Legislative Assembly of Alberta

The 27th Legislature
Fourth Session

Standing Committee
on
Public Accounts

Health and Wellness

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Fourth Session

Standing Committee on Public Accounts

MacDonald, Hugh, Edmonton-Gold Bar (AL), Chair
Rodney, Dave, Calgary-Lougheed (PC), Deputy Chair

Allred, Ken, St. Albert (PC)
Anderson, Rob, Airdrie-Chestermere (W)
Benito, Carl, Edmonton-Mill Woods (PC)
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Griffiths, Doug, Battle River-Wainwright (PC)
Groeneveld, George, Highwood (PC)
Kang, Darshan S., Calgary-McCall (AL)
Mason, Brian, Edmonton-Highlands-Norwood (ND)
Sandhu, Peter, Edmonton-Manning (PC)
Vandermeer, Tony, Edmonton-Beverly-Clareview (PC)
Xiao, David H., Edmonton-McClung (PC)

Also in Attendance

Swann, Dr. David, Calgary-Mountain View (AL)

Department of Health and Wellness Participants

David Breakwell	Assistant Deputy Minister, Financial Accountability
Mark Brisson	Assistant Deputy Minister/Chief Information Officer, Health Information Technology and Systems
Martin Chamberlain	Assistant Deputy Minister, Corporate Support
Margaret King	Assistant Deputy Minister, Community and Population Health
Glenn Monteith	Assistant Deputy Minister, Health Workforce
Jay Ramotar	Deputy Minister
Susan Williams	Assistant Deputy Minister, Health Policy and Service Standards

Alberta Health Services Participant

Chris Mazurkewich	Executive Vice-president/Chief Financial Officer

Office of the Auditor General Participants

Merwan Saher	Auditor General
Doug Wylie	Assistant Auditor General
Teresa Wong	Principal

Support Staff

W.J. David McNeil	Clerk
Shannon Dean	Senior Parliamentary Counsel/ Director of House Services
Robert H. Reynolds, QC	Law Clerk/Director of Interparliamentary Relations
Corinne Dacyshyn	Committee Clerk
Jody Rempel	Committee Clerk
Karen Sawchuk	Committee Clerk
Rhonda Sorensen	Manager of Corporate Communications and Broadcast Services
Melanie Friesacher	Communications Consultant
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8:30 a.m. Wednesday, May 11, 2011

[Mr. MacDonald in the chair]

The Chair: Good morning. My name is Hugh MacDonald. I would like to call this Standing Committee on Public Accounts to order, please. On behalf of all members I welcome everyone in attendance this morning.

Again, for the record please note that the meeting is recorded by *Hansard*, and the audio is streamed live on the Internet.

We're going to quickly now go around the table and introduce ourselves. Perhaps we'll start with the hon. Mr. George Groeneveld.

Mr. Groeneveld: Good morning. George Groeneveld from Highwood.

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

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

Dr. Swann: Good morning and welcome, everyone. David Swann, Calgary-Mountain View.

Mr. Monteith: Good morning. Glenn Monteith, assistant deputy minister, health workforce division, Alberta Health and Wellness.

Mr. Ramotar: Good morning. My name is Jay Ramotar, Deputy Minister of Health and Wellness.

Mr. Breakwell: Good morning. Dave Breakwell, assistant deputy minister, financial accountability, Health and Wellness.

Ms Williams: Good morning. Susan Williams, assistant deputy minister, health policy and service standards, Alberta Health and Wellness.

Ms King: Good morning. Margaret King, assistant deputy minister, community and population health, Alberta Health and Wellness.

Ms Wong: Good morning. Teresa Wong, audit principal, Ministry and Department of Health and Wellness.

Mr. Wylie: Doug Wylie, Assistant Auditor General.

Mr. Saher: Merwan Saher, Auditor General.

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

Mr. Allred: Ken Allred, St. Albert.

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

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

The Chair: Thank you.

May I have approval of the agenda that was circulated? Mr. Allred. Moved by Mr. Allred that the agenda for the May 11, 2011, meeting be approved as distributed. All in favour? None opposed? Thank you.

Approval of the minutes of the April 27 meeting as circulated. Mr. Groeneveld. Moved by Mr. Groeneveld that the minutes for the April 27, 2011, Standing Committee on Public Accounts be approved as distributed. All in favour? Thank you very much.

I would note that we have the hon. Member for Calgary-Mountain View with us this morning. According to the standing orders any member of the Assembly is allowed to participate in the proceedings of our meeting but cannot vote. Only members of this committee can vote on committee matters.

Of course, this gets to our meeting this morning with Alberta Health and Wellness. We are dealing with the reports of the Auditor General this morning from October 2010 and the latest one, from last month, April; the annual report of the government of Alberta 2009-10, which includes the consolidated financial statements; the Measuring Up progress report; and also, perhaps most importantly, the annual report of Alberta Health and Wellness from 2009-10. I would remind everyone again of the briefing material that was prepared for us by our research staff, and again thank you very much.

Now, at this time I would invite Mr. Ramotar, please, the deputy minister, to make a brief 10-minute opening statement on behalf of Alberta Health and Wellness. Proceed, please.

Mr. Ramotar: Thank you, Mr. Chairman. I'm happy to be addressing the committee this morning on behalf of Minister Zwozdesky. With me at the table are assistant deputy ministers Dave Breakwell, Glenn Monteith, Susan Williams, and Margaret King. Also, behind me are ADMs Martin Chamberlain and Mark Brisson as well as Charlene Wong, our executive director for financial planning. I am also very pleased to introduce Chris Mazurkewich. Chris is the CFO and executive vice-president of Alberta Health Services, and I'm pleased that he's here with us.

I'll be making some brief opening comments before taking your questions.

The year 2009-10 was a very significant year for Alberta Health and Wellness. As indicated in our annual report, some of our accomplishments included committing to the five-year funding plan for Alberta Health Services, a first in Canada; eliminating the Alberta Health Services deficit; having the Minister's Advisory Committee on Health complete a review of health legislation and recommending a new Alberta Health Act and a health charter; responding to the H1N1 pandemic; transitioning EMS operations from municipalities to Alberta Health Services; and rolling out the Alberta pharmaceutical strategy.

I'll turn now to the October 2010 Auditor General report. The Auditor General made some very good recommendations in his report, and both Alberta Health and Wellness and Alberta Health Services have been working really hard to address the areas he identified. We take his recommendations very seriously.

Many of these changes are complex and impact multiple government departments and Alberta Health Services. As a result, it may take more than one fiscal year to develop and fully implement the responses to the recommendations. However, there are recommendations from the perspective of Alberta Health and Wellness and Alberta Health Services where the responses are fully implemented, and we are just waiting for the office of the Auditor General to do its review and confirm that the recommendations have been fully addressed.

As of today there is a total of 53 outstanding recommendations, 26 from Alberta Health Services and 27 from Alberta Health and Wellness. Of these, 10 recommendations for Alberta Health Services and 19 for my department are awaiting review by the office of the Auditor General, and action is being taken to address the rest.

Consolidating the diverse accounting structures of 12 former health entities is a complex process and cannot be accomplished overnight, but despite the challenges smooth system integration is a high priority for Alberta Health Services, and work is well under

way. Alberta Health Services accepted the Auditor General's recommendations and is working diligently to consolidate its major business systems and resolve any future accounting issues.

It is important to note that the Auditor General gave an unqualified opinion on the ministry's, the department's, and Alberta Health Services' financial statements. In the 2009-2010 annual report there were 11 performance measures where the targets were not met and 10 performance measures where the targets were met or exceeded. An example of where the target was not met is the number of persons waiting in acute-care hospital beds for continuing care placements. The target was 505; the actual result was 707. Alberta Health Services has implemented changes to address this as part of its new emergency department capacity protocol.

Another example would be the percentage of Albertans 18 and over with an acceptable body mass index. The target was 47 per cent, and the actual result was 42 per cent. In response Alberta Health and Wellness is developing a province-wide strategy focused on the prevention and management of obesity for Albertans.

However, we have, like I said, met or exceeded several targets. One example would be the public rating of the health system overall, which met the target of 65 per cent. The target was also exceeded for prevalence of smoking among young adults. The target set was 29 per cent; the actual result was 25 per cent.

