are more people who need accommodation of this kind. It's more efficient to build these facilities in a single capital build. You want to actually provide some flexibility for both short- and long-term growth.

One of the options we have is: do we build just a little bit bigger than we actually need today so that we can more easily expand it? And some of that expansion can come on stream in a month, in six months, in 12 months. So I think planning and building for the future is a good thing. You know, I won't stand up and say we've got it precisely right in every community, but certainly I'm strongly in favour of building for the future and being ready to adapt to those changes and those changing needs.

9:30

Mr. Jacobs: Thank you.

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

Mr. Chase: Thank you. I'm referencing page 261 of the Alberta Health Services 2008-2009 report. Page 261 states that the former CEO of Calgary health region, Jack Davis, on top of the millions in severance and benefits received pensionable credits for 28 years of work when he actually worked eight years for the region. How is this generosity justified?

Mr. Liepert: I think we've been pretty clear that there were contracts entered into by the previous health regions that were legally binding. There's nothing further that we can add other than that we are going to ensure that going forward, those same kinds of contracts do not exist. That was a commitment we made earlier today, and we are going to hold to it.

Mr. Chase: Thank you. I am glad to hear that the minister is now in charge of the ministry. I gather that wasn't the case prior.

How is the amount of $22,000 a month for an indefinite period, in other words the rest of Jack Davis's life, determined, and what tax obligations does Mr. Davis have on this money?

Mr. Hughes: This goes back to the contractual arrangements that were established by the previous board of the Calgary health region. As I mentioned earlier, compensation on boards in general in both

the public sector and the private sector is one of the most difficult areas in which board members have accountabilities. We can't frankly speak to what was done previously. There were contractual arrangement in place. The question you ask is the responsibility of the individual that deals with his own tax matters. I can't speak to that. But I can tell you that that kind of arrangement will never happen again under Alberta Health Services.

The Chair: Mr. Dallas, please, followed by Mr. Kang.

Mr. Dallas: Thanks Mr. Chair. My question is for Dr. Duckett. In the 2008-2009 fiscal year Alberta spent more per capita than almost any other jurisdiction in the country. Actually, there's a good detailing of that in the Alberta Health Services performance report September 2009. The very last page is most instructive. Now that we face some challenges working within the budgeted funds that are provided, we see the need to reorganize some aspects of health care delivery. We've had a good discussion about that this morning, including, potentially – and this is what concerns Albertans – the concept that might involve a reduction of services as opposed to a change in services. Can you speak a little bit to Alberta's challenge relative to other provinces with respect to deficit and their initiatives to reorganize? If we're consulting with those provinces, are there best practices that are happening there that we're picking up on?

Dr. Duckett: Thanks very much. This is something that the board has asked me to come forward with a report on later this year. That is, they've said: look at the difference. Why is it that Alberta is the top-spending province? What do we get for it, and what leads to that change? There are a number of ways of looking at that. One is to think back to the mid-90s, when Alberta was the same as the Canadian average, roughly. How is it that between the mid-90s and now we have grown faster than the rest of Canada? That's something we need to look at very carefully, and there's some of that information, as you point out, on the back page of our performance report. Certainly, it's one of the things we want to do better: to look at benchmarking across Canada.

I just might mention two provinces, Saskatchewan and B.C. On the weekend I read the Saskatchewan Patient First report, which is a commission of inquiry set up by the Saskatchewan government looking at health care in Saskatchewan. What is very interesting about that report is that much of what he was suggesting is stuff that we're already doing here in Alberta.

I also met with the Deputy Minister of Saskatchewan Health last week and had a chat with him about some of the things we are doing and what he is doing. The amusing thing is that he said, "Look, what I've said to the regional health authorities in Saskatchewan is: we haven't decided to have a single health authority in Saskatchewan, brackets, yet, but you'd better be acting like a single health authority otherwise, dot, dot, dot." So a lot of what they are suggesting, we are already doing.

British Columbia is more challenging. Two of our senior executive used to work in British Columbia. What we are trying to do is pick the eyes out of the other provinces into our executive. I'm not saying we are trying to cripple them with the appointment of Chris Mazurkewich and Mike Conroy, but we are certainly trying to get the best we can for our executive. I get little snippets from these two when their friends gossip about further reductions in staffing and so on. I think that just a couple of weeks ago British Columbia announced a significant reduction in services. We are trying to avoid that in Alberta. We are trying to ensure that when we are addressing our financial challenges, we protect access and quality. But we are certainly looking to British Columbia, certainly looking to Saskatchewan.

Some of the other stuff we are doing is in terms of procurement, looking at jointly working with B.C., looking at payroll jointly working with B.C. We are trying to harness the best ideas from wherever we can and also use economies of scale to effect the changes that we're trying to do.

Mr. Dallas: Thank you.

