Legislative Assembly of Alberta

The 28th Legislature
First Session

Standing Committee on Public Accounts

Health
Alberta Health Services

Wednesday, October 24, 2012
8:32 a.m.

Transcript No. 28-1-3

Legislative Assembly of Alberta
The 28th Legislature
First Session

Standing Committee on Public Accounts

Anderson, Rob, Airdrie (W), Chair
Dorward, David C., Edmonton-Gold Bar (PC), Deputy Chair

Allen, Mike, Fort McMurray-Wood Buffalo (PC)
Amery, Moe, Calgary-East (PC)
Anglin, Joe, Rimbey-Rocky Mountain House-Sundre (W)
Bilous, Deron, Edmonton-Beverly-Clareview (ND)
Calahasen, Pearl, Lesser Slave Lake (PC)
DeLong, Alana, Calgary-Bow (PC)
Donovan, Ian, Little Bow (W)
Fenske, Jacquie, Fort Saskatchewan-Vegreville (PC)
Fraser, Rick, Calgary-South East (PC)
Fritz, Yvonne, Calgary-Cross (PC)
Hale, Jason W., Strathmore-Brooks (W)
Hehr, Kent, Calgary-Buffalo (AL)
Kang, Darshan S., Calgary-McCall (AL)
Kubinec, Maureen, Barrhead-Morinville-Westlock (PC)*
Pastoor, Bridget Brennan, Lethbridge-East (PC)
Quadri, Sohail, Edmonton-Mill Woods (PC)
Sarich, Janice, Edmonton-Decore (PC)
Starke, Dr. Richard, Vermilion-Lloydminster (PC)
Stier, Pat, Livingstone-Macleod (W)
Webber, Len, Calgary-Foothills (PC)

* substitution for Janice Sarich

Also in Attendance

Forsyth, Heather, Calgary-Fish Creek (W)
Sherman, Dr. Raj, Edmonton-Meadowlark (AL)
Swann, Dr. David, Calgary-Mountain View (AL)

Office of the Auditor General Participant

Merwan Saher	Auditor General

Support Staff

W.J. David McNeil	Clerk
Robert H. Reynolds, QC	Law Clerk/Director of Interparliamentary Relations
Shannon Dean	Senior Parliamentary Counsel/ Director of House Services
Philip Massolin	Manager of Research Services
Stephanie LeBlanc	Legal Research Officer
Nancy Zhang	Legislative Research Officer
Nancy Robert	Research Officer
Corinne Dacyshyn	Committee Clerk
Jody Rempel	Committee Clerk
Karen Sawchuk	Committee Clerk
Christopher Tyrell	Committee Clerk
Rhonda Sorensen	Manager of Corporate Communications and Broadcast Services
Jeanette Dotimas	Communications Consultant
Tracey Sales	Communications Consultant
Liz Sim	Managing Editor of *Alberta Hansard*

Transcript produced by *Alberta Hansard*

Standing Committee on Public Accounts

Participants

Ministry of Health
- David Breakwell, Assistant Deputy Minister, Financial and Corporate Services
- Lorraine McKay, Acting Assistant Deputy Minister, Health Benefits and Compliance
- Glenn Monteith, Assistant Deputy Minister, Health Workforce
- Marcia Nelson, Deputy Minister

Alberta Health Services
- Chris Eagle, Chief Executive Officer
- Chris Mazurkewich, Chief Operating Officer
- David Megran, Executive Vice-president and Chief Medical Officer, Clinical Operations

8:32 a.m. **Wednesday, October 24, 2012**

[Mr. Anderson in the chair]

The Chair: Good morning, everyone. I'd like to call this meeting of the Public Accounts Committee to order, so if everyone could take a seat. My name is Rob Anderson. I'm the committee chair and the MLA for Airdrie. I would like to welcome everyone in attendance.

If we could quickly go around the room and introduce ourselves around the table, that would be great, just starting to my right.

Mr. Dorward: David Dorward, deputy chair, MLA, Edmonton-Gold Bar.

Ms Fenske: Jacquie Fenske, Fort Saskatchewan-Vegreville.

Ms Calahasen: Pearl Calahasen, Lesser Slave Lake.

Ms Pastoor: Bridget Pastoor, Lethbridge-East.

Mr. Webber: Len Webber, Calgary-Foothills.

Dr. Starke: Richard Starke, Vermilion-Lloydminster.

Mr. Fraser: Rick Fraser, MLA, Calgary-South East.

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

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

Mr. Allen: Good morning. Mike Allen, Fort McMurray-Wood Buffalo.

Mr. Mazurkewich: Chris Mazurkewich, Alberta Health Services, chief operating officer.

Dr. Eagle: Chris Eagle, CEO, Alberta Health Services.

Ms Nelson: Marcia Nelson, deputy minister, Alberta Health.

Mr. Breakwell: Dave Breakwell, ADM, financial and corporate services at Alberta Health.

Mr. Saher: Merwan Saher, Auditor General.

Mrs. Fritz: Yvonne Fritz, Calgary-Cross.

Mr. Anglin: Joe Anglin, Rimbey-Rocky Mountain House-Sundre.

Mr. Bilous: Good morning. Deron Bilous, MLA for Edmonton-Beverly-Clareview.

Mr. Donovan: Ian Donovan, MLA, Little Bow. I've had the pleasure of meeting a couple of you before.

Mr. Hale: Jason Hale, Strathmore-Brooks.

Mrs. Sarich: Good morning. Janice Sarich, MLA for Edmonton-Decore.

Also, I'd like to say to the chair that I'll be here for only the first portion of the meeting. I do have a representative, Ms Maureen Kubinec, in my place this morning. Thank you.

Ms Kubinec: Maureen Kubinec, Barrhead-Morinville-Westlock.

Ms DeLong: Alana DeLong, MLA, Calgary-Bow.

Mrs. Forsyth: Heather Forsyth, Calgary-Fish Creek.

Mr. Stier: Pat Stier, Livingstone-Macleod.

Mr. Tyrell: Chris Tyrell, committee clerk.

The Chair: All right. A reminder that the microphones are on and are operated by our *Hansard* staff, so everything you say can and will be held against you.

The audio of committee proceedings is also streamed live on the Internet and recorded by *Alberta Hansard*. Audio access and meeting transcripts are obtained via the Legislative Assembly website.

Also, if you could please just make sure to keep your cellphones on vibrate or silence or off, that would be fantastic.

First, I'd like to just quickly get approval of the agenda. It's been circulated. Yes? Okay. I guess Ms Calahasen is going to move to approve the agenda. All in favour? Any opposed? Carried.

Next, also circulated to you were the minutes from the last meeting. Do we have a mover to accept those minutes? Mr. Anglin will move that. Those in favour? Any opposed? Carried.

All right. Of course, the reports to be reviewed today, just for everyone who is listening at home or here, are the 2011-12 annual report from Alberta Health and Wellness, the reports of the Auditor General – particularly, July 2012 will be our focus today but also March 2012 if need be – and then, of course, the 2011-12 annual report of the government of Alberta, including its consolidated financial statements and the Measuring Up progress report.

Before we get to the presentation by Alberta Health, I want to just remind people how we're going to handle the day today. After we hear from Alberta Health for about 10 minutes, I'll ask the Auditor General to speak for a little bit as well, briefly, to introduce what he's looking at. With regard to questions we discussed this last time. How we're going to do it is that we're going to take the remaining time after those presentations and divide it up, 50 per cent between government members, 50 per cent between opposition members, and then for the opposition members 50 per cent of that time will be allocated to the Wildrose, 25 per cent to the Liberals, 25 per cent to the ND representative. I know the Wildrose and the PCs have asked that their time be done in certain blocks of time. Also, I've talked to Dr. Swann about that with regard to the Liberals. If the folks in the ND want to take it all at once as well, then please drop me a note.