Those are my brief opening remarks. We'll be happy to take your questions.

Thank you very much, Mr. Chairman.

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

Mr. Saher.

Mr. Saher: Yes. Thank you, Mr. Chairman. Doug Wylie will make some opening comments on our behalf.

Mr. Wylie: Mr. Chairman, I won't repeat what the deputy has referred to with respect to our work but maybe just highlight a couple of things. On page 67 of our October 2010 report we indicate that the Health Quality Council of Alberta has implemented our 2008 recommendation to improve its investigative role and practices. The Health Quality Council of Alberta has also implemented another 2008 recommendation, to provide guidance on the use of legal assistance when conducting investigations.

The deputy has indicated we issued unqualified audit opinions, which is absolutely correct. We also issued an unqualified review engagement report on the performance measures included in the 2009-10 annual report.

I'll leave it there, Mr. Chair.

8:40

The Chair: Thank you very much.

Wait times. Mr. Ramotar, I'm sure there will be some questions on wait times, but I'm told this morning that the wait time on the south side of the Walterdale Bridge is quite long. Some of our members are on the south side, but they'll be along in a few minutes.

I would like to welcome Mr. Xiao to our meeting this morning.

We will now proceed quickly to questions. Mr. Chase, followed by Mr. Groeneveld.

Mr. Chase: Thank you. Seniors' care: effectiveness of services in long-term care facilities. In October of 2005 the Auditor General first recommended that the department, working with the Department of Seniors and Community Supports, assess the effectiveness of services in long-term care facilities. As page 105 of the AG's April 2011 report indicates, this recommendation remains outstanding. That's kind of an oxymoron. As a former teacher there were consequences for my students when they failed to complete assignments. That, unfortunately, is not the case for Alberta government ministries. Please explain why it has taken six years and counting for Health and Wellness to act on the AG's recommendations and assess the quality of nursing, physical therapy, and other services delivered in the province's long-term care facilities.

Ms Williams: Basically, from the Auditor General's recommendation the department developed continuing care health standards in I think it was 2006. They have been revised two different times, I think in 2007 and 2009. We are currently reviewing them again now. The continuing care health standards are audited by Health and Wellness staff and by Alberta Health Services going into Alberta Health Services facilities, and all of its contractors have to be consistent with the standards that exist. The results of the audits are basically made public on our website and on Seniors and Community Supports' website as to what facilities are being audited and the results of those audits. If there are issues, they are followed up, and they are basically addressed.

Also, Seniors and Community Supports has standards on the accommodation part, not the health services but the accommodation part, and they also audit to their standards, and the results of those audits are made public every year also.

Mr. Chase: The fact that the Auditor General has said that this recommendation remains outstanding would suggest that the department of the Auditor General is not satisfied. Would the Auditor General care to qualify?

Mr. Saher: Yes. You're referencing a page in our last report which was a sort of chronology of the state of outstanding recommendations subdivided into two parts, those that we understand are ready to be followed up and those which at that date we understood were not ready to be followed up.

I'd like to go on the record this morning to say that we are fully engaged in a follow-up audit of seniors' care, and that audit is under way. Because it's an audit under way, I can't talk about it because I would be just speculating, but our intention is to complete that follow-up work – it is an important area – and report publicly as soon as possible.

Mr. Chase: Thank you.

My second question . . .

The Chair: No. That was your second question.

Mr. Chase: Oh, it was. Yes, of course. I thought my last name was Xiao there for a moment.

The Chair: Mr. Groeneveld, please, followed by Dr. Swann.

Mr. Groeneveld: Thank you, Chair. I would suggest that probably Mr. Ramotar could fix the Walterdale Bridge wait times a lot quicker than he can solve most of the problems out there after what he's been through. He may take you up on that.

As I mentioned, I'm from Highwood, and of course in Highwood we struggle a little bit with seniors' long-term care, particularly in the town of Okotoks, where we're approaching 30,000 people. We struggle mightily with what we have with our seniors there. I'd like you to talk just a little bit about what your minister is doing to ensure that proper care is being taken of our seniors, you know, in the continuing care settings, I guess, and home care programs because that's an essential part of it now.

Mr. Ramotar: Long-term care is part of continuing care. Continuing care has for me three parts: home care, assisted living, and

long-term care. What has happened over the past several years is that the government has done separate studies on care for seniors and the disabled. What we have done over the past year is try to put all of those documents together and tie the operations piece for continuing care with the infrastructure piece to make sure that we have a strong connectivity between the supply of beds and the operation of providing service to seniors and the disabled.

The government made a commitment recently that they will provide 5,300 new continuing care beds over the next five years. I believe that commitment will be met and, as a matter of fact, may be exceeded.

Mr. Groeneveld: Well, thank you. I know we're working to get there, no doubt.

Referring to page 36 of your 2009-10 annual report, in March 2010 the government announced it had raised $74.5 million for the construction of seniors' accommodations in the province. Could you talk a little bit more, then, about specifically how this will add to the capacity of the continuing care system, particularly in the supportive living stream, and reduce the wait in the acute-care system, which, of course, is probably the most nagging problem that we have had going for the last few years?

Mr. Ramotar: Well, I have in front of me here the sites that are under development. Most of these sites are being funded under the capital bonds project. The money is basically funneled through what we call an ASLI program for the development of these facilities. They are scattered in several locations. I would say, just quickly looking at this, about 12 different locations. The level of service varies from supportive living group homes, long-term care lodges all across the province. This is the first step towards the goal of providing 5,300 new beds in the province.

Mr. Groeneveld: Good. That would spawn another question. Like Mr. Chase, can I try for a third?

The Chair: No.

Dr. Swann, please, followed by Mr. Allred.

Dr. Swann: Thank you, Mr. Chair. Alberta spends more per capita than any other province on health care. According to a recent Environics poll two-thirds of Albertans feel the health care system is in crisis. Professionals in the system were polled a year ago; 20 per cent of physicians said they had confidence in the management of the health care system. In passing, I hope the department will have the courage to repeat that staff survey and find out what the confidence level is today.

We experience continued expressions of confusion from front-line staff about the role of health services versus Health and Wellness around decision-making. That and the lack of accountability for some of the decisions and the impacts to the front line have caused and contributed to not only confusion but tension and a detachment from health professionals. That has contributed to conflicts and, we believe, a culture of fear and intimidation in the province, that we have highlighted in the last while.

According to note 18 on page 154 of the ministry's annual report Alberta Health Services was as of March 31, 2010, a defendant in 379 legal claims. My first question: please explain where in the consolidated financial statements the amount that Alberta Health Services has spent in legal fees this last year might be found.

8:50

Mr. Ramotar: I'll ask Chris from Alberta Health Services to respond.

Mr. Mazurkewich: I would have to go back and get the exact figure for legal fees. I don't know that off the top of my head.

Dr. Swann: You could provide that for us, then, could you?

Mr. Mazurkewich: Yes.

Dr. Swann: Thanks very much.

Where are the amounts that Alberta Health Services paid in out-of-court settlements to be found? Are these included under, quote, contracts with health services providers, end quote, or under, quote, other, in the line items?

Mr. Ramotar: We'll get back to you.

The Chair: Thank you.

The chair would like to welcome Mr. Griffiths, Mr. Mason, and Mr. Rodney, who have joined us. Good morning, gentlemen.

We'll now go to Mr. Allred, followed by Mr. Chase.

Mr. Allred: Thank you, Mr. Chair. With the amalgamation of the nine regional boards and the two specialized boards we had a duplication of payroll systems, computer systems, and several other systems. What staff reductions have been realized as a result of the elimination of some of this duplication of services?

Mr. Mazurkewich: In fiscal year '09-10 we reduced about 120 to 130 financial positions. At this point we haven't reduced any positions in the payroll system.

Mr. Allred: Okay. I guess the follow-up on that is: why not? If there were nine systems before, why have you not been able to reduce staff by going to one payroll system?

Mr. Mazurkewich: We are in the process of consolidating the payroll; however, we haven't consolidated any of the payroll systems at this point in time.

Mr. Allred: Oh. It hasn't been consolidated.