The Chair: Thank you, Mr. Dallas.

Mr. Kang, please, followed by Mr. Vandermeer.

Mr. Kang: Thank you, Mr. Chair. Alberta Health Services' 2008-09 annual report page 157 reports that supplemental executive retirement plans, SERPs, are a noncontributory plan, meaning that the employer pays the full amount of the contribution to the plan and that the plan is unfunded but is secured by a letter of credit. Page 162 further reports that the lump-sum payment for the SERPs is sufficient "to pay the member's income tax on the lump sum and interest thereon to the date of pension commencement." Can the board clarify this? Does Alberta Health Services not only contribute fully to these pension but also pay the taxes on them as well?

Dr. Duckett: In broad, general terms, we are trying to move away from these unfunded SERP-type initiatives. As some of the questions have suggested, there was a level of generosity in these SERPs that isn't appropriate these days. To put this in perspective, I think one of the members, Mr. Chase, mentioned that the previous CEO of the Calgary health region gets $22,000 per month for life. You will be pleased to know that the contribution to my pension plan is an RRSP, and its total is $22,000 per annum, so you can see the dramatic difference in the generosity of the previous regions and Alberta Health Services.

In terms of the SERP arrangements we are looking to move from the sort of defined benefit arrangements, which are open ended, to more defined contribution arrangements, where Alberta Health Services specifies what is the contribution we are going to make to a person's pension arrangements. So for the executives across Alberta Health Services we'll be looking to rein in that sort of generosity into the future.

Mr. Kang: Thank you. My supplemental is on page 175. We are talking about taxes here. Are the taxes paid for the individuals when they receive the monthly payments or only if it's a lump sum?

Dr. Duckett: I think they pay their own taxes. We don't.

Mr. Mazurkewich: I actually don't know. We'd have to get back to you on that question of the taxes. Do you know, Susan?

The Chair: Whoever Susan is, please come to the microphone. That's not Susan.

Mr. Hawes: Robert Hawes from Alberta Health Services. The pension plan, the SERP, is established in such a way that the benefits paid to the individual are taxable in their own hands. However, I believe the reference in the Auditor General's report is in relation to the letter of credit. A letter of credit is established in case the SERP plan itself is disestablished. At that point under CRA rules we're required to pay to the individual the full amount of their pension benefit accrued to that date plus any income tax implications so that they would then be able to have that lump sum and pay all their taxes along with it as if they'd earned it under a normal situation.

9:40

The Chair: Thank you very much.

Mr. Kang: In order to be clear on that, they get the lump sum and they will be paying the taxes, or the taxes will be paid for them?

Mr. Hawes: Those are Revenue Canada rules to protect the individual's rights under the pension plan. If the plan was to be disestablished – and there are only certain rules under which the pension plan can be disestablished. In those rare situations, then, the calculation of the amount paid to the individual includes their future tax liability.

Mr. Kang: Thanks.

The Chair: Thank you.

Mr. Vandermeer: Thank you very much for coming here today. The transition to one board is probably one of the most significant changes in our health system for '08-09. My questions are to Dr. Duckett. I know you've touched on this somewhat already, but where would you say you would find the most cost benefits in going to one health services board?

Dr. Duckett: There are two that I'd highlight. The first is procurement. In purchasing we are looking to save $210 million next year through centralizing the procurement process, the purchasing process in Alberta Health Services. We're able to do that in a number of ways. First, we're able to achieve economies of scale. We're a much, much bigger organization. We're one of the largest purchasers in Canada. We're the largest health authority in Canada by a factor of two or three, which means we are a very, very strong purchaser.

My favourite example, which isn't the biggest saving, is egg products. We used to have 34 different types of egg products. Now, I would challenge anyone in this room to name 34 different types of egg products, but we used to purchase 34 different types of egg products. We've standardized the egg products across the province and are saving $50,000 just in egg products alone. That's a 5 per cent saving in egg products alone. But there have been bigger items of saving in prostheses and others, in the millions of dollars.

The purchasing function we're standardizing and so on. The standardization is not just done by bureaucrats; it's done by the health professionals, who have to agree that they actually can work with this standardized purchasing. So purchasing and procurement is one of the big ones.

Also, getting rid of redundancy across the organization. How many payroll systems do you need to pay staff? We used to have 12. We've still got 12, as a matter of fact, but we're moving to have one. How many HR systems and so on? In terms of senior leadership positions, if you just count people with the title of vice-president and above, there used to be across Alberta 144 people in the health authorities with vice-president, senior vice-president, executive vice-president, and so on titles across Alberta. We have cut that by almost 50 per cent. We're down to 74 people with those levels of titles so that we're just being tighter on the management arrangement.

Both of those are areas where we're making significant savings.

Mr. Vandermeer: Thank you.

The Chair: Thank you.

