Title: Wednesday, April 18, 2007 Public Accounts Committee
Date: 07/04/18
Time: 8:31 a.m.
[Mr. MacDonald in the chair]

The Chair: I'd like to call this Standing Committee on Public Accounts to order, please. I would welcome everyone in attendance this morning, and perhaps we can quickly go around the table and introduce ourselves, starting with the vice-chair, please.

[The following committee members introduced themselves: Mr. Cardinal, Mr. Cenaiko, Mr. Chase, Mr. Dunford, Mr. Eggen, Mrs. Forsyth, Mr. Herard, Mr. MacDonald, Mr. R. Miller, Mr. Prins, and Mr. Strang]

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

[The following departmental support staff introduced themselves: Mr. Gilmour, Mr. Hegholz, and Ms Meade]

Mr. Hancock: Dave Hancock, Alberta Health and Wellness.

Mrs. Dacyshyn: Corinne Dacyshyn, committee clerk.

The Chair: I would like to advise the members that the agenda packages for today's meeting were delivered on Monday. If there are no questions, may I have approval of the agenda, please?

Mr. Strang: So moved, Mr. Chairman.

The Chair: Approved by Mr. Strang that the agenda for today's meeting, April 18, 2007, be approved as distributed. All in favour? Opposed? Seeing none, thank you.

The chair at this time would also like to welcome Mr. Griffiths to the meeting. Good morning.

Mr. Griffiths: Good morning.

The Chair: May I also have approval of the minutes of the April 4, 2007, committee meeting, please? Mr. Chase?

Mr. Chase: Yes. I'll just beat Mr. Strang to the punch.

The Chair: Okay. Moved by Mr. Chase that the minutes of the April 4, 2007, committee meeting be approved as circulated. All in favour? Seeing none opposed, thank you.

Now I would like to welcome the hon. Mr. David Hancock, Minister of Health and Wellness, to our meeting. If he would like to introduce any of his staff that are seated behind him – and if they would like to participate in the proceedings this morning, they certainly are welcome. They can just go to the microphone.

If there are any additional materials to be provided to the committee from the department regarding a question, if we could have that through the clerk, please, to all members, we would be grateful. I would like to remind you at this time that we have allotted 10 minutes for a brief overview of the department.

Mr. Dunn, do you have anything at this time before we get started?

Mr. Dunn: No. I will follow the minister with very brief comments.

The Chair: Okay. Sure.

Mr. Hancock: Well, thank you, Mr. Chair, and committee members. It's a privilege to have the opportunity to appear before Public Accounts again, albeit in a different capacity for me. I'd like to start by introducing the Department of Health and Wellness staff who are here, beginning with our deputy minister, Paddy Meade; Annette Trimbee, who's the ADM, strategic directions; Janet Skinner, ADM, program services; Linda Miller, ADM, information strategic services; Richard Butler, ADM, health workforce; Ray Gilmour, ADM, corporate operations; Neil MacDonald, acting ADM, public health; Peter Hegholz, senior financial officer; Jason Cobb, who works in the deputy minister's office; Murray Finnerty, from AADAC; Jim Hearnden, from AADAC; Michael Shields, who works in our communications area; as well as my executive assistant, Fred Horne.

So with this complement of staff there are two things that I think need to be said. First of all, in the short period of time that I've had to work with this organization, I can tell you that we have very dedicated civil servants working on our behalf, and I think Albertans can count themselves fortunate to have this type of quality not only represented by the leadership that you have here but by the people that they work with in the departments and agencies. I'm very pleased to be working with them. Having said that, I want to say that they also have many of the answers to the questions that you want to ask, so I will be calling on them to participate fully in demonstrating that quality that I've just acknowledged.

I'd also like to acknowledge, having had the opportunity to meet on several occasions now with the Auditor General and members of his staff, and indicate that I believe we're developing a very good working relationship in terms of ensuring that the structure – as the Member for Lethbridge-East pointed out, we have a significant portion of the budget, and it's important that we know that the budget is being spent in accordance with the policy directions that we're giving in achieving the outcomes that we're trying to achieve. So I look forward to an ongoing good working relationship both with respect to the work of the department and working with our partners in the regional health authorities and the other boards and agencies.