Mr. Mazurkewich: Yeah. The payroll system hasn't been consolidated. The procurement system has been consolidated, and the financial systems are in the process of being consolidated.

Mr. Allred: Okay. What is the total staff complement of Alberta Health Services, then, at this point in time?

Mr. Mazurkewich: We have approximately 90,000 staff, and that would be in full-time equivalents about 60,000.

Mr. Allred: Thank you.

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

Mr. Chase: Thank you. Implementing the provincial mental health plan. Three years ago the Auditor General recommended several means by which the department might advance implementation of its provincial mental health plan. According to page 105 of the AG's April 2011 report this recommendation has still not been addressed. My first question: why has the department not acted on the AG's recommendation and improved its monitoring of and reporting on implementation activities?

Mr. Ramotar: The issue of mental health is extremely complex. We have been working with 16 departments and over 21 stakeholders to develop an addictions and mental health strategy. The mental health strategy is developed in two phases. Phase 1 is stra-

tegic. Phase 2, or part 2, is an action/implementation plan to make sure that we move on that file. Within a month or two I expect the government to approve both the strategic plan and the action plan. It's extremely complex, lots of stakeholders. We've got them all at the table to develop both pieces.

Mr. Chase: Thank you.

A long time occurring. In the meantime Alberta's suicide rate is the second highest in Canada. Why has the department failed to assign it a heightened priority within the provincial mental health plan as the AG also recommended?

Mr. Ramotar: It is being highlighted in the new plan that we are developing.

Mr. Chase: Thank you.

The Chair: Thank you.

Mr. Xiao, please, followed by Mr. Mason.

Mr. Xiao: Thank you, Mr. Chair. You know, I'd like to ask a macro question here if I may. I look at the expense of the budget for health care. In 1998 our budget was $4 billion. A decade later our budget is $14.4 billion, but our population has not increased accordingly. Why is that?

Mr. Ramotar: Well, that's a very good question. I would say that the cost escalation is not unique to Alberta; it's across the country. There are key drivers. The Alberta population increased significantly because of the energy industry that we have in Alberta. We have a growing aging population in Alberta. We have more kids per capita in relation to the other provinces. We have new technologies that are coming onboard, and they are not cheap technologies. Folks, whether they are patients or health care providers, would like to use the new or latest technology. That's not cheap.

On the pharmaceutical side, which is another key driver of cost, the cost is going up rapidly. We have taken steps in all of those areas to try to so-called bend the curve, and that's why the government decided to provide Alberta Health Services with a five-year funding plan, 6 per cent in the first three years, and then it will come down to 4.5 in the last two years. Hopefully, it will stay at that level where we can peg it at population plus inflation.

Health care costs are going up all over the place. It's not unique to Alberta.

Mr. Xiao: But we spend more than anybody else on a per capita basis.

My second question, Mr. Chair. I wonder if you can tell me how much we spend on overtime pay, you know, to the nurses. Right now we've got a lot of trained nurses who are looking for jobs, but the nurses who are on the job are overstretched. Do you have a number for how much we spend on overtime pay?

Mr. Ramotar: I don't have a number with me. I'll see whether Chris has a number.

Mr. Mazurkewich: I don't have a number off the top of my head specifically for nurses, but we can definitely get that to you.

Mr. Xiao: You'll provide that to me?

Mr. Mazurkewich: Yes.

Mr. Xiao: Okay. Thanks.

The Chair: Yes. Mr. Ramotar, not only information regarding this question but also Dr. Swann's. If it could be addressed to the clerk, it will be distributed to all members of the committee.

Mr. Mason, please, followed by Mr. Sandhu.

Mr. Mason: Thank you very much, Mr. Chairman. In the 2009-10 annual report performance measure 6(c) provides the number of persons in acute-care hospital beds waiting for long-term care placement, and the number was 707, which is well above the target of 505. Of the 707 waiting in acute care for continuing care in 2009-10, how many were assessed specifically for long-term care? I don't mean broadly the things the government talks about as continuing care. I'm talking about long-term care; that is to say, part of the health system. And how many were waiting in the community for long-term care?

Mr. Ramotar: Do we have that information? If you give us a few seconds, we'll try to find it.

Okay. We'll get the information to you.

9:00

Mr. Mason: Okay. Thank you.

Then my follow-up question is: what is the current number of long-term care beds in the system, and what are the plans to bring additional long-term care beds into the system over the next five years?

Mr. Ramotar: We have approximately 14,500 long-term care beds in the province. We are doing a comprehensive assessment as to how many of those 5,300 new beds over the next five years should be assisted living versus long-term care. That work is ongoing. One of the key pieces of that work is a focus on aging in place. A big component of that is home care. In Ontario home care is provided for folks that want to stay in their home even if they need a level of care equivalent to long-term care. So we are exploring that option because we were told by Albertans that most of them would like to stay in their own home, whether it's assisted living or long-term care. We have to look at the entire model. We will adjust those numbers on an as-required basis, and hopefully by the end of the year we'll come up with more definite numbers.

The Chair: Thank you.

Mr. Sandhu, please, followed by Dr. Swann.

Mr. Sandhu: Thank you, Mr. Chair. My question is regarding the primary care network. In the last budget, 2009-10, we spent $109 million on the primary care network. I'm just wondering what we got for that money.

Mr. Ramotar: That's an extremely good question. Today we have 40 PCNs; in 2009 we had 32. The concept of a PCN is a very, very good one. A PCN is a group of service providers that provide services to a community. Not everybody would have to end up in a family physician's office. As part of the agreement in principle that we signed with Alberta Health Services and the AMA, one of the focuses there is to do a comprehensive review of primary care as a whole. PCNs are a key part of primary care. Do we have a report that would tell us today about the benefits that we are getting for $109 million? I would say not.

When I came onboard – I have to be honest about this – that's one of the first things that I said that we would investigate. I want to look at the governance; I want to look at the accountability; I want to look at the output; I want to look at the performance measures. It's a lot of money, but many people that I spoke with wouldn't argue with the concept. Are we going to tweak it?

Chances are that we will. Are we going to put better governance in place? Chances are that we will. Are we going to have performance measures to measure the performance and the benefits we are getting out of the investment? Absolutely. I believe that if we do it right, we may not need more family physicians per capita in this province.

Mr. Sandhu: A leading question. We all know that access to health services is a big issue in Alberta. What are PCNs doing differently that will help to address the problem?

Mr. Ramotar: Well, like I said, a PCN is part of the primary health care network, which is the core of the health care system. PCNs should be, essentially, in my opinion, a community care centre. That should be the first place, if you don't have a severe illness, to access. That's where you should have education for chronic diseases. That's where you should have linkages to provide services to folks with addiction and mental health. It is where you start to build community capacity, and if you do it right, like I said, folks don't have to go to be triaged at a doctor's office or in the emergency department. That's where the triage should be. Are we there yet? I would say not.

The Chair: Thank you.

Dr. Swann, please, followed by Mr. Vandermeer.

Dr. Swann: Thank you, Mr. Chair. I want to ask a question about accountability of Alberta Health Services to the Minister of Health and Wellness and the continuing confusion around roles and responsibilities. The Auditor General recommended various means by which the department might improve accountability of Alberta Health Services to the ministry. In particular, he recommended setting explicit and accepted performance expectations. According to page 103 of the April 2011 AG report the recommendation remains outstanding after three years. Why has the department waited so long to take steps that would improve Alberta Health Services' accountability?

Mr. Ramotar: Well, I'll start with the new roles and mandate document. That document is on the web. It clearly defines the roles and responsibilities between Alberta Health and Wellness and Alberta Health Services, and it is there for everyone to see. It was signed off by both the minister and the chair of Alberta Health Services.

The other thing that we have done is that we worked with the Health Quality Council, Alberta Health Services, and specialist doctors to develop 50 performance measures at the tier 1 level to hold Alberta Health Services accountable for the delivery of health services in this province. We are putting a structure in place to monitor each one of these performance measures, and the results will be posted publicly.