Where is our guy from the NDP? Oh, there you are. Sorry. Well, there's just one of you, so do you want to take it in a block?

Mr. Bilous: Yeah, that makes sense. Sure. That's great.

The Chair: All right. So that's what we'll do.

Please stay on topic and make sure that we don't turn this into a policy discussion or that it gets confrontational in any way.

Also, with regard to our guest: we're very grateful that you're here, but please do try to answer the questions as best you can, and we can go from there.

With that, I would now like to invite a representative from Alberta Health to make your opening statement.

Ms Nelson: Thank you, Mr. Chairman. I'm happy to be here this morning to address the committee on behalf of Minister Fred Horne. With me today are a number of folks that I'd like to introduce. We have our assistant deputy ministers, Glenn Monteith, Mark Brisson, Lorraine McKay, Christine Couture, Neil MacDonald, Chi Loo, and David Breakwell, who is beside me. We also have Carol Chawrun from our communications branch.

Line Porfon is representing our primary health care division, and Frank Bosscha represents our legal and legislative services branch.

We also have today representatives from Alberta Health Services. I'm joined by Dr. Chris Eagle, president and CEO; Chris Mazurkewich, executive vice-president and chief operating officer; Dr. Dave Megran, executive vice-president and chief medical officer of clinical operations; and Deborah Rhodes, the acting chief financial officer.

I'll basically make some brief opening remarks, and then I'll be happy to take your questions.

When we look at 2011-12, we see many accomplishments that Alberta Health and Alberta Health Services achieved in that year, and I just want to present a couple of highlights. Most recently, of course, we announced three family care clinic pilot projects in Edmonton, Calgary, and Slave Lake aimed at improving primary health care in those regions.

8:40

We launched two affordable supportive living projects in Red Deer and Calgary in order to demonstrate a new aging-in-place model that will help people receive multiple levels of care in one setting without basically having to move as their care needs change.

We've reduced sexually transmitted infection rates across the province, we've expanded funding for diabetes supplies, and we've introduced two long-lasting insulins to the drug benefit plan, which will have significant benefit for those with diabetes.

We've invested in services for children through the completion of the new emergency department at the Stollery children's hospital and with the announcement of 14 new neonatal intensive care beds for Alberta Children's hospital in Calgary.

We've launched MyHealth.Alberta, which is the first phase of a personal health portal linking Albertans to online health care information, and after a long absence Alberta has joined the Health Council of Canada.

When we look at our 13 performance measures in the annual report, I can say that targets were met or exceeded in the areas of newly reported rates of sexually transmitted diseases as well as increasing the percentage of generic prescription drugs dispensed by community pharmacies. While targets weren't met in the remaining performance measures, progress was made in achieving those targets, and we believe we are on the right trajectory.

Looking to our 2011-12 expenditures, you can see when you look at the revenue picture that revenue increased by $0.9 million from '10-11 while spending remained relatively constant at $14.8 billion, with an increase of less than 1 per cent from the fiscal period '10-11; $9.6 billion of Alberta Health's budget was provided to Alberta Health Services for operational support for the health care system. Hence, they're joining me here today.

As part of government's five-year funding commitment to Alberta Health Services a 6 per cent increase was provided for the '11-12 year to AHS's base operating funding.

You'll also see that spending on physician compensation and development was over $3.5 billion for items such as fee-for-service schedule, physician office automation, on-call services, and other physician supports programs.

We also continued with the operation expansion of primary care networks, which I know will be a subject of discussion today. Our alternate relationship plans and residency training positions for new graduates were also supported.

Costs were about $958 million for prescription drugs, ambulance services, and other health benefits for Albertans, and included in that $958 million was spending on items such as cancer therapy and the specialized high-cost drug program.

A further $714 million supported the allied health professionals, and I'll just list out what some of those are. That includes oral surgeons, optometrists, podiatrists. It supported our vaccination programs, community health services, provision for blood and blood products, as well as health services and correctional facilities and infrastructure support.

Turning now to the Auditor General's reports for Alberta Health, as of today we have a total of 21 outstanding recommendations for the department. Over the past year significant work has gone into addressing 14 of those 21 recommendations, and we are basically awaiting a follow-up audit from the Auditor General to confirm that those have been implemented. So we're very pleased to have made that kind of progress on the 14.

Of the remaining seven there are three that are related to mental health. The need for an accountability framework in provincial standards as well as alignment of funding, planning, and reporting are all being addressed through our new Alberta addiction and mental health strategy and its implementation plan that were announced, in fact, late in 2011.

The final four recommendations on our books are related to the report the Auditor General provided to us in July regarding the primary care networks, and I'll spend a couple of minutes speaking to what we have planned with respect to those recommendations. First and foremost, we have accepted those recommendations, and we have developed a detailed implementation plan for each one of them. Regarding overall accountability for the PCN program, our department in consultation with AHS will develop an evaluation framework that sets clear expectations, measurable targets, and systems to evaluate and report on the performance of the PCN program. PCNs will begin using this new system and new measures in 2014-15, and we anticipate to be able to start publicly reporting on those findings in 2015-16.

Regarding the recommendation for engagement and accountability to PCN patients our department will provide a patient panel information to PCNs, and we will approve the communications that are being developed for PCN patients by the PCNs themselves. Implementation of this is expected to begin in the 2014 fiscal year.

Regarding the recommendation for our department to provide support to the PCN program, we are in the process of hiring staff to provide leadership for the development, management, and implementation of systems to allow our data sharing and increased oversight to PCNs and support data sharing between the PCNs, AHS, and the department. Implementation on that plan is expected to be complete by 2015-16.

There is also a plan in place regarding the recommendation that the department provide increased oversight to the PCN program. We are amending our PCN grant agreements to require audited financial statements to be included in the PCN annual reports, and we will be obtaining assurances regarding PCN compliance with the financial and operating policies as well as surplus reduction plans for those that are running surpluses. That is expected to be complete in the 2014 fiscal year.

For Alberta Health Services there were about 10 new recommendations made by the Auditor General in 2012. Five were reported in the July 2012 report related to waste management and PCNs, and the remaining five relate to AHS's '11-12 year-end fiscal report. AHS has accepted all these recommendations and is taking steps to implement them. There are a remaining 33 recommendations at various stages of implementation, and target dates for completion vary across them due to the longer term nature of many of those recommendations and, frankly, the

complexity associated with amalgamating the former health regions into the single regional platform of AHS. Work is proceeding against all of those.

In conclusion, Alberta Health will continue to build on the improvements in the health care system that we believe were made in ’11-12. Of course, more work lies ahead in areas that really matter most to Albertans.

Those are my opening remarks, and I’m happy to take questions from there.

The Chair: Thanks, Ms Nelson.

If we could go to Mr. Saher, our Auditor General, for some comments.

Mr. Saher: Thank you, Mr. Chairman. Some brief comments. I’ll restrict my comments to the July 2012 report of the Auditor General, which included audit work related to the Ministry of Health. This includes our audit of the primary care networks and an audit of the systems to manage health care waste.

We concluded that the department and Alberta Health Services did not have comprehensive systems to evaluate the PCN program and demonstrate that their efforts are bringing the province-wide benefits envisaged for this initiative. We made four recommendations to the department and one recommendation to Alberta Health Services. The deputy minister has just spoken about her action plans for those recommendations.

Although we found weaknesses, we also observed many examples of positive outcomes and good practices by individual service providers, management and staff at PCNs, and Alberta Health Services as well as at the department.

The historical context of the PCN program is also very important. This was the first initiative of its kind in Alberta. It represented a significant change in structure and delivery of primary care services.