Mr. Chase, please, followed by Mr. Fawcett.

Mr. Chase: Thank you. Again I'm referencing the Health and Wellness 2008-09 annual report. With regard to gold-plated severance packages, if I heard Ken Hughes correctly and *Hansard* recorded, he stated that that type of arrangement "will never happen again." Yet, under the watch of Messrs. Hughes, Duckett, and Liepert, Paddy Meade received a total of $1.323 million in severance after leaving her position as Alberta Health Services' executive operating officer of continuum of care, a position she took after leaving her role as deputy minister of health. Is Paddy Meade also receiving a pension from Alberta Health and Wellness from her position as deputy minister?

Mr. Liepert: I wouldn't know if an ex-employee is receiving a pension. That's a personal choice. Some of it depends on age. But if she paid into a pension plan, into the public service pension plan, when she reaches a particular ability to receive pension, of course she would receive it if she's paid into it.

Mr. Chase: This has more to do with the topping up.

Who made the decision to remove Paddy Meade from her position as the executive operating officer of continuum of care, and why was she removed from this position so quickly after receiving it? She worked for nine months and received two years' worth of salary and several years of health care benefits.

Mr. Hughes: I'll take that, Mr. Chair. As I described earlier, there were several phases in this evolution of creating Alberta Health Services. Paddy Meade was hired as a senior officer by the interim chief executive officer in the early phases of the transition phase. When we got to the point of having been, I'd say, fortunately successful in recruiting a global leader for health care administration from Australia in Dr. Duckett, I had discussions with Dr. Duckett about the kind of organization that he wanted to lead, and before he arrived, I made the decision to terminate the employment of Paddy Meade.

Mr. Chase: Thank you.

The Chair: Thank you.

Mr. Fawcett, please, followed by Mr. Kang.

Mr. Fawcett: Thank you, Mr. Chair, and thank you to all those that attended here and for the extremely complex work that you do within our health care system. In talking with my constituents, one of their biggest concerns is the perceived lack of accountability right from the macro level down to the micro level within our health care system. I think they're starting to realize some of the opportunity costs regarding expenditures on health care, so I want to focus my questions on value for money. I think they want to see increased accessibility and quality, but they want to see that done at the best value for the taxpayer's dollar, which might not necessarily have been the case in the past.

On page 29 of the Health and Wellness annual report it talks about strategy 2.2, increasing the ministry's capacity to measure, monitor, and report costs through the value-for-money strategy, and it talks about some data and development measures related to ambulatory care, management information systems, and costing. I'm just wondering if I could have some comments about some of those initiatives that you're undertaking.

Mr. Liepert: I'm going to let my deputy get into some of the details, but I think we made it fairly clear earlier that the previous model for health care governance in this province was one of considerable autonomy. We've spent a lot of time this morning talking about, as an example, certain contractual arrangements that were entered into by those previous entities.

I certainly support everything that the member said relative to more value for money. I'll let Deputy Minister Miller elaborate on some of the details.

Mrs. Miller: Thank you for the question. We have recently undergone a re-organization within the ministry, and we have established a division dedicated to performance measurement and information management support. Due to the hiring freeze that the government is in right now, the position at the assistant deputy minister level remains vacant or filled in an acting capacity. However, we are looking within the ministry to staff that function because we recognize that that is a core function with the ministry in support of the minister.

We also are working with Alberta Health Services to improve the data and information reporting, the frequency and the quality of information. One particular initiative I would highlight is the dashboard initiative that we are co-funding with Alberta Health Services to get, essentially, real-time data reporting at both the operational level for AHS and at the macro level for the department so that we can enhance our performance management and monitoring function.

Mr. Fawcett: Thank you. I'm glad to hear that. I think Albertans know that we do spend a lot of money on health care relative to anybody else in the province. They're just concerned about where that money is going. Sometimes they feel it's going into a big black hole.

My supplemental question is around a specific issue, and that is the McKinsey & Company provincial service optimization review. Can you show that there was some value for money created with that particular contract?

9:50

Mr. Liepert: Any time you go through a reorganization or a restructuring as massive as we did, I believe it's very important to get internationally recognized experts to help guide you along. Much has been made about the contract that the department had with McKinsey, which by the way ended at the end of the fiscal year 2008-2009. Clearly, the McKinsey group had significant guidance and input into our Vision 2020 document, which is going to guide health care delivery in this province for the next decade, had significant input into all of the other policy documents and initiatives that we've undertaken in the past year. But maybe the most important work that McKinsey did was help guide us through some of the things that Dr. Duckett just talked about: how do other countries, how do other health systems around the world procure goods, and where is it that we're not doing a good job? Dr. Duckett just explained in quite considerable detail the potential savings that have been identified in something as simple as procurement, and the McKinsey group had an awful lot to do with that.