I'd like to spend a few moments to go over the Health and Wellness financial situation of 2005-06, accomplishments for the year, and some of the Auditor General's concerns that have been raised and how the ministry has taken action on those concerns. Looking at the financial picture, the ministry's original budget was $9 billion in 2005-06, an increase of 8.6 per cent, or $707 million, from the 2004-05 forecast. Over $5.6 billion was allocated to provincial health authorities, an overall increase of 11.3 per cent, or $572 million.

The budget included $25 million for a mental health innovation fund, and 2005-06 was the first year of a three-year commitment for that fund. Included in the budget was $561 million in capital funding for the first year of a three-year $1.6 billion capital plan for health facilities and equipment. During the year the department received additional operating dollars of $238.5 million. The first-year requirement, $64.6 million of $1.4 billion, announced in October 2005 for 20 capital projects, asset acquisitions for diagnostic and medical equipment in the amount of $4.6 million, access and wait time projects in the amount of $27 million, continuing care enhancements in the amount of $26.3 million, and Alberta Netcare electronic health records in the amount of $116 million. With this increase the budget rose to $9.2 billion, an increase of $912 million, or 11 per cent, over the 2004-05 actuals.

So what did the money go for? Well, in 2005-06 Health and Wellness had three core businesses: advocating and educating for healthy living, providing quality health and wellness services, and leading and participating in continuous improvement in the health

system. Under the first core business, to advocate and educate for healthy living, our goals were for Albertans to make choices for healthier lifestyles and for Albertans' health to be protected.

The Smoke-free Places Act became effective June 1, 2006, to protect minors from smoke in public places. Provincial regulations were amended so that one of the main ingredients used in the production of crystal meth was put behind pharmacists' counters. The Premier's award for healthy workplaces program was announced to celebrate Alberta employers who encouraged their staff to make healthy eating choices and to incorporate active living into their workday. And I trust that the doughnuts, et cetera, that are back there have no trans fats in them today.

Nine Alberta communities were recognized for their commitment to improving the health of their residents as the winners of the fall-winter community Choose Well challenge. That challenge encourages Albertans to make changes, small or large, in their daily eating habits and physical activity. Type 2 diabetes awareness and promotion programs were continued in three Alberta communities – Edmonton, Bonnyville/St. Paul, and Medicine Hat – through the keep-your-body-in-check program. An evaluation of the media campaign that ran across Alberta showed that it was successful in raising awareness among Albertans that type 2 diabetes is largely preventable.

The Alberta provincial stroke strategy was approved to reduce the incidence of stroke, to improve care, optimize recovery, and reduce the financial burden on the health system. The Alberta Stroke Council was established, and the council has implemented a work plan for the four pillar components of stroke care.

8:40

Under the ministry's second core business, to provide quality health and wellness services, we had three goals: improve access to health services, a contemporary health workforce, and improved health service outcomes. To achieve these goals, Health and Wellness introduced a one-year pilot project to provide better access to hip and knee replacements and to improve overall the way orthopaedic care is delivered. The goal of the Alberta hip and knee replacement project was to test a new, more patient-centred care model that included central assessment and better pre- and post-care. An additional 1,200 hip and knee surgeries were performed during the year. Given the optimistic results of the project funding was provided to improve the care path for cardiac services and the breast and prostate cancer services.

A $500 million Alberta cancer prevention legacy fund was announced to expand cancer research and screening. The fund puts Alberta at the forefront of cancer prevention screening and research. Initiatives will include the expansion of cancer screening programs and the development of a virtual cancer research institute to co-ordinate cancer research.

Access to mental health services was expanded through 36 new projects approved under the mental health innovation fund. These new projects, ranging from outreach to day treatment and crisis intervention services, will share $75 million over three years as part of the new mental health plans developed by all nine regional health authorities.

The ministry invested an additional $2.26 billion in health infrastructure. This will provide for nearly 2,200 additional acute-care beds and targeted capacity growth in areas such as surgical, diagnostic, ambulatory, and emergency care. Additional funding of $26.3 million was provided to address the recommendations of the MLA task force to increase nursing hours of care per resident from 3.1 to 3.4 hours per day, implement a safe lift policy in all nursing homes and auxiliary hospitals, speed up implementation of new resident assessment and care planning tools, and review medication use and administration in continuing care facilities.