Our report also dealt with health care waste management at Alberta Health Services. Our objective in that audit was to determine whether AHS had effective systems to manage its health care waste materials handling and disposal. We found weaknesses in systems for oversight of the management of health care waste materials across AHS sites, weaknesses in the standardization of health care waste management procedures, and weaknesses in the management of waste disposal vendor contracts.

I’ll now turn briefly to our audit work on the financial statements and nonfinancial performance measures. The financial statements in the ministry’s annual report, which is within your scope of examination today, include the consolidated financial statements of the Ministry of Health and Wellness, the financial statements of the department, the consolidated financial statements of Alberta Health Services, and the financial statements of the Health Quality Council of Alberta. We completed audits on all of these financial statements and issued unqualified, in simple language, clean audit opinions on each of them.

Pages 10 and 12 of the ministry’s annual report identify the nonfinancial performance measures used by the ministry. We reviewed two of these measures and issued an unqualified review engagement report on them. I encourage committee members to read our review engagement report as it sets out the nature of our work in relation to nonfinancial performance measures.

Mr. Chairman, that concludes our opening comments. Thank you.

8:50

The Chair: Thank you very much, Mr. Auditor General.

All right. We are going to start the questions now. We have exactly an hour left before we have to wrap up because we have some business from 9:50 to 10 o’clock that we’ll have to get done as a committee. That breaks down to the government having roughly 30 minutes, broken into 10-minute segments each, from what I understand. The Wildrose will have 15 minutes, the Liberals seven and a half, and the NDP seven and a half.

With that, my understanding is, Ms Fenske, that you’d like to begin.

Ms Fenske: Yes. Thank you very much. My questions will be on the health care waste materials and the report from the Auditor General in that way. Certainly, we’re concerned about the cradle-to-grave aspect of those waste materials. Since the Auditor General’s report I’m assuming that one of those 14 recommendations that are in progress would be one of those. Could you clarify what has been done?

Mr. Mazurkewich: The first step that we’re taking is, in my mind, the key recommendation, which is the oversight, because from the legacy entities there were a number of different practices in where waste management reported to. What we’ve got as a focus for October 31 coming to our executive committee is a proposal on how we should govern waste management. That’s our key recommendation. The second one that we’ve been working on is that we’ve been developing standards that we’re going to bring forward to implement.

Ms Fenske: Is that all on October 31 that you’re bringing those forward?

Mr. Mazurkewich: No. The standards are taking a little bit longer to develop, though I would like to point out that at our major sites we do have good standards in place from the former entities, and we’ve been following those standards. What we’re looking for is consistent standards across the province, and that’s what we’re doing. Where the majority of the waste is generated we actually have reasonable standards in place. They’re not consistent. We want them consistent, and then we want them rolled out to the smaller sites and to some of the service providers.

Ms Fenske: Just following on that, will that include doctors’ offices, private offices, dentists, et cetera?

Mr. Mazurkewich: Yeah. That’s the group that will be the hardest to reach. They’ll be the last point because they’ve got the smallest amount of waste. In previous entities those were the most variable, so we’re trying to figure out how to work with that group. How do we reach all of them, and how do we put in plans? How do we do that? There are issues around how we remove the waste and whatnot. The bulk of our waste is created in the larger hospitals, and we’ve got that under control.

Ms Fenske: You also have contractors, and the range of the costs for disposal are significantly different from one site to another. How are you incorporating that within the procedures?

Mr. Mazurkewich: There are two elements. One, what we’re talking about is: do we actually create a subsidy because in some of the smaller places it costs more to remove the waste simply because there’s not the volume? The second piece is: do we create through an RFP process more of a mass collection process divided by geography within the province? Right now internal people are debating that to see which would be the best way of going about that. The third piece is some of the equipment for waste management. The question is: for some of our service providers

do we actually build into contracts a rate that would pay for some of the equipment that they need for improved waste management handling? So there are a couple of elements to it.

Ms Fenske: Thank you. With respect to the risk of disposal, how are you planning on training staff?

Mr. Mazurkewich: We've begun with the development of the standards. What we're looking to do is make sure that for all the staff that handle waste management we have a consistent education program to roll out. Again, what we're doing is relying on the education processes at the larger sites, and we're looking for a standardized one that we can roll across the province. So that's one of the pieces. As we develop the standards, then the next piece is to do the education using the methods used at the larger hospitals.

Ms Fenske: Could you comment, perhaps, on your approach to water material management. Will that be different?

Mr. Mazurkewich: I'm not sure I understand the question.

Ms Fenske: Have you adopted an HACCP for water material management system?

Mr. Mazurkewich: Sorry.

Dr. Starke: If I could jump in, Mr. Chair, the question with regard to that is: for environmental services have they adopted a hazard analysis critical control points approach to waste management?

Mr. Mazurkewich: For materials waste management, yes. That's what we're working on right now.

Dr. Starke: Is that approach clearly identified, and does it identify a cradle-to-grave procedure? Is there a way to track medical waste from source to disposal site?

Mr. Mazurkewich: At the larger hospitals, yes. Across the province uniformly, no.

Dr. Starke: Does that involve using bar-coding? What's the identification? If a bag of used syringes falls off the back of a truck, do we know where that bag of used syringes came from?

Mr. Mazurkewich: No, not at this point in time.

Dr. Starke: Okay. According to the report 80 per cent of the sites at present are not adequately monitored. Is that correct?

Mr. Mazurkewich: The majority of the waste is created at a minority of the sites. We have over 400 sites; 69 of the sites create the vast majority of the waste.

Dr. Starke: I understand that, but my concern is the number of sites that are at this point identified by the Auditor General as not being adequately monitored. Those are the smaller sites that you're referring to that are being worked on?

Mr. Mazurkewich: Yes. Those are the sites where over the next two years we want to have a robust system in place. That's where the consistency of the standards and the collection points in the equipment being used are all things that we have to put into place.

Dr. Starke: Okay. Finally, Mr. Chair, I'm a little concerned about the training for staff working especially in the smaller facilities, especially as we push to decentralize treatments, for example cancer chemotherapy. As that becomes more decentralized in terms of its treatment, we're handling a lot of cytotoxic substances: vincristine, vinblastine, cisplatin, you name it. Do we have training methodologies in place so that staff at these facilities are going to know that they have to exercise specific – this doesn't necessarily deal specifically with waste management but just the handling of cytotoxic agents.

Mr. Mazurkewich: Yeah. The cancer agency has got programs in place. In Lethbridge, where we've opened up a clinic, those people are trained. For example, on our medical device reprocessing we're going through certification, and we're training hundreds and hundreds of people on medical device reprocessing. So we've created standards for that. We'll go through the same process with the waste management next.

Dr. Starke: Okay. The question was asked about doctors' and dentists' offices. One other area that is producing some biomedical waste and will produce more, I think, as their scope of practice is expanded is pharmacies. Does that come under your purview, or is that handled under a different area?

Mr. Mazurkewich: No, community pharmacies don't come under our purview.

Dr. Starke: Okay. I guess I do have a concern, Mr. Chair, that we're going to be seeing more administration of injections. The flu season is around, and a lot of pharmacies are administering flu shots. I would think that that's another area that if AHS is not controlling it, then it needs to be controlled at some point.

I think the thing we have to be cautious of here is, you know, that in terms of the procedures, a disaster is finding a bag of medical waste dumped out on a street corner somewhere. You know, that's a disaster, and we can't have that happen just because of public risk.

I guess I'm encouraged. I hope that the steps that are being taken as a result of the Auditor General's recommendations are going to prevent or mitigate that situation from happening. But I guess I'm not satisfied that the current level of control would be adequate in preventing that from happening.

Thank you, Mr. Chair.

The Chair: Thank you.
Ms Kubinec.