The latest thing that Alberta Health Services has done is look at their organization and tweak their organization to provide more accountability within their organization and a better linkage to the community. At one time, just two weeks ago, for example, we had three executive vice-presidents responsible for hospitals in this province. We had five of the seven executive vice-presidents responsible for each zone for health care in this province, okay? When you have five silos, you cannot transfer best practices across the province and provide consistent health care for folks. So that change is being made.

Up to two weeks ago there were hospitals where administrators were responsible for only part of the operations in the hospital. That will change. There will be one point person responsible for that hospital. Once you drive in that parking lot and you have a problem, you go and see one person.

So the whole structure is being tweaked to provide more accountability.

The Chair: Thank you.

Dr. Swann: It sounds like more than a tweak. It sounds like another transformation in the system, which obviously is needed.

How has the department reviewed and provided feedback so far on Alberta Health Services' performance in the absence of those explicit and accepted expectations and benchmarks?

Mr. Ramotar: Alberta Health Services has to provide a quarterly report to Alberta Health and Wellness, and that report includes a report on all 50 performance measures.

The Chair: Thank you.

Mr. Vandermeer, please, followed by Mr. Chase.

Mr. Vandermeer: Thank you. In 2008 we eliminated health care premiums. My understanding is that there was a huge bureaucracy there to implement the premium system in collections, et cetera. Where did all these employees go?

9:10

Mr. Chamberlain: The answer simply is that the premium collection system was in fact tied very closely to our registration system. Albertans had to register in order to be eligible for Alberta health care, and that's how the premiums were collected. In fact, most of the people who were involved with the premium collection are still involved in the department doing the registration, so there hasn't been a significant change in staffing. There's been some attrition over time, but no significant change.

Mr. Vandermeer: Okay. That eliminates my second question.

I'm going to go to a different topic, Health Link. I'm not convinced – and I've asked this question here before – that that is a cost-effective way of saving our system, with people going to emergency rooms and so on. Can you tell me if that is working, the Health Link, or if we'd be better off with nurses in emergency rooms rather than on telephone lines?

Mr. Ramotar: There are mixed reactions to the Health Link. If you talk to average Albertans, they like it, and they are making use of it. If you talk to folks that run the emergency department, some of them will tell you that it's one of the reasons that people end up in the emergency department. Yes, we have qualified registered nurses that work in that system. Yes, I've heard the comments on whether these people wouldn't be better off within the health care system itself. So we'll be taking a hard look at that, working with Alberta Health Services, to answer those tough questions.

Mr. Vandermeer: Thank you.

The Chair: Thank you.

Mr. Chase, please, followed by Mr. Allred.

Mr. Chase: Thank you. Goal 6, increase access through effective service delivery. As page 33 of the ministry's annual report indicates, the wait times for two procedures that first ministers agreed in 2004 were of high priority were well above the 2009-10 targets. My first question: why did 90 per cent of patients in need of hip replacement surgery wait 35 weeks, 11 weeks longer than the targeted time?

Ms Williams: I think how I would answer that is that a significant number of people have come into the province. There has been significant demand for both hip and knee replacement surgeries. The provision of services in the area, particularly in Edmonton and Calgary, has not been able to keep up with the demand, which is why the wait times did not significantly decrease over this period.

Since that time we have had both our HSs do blitzes in the last year to try to reduce the wait times for those two procedures, and they have looked at the provision of how service has been done. So you have the new hip and knee clinic and the new centralized booking system. They have looked at how services are actually being done to make the service more effective, to allow more people to actually get their hips and knees replaced with the existing amount of complement in that. There has been more significant work done in the last 18 months than what is being shown in this annual report.

Mr. Chase: Thank you. You've painted a picture of people hobbling across our borders looking for our services.

My second question: why did 90 per cent of patients in need of knee replacement surgery wait 49 weeks, nearly double the targeted wait time of 26 weeks?

Mr. Ramotar: Why don't we get back to you on that question so that we can move on?

Mr. Chase: Thank you.

The Chair: Okay. Mr. Allred, please, followed by Mr. Mason.

Mr. Allred: Thank you, Mr. Chair. With the move to engage the private sector in the provision of assisted and long-term care facilities, what is the multiplier effect of private-sector dollars being added to public-sector dollars? Do you understand what I mean? We're engaging the private sector. How many more facilities are we able to get by using private-sector dollars as opposed to just public-sector dollars?

Mr. Ramotar: Well, you know, there are different models. There are private sector that use their own funds to build continuing care facilities, and those rooms are essentially high-standard rooms that so-called rich Albertans can afford. As you move to the next tier below that, we have a program called the ASLI program, where the government of Alberta can contribute up to 25 per cent of the capital cost to private sector through a competitive process to ensure that we have the beds that we need in the location that we need the beds. So we can lever: for 50 cents on the dollars, we can get the private sector to put in the other 50 cents. But it's only for a portion of the continuing care facilities, not all.

Mr. Allred: Okay. I recognize that it's pretty complicated to put it down to a specific number.

Do the same standards apply to the private-sector facilities as to public-sector facilities in the instances you mentioned, where you contract them to provide facilities in an area where we want them?

Mr. Ramotar: Absolutely. They have to follow the building code for the different levels of continuing care service that are provided. So a long-term care unit built by the government is built to the same standard as a long-term care unit built by the private sector.

Mr. Allred: Is it just the building code, or do you have standards that are above the building code for health?

Mr. Ramotar: Are you talking about engineering design, or are you talking about operations?

Mr. Allred: Well, I'm talking about both. You use the term "building code," which is basically a national standard for buildings. But I presume that for the specific types of facilities you're speaking of, you don't just use the basic building code standards; you have some extra standards for medical facilities.

Mr. Ramotar: The building codes are the minimum standards that everybody must meet, including government. In terms of the operating piece for the different levels of care the government sets minimum standards for operations that everyone must meet, including Alberta Health Services or any private-sector provider.

Mr. Allred: Thank you.

The Chair: Thank you.

Mr. Mason, please, followed by Mr. Xiao.

Mr. Mason: Thank you very much, Mr. Chairman. My questions are for the Auditor General. In I think 2005 the Auditor General conducted a fairly comprehensive audit of our seniors' care in this province and made a number of recommendations. According to documents that we have tabled – and I'll provide them later today to members of the committee – the situation affecting patients in long-term care remains extremely negative, with people being left in diapers for long periods of time, missing baths, waiting an excessive time for meals, and facilities being operated chronically on a short-staffed basis. So my question to the Auditor General is whether or not he's planning a comprehensive follow-up, not just to look at whether the systems sort of are in place but whether or not the actual care is being delivered so that people can live in dignity. Is he planning to do a follow-up to that audit at any time?

9:20

Mr. Saher: Yes. In answer to that question, I can state categorically that we are more than planning to; we're actually engaged in a follow-up audit. Follow-up audits by their characterization are a follow-up of the recommendations that were originally made.

Since the time that the recommendations were originally made, my sense is that some new language has come into the equation. Earlier questions that you posed I think were addressed: the differentiation between pure long-term care, assisted living, and other dimensions, which the deputy minister himself talked about when he answered an earlier question. In a follow-up audit we have to take note of how the environment, the context have changed since the original recommendations were made to ensure that the follow-up is meaningful in today's context. We will do that.

Yes, we do look at systems. But in order to know whether a system is functioning, one has to look at the actual day-to-day outcomes. A system could seem to be functioning in design, but if the actual care is not meeting standards, that would be evidence that the system is not functioning. So we always look at what is actually happening to draw conclusions on the system as a whole.

In summary, we have a follow-up audit under way, and as soon as it's completed, it will be available for public reporting.

Mr. Mason: Thank you.

My subsequent question, and I guess it's just a restatement: will the audit actually go into a number of long-term care and continuing care facilities to examine whether, in practice, the people who live there are living in dignity?

Mr. Saher: The follow-up audit will certainly require staff from the Auditor General's office to visit facilities. We have to be very

careful with subjective terms. We do our work fact-based, looking at the standards. What the standard says has to be there. Is there evidence that the standard is being met? If we have evidence that the standards are not being met and the system itself is not recognizing that, taking that information to those who can make the change that is necessary, then that would be a reportable item.

Mr. Mason: If somebody is being left in soiled diapers for an extended period of time, is that a standard that you measure?