The ministry continued its work in primary care reform. Fourteen primary care networks were operating as of March 2006, involving 550 family physicians to provide services to more than 700,000 patients. Through the networks family physicians work with health regions and other health providers to better integrate and co-ordinate health services to patients. More physicians were encouraged to locate in smaller communities through a new program of the Alberta rural physician action plan. Ten bursaries were offered to medical students to commit to five years of rural practice once they've graduated. The Alberta rural family medical network was also expanded to place more medical residents in rural Alberta.

Under the ministry's third core business, to lead and participate in continuous improvement in the health system, the goal was for health system efficiency, effectiveness, and innovation. The May 2005 international symposium on health was held. It provided us with better information and better education on the best practices around the world. In July 2005 a package of 13 priority action areas called getting on with better health was announced to improve the health system in many areas such as wellness, injury prevention, children's health, mental health, primary health care, and the use of new technologies such as Alberta Netcare.

The health policy framework was released in February 2006, and considerable consultation around that guideline framework provided direction to guide future health system decisions into taking into account the factors that impact on the public health care system such as the rising cost of pharmaceuticals, the need to keep up with rapidly changing technology, and the increase of Alberta's aging population.

There were many other things that happened in the course of the year, and there's much, much more to say, but cognizant of your admonition to keep it to a 10-minute time frame, I think rather than going through the remainder of the details, I'll curtail my comments there and end by saying something that I should have said at the start. I've had the privilege of now being in the department since, I think, December 15, so much of what we're talking about today happened under the guidance of my predecessor, the Hon. Iris Evans. You can tell, I think, from the number of things that I touched on in those brief opening remarks that she was engaged in a very, very active year, and I would suggest, having had the opportunity to pick up where she left off, that she has set a considerable pace and done yeoman work with, again, the superb backing of a very talented staff of people in the department, who do excellent work for Albertans.

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

Mr. Dunn: Thank you, Mr. Chairman. I would agree.

Our comments are contained in all three volumes of our report for 2006. We completed two major systems audits impacting this ministry in 2006. The results of our food safety audit are contained on pages 63 to 107 of volume 1. This audit, which also involved AFRD, produced 10 recommendations. We found that there is a need to improve the inspection programs, the food safety information systems, and the accountability for food safety.

On pages 133 to 161 of volume 1 we report the results of our review of the RHA global methodology for funding. Overall, we found that global funding is an effective funding allocation methodology, but we made a number of recommendations to the department of Health and Wellness in areas where we believe the methodology can be improved.

On pages 185 to 193 of volume 1 we include comments on the progress made by the departments of Health and Wellness and Seniors and Community Supports to develop new long-term care and accommodation standards. We found that the departments have developed new standards but still have to implement a system to regularly review and update the standards to ensure that they remain current. We also comment on the progress made by the departments and health authorities on the recommendations to improve the systems used to provide the services in long-term care facilities.

Other comments on the Ministry of Health and Wellness are on pages 113 to 133 of volume 2 of our 2006 annual report. There are two key recommendations in this section. The ministry needs to explain and quantify in its annual report the key factors affecting health care costs, and the ministry needs to link the health care costs to outputs for the ministry as a whole in its annual report.

In addition, we reported on our special audit at the Alberta Alcohol and Drug Abuse Commission in the November 2006 report. Our audit revealed that a diversion of funds had occurred through the use of false contracts, and we made three recommendations to improve AADAC's internal controls and processes.

In total we made 16 numbered recommendations in our annual report impacting this ministry. Eleven have been accepted, and five accepted in principle by the government. The three recommendations arising from our work at AADAC have been also accepted by the government.

That concludes my opening remarks, Mr. Chairman and committee members.

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

I would like to welcome at this time also Dr. Neil Brown. Good morning.

I would again remind hon. members that we're dealing with the respective report from 2005-06 of Health and Wellness, the government of Alberta's annual report, and the documents referenced by the Auditor General. If we could please proceed with questions, but before we do so, the chair asks the members, please, to be direct. Last week we ran out of time. We had too many questions. So if we could be considerate of one another, the chair would be very grateful.

We'll proceed this morning with Mr. Chase, followed by Mr. Strang.

Mr. Chase: Thank you. My questions have to do with page 82 of the annual report, section 1, of 2005-06. They have to do with diagnostic medical equipment. Why was the diagnostic medical equipment budget cut from $200 million in 2005 to $62 million in 2006?