Ms Kubinec: Thank you, Mr. Chair. The five-year plan called for the creation of a provincial health care plan by March 2012, and that hasn't happened. Can you tell us a little bit about when we might see it?

Ms Nelson: With respect to the five-year action plan on health care, that was part of an initiative that the Alberta government undertook in concert with Alberta Health Services to really try and drive out to the degree that we could as many efficiencies in terms of administration and streamlining of cost but also improving overall system performance. In support of that the single region of Alberta Health Services was created. A five-year funding envelope was established in order to allow AHS to have a longer term planning horizon in which to plan their services and, basically, undertake a system transformation that they had identified, and with that came the five-year action plan called Becoming the Best.

9:00

In that five-year action plan we worked very closely with Alberta Health Services to identify the priority actions for system

transformation that we felt together would most and best advance Alberta as becoming the best performing health care system in Canada. Some of the benchmarks that were chosen were adopted from nationally recognized standards, and Alberta Health Services has been applying themselves to basically achieving those targets over the last couple of years. You'll see, I think, on a quarterly basis AHS reporting on how their performance is stacking up against those pieces.

It's a massive undertaking. I think there are a hundred different performance measures and against all of those there are numerous initiatives. I think our view was that we needed to focus on the plan in front of us and ensure that we were making progress and take the opportunity to adjust and realign our resources along the way as best we could. So that's been the focus in the health care system since the announcement of that plan.

Ms Kubinec: I appreciate that, but there's a lot of money spent in health care.

The next thing that kind of concerns me was your comment that it was going to be 2014 before some of these recommendations were implemented. That seems like a long time to me. They were been identified a few months ago, and it's going to take a year and a half to have them implemented? That concerns me. Do you have anything to say about that?

Ms Nelson: Sure. The primary health care system, let alone the broader health care system, is a very complex piece of business, lots of money, certainly a wide array of stakeholders. In order for us to advance in that arena, we need to be certain that we're consulting with our partners and making sure that whatever it is that we design makes sense to those folks that actually have to implement it. If you look at our plans in relation to the primary care network recommendations, we are incorporating those in the development of an overall primary health care strategy for the province. That's not a small undertaking. That does require us to consult not just with the providers with AHS but with Albertans at large and, certainly, the other health professions. Then we have to bring it forward, get it approved, and start the implementation. So from our perspective we feel that these are aggressive timelines because we want to make sure that we've consulted effectively and we've developed the right directions and we're moving ahead.

Ms Kubinec: Thank you.

The Chair: Thank you.

That's 12 minutes, so we're going to move on and then come back to the government in 15 minutes. We'll turn over the next 15 minutes to Mrs. Forsyth representing the Wildrose caucus.

Mrs. Forsyth: Thank you, Mr. Chair. I would like to thank Alberta Health and AHS for being here, and I appreciate the opportunity to have some time to ask some questions. I want to get on the record, to begin with, that the Wildrose supports PCNs. I've spent my summer doing health consultations, and I can tell you that I've spent a lot of time talking to PCNs, so some of the questions that I'm going to be asking are from them. I'm going to start with the Accountability Monitoring Evaluation Working Group. It was established in 2005 for the sole purpose of developing and evaluating and reporting methods for the PCN program. In 2006 the Accountability Monitoring Evaluation Working Group released an evaluation framework that could be used to measure performances of PCNs. Why was this framework never implemented?

Ms Nelson: This goes to the overall governance structure that basically governed the PCN program. If you'll bear with me, I'll spend a couple of minutes explaining that. In 2003 when Alberta first moved ahead on the PCN program, it was within the context of the trilateral master agreement that we had entered into with Alberta Health Services and the Alberta Medical Association. That agreement effectively governed all of our interactions with physicians, physician support, program, compensation, you know, the whole basket. There was no other agreement like it in the country, and there was certainly no other program like the PCN program in the country. So Alberta was sort of on the leading edge of primary health care reform in the country.

As part of that model we set up a governance structure whereby decisions would be made by consensus, and that effectively provided every partner with a veto on what elements could be advanced and brought forward. What also grew up under that particular arrangement was a quite complex administrative structure. I think it was quite administratively heavy. It became rather cumbersome to move items through that structure, and I think we found it to be not as effective as we would have liked. My understanding with respect to that particular evaluation framework is that we were not able to achieve consensus, and hence we were not able to move that forward.

Mrs. Forsyth: In 2009-10 over 1,350 physicians took part in phase 1 of the performance and diligence indicators program. The program was developed by the Department of Health, AHS, and the AMA to introduce a set of primary health care indicators, including chronic disease screening, wait times to see a family doctor, among many other things. I'd like to know why the department cancelled this program in 2012 before physicians were able to report the measures.

Mr. Monteith: Good morning. I'm Glenn Monteith.

The Chair: Excuse me. Can you just for everyone explain your name and title.

Mr. Monteith: I'm sorry. I'm Glenn Monteith, assistant deputy minister, health workforce division.

The performance and diligence indicator fund came forward as an innovation in the last financial reopener of the old trilateral master agreement. The idea was to get physicians to report on a number of measures to actually get to some of the accountability on: are we making a difference? During the course of that program a couple of things came to light. One which was an important and fundamental one was that while a physician knew who they had as a patient, what was not clear was whether that patient was only that physician's patient. So we spent an awful lot of time and a lot of resources paying physicians to do what we call a validated patient list, or a VPL. We went through a confirmation process both with the physician office as well as with the individual patients for physicians in PCNs to determine that those patients were in fact their patients. That was a fundamental piece of work that was required to then determine the screening and other kinds of measures that we chose to measure against.

We actually paid – the transactional piece was $3.50 per patient for the physician to do their part and $3.50 once it was validated back – $7 per patient to go through that process. Over the course of that effort, which was much longer than anticipated, to validate those patients – it took us well over a year to do that. It was determined that given where we were at and the resources that were taken to then implement the series of tests and screenings that were required to measure that, essentially we were not going to be able to do it before the program would have expired with the expiry of the trilateral master agreement. So what we chose to do

with the residual dollars is that we reserved those dollars, and those dollars are still reserved for other primary care uses yet to be agreed upon by the three parties: Alberta Health Services, AMA, and Alberta Health.

Mrs. Forsyth: That goes to my next question, Mr. Chair. I think that with the history of the primary care initiatives under a trilateral agreement between Alberta Health, Alberta Health Services, and the AMA that changed, obviously, when the contract was finished in March 2011, and you're still negotiating. Going forward, have you any idea if the trilateral agreement will still be used for the primary care networks?

Ms Nelson: I think it would be inappropriate for me to speak too broadly about the negotiations that are currently under way because we are still at the table with the AMA, but I can speak to what some of the government's broader objectives are with respect to primary health care. When you look at the primary health care objectives that were part and parcel of the PCN program, you'll see that they remain as relevant today as they were in 2003.

The key objectives for the PCN program were to increase the proportion of residents with ready access to primary care. That's crucial, and that remains a challenge today. We want to provide co-ordinated 24-hour, seven-days-a-week management of access to appropriate primary care services. Again, as important today as it was when we launched the PCN program. We want to increase emphasis on health promotion, disease and injury prevention, and care of medically complex patients and patients with chronic disease. We want to improve co-ordination and integration with other health care services, including secondary, tertiary, and long-term care, through specialty care linkages to primary care. Finally, in terms of the last major objective for the PCN program, facilitating the greater use of multidisciplinary teams to provide comprehensive primary care.