Mr. Saher: I assume that the standard would not consider that state to be tolerable. If the standard considered that to be a tolerable state, then there's something wrong with the standard.

Mr. Mason: And you'd say so?

Mr. Saher: Yes.

The Chair: Thank you.
Mr. Xiao, please, followed by Dr. Swann.

Mr. Xiao: Thank you, Mr. Chair. Looking at the expenses incurred in the physical year 2009-2010, we spent $2.34 billion on diagnostic and, of course, therapeutic and other patient services. Does this expense include the expense of lab tests?

Ms Williams: Yes would be the answer, to the extent that they are funded by the health care system through Alberta Health Services.

Mr. Xiao: Okay. My next question. Given the population that we have – there are 3.75 million people – according to my information it seems we had more than 100 million lab tests. Based on my family's parents, through the years we have done so many of the same lab tests repeatedly. What kind of measures have you taken to try to minimize that repetition, you know, which is prescribed by the doctors?

Mr. Ramotar: Well, we have to be very careful not to cross the line into dictating to physicians how they should do their job and how many tests they should do on different patients. At the global level we have that information within the department, and we are monitoring growth or reduction in the use of labs, but I think it's dangerous to tell doctors how to do their work.

Mr. Xiao: No, I'm not talking about telling doctors. How can we set up the system, I mean, for the doctors to share the information instead of sending the same patient for the same test again and again? Repeatedly. That's my point.

Mr. Ramotar: Yeah. That's a very good question. We are working on it. We are working on something called electronic health records. Electronic health records are going to be the defining repository for all of this information, including imaging, and that information will be shared once we have quality information in the system and enough information in the system.

The Chair: Thank you.
We're moving on now to Dr. Swann, followed by Mr. Sandhu.

Dr. Swann: Thank you. According to page 30 of the ministry's annual report 55 per cent of Albertans were enrolled in primary care networks as of 2008-09. Why did the minister set a 2009-10 target for access to primary care networks that was achieved two years before? What is your real commitment to primary care network expansion?

Mr. Monteith: What we've done is that we actually had set those as three-year rolling targets. When you bring a primary care network on, some can be small, some can be large. The group of patients that then come in with the physicians in Alberta Health Services and into the network: there can be significant or relatively small growth swings depending on the scale and the size of the primary care network that has come in. In that period we had a couple of fairly large primary care networks that had come into the system, so we went over our projected three-year target that was set. That target was actually not set by Health and Wellness. It was set trilaterally with Alberta Health Services and the Alberta Medical Association. So that's how we exceeded that particular target that was set at that time, and we definitely exceeded it early.

Dr. Swann: I'm not sure I understand that, but the other side of this question has to do with investing in primary care networks. It's my understanding that the per patient funding to primary care networks has not changed since 2005. What is your real commitment to primary care networks if your funding formula has not increased since 2005?

Mr. Monteith: The way the funding formula works for a primary care network is that for each patient that is viewed to be a patient of a participating physician, that creates an annual payment of $50 per patient into the primary care network through a holding company, which is a not-for-profit corporation co-owned by the physicians and Alberta Health Services. It's important to know that the earliest primary care network that came into the system was actually in 2005. As of today we have 40. The vast majority of our primary care networks are still in surplus on the original budgets that they've been given as they're continuing to implement their business plans. So the change or the addition of funds on the per capita ratio is one that is under contemplation, but at this point in time no additional funds are viewed as necessary given the rate of surplus each of the businesses that are managing all 40 networks is currently at.

Dr. Swann: If I may just supplement slightly, that's not my experience in talking to front-line primary care network leaders.

The Chair: We're moving on, please. That's not fair to other members, Dr. Swann.
Mr. Sandhu, followed by Mr. Chase.

Mr. Sandhu: Thank you, Chair. During 2009-10 we spent $42 million to implement the health workforce action plan. Where was the funding allocated?

Mr. Monteith: If I may answer, Employment and Immigration actually is the fund holder for all of the dollars. Health and Wellness, which is one of the three ministries who are involved in the health workforce action plan, managed that year $15.3 million of the $45 million that was allocated in that period for the action plan. I will make sure you get the detailed breakouts of where we spent.

9:30

Some of the pieces that we actually funded were $4 million in midwifery in Alberta to establish the initial compensation model that Alberta Health Services has continued with. That was $4 million that went to establish midwifery funding in the province of Alberta, and that was the first year for that service to be publicly funded in the province. We also spent a significant amount of money on our international medical program. In fact, we funded 42 new spaces in that period. We also fund the assessment of in-

ternational medical graduates for that. I believe that year we funded assessments of 299 folks at that point. That year we also brought a third-year medical student clerkship program into rural communities to give medical students rural experience and training. In fact, that year we had 29 medical students who actually went out and gained that experience.

In terms of the detailed breakout of the $15.3 million we can provide that in writing to the committee.

Mr. Sandhu: Okay. My second. In 2009-10 it appears that a bonus was paid to executive staff. Given the challenges the health system faces, are these payments, the bonuses, a bang for the buck?

Mr. Ramotar: Bonuses for Alberta Health Services staff?

Mr. Sandhu: Executive staff, yeah.

Mr. Mazurkewich: Sorry. Could I have the question repeated?

Mr. Sandhu: Okay. In 2009-10 it appears that bonuses were paid to executive staff. Given the challenges the health system faces, are these payments a bang for the buck?

Mr. Mazurkewich: Are they a bang for the buck?

Mr. Sandhu: Yeah. Was it worth it to pay bonuses?

Mr. Mazurkewich: We have performance agreements with senior people within Alberta Health Services that outline different performance targets. Some of the performance targets they achieved and some they didn't, and for those that they achieved, that's where they would earn the pay at risk under the new contracts that many employees have. For some of the older employees, that have been around for a while, they have bonuses built into their contracts. Again, they have to achieve certain things to be able to be awarded the bonuses. Those bonuses are based on achieving certain performance targets, and if they didn't achieve the performance targets, then they wouldn't be paid for it.

The Chair: Thank you.

Mr. Chase, please, followed by Mr. Groeneveld.

Mr. Chase: Thank you. I'm looking at a sheet entitled Schedule of Other Expenses per Consolidated Schedule of Expenses by Object, Alberta Health Services 2009-2010. There are two columns: expense description and amount in millions. It goes down from clinical supplies, sundry expense, utilities, and then it comes to other fees of $42,450,000. In the name of transparency and accountability would you please provide a breakdown for this $42 million or almost $43 million expenditure? Now, my expectation is that you're not going to be able to do it at this time based on inability to answer other questions, but through the clerk we would appreciate that $42,450,000 broken down.

Mr. Ramotar: Will do.

Mr. Chase: Thank you.

My second question has to do with healthy people and healthy communities. According to page 23 of the ministry's annual report the prevalence of regular heavy alcohol consumption among Albertans 15 to 29 years of age has not declined since 2003. Regular heavy alcohol consumption is associated with many kinds of risky behaviour; impaired driving, unprotected sex, for example. What increased burden has the ministry's lack of success in reducing regular heavy alcohol consumption among Alberta youth placed on the health care system?

Ms King: The issue of underage drinking is one of great concern for all of us. Specifically within the addiction and mental health strategy, that was referenced earlier by Mr. Ramotar, there is a section that is looking at children and families. So part of what we want to be doing is addressing these issues. As Mr. Ramotar indicated, we are actually engaged with Education, with Children and Youth Services, with Transportation, with multiple ministries to ensure that what we develop as an implementation strategy with Alberta Health Services will be addressing these areas of concern.

Mr. Chase: And it's not just children; we're talking about 15 to 29.

The Chair: Thank you.

Mr. Groeneveld, please, followed by Mr. Anderson.

Mr. Groeneveld: Thank you, Chair. I'd like to switch gears a little bit here and talk about the pharmacy business, which, of course, is talked about extensively in places. Certainly, the pharmacy industry has expressed concerns about the impact of reduced generic prices on the revenues for the pharmacy business. I guess I would like to know what measure your ministry has taken to ensure the sustainability of the pharmacy business in Alberta as, indeed, the chickens are now coming home to roost on a lot of the generic drugs.

Mr. Ramotar: That's a very good question. As I mentioned, one of the key cost drivers for the health care system is drugs.