The Chair: Thank you.

Mr. Kang, please, followed by Mr. Drysdale.

Mr. Kang: Thank you, Mr. Chair. Page 276 of the October 2009 Auditor General's report shows several serious and concerning accounting errors that took place. How was it possible that East Central made reporting errors of $49 million? What are those errors, and what has been done to ensure that these errors do not recur in the future?

Dr. Duckett: Basically, as I said earlier, East Central was the co-ordinating account system that was used for the transition management. Money would come into East Central, which was then distributed to other former regional health authorities. In some circumstances the other regional health authorities would also record the money as arriving. The way it was recorded in East Central and the way it was recorded in the other region weren't identical. As a result, they were what is referred to here, I think – this is what I'm talking about – the classification errors. Of course, since we've now got a single health authority, Alberta Health Services, we don't have any of those interregional transfers any more, so this problem will not exist in the future.

Mr. Kang: So the answer is, you know, that you have given clear directions on accounts . . .

Dr. Duckett: The answer is that this audit was – I would have to pay tribute to the work of the Auditor General and his agent. The amount of work involved in auditing the 12 previous entities was immense. The good news is that because we are one entity, this issue will not arise. This has been fixed.

The Chair: Thank you.

In light of the time, we're now going to have to read our questions into the record. There is still a long list of members requesting information regarding these annual reports, so if you could please provide through the clerk to all members written responses to these as well as to previous questions that were not answered completely, we would appreciate it. We'll start with Mr. Drysdale, please.

Mr. Drysdale: Thank you. There's been a lot of discussion and press regarding how difficult it is to access health care services in our province mainly due to long wait times. In order for Albertans to receive the care they deserve, they must be able to get in the door. My question is to Dr. Duckett. Can you please explain what Alberta Health Services did in 2008-09 to reduce wait times and improve access?

The Chair: Thank you.

Mr. Chase, if you have a question, could you read it into the record, please?

Mr. Chase: Yes. Thank you. I'm referencing page 262 of the Auditor General's October 2009 report. A grant provided by Alberta Health and Wellness for the unfunded supplemental executive retirement plans amounting to $20 million was reported as being unfunded. Why was it necessary to ask for a grant to fund these SERPs? Are funds not routinely set aside to cover this liability?

The Chair: Thank you.

Mr. Sandhu: My question is to Dr. Duckett. It has been suggested that since you started as CEO in March 2009, your primary responsibility as CEO has been to cut budget costs and better delivery of services. It's not an easy job. Is it true that when you signed your contract in the 2008-2009 fiscal year, the main task you were charged with was reducing spending? If not, then what's your main explanation for your operations?

Can I add another one? Alberta Hospital is in my constituency, Edmonton-Manning. Alberta Health Services is closing beds. I do realize the hospital is a very old building. My constituents are very concerned about closing beds. Is it due to the life of the building? How are you going to correct the situation?

The Chair: Thank you.

Mr. Kang, please, followed by Mr. Denis.

Mr. Kang: Thank you, Mr. Chair. Why does Alberta Health Services not fund its SERPs obligations? Did Alberta Health and Wellness provide the money to fund these SERPs? If so, where did it go? If not, why not? On page 276: how could you not know the restrictions on grant funding?

The Chair: Thank you.

Mr. Denis, please.

Mr. Denis: Okay. Just one question, no supplemental. I wanted to ask about the number of capital projects that have been completed over the last year without being able to open new capacity. What's being done to make sure that these spaces that are built can actually be operated on a functional basis?

The Chair: Ms Woo-Paw.

Ms Woo-Paw: Thank you. Your response to the Auditor General's recommendation with regard to approval of drug purchases, instituting proper approval process, and delineating the roles and duties.

The Chair: Thank you.

Any other questions at this time?

On behalf of the committee, hon. minister, Mr. Hughes, Dr. Duckett, Deputy Minister Linda Miller, thank you very much for your time this morning. We have some other items on the agenda that we will have to deal with this morning, but please feel free to exit. Thanks.

Item 5. I would like to note for the record that at this point written follow-up responses have been received for the committee regarding 2009 spring meetings. We've also received a very prompt follow-up from the Alberta Gaming and Liquor Commission.

Are there other matters to discuss this morning? Seeing none, we'll move on to the date of our next meeting, which will not be this Wednesday. That meeting was cancelled as a result of the motion from the hon. Member for Athabasca-Redwater, but we will meet on November 4 at the usual time, 8:30, with Alberta Finance and Enterprise. So there will be no meeting this Wednesday. The usual meeting has been cancelled as a result of that motion. Okay?

Can I now please have a motion to adjourn? Moved by Mr. Sandhu that the meeting be adjourned. All in favour? Thank you very much, and have a good week.

[The committee adjourned at 9:59 a.m.]

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