9:10

Those objectives remain foundational to the primary health care initiative currently under way. I would say, as the Auditor General has pointed out, that we've seen some tremendous successes through the PCN program, and we support the PCN program as well for some of those great successes. What we've failed to be able to do is leverage those successes broadly across the province at the same level for all residents of Alberta. We would like to basically take the lessons that we've learned from our experience with the PCN program, situate it in our current context today, and advance the agenda on primary care. That's what you'll see as we move ahead with the primary health care strategy and the implementation of family care clinics in the province.

Mrs. Forsyth: I'd like to go to page 38 of the Auditor General's report that talks about the implications for family care clinics. He talks about analyzing and assessing the major initiatives in primary care. I understand that you have three primary care clinics up – you referred to that in your opening remarks – in Edmonton, Calgary, and Slave Lake. I'd like to know what the cost per patient is under your new pilot project of family care clinics.

Ms Nelson: I don't have that information right at my fingertips, but that is something we can provide to you.

The Chair: We're not going to discuss family care clinics except in the context of systems being in place for performance evaluation. You're referring to page 38 of the report?

Mrs. Forsyth: If I can, Mr. Chair. On page 38 of the Auditor General's report it talks about the implications for family care clinics. The Auditor General refers to the PCN program and the major initiatives, the defined expectations, the systems, and the reporting measures. Have you defined that under the FCCs?

Ms Nelson: I can answer that question. As I mentioned in my previous remarks, we will be taking the lessons from the PCN program and, certainly, the recommendations that have been identified in this report, and we will carry it forward in the development of our primary health care strategy and the implementation plan for the FCC program. The first example I'll give on that is with respect to the establishment of an outcomes and evaluation framework. We will be very specific about the outcomes that we expect family care clinics to achieve, what the standards are that one would need to achieve in order to be designated as a family care clinic, and we will have the evaluation and accountability framework in place to assure ourselves that our partners are complying with those standards both from a program perspective and on the financial side. So this audit was very important to us as we move forward on the primary health care strategy.

Mrs. Forsyth: Under the implications for the family care clinics and the pilot projects and the criticism that the Auditor General has talked about on page 41 in regard to the performance reporting to the AHS board and the public, he talked about that "PCNs have developed a number of performance measures to manage the delivery of their individual clinical programs, but AHS does not compile or assess this information on an overall basis." Can you please tell me, then: when are we going to have that? I think, Madam Deputy, that you did mention in some of your speaking notes that you were looking at 2014-15. I'd like to know when you're going to have that done for the family care clinics also.

Dr. Eagle: We have experience now with three FCCs in the province, and we're currently looking at what evaluation framework we need to develop for FCCs across the board in conjunction with the Department of Health. The initial outcomes from those clinics has actually been very positive. The uptake of new clients has been very good. There are about 14,000 patients who are now attached to the total number of the three FCCs. The satisfaction index in terms of patients is quite high and of physicians as well. We have physicians who do work in these clinics. We have looked at what it's doing in terms of the wait times patients have and the ability to access community services. In Slave Lake they have basically got same-day access to this family care clinic wherein before they were waiting for three days or so.

Those are the types of measures that we'll be looking at as well as financial measures for the FCCs as we move forward.

Mrs. Forsyth: If I may – and I know my time is short, Dr. Eagle – I think the Auditor General has clearly laid out in his report what needs to be done in regard to monitoring, reporting, and evaluation of the PCNs, so it should be quite easy to use the same monitoring, evaluation, and recommendations that the AG has put in place for your new FCCs.

I'd like to ask you if the primary care networks and the FCCs are meeting the objectives clearly under the contract, which talks about the number of Albertans in the 24/7 model, that they've asked for under the objectives of PCNs. Is that going to be the same with FCCs?

Dr. Eagle: The FCCs are a somewhat different model, and we're

still working on what that model will be. In terms of the roles and responsibilities for primary care networks we'll put in place a reporting system within the next six months. We hope to have that reporting system done by March of 2013, and we'll be using, you know, similar measures for the FCCs.

Mrs. Forsyth: My last question. In spite of the fact that PCNs are a joint venture between AHS and a group of family physicians, the day-to-day operation of the PCNs is under the control of the physicians while AHS is involved only at a governance level on PCN boards. I wonder if you could explain what exactly that means, at a governance level, from your aspect.

Dr. Megran: Indeed, in our joint venture model there are two legal models for the agreement. The most commonly used one does see the funds flow to the PCN and to the PCN physicians, and in that model the day-to-day operations are far more within the sphere of control of the physicians and the PCN itself. Regardless of the model, every PCN has a governance board, and on every governance board there are what were formerly regional representatives and now AHS representatives. The role of those representatives is obviously to try and influence the direction of the PCN, to comment on and shape the business plans, and eventually those business plans do need to come to AHS itself for approval before they go forward into the trilateral and government process.

I think you've touched on an important issue in terms of the governance. AHS's ability to actually direct or ensure that all of the goals and objectives are aligned is limited somewhat in this model. We obviously try to work in partnership and try to influence where we can.

The Chair: Thank you very much.

That's 15 minutes. Thank you very much, Mrs. Forsyth.

We'll go back to the government side. The last speaker I had on that was our deputy chair.

Mr. Dorward: I have a general question. I guess it relates to the financial statements. It looks through to something that's not necessarily a line item in the financial statements. If I'm a person from a different province or a person from another country and I have a service at a hospital in Alberta, what is the methodology for determining the costs that I'm charged from a managerial accounting perspective? Then is that cost determination broad in the sense that it takes into account the University hospital versus the Royal Alex versus another hospital? In other words, is it consistently applied whether you have to stop somewhere in Lethbridge versus a place in Edmonton? I realize that's a fairly far-reaching question, and appreciating the time, an answer of one minute is sufficient. We don't need to get into a long discussion in this area.

9:20

Ms McKay: If someone has treatment out of the country or in another province at a private facility and they come back into Alberta and provide their receipts for the physician costs, it'll be paid at that cost but just the physician costs.

Mr. Dorward: A supplementary question: how about the other way around where an individual from a different province or another country, indeed, gets services in Alberta, the amount they're charged that is not insured?

Ms McKay: If a person from another province comes to Alberta and has treatment here, there is an interprovincial reciprocal billing process. We charge back to the other province or they charge back to us, so it's reciprocally billed.

If a person comes from another country, they are charged at the full hospital rate, and we have rates for the University hospital versus a small hospital in a rural community. The daily rates are different from one to the other, and the physician costs will be based on the costs that the physician charges for the particular surgery.

Mr. Dorward: Thank you.

Do you have a speaker on the next section?

The Chair: Go ahead as much as you want.

Mr. Dorward: Ms Pastoor, would you like to take some of this next section?

Ms DeLong: I'll take some.

Mr. Dorward: Please. By all means.

Ms DeLong: Thank you very much. You know, the one thing that I get out of this whole Auditor's report is the lack of reporting of the PCNs. I am a little concerned when you say that you've got 100 different data points that you're looking at. You know, if a person says that they've got a hundred different goals, usually they don't have a goal. I'm a little concerned that a hundred different data points is going to just add an awful lot of administration without an awful lot of improvement in quality. I'm wondering if maybe there is a possibility of a different approach to this, where you pick the top five and just get going on those in the short term rather than looking way out there in terms of: well, we're going to do this eventually and have all of this wonderful data. Is there the possibility of a short-term win here?

Ms Nelson: Let me clarify those remarks. The hundred data points was not directed specifically at primary care or the primary health care strategy. Those were really in relation to a system transformation for the entire health care system. I'll ask Dr. Eagle to talk a little bit about what some of those examples are, but it's everything from cataract surgery to hip and knee replacement to continuing care to immunization. You know, it's a long list, and it's a big system, and there are a number of points. We want to make sure that we're providing the best services and best supports to Albertans that we can. It isn't that having a hundred things to do means we don't have any priorities. It means that there are more than a hundred things to do in health care.