With that introductory remark, I'll throw it over to Glenn.

Mr. Monteith: Sure. Thank you very much. It's important to know that there's a continuing trend downward on the price of generic drugs in Canada. For example, Ontario has now moved to 25 per cent of the brand name price over the next year and a half. That will be their new, if you will, threshold for generics. Currently we're at 56 per cent if it was existing and 45 per cent if it's a new generic and moving down.

What we've done is that we've worked very closely with the pharmacy industry as well as the pharmaceutical manufacturers, which is the other side of it, that doesn't often get talked about, to come forward with a transition plan. The first thing that we did was establish a three-year program that allowed for additional dollars to flow to the pharmacies, linked to their dispensing fee, to allow them to have appropriate resources to deal with some of the adjustments. The first year of that, which was actually '10-11, was a $3 rider on top of the dispensing fee. This year as of April 1 it moved to $2, and then next year we'll get it down to $1.

In the meantime we also spent on a $5 million rural transition fund to deal with the smaller community pharmacies to ensure that they had some additional resources to deal with some of the transition in their business lines that were affected.

We're now evaluating where it is that we need to go next to minimize any loss of primary care access. Really, in the primary care system pharmacists are a very important part of it although we usually talk about physicians in that case. We're looking very closely with industry to come forward with a plan. Part of that is working with the Pharmacists Association of Alberta, the Canadian Association of Chain Drug Stores and independent pharmacies as well to look at other compensation models, to utilize their skills for better patient outcomes going forward. We have a number of initiatives under way today.

Mr. Groeneveld: Well, thank you.

Just looking down the road here a little bit – and I'm looking backwards, Chair; I'm not looking forward. I had a patient in my office just this last week, and she's on a new drug that's out there right now, which is being covered in Quebec thanks to Alberta. But that's just a comment. This drug that she's now on will cost over $400,000 per year per patient. [interjections] Yes, $400,000 per patient. Looking back, this started a few years ago. Certainly, with your five-year budgeting – that's great and whatnot – what's this tsunami going to do to your budget down the road?

9:40

Mr. Monteith: You may or may not be aware, but Alberta is actually the only province that has put in place an expensive drug for rare disease program, and it's not entirely broad spectrum enough for the development of these what will be called in the drug industry ultra-orphan drugs, where they're designed for very, very rare diseases. By the World Health Organization's definition of a rare disease, there are about 6,000 rare diseases. This is an emerging area of drug development for lots of reasons, not the least of which is that there are patients out there who typically wouldn't get access to medicines because manufacturers and researchers wouldn't experiment to find medicines.

The challenge is cost, so we're working very closely – this started a few years ago with a group of drugs for a disease called Fabry, which you may be familiar with, and the average drug price in there was about $327,000. We've managed, by working collectively as provinces, to bring that price down on an average annual basis to $186,000. We do have to work very carefully, and it is beyond provincial jurisdiction to deal with these things. At some point we have to have exceptional processes put in to determine: where do we put our resources relative to more common disease areas, where there are many, many more people who have these diseases?

Today, when you add up the total dollar effect versus the total dollars spent on drugs, there's still not a significant amount to the total dollars. The issue is one of equity, of access, and where you actually get the best investment for people.

The Chair: Thank you.

Mr. Anderson, please, followed by Mr. Allred.

Mr. Anderson: Thanks, Mr. Chair. I had a few individuals come to my office to talk about the electronic health record, and they told me a story. I'm hoping you can tell me that it's not true. Essentially, they told a story about, you know – clearly, a lot of money has been spent on this electronic health record initiative. There have been a lot of regulations set up with regard to what the vendors of the system that the doctors use in their offices have to build, obviously. In order to build those systems, you have to meet certain requirements, certain standards, et cetera. I guess the reason you need to do that is because eventually, when things get sorted out, there's going to be this massive brain centre where the electronic health record can be accessed. When somebody sees a doctor in one place and gets a test done, et cetera, et cetera, if they move or they go somewhere else, the new doctor can see what has already been done so that we don't have a duplication, et cetera, et cetera.

These vendors that provide the service to the doctors and build these systems are saying that (a) we've spent millions and millions and millions of dollars, tens of millions of dollars on the system and still don't have one in place, the actual centralized health record, and (b) that now apparently you've limited the number of vendors that are able to provide this service – I don't know what the number is, three or five – to three. Some of these vendors are the ones that were in my office. The two that were in my office are Alberta companies that had been doing it for years and were complying with the standards, which apparently have been changing over time.

The Chair: Could you get to your question, please?

Mr. Anderson: It's context. It's so complicated. It confuses me.

The Chair: With respect, there are still people . . .

Mr. Anderson: I will. I will, Mr. Chair. Absolutely.

My question: can you please let me know how close we are to an electronic health system? Two, why have you limited the amount of vendors that are able to build these systems? Why would you arbitrarily do that?

The Chair: Mr. Ramotar, I believe you have one of your staff that's very anxious to go to the microphone and answer that question, but before he does, I would like to note to the members and to Mr. Anderson in particular page 124 of the annual report. For 2009 we spent $280 million on information technology. For 2009-10, the year in question, we spent $299 million, an increase of $19 million.

So, sir, if you have an interest, please proceed.

Mr. Ramotar: Before he proceeds, I just want to clarify, Mr. Anderson, that I think what you're referring to is the electronic medical records. Those are the ones in the doctor's office.

Mark.

The Chair: You have very anxious, diligent staff.

Mr. Brisson: Two pieces to answer your question. We do have a provincial electronic health record. It does exist today. It contains your labs, your drugs, and your diagnostic imaging tests for all Albertans in the province. It is accessible to those providers in their physician offices if they have access to Alberta Netcare, and they can do that through their electronic medical records, which is the system that they have in their offices.

Three years ago we initiated a provincial procurement for moving to a reduced number of vendors in the electronic medical records to provide for physicians' offices as part of the physician office system program. That was done in support of working with a reduced set of vendors that could meet the specifications required to connect to the electronic health records, that being able to also support physicians with solutions that were reliable, that could provide end-to-end support for the physicians so that they could have that access to the electronic health record. All of the vendors in the marketplace at the time were not able to provide those services to those physicians.

Mr. Anderson: Why not just give the criteria and say that this is how much we're going to give doctors to pay for this thing or whatever and just let them, you know, compete? Why would you arbitrarily make it just three? That doesn't make much sense.

Mr. Brisson: We actually had only three vendors make it through that open and fair procurement process; hence, we selected those three.

The Chair: Thank you. And I really appreciate your effort, sir.

Mr. Allred, followed by Mr. Mason.

Mr. Allred: Thank you, Mr. Chair. There's been some reference earlier in the discussion about the amount of money spent on legal expenses defending some of these lawsuits, and I recognize that the lawyer's tactic is to use a shotgun approach and name everybody. From my reading of some of those lawsuits, there seems to be a lot of infighting between doctors: racial attacks, name-calling, lack of respect for team decisions, and that sort of thing. Are there any monies in your budget for team-building efforts amongst these medical professionals? Because that seems to me to be the problem.

Mr. Monteith: Within the agreement with Alberta Health and Wellness, Alberta Medical Association, and Alberta Health Services we don't actually have funds in there because that's for compensation for services and kind of building and ensuring that the offices are maintained.

At Alberta Health Services – and Chris Mazurkewich, who's here, may be able to address it – they are working diligently on what they call clinical networks. In that clinical network approach one of the pieces that they're working very hard at – and the AMA is very much engaged in this as is the physician leadership within Alberta Health Services – is really working on team-based care, getting the various types of generalists and specialists within each of the sectors of medicine and surgery working much more cohesively and collectively together to get better patient outcomes. I know it's in the early stages, and I don't know if Chris has a lot of detail that he can share at this point, but I know it is a key effort in the Alberta Health Services world, and the AMA is actively engaged with them on that.

Mr. Allred: Just a short follow-up. I really appreciate that. I know there's money spent on legal services, and I think there's a program for psychoanalysis of doctors, whatever it is – I don't know – but I think we really need to look at the team-building exercise. I appreciate what you're saying, that we need to prevent these problems rather than fight them, especially in court.