With respect to your comment on focusing on what our objectives are for primary health care, I think you're absolutely right. We are going through the policy approvals process right now, but I don't think I'd be out of order to say that we are focusing very specifically, I think, on four or five objectives. That will be no surprise to people here. It'll be objectives around access, quality of care, prevention, and health promotion. So it'll be very tight. Those will be the core outcomes that we drive to, and we will build our evaluation framework around that. I think your comments are well pointed.

Perhaps Dr. Eagle can speak to some of the other performance measures.

Dr. Eagle: Our quarterly performance reports look at basically 55 measures that cover the gamut, but the key streams of work are in quality, access, sustainability. The number of measures is high, and we are thinking about having a more limited number of measures.

The advantage of starting with that broader number of measures is that it creates a much greater sense of accountability for performance in the health care system and a much greater transparency. You can look across our performance measures and see, you know, for individual zones how they are performing versus other zones. Eventually we'll have more hospital-based performance, which is something that I'm taking as a very significant priority, so you can compare how different hospitals are doing, and that will be publicly reported.

I think that degree of transparency forces accountability. The trick is to make sure that it doesn't just devolve your focus. You know, as long as we keep these access, quality, sustainability measures, I think that will help us move the system in a much better way.

Ms DeLong: Again getting back to the PCNs, in terms of the measurements there, is there any possibility of getting some early measurements going in the short-term for PCNs?

Ms Nelson: I was just going to look for my notes. I mean, our commitment is to have accepted all the recommendations of the Auditor General's report. As part of our primary health care strategy we are developing an evaluation framework for PCNs, and we'll be moving as expeditiously as possible on that.

Ms DeLong: So is there any possibility of staging this, you know, to get the most important measurements in place in the short term and then, perhaps, get more to it later?

Ms Nelson: In terms of the detailed implementation plans I do believe they encompass that.

Ms DeLong: Thank you very much.

The Chair: Thank you, Ms Delong.
Ms Pastoor.

Ms Pastoor: Thank you, Mr. Chair. I wanted to follow up, perhaps a little out of context, from Mr. Dorward. If someone has services outside of the country, what is the obligation of our physicians to perhaps correct mistakes that were made outside of the country, and how is that charged? Probably the first place they would go would be the PCN because that's their first access back into the system.

Dr. Megran: Well, I think when people receive care outside of the country or outside of the province and return home, it's the obligation of their physicians and the physicians in the province to assume the care from that point forward. Obviously, we would prefer and hope that that care would come back home with a detailed plan and record of what happened. Sometimes that isn't the case. We would obviously hope that the care most of the time would be equivalent to what would have been provided under the same circumstances and conditions as in Alberta, but sometimes that is not the case.

I sense that perhaps you are asking about controversial treatments or things that don't meet our standards or are not necessarily offered here. In that case, the physician still, obviously, has the obligation, as does the system, to continue care and to render an opinion even if it's different than the place where treatment was originally provided and to carry on and look after that individual.

Ms Pastoor: Thank you. Just one more. What we're talking about is health services. We've certainly kept it at the level of business is what I've been listening to. When you're doing your business plan, somewhere along the line – and I'm particularly coming out of my specialty of geriatrics – I would like to see a budget line item that actually budgets the time that staff has to make sure that they respect and dignify the service that they're giving to our seniors. They go too fast. You all know you're understaffed. They work short, they work fast, and respect and dignity is not given. I'd like to see somewhere or another the time that would reflect that.

Thank you.

The Chair: Mrs. Fritz.

Mrs. Fritz: Thank you, Mr. Chair. You know, this is very interesting to me about the PCNs having shared the secretariat for the family care clinics, and I want to thank Glenn Monteith. Glenn, to you and your staff: thank you very much. I hear those three pilot projects are going really well. I can remember being in the Leg. with you and staff and interviewing people the very first week. I don't know what everybody else was doing the first week of New Year's, but there we were in the building all on our own. Anyhow, it's good to see you here today. Thank you for that.

I followed closely what has been happening with the family care clinics. Then we get to today, of course, where we're here at this very important meeting and looking at what the outcome is of – you can correct me if I'm wrong, but I think that it was the department that requested that the Auditor evaluate the PCNs and do the audit, and here we are with the information. What surprises me in looking at this – and I get a bit cynical and critical about this kind of information that came forward – is that you had mentioned that it's been 2003 since the PCNs were put into place. Here we are nine years later, and I understand that there are not, you know, adequate performance measures. There are not clear corporate objectives. There are the targets for work being done with PCNs. Evaluation is fragmented.

Back to what Ms Pastoor and Mr. Dorward said, I'm wondering. You get through the business plans, you interface with the people that have these programs in place, whether it's the patients or the physicians or the nurses, people that are offering the programs. How is it that it could be nine years that this would be before you?

9:30

I know that what you mentioned in your remarks was that there are many successes and that you want to take those successes and that you're not able to leverage them broadly, I think is how you said it, across the system right now. I know you must be thinking of family care clinics in that context of primary care networks, and I'm pleased to see how you are going to go forward, but I am interested in how it got to be to the stage that it's like this.

Ms Nelson: I guess I'll have to start with what it takes to actually mount a program of this nature. It was a very significant leading-edge reform in primary health care that Alberta undertook in 2003, and we did it in concert with our two partners. At that time it was the regions and the Alberta Medical Association representing physicians. I would suggest that at the outset there was a lot of work to be done to establish the programs and the criteria. I think certain sacrifices were made in order to get the services up and running.

Over time, as I believe I mentioned, the government structures that we had in place at the time I don't think supported as effectively as we would have liked the full development of that program. I can only speak to where we are today, and where we are is that we've identified that there were some issues with how the program had evolved and where we wanted to move to. We

did invite the Auditor General to review the program and give us advice on how we might strengthen it. We've identified some critical areas where we want to take that forward, and we'll take it forward across the whole primary health care system.

Dr. Eagle: Just a follow-up. One of the advantages of being old is that you've seen the system develop for many years. Prior to 2003 there was almost no relationship at all between community physicians and the health regions as they existed at that point. When the trilateral agreement was brought in in 2003, there was no attitude of trust between the health regions and the physicians. In fact, the physicians were quite concerned about this being a corporate takeover of their businesses by the health regions. So it was really only in 2005 that significant progress started to be made.

What happened because of the lack of trust was that each one of the PCNs developed as an individual entity. There was much more of an invitational thing: let's look at how we can work together. They were very custom crafted to those local physicians. The kinds of things that are mentioned in the Auditor General's report, which are really the systematic governance pieces, were never built in. It was built around: how can we work at this local level with you? Clearly, those things should have been thought about and should have been built in, but the atmosphere of trust was not there to do that at that point in time.

I think that the Auditor General's report gives us a very clear platform to move forward on, to be systematic about how we deal with the primary care networks because they have been a tremendous success.

Ms Nelson: Just one comment to close on that. The PCNs themselves also provide a very strong platform for us to work from as we want to advance primary health care reform. There are some excellent models operating out there. We've actually heard a lot of enthusiasm from physicians and primary care network leads about the directions that we've identified for primary health care, so we think it's going to give us a leg-up as we move into the future.

Mrs. Fritz: Thank you. Just a follow-up to that, Mr. Chair, I also know, and we've heard it around this table – we heard it earlier this morning from colleagues here – that Albertans really enjoy being a part of the PCNs. They really value the care that they receive. The PCNs have served them well in the primary care system.

But we have heard from the Auditor that many people do not know that they are formally assigned to a PCN. Do you think that it's important that they know that they've been assigned to a PCN? When people go to emergency, they know they're going to emergency, and urgent care is urgent care although it's still, you know, care just stepped up from going to their physician's office, but they know where they are. With the PCNs they don't. I wondered if you thought it was important that they know that they're a part of the program, and if you do, if it's because it's related to the services that are offered.

Ms Nelson: I should just clarify that the way that people were assigned to PCNs was really a part of a funding model that we had developed, so it wasn't around a specific communication with those patients. It was a way for us to construct a program and to assign resources to the primary care networks that they could then use to purchase services of nonphysicians or extend out some of the services that they had for the broader clinic.

We do think it's important as we move forward on primary health care that patients do understand that they are part of a primary health care network, that they understand what the services are that may be available to them, and that they have that relationship made explicit. I'm personally a member of a primary care network. I have a good understanding of the services that my clinic offers, and I've availed myself of those services because I was aware of them. I think every Albertan should have that same level of information.

Mrs. Fritz: Just one last question, Mr. Chair, is why it would take so long, you know, back to 2004.

The Chair: Mrs. Fritz, actually the time is up on the government side. We're really close today.

We're going to move on to seven and a half minutes each for the Liberal and NDP caucuses. If we could start with Dr. Swann.

Dr. Swann: Thanks very much, Mr. Chair. Thanks for being here today. One question, really, that relates to seven years of primary care networks development. Obviously, a weak evaluation system, but many indicators that they're working in some ways for the people that are accessing them. The department's 2011-12 annual report states that "the Alberta Government is committed to further expanding and fine-tuning Primary Care Networks." At the same time they're talking about 140 family care clinics. In primary care we're talking here about \$50 per patient, now up to \$62 per patient. In the family care clinics we're talking about \$500 per patient, if it's 10,000 patients, for a \$5 million clinic. How do you reconcile the lack of evaluation process and a leap to a whole new system with the commitment to expanding and learning from the primary care networks? There are some disconnects here.

Ms Nelson: I would say that we have learned from our experience on the primary care networks. It's not just learning here but learning all across the country. The Council of the Federation recently established a health care innovation working group. One of the areas they looked at was best practices in primary health care. One of our primary care networks was identified as a best practice nationally for how to deliver primary health care. I think we have access to a lot of information. Certainly, we agree with the Auditor General's recommendations, and we will be implementing them. We also see that we can take the lessons that we've learned and leverage those for our plans as we move forward.

With respect to some of the differences between primary care networks and family care clinics as they currently stand, the family care clinics that we have in place right now are pilot projects to help us learn what we might need to take forward in terms of new models. It's a process that builds on the experience that we have. We know we have lots to learn, and that's why we're trying to take a staged approach and why we've established these pilots. We certainly don't view that every family care clinic as we move forward into the future is going to look exactly like the clinics that are currently established by AHS. I expect they could look a lot more like some of the primary care networks that currently exist. We're trying to take the full range of knowledge and sort of the body of expertise that exists out there and bring it forward through our primary health care strategy development. That's why it's going to take a little bit of time.

Dr. Swann: Thank you. There's a contradiction – is there not? – between indicating a support for expanding primary care networks and at the same time talking about 140 new family care centres. How do you reconcile those two comments?

9:40

Ms Nelson: I don't see it as a contradiction because I don't think

we're pursuing one model at the exclusion of the other. There currently are several different models of primary health care that exist in the province. You know, there are still single practitioners that are operating their own offices and meeting their own patients and are not part of primary care networks. We do have primary care networks. We have community-based clinics. So there is a variety of different approaches that we currently support, and our intention is not to have FCCs displace or take over primary care networks. It's another model. We'll be setting standards, and we'll be offering incentives for people to move to that model, but I can certainly envision a future where primary care clinics and primary care networks and sole practitioners and community clinics all can exist in the same space because they are just different models of how to deliver care. We see that there is space for family care clinics to fill some of the gaps we are currently experiencing with respect to access to the primary care.

Dr. Swann: Just a final follow-up, Mr. Chairman. The process has not been helpful to instituting this major change in our health system. How are you going to get the trust of physicians back into the system and their active participation in the changes that are needed in the system?

The Chair: You know what? I'm going to say that's probably a little bit too policy oriented, Dr. Swann. We've got to stick to the Auditor General's report if possible.

Dr. Swann: You've got the question anyway.

The Chair: Dr. Sherman, you've got three minutes remaining.

Dr. Sherman: Thank you. Thank you for this opportunity. In this country and in this province we have a broken primary care system. The reason health care costs are escalating is because of costs of acute care. As a front-line practitioner we have a lot of patients who don't have good primary care, so they end up in hospital acutely ill, and when they're discharged from hospital, there's no primary care to follow up with. They're admitted under a stranger specialist who has no relationship with them, so every test under the sun is ordered. A specialist is a specialist, billing specialty fees, double or triple the fees of a good generalist, a good GP.

We need to fix up primary care. Primary care networks were a great idea. I believe they should have been implemented better because of lack of accountability. The model was: the money follows the patient at $50 per patient. So what happened was that all of the healthy patients were rostered. The people that needed to be rostered first were the ones who were discharged acutely from hospital because they're the ones with the highest needs, not getting any primary care, and costing acute care a lot of money.

I see a tremendous opportunity to actually fix this. After talking to all the health providers, my feeling is that primary care networks need to be connected to acute care. We need to bring family doctors back into the hospitals so that continuity of care happens. We need to connect these primary care networks to home care and to long-term care and deliver what we call the medical home model of care. They do this in Oregon. They do this at Harvard. It brings back the world-class primary care we used to have.

I'd like to hear from you what your thoughts on a model of primary care would be with respect to that. It's not policy; it's actually implementing how primary care networks should be implemented. It directly addresses why primary care networks have failed. Dr. Eagle, I'd like your thoughts on that continuity of care.

The Chair: Dr. Eagle, I'm sure that Dr. Sherman and you can have a great discussion on that excellent idea that he's just brought forth at another time. Unfortunately, I don't think you can answer it in 15 seconds.

I think we'll move on to Mr. Bilous for the last seven and a half minutes. Thank you.

Mr. Bilous: All right. Thank you, Mr. Chair. I'd like to thank each of you for attending today before the Public Accounts Committee. I'll jump right into it because I have several questions. On page 25 of the AG's report it indicates that

> Albertans are not informed that they are assigned to a PCN, and PCNs do not have the names of those the Department has assigned to them. PCNs know only the total number of patients assigned and the amount of funding they receive.

Why is it that PCNs don't have the names of the patients assigned to them? You've already answered the next part, but I'll let you answer that one, please.

Mr. Monteith: The model that was used to actually fund the PCNs was really based on the pattern of use of the patient with the physicians, and that's how they were assigned. So it was what we might call an informal enrolment. At the time it wasn't necessarily considered to be all that important to move the data lists over to the primary care networks because the interaction initially was with the individual clinics. It's important to know that for the 40 primary care networks today there are approximately a thousand family medicine clinics associated with them.

I think as we move forward on a systematic and systems approach, that was articulated in the Auditor General's report as being critical, having that knowledge about basic information around who the patients are in the primary care network became a glaring gap in the way in which the primary care networks evolve. It is our intent to move that information forward to the primary care networks as well as to Alberta Health Services as part of their joint venture partnership with the primary care networks going forward.

Mr. Bilous: Thank you. A follow-up on that. I'm just curious as to why the department has waited until now to take that kind of outreach step. Again, we're at nine and a half years since PCNs have existed. I'd like to just ask why it's taken this long to start to remedy this issue.

Mr. Monteith: Again, one of the challenges we had – it was a benefit and a challenge – under the old trilateral master agreement, where we were in a partnership, essentially, with the Alberta Medical Association and what is now Alberta Health Services, was the governance model for all of these things. There was a very important committee for primary care networks called the Primary Care Initiative Committee. All of the policies, broader and operational around primary care networks, were decided at that level, and it was only when there was some confusion that they would take it to a different committee for clarification. Nothing would be adopted by that committee unless there was unanimous agreement of the three parties. It was a consensus model. Essentially, if the three parties couldn't agree on a policy issue, then the status quo stayed the same.