The Chair: Thank you. That was more of a comment than a question?

Mr. Allred: Yes, it was. That's all it was.

The Chair: Okay. Mr. Mason, in the time we have left, if you could be brief, I would appreciate it

Mr. Mason: Sure.

The Chair: I think we're going to have to have questions read into the record and get a response.

9:50

Mr. Mason: You bet. Well, my question has to do with the development of facilities around the province to provide medical care and then the inability of the department to open them because of staffing considerations. One example, of course, is the east Edmonton health centre, which was supposed to contain a number of functions, including an urgent care centre, that are still not operational. I would like to know, not just in connection with the east Edmonton health centre but province-wide, the number of spaces, the number of beds, the types of facilities and equipment that have been purchased and built that have been inactive as a result of your department being unable to staff them for financial or whatever reasons and what the costs of those have been over the last five years.

Mr. Ramotar: I'm not aware of any facility that was built recently that is closed because of funding for staffing or equipment. I am, however, aware of facilities that were built that are not functioning today to capacity. I want to make it clear that as an engineer we build things looking ahead 20 years. We do shelled-in space for future expansion in hospitals because it does not make any sense to go back in five or 10 years and put another floor on top of an existing hospital. I think there's confusion when people look at those shelled-in spaces and say, "Well, geez, it's not furnished," or "We don't have people to work in there." That was planned. So it's a phased approach.

Mr. Mason: Mr. Ramotar, with all due respect, I agree that there's confusion around this issue, but I don't think that it's coming from my conception of what's happened. I know, for example, that the east Edmonton health centre was announced that it would be fully staffed and open. It was not planned, sir, to remain vacant and to not bring that online. Similarly, other announcements were made with respect to other hospitals, that they would be open at certain times, and it was only after they were built that the situation was changed. I don't accept your answer, sir, with all due respect.

Mr. Ramotar: Well, I'm not aware of any hospital that is built and is not open. Like I said, I'm aware of some facilities that were built but are not fully operational for one reason or another. For the one that you referred to in Edmonton, I'll ask Chris Mazurkewich to answer that specifically, if you'd like.

Mr. Mazurkewich: I can't answer that specific one, but I just want to point out that last year we opened approximately 360 beds within various hospitals between Edmonton and Calgary and around the province, so we have been expanding within the facilities as they've come on stream and as we've geared up. So we've been using up a lot of the space. We do have future expansion space built into some of the facilities, as Mr. Ramotar has pointed out, so we are going through that exercise. We're looking over a five-year period at how we bring on space, when do we need to bring on space, what makes sense. So we're looking at plans as well.

The Chair: Thank you very much.

Mr. Mason: I'd appreciate the answer to my initial question, though, later in writing. Thank you.

The Chair: Thank you, Mr. Mason.

We have members with questions, and we do not unfortunately have enough time. Mr. Kang, if you could read your questions into the record.

Mr. Kang: Thank you, Mr. Chair. Darshan Kang, MLA, Calgary-McCall. Good morning, everyone. My question is regarding health records. Twice since 2006 the Auditor General has recommended that the department carry out a comprehensive risk assessment of its information technology environment and develop and implement an information technology disaster recovery plan. According to page 103 of the AG's April 2011 report this recommendation remains outstanding. My first question. Amendments to the province's Health Information Act in 2010 facilitated the development of Alberta's electronic health records. Why has the minister not implemented the accompanying security steps that are a necessity?

My supplemental is: please detail the plan that is in place should the department suffer the kind of catastrophic security breach that Sony PlayStation recently experienced.

Thank you.

The Chair: Thank you.
Mr. Chase and Dr. Swann.

Mr. Chase: Thank you. As page 20 of the ministry's annual report indicates, there has been no significant change over the past five years in the percentage of adult Albertans with an acceptable body mass index, or BMI. How does the ministry account for its continued lack of success in combating obesity?

Secondly, chronic diseases such as type 2 diabetes and high blood pressure are associated with obesity. How much did obesity and its associated conditions cost Alberta's health care system in 2009-10?

The Chair: Thank you.

Dr. Swann: According to page 21 of the ministry's annual report only 55 per cent of seniors aged 65 and over received the flu vaccine in 2009-10, a significant drop from earlier rates. Indeed, children's vaccination rates also declined substantially, from 59 per cent to 43 per cent. What is this government's commitment to prevention? What increased burden did this lack of uptake among particularly vulnerable populations place on our health care system?

On page 40 of the ministry's annual report $29 million was provided to Alberta Health Services and various other organizations in support of communicable disease control and prevention. It went unexpended. Why?

The Chair: Thank you.
Mr. Ramotar, again, in writing through the clerk to all members.

Mr. Ramotar: Will do.

The Chair: Mr. Mason, do you have a tabling?

Mr. Mason: I do, Mr. Chairman. These are documents that support my first line of questioning in the committee. These are 43 separate working short forms filled out by people who work in long-term care centres, indicating that because they were short-staffed, they were unable to get patients up to bathe them and to give them the care that they needed. We have tabled hundreds of these documents in the last year or two, which, in my view, shows a very consistent pattern of neglect in our long-term care centres in this province.

The Chair: Did you say you have 43 pages?

Mr. Mason: Yes.

The Chair: Okay. In light of that we will certainly take those, but we will put them on our website. Is that fair enough?

Mr. Mason: That would be fine.

The Chair: The internal website.

Mr. Mason: Save a few trees.

The Chair: Okay. Thank you for that.

Now, on behalf of all members of the committee, Mr. Ramotar, I would like to thank you and your staff for your time this morning. It's a very vital, interesting department, and we obviously ran out of time. On behalf of all members I wish you and your executive team the very, very best. We have other items to discuss on our agenda, so feel free to exit the room. Good luck, sir.

Mr. Ramotar: Thank you very much.

The Chair: Item 5 on our agenda, the meeting schedule. At the last meeting a motion was passed to invite the Workers' Compensation Board to meet with this committee on May 18 if we are still in session. At this point it is not clear – I think it's rather doubtful – whether or not we'll be in session this time next week. If our meeting on May 18 does not go ahead, are members still interested in inviting the Workers' Compensation Board or other groups to meet with the committee outside of session?

Mr. Chase: To formalize the procedure, I move that we follow through with our WCB scheduled meeting next week, Wednesday, May 18. Unfortunately, like so many other sessions this has drawn to a close earlier than anticipated. It was supposed to go through to June 3; we surpassed our April 14 closing of last year.

The WCB, as I say, takes up the majority of the caseload at least in my office and I'm sure other MLAs' offices. These people weren't held to account when Employment and Immigration came; therefore, it's time.

The Chair: Thank you.
Mr. Rodney.

Mr. Rodney: Thank you very much. I certainly appreciate your passion and concern, Mr. Chase. We all have different people contacting our offices at all times on various occasions, well, for many, many different reasons. I believe it's important to see WCB as well.

I would like to say that June 4 was an end date. That's not when we're supposed to go till. That's the date that we must be done our business. Some might say that ending before that point indicates that we've been efficient and accomplished the agenda. You may disagree, and that's completely fine. What I would say, though, is that this has been an extremely gruelling spring session, that goes back a number of months ago. In the last 24 hours I've been to Calgary and back. I had a 20-hour day a couple of days ago; I've got another one today. That's up here in Edmonton.

10:00

Our job is to represent our constituents, and I believe it's high time that we went back there. I'm happy to see the WCB, but if we're not in session, I don't want us all to have to be dragged back here on Wednesday for that meeting only. I would prefer that we set another date that makes sense. I do want to say that in September a practical reality for – not that this is partisan. We're trying to be all party, but your party and my party and others, too, have leadership questions to be answered in the month of September. I'm open to discussing dates, but I don't think September makes a whole lot of sense at this point, and I don't think Wednesday makes a whole lot of sense at this point either.

Mr. Chase: I'm extremely concerned because in talking to Conservative colleagues, it's been suggested that because of the leadership race there's not going to be a fall session, so the likelihood of being able to address the WCB in a normal November isn't going to happen. Likewise, there's a very good possibility of an election being called in March, which would effectively wipe out another session. We'd go a year without the opportunity to have legislative sessions and, therefore, to call people within our sessional times. That, to me, is unacceptable, and that's why I've put forward this motion.