It's fair to suggest that a lot of these things came from that model, where you didn't have a majority say or you didn't have a clear policy direction from the beginning at a higher level. I think that was one of the challenges that we experienced over the eight-year trilateral master agreement. It's a fundamental issue, quite frankly, of where we're at today.

Mr. Bilous: Okay. Thank you. It would be interesting to note that that trilateral agreement expired, I believe, in March of last year, so we're 18 months out since that.

Ms Nelson: To that point I would say that since the trilateral master agreement has expired, we have been in negotiations with the AMA to address the issues that we are identifying here today, and we remain at the table today.

Mr. Bilous: Thank you. One of the stated objectives of PCNs according to page 32 of the Auditor General's report is to increase the "number of Albertans with a personal family physician." If it's the case that Albertans are primarily assigned to a PCN by having a physician who is a member of one of these networks, and therefore nearly 1 million Albertans are not formally enrolled in the PCN, it likely includes a large number of people with no personal family physician. So how exactly does the PCN program meet the objective of increasing the number of Albertans with a personal family physician?

Ms Nelson: Well, I think part of our effort has been to establish and enroll more PCNs over the period of the agreement. I think at present we have 40 PCNs, and we did just add a couple more in the previous year. The purpose of the program is that by expanding PCNs and the coverage of the PCN program, we'll be enrolling more Albertans.

Mr. Bilous: Okay. Do I have time for another question, Mr. Chair?

The Chair: You have another two minutes and 40 seconds.

Mr. Bilous: Oh, wonderful. The advantages of being a one-person caucus.

This was touched on by some of my colleagues. The AG has made one recommendation to AHS specifically. Namely, that is to "define goals and service delivery expectations" for PCNs, to "define performance measures and targets," and to "evaluate and report on its performance as a PCN joint venture participant." Again, I'm struggling to get my head around how AHS still has not developed performance measures for a program that's been running for almost 10 years. You had mentioned earlier that you're still developing an evaluation framework. The success of PCNs – I mean, maybe we should get into the definition of success because if you don't have a target or measures, I'm not sure how you can define whether it's been successful or not.

9:50

Dr. Megran: A complicated question in a short time. I just go back to Dr. Eagle's comments. This has been a long journey. We came from a place where family docs did not work together, often in isolated practice, didn't have a relationship. The greatest success of the PCNs over their first few years was to bring family docs in a geographic area together, to have them ask: "What do our patients need? What are our problems? How can we provide better care, and how do we get there?" Second, was to develop that relationship with the health service delivery organizations, now AHS.

I think others have commented on the governance system and some of the problems in moving things forward thereafter. There have been great advantages, but we need to go further, and clearly time has marched on.

The former regions, now AHS, work with each PCN to look at their business plans, to say: what do we need to have in there? We try to bring objective measures into those individual business plans, but clearly – clearly – as the Auditor General has pointed out, that's not being done in a systematic way. We need to have a clear vision for primary health care. We need to tell PCNs what we, AHS, need in the health care system from them and, obviously, support them and help them to help us deliver on those primary care needs.

A very complicated question. I apologize for a brief, general answer.

The Chair: Real quick, just a comment.

Mr. Bilous: Yeah. Thank you for the attempt at answering that in a very short period of time. I just wanted to say that I do feel that, you know, PCNs and the folks that are working in PCNs are doing a great job and have an enormous task laid out for them.

I look forward to seeing these performance measures in the future and looking back and evaluating our successes. Thank you.

The Chair: Thank you.

We have literally no more than two minutes. Mr. Fraser, go ahead.

Mr. Fraser: Very quickly, you talked about the trilateral master agreement that started. I have some concerns in terms of if we're going to create accountability and oversight. A couple of things. Obviously, the College of Physicians & Surgeons is an oversight body and a governance model for physicians throughout the province that speaks to the type of care they're delivering and has the ability to step in and discipline them, if need be, based on the outcome.

The Alberta Medical Association, however, is a body that negotiates contracts and advances the profession. While I'm an advocate to make sure that everybody involved in the system – because I do believe physicians are a key component as we move forward developing processes to evaluate the system not just from a monetary perspective but patient outcomes at the end of the day. My concern, and maybe you can answer it, is: do you feel that there is perhaps a conflict of interest since the Alberta Medical Association is the very group that negotiates the contracts and the monetary position for physicians rather than governance and oversight? Has there been any thought as we move forward in terms of looking at another group like the College of Physicians & Surgeons to sit at this trilateral group and to have governance or to have the faculties of medicine at the University of Alberta or Calgary look at best practices so that we can groom this process along? The bottom line is better patient outcomes.

Ms Nelson: I would agree that physicians are our most important and scarce resource. We have to make sure that we're using them wisely and we're addressing their interests in anything that we do moving forward in terms of primary health care reform or primary health care delivery.

I can say that as we move forward on the primary health care agenda, we are looking at models of governance, we are looking at the evaluation framework, all the opportunities that we have to address the needs of the profession. We're considering that, and we'll take that forward as we move ahead.

The Chair: Thank you very much, everyone. Great job. I thought that was a very, very good discussion. I'd like to thank Dr. Eagle, Mr. Mazurkewich, Ms Nelson, and Mr. Breakwell for coming and to thank all the folks that participated today and were in the gallery.

We have some quick business that we've got to take care of here before we leave. Folks, we're still in committee for the next

few minutes. If there are people that need to leave, if our guests need to leave, that's fine. Could I please ask members of the committee to sit? Thanks.

Our next meeting dates are October 31 with Alberta Education and November 7 with Treasury Board and Finance.

At the last meeting Dr. Starke had mentioned an interest in calling Enterprise and Advanced Education before the committee. I believe this came up because of the postsecondary institution scorecard in the Auditor General's March 2012 report, which was used as a sample document in the presentation from the CCAF, that was well received.

The Auditor General also recommended during our informal working group that when we call advanced education, the committee might want to also call Athabasca University as they're mentioned in quite a few instances in that March 2012 report, just like we had Alberta Health Services here today with Alberta Health. The working group thought that was a good idea from Dr. Starke. Would a member like to move that? Dr. Starke has moved that

> the Standing Committee on Public Accounts invite Alberta Enterprise and Advanced Education and representatives from Athabasca University to appear before the committee to address the recommendations contained in the March 2012 report of the Auditor General of Alberta as well as any subsequent reports issued by the office of the Auditor General prior to the meeting date.

All in favour? Any opposed? All right. That is carried.

If anybody has any additional research requests, rather than hash those out here, what I'd like you to do if you could is to please submit them to your caucus representative on the working group. Then we'll bring a motion forward in this committee explaining what research has been requested and then get a vote on it at that time. That way we're not talking around the table, trying to figure out what research we want done and so forth. Would that be acceptable to everyone? Is that all right? Okay. So, obviously, for the government side it's Mr. Dorward, for the Wildrose it's myself, and then you can have a discussion with yourself, Mr. Bilous, and decide what you want to do.

Mr. Bilous: Yes. It might take some time for me to get my caucus together.

The Chair: All right. Is there any other business committee members wish to raise at this time? No?

Our next meeting will be held on Wednesday, October 31, with Alberta Education from 8:30 to 10 a.m. Of course, there will be that informal briefing at 8 o'clock that same day as well.

Would anybody like to move adjournment? Ms Fenske. All in favour of adjourning the meeting? Opposed? Carried.

Thank you very much, everyone.

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

Published under the Authority of the Speaker
of the Legislative Assembly of Alberta