The Chair: Well, we can't speculate on a fall session. We can't speculate on a provincial election. We do know there are leader-

ship races, but they should not affect the work of this committee. We all get paid to serve on this committee, and there is, in the chair's view, no reason in the world why we could not meet. We met in the summer before or in the fall or in June. We've got lots of time. But it's up to the will of the committee, and the chair is seeking direction from the committee. You guys set the rules.

Mr. Vandermeer: I live in Edmonton, so for me it's not too bad to come here. With telecommunications and so on I think we can probably still meet, and some members can meet over the wires, and we can get our work done. I don't have a problem with meeting.

Mr. Xiao: Next Wednesday is an originally scheduled meeting, right?

The Chair: Yes.

Mr. Xiao: You know, I have full sympathy with you guys that have to travel, so let's get it done, okay? You can make a phone call from Calgary, and we'll be here. Then we can have our meeting, and then we'll move on.

The Chair: Are you suggesting we should have an organizational meeting?

Mr. Xiao: No. What I'm saying is that we just proceed with the scheduled meeting on May 18, next Wednesday, and then the people who are living in Calgary or outside of Edmonton can participate through the phone. They're all scheduled. Let's get it done.

Mr. Groeneveld: I hate to see us basing this on pure speculation of what's going to happen. I think that's ridiculous. There's no reason why towards the fall we can't see what is happening at that stage of the game. If the chair would care to get hold of us at that time, then I would be in favour of doing that rather than for me to come back next week or even get on the phone at that particular time when I've got constituents who have been sitting there for a long time. That doesn't work for me.

Mr. Kang: If we cannot do it next week, maybe in June we can have the meeting with the WCB because it's been a long time, and we've been getting lots of complaints about the WCB, with every week one or two people getting cut off and, you know, that they're not being fair and all that. I think it's about time we brought the WCB in and questioned them.

Mr. Griffiths: Well, I don't think it has anything to do with the leadership race or the fall session or anything. We've advocated and worked very hard over the last few years to be able to meet outside of session. The WCB has already been informed. The meeting has already been booked. They've probably done a lot of preparation, and I think the meeting could proceed. We do have new technology that allows people to join from wherever, and I would suggest we get it done, in fairness, because I would be concerned that the reputation of the committee could be affected if we call people to come, we schedule a meeting, and then we cancel. We'd better be prepared, then, to have them cancel on us. It's just fair, and I think we should stick to our obligations. The meeting is already scheduled.

The Chair: Thank you. That's an interesting perspective and a wise one.

Mr. Rodney: Ladies and gentlemen, when this came up, the question was whether or not we'd be in session, and the suggestion was made: if we are still in session, who should we see? So we brainstormed. "Okay. Let's see WCB." Again, I'm in agreement with seeing them, but that was a contingency plan. That was a contingency plan in case we were in session. I respect the notion that if we've asked someone to come, they come. I also understand that things change. I'm not saying to cancel on the WCB. I'm saying: let's postpone to a time that makes sense.

Folks, we'd be out of session next week. If we're out of session, then people have to make a specific trip in. And I'm sorry; yeah, we do have technology, but there's absolutely no replacing the in-person. I do want to stress that. It would be best if people were here in person, and I'd like to see that happen.

If we're meeting outside of session, which this would be, I would propose that we have more of a full-day meeting, that we see someone in the morning and we see someone else in the afternoon. I'm a big fan of piggybacking meetings, being here for a whole day instead of for an hour and a half. I also believe that in this province we should allow some travel time. This has happened before. We've met someone at 10:30, which would mean that even for me, driving four hours, like I did this morning, I could leave in the morning and be here. I could see, with you, a group like WCB at 10:30, have a break for lunch, see somebody else at 12:30 – you're done by 2 – or even see a third group if you want. You can be home for dinner anywhere in Alberta.

That's what I would like to see happen. I would like that to happen perhaps in October. I'm saying: let's see them, but let's postpone it and piggyback meetings so that we can see them and somebody else if that's the desire of the committee.

Thank you.

The Chair: Okay. I appreciate that. I would like to point out that other committees that I serve on meet routinely and use teleconferencing for out-of-town members, and it seems to work quite well. We do have a motion to meet with the Workers' Compensation Board next week, but the motion indicates: only if we're in session. If we were to have them here next Wednesday, we would have to have a motion to change that so that we're going to meet with them regardless. I have spoken to the Workers' Compensation Board regarding their meeting next week, and they were very gracious and co-operative, and they're anxious to appear. They're getting prepared.

Now, it's up to the committee. We've changed the rules. The government majority on this committee wants to schedule the meetings. We all have commitments after 10 o'clock this morning, so I want a decision from you one way or the other in the next couple of minutes.

Mr. Allred: Mr. Chair, do we not have a motion on the floor? I believe Mr. Chase moved a motion to have it next week regardless. Am I not correct?

Mr. Chase: The motion, very simply, is to meet next Wednesday, May 18, with the WCB.

Mr. Groeneveld: I'd like to amend the motion.

The Chair: Yes.

Mr. Groeneveld: I'd like to amend the motion to read that the next meeting be called after September 1 at the call of the chair.

The Chair: No. We're going to vote on this motion.

Okay. Mr. Chase, your motion, please.

Mr. Chase: Again, I'll repeat it, and it can be clarified if it's not that

we meet with the WCB next Wednesday, May 18.

10:10

The Chair: Thank you.

All those in favour of the motion? All those opposed to the motion? It is 7 to 2. So we're going to meet with them, and we will arrange teleconferencing for those who are interested in participating that way. Is that fair enough?

The clerk will correspond today with the chairman of the board of directors of the Workers' Compensation Board and Mr. Kerr to inform them that this meeting is proceeding. We can certainly do it. It seems to work with the heritage savings trust fund, that there was in the past. There's teleconferencing, and that works. Okay? Next week, if you have any other agencies, boards, or commissions of the government or departments that you want to meet with, let us know.

Now, if there are any requirements of Dr. Massolin and the research team regarding the Workers' Compensation Board, let him know, please.

Is there any other business the committee members want to raise?

Mr. Allred: Just on that point, do we not get the standard report regardless, or do we have to request it from Dr. Massolin?

Dr. Massolin: Mr. Chair, that's certainly up to the committee to decide. We're fully prepared to write a report for next week.

Mr. Allred: Well, from my perspective, I really appreciate your report. It's very well prepared, and it's good background information. I would request it.

Thank you.

Mr. Sandhu: The same for me.

The Chair: Yes.

Mr. Chase: If I could put it on the record for Dr. Massolin, a question I would like to know is a comparative one. How many other provinces provide bonuses to their WCB equivalents for reducing case files?

The Chair: Thank you.

Item 6. The date of the next meeting will be Wednesday, May 18, with the Workers' Compensation Board from 8:30 in the morning until 10.

Mr. Rodney: One final question, a quick one for the clerk?

The Chair: Yes.

Mr. Rodney: I presume our great clerk will be able to e-forward to each of us the correct information in terms of how we phone in from our constituency offices or wherever we happen to be on Wednesday.

Ms Rempel: Absolutely. Any committee members that wish to participate by teleconference should let me know, and then we'll follow up with you shortly before the meeting with all the necessary dial-in information.

Mr. Rodney: Thank you so much. I can't wait.

Mr. Sandhu: Mr. Chair, you mentioned yesterday that a couple of guys dropped out of the conference. I'm next in line?

The Chair: Yes. You are next. I know it's short notice, but if you could let us know through the clerk your intentions or your plans. Jody Rempel has the details. Please let us know. Next week, if Mr. Sandhu cannot attend the Public Accounts national conference in Halifax, we're going to have to get someone else.

Mr. Sandhu: Could Jody please send me the itinerary?

The Chair: Yes.

Mr. Chase: Is it true that we are only able to afford a one-way ticket for Mr. Sandhu?

The Chair: Oh, no, no. That's not true.

Could I have a motion to adjourn, please? Peter Sandhu. Thank you very much. All in favour? The meeting is adjourned.

Thank you.

[The committee adjourned at 10:13 a.m.]

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