Mr. Hegholz: The reason for that was that we did receive some additional funding from federal government in '04-05, and that was one-time funding. Therefore, it didn't come forward again in '05-06. So, basically, that was the rationale behind that.

Mr. Chase: Thank you.

My second question: given the series of complications at St. Joseph's hospital in Vegreville, Canmore, et cetera, why didn't the ministry adequately fund a monitoring and enforcement branch within the department?

Mr. Hancock: You're talking about the '05-06 annual statements. Basically, as a result of the review that happened and the findings at St. Joe's, we're undertaking a thorough look. We've asked each of the regional health authorities to review their processes for infectious disease control and what they're undertaking now, and we will have a report back from that on the 30th of April to the ministry.

8:50

We also will have a report back from the various medical colleges by the 30th of April, and we'll be dealing with those reports in terms of what types of processes we need to have in place to make sure that we have an auditable infectious disease control process within the province.

Mr. Chase: Thank you. I'll look forward to the tablings.

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

Mr. Strang: Thanks, Mr. Chairman. To the hon. Hancock. What I want to talk about is on page 54 of your annual report, your goal 6. You had mentioned in your speech that you had $116 million in electronic health records. But what I'm wondering about is: can you sort of give us an update of where we're at with that and our anticipation of more spending on that? I think this is just a deep black hole. I don't know how we're gaining on it. If you could explain that.

My other question. The Auditor General had recommended that the minister consolidate its financial statements with health authorities. I don't see this happening in your 2005-06 statements. Can you comment on that one, too, please?

Mr. Hancock: With respect to the consolidation I believe that that consolidation will be happening in this fiscal year. So that'll be reported as we go forward. I believe that one of the reasons for the timing of it was to make sure that annual reporting mechanisms could be aligned so that there would be a meaningful reporting process. But I'll ask Ray to elaborate on that if I've left something out that's needed.

With respect to the electronic health records rather than a black hole I think we should be looking at this as an essential tool to deliver appropriate health care across the province. It's expensive, no question, to get the system up and running and to make it work together, but the goal of having every Albertan with an electronic health record by 2008 I believe that we're on track for. I'll ask Linda Miller to expand on that.

Making sure that the health record systems that are being established in Capital and Calgary and in RSHIP, working together through an appropriate portal, making sure that diagnostic, that laboratory, that pharmaceuticals are all available online so that an Albertan, regardless of where they present, the health care provider has access to that essential information, reduces the duplication and testing, and not only the efficiency of the system but the more effective care that can be provided is well worth the investment. I'll ask Linda Miller to expand.

Ms L. Miller: Good morning. My name is Linda Miller, and I'm the assistant deputy minister responsible for the area. The $116 million to which he referred is funding that we received as one-time funding. Essentially, all of that money was granted to the health authorities to assist them to help to replace some of their what we call old legacy systems or clinical information systems in their large hospitals, and they are in progress doing that.

In addition, we spent money allocated to the department within my division to assist with the electronic health record. As of 2005-06 new development costs from 1996 to 2005-06 – we estimate that the total cost of the electronic health record at that time was approximately $270 million. We are well on our way with the

electronic health record. We are definitely well ahead of the rest of the country. We anticipate that by the year 2008 we will have a hundred per cent of all drugs dispensed. We'll have approximately 75 per cent of all diagnostic images made available throughout the province. We will have a hundred per cent of the lab results available within the electronic health record as well as all of the key demographic information of every Albertan that has access to the health care system to ensure that we match the right record with the right person. We feel that those targets are reasonable, and we are well on target to making those targets by the fiscal year 2008.

Mr. Hancock: Thank you.

The Chair: Thank you very much.
Mr. Miller, followed by Heather Forsyth, please.

Mr. R. Miller: Thank you, Mr. Chairman. My questions refer to pages 63 and 65 of the Health and Wellness annual report, schedule 2, specific to the president and CEO of the Calgary health region and the rather lucrative compensation package that that gentleman receives. I think it's fair to say that a lot of Albertans question, given that high salary, whether or not we're getting, you know, proper value for the money given the number of red alerts, code burgundies, and miscarriages taking place in the waiting rooms.

My first question would be for the Auditor General. Currently the CEO's retirement package is valued at in excess of a million dollars when you look at pages 63 and 65. Those numbers are found on separate pages. I'm wondering whether or not you believe that these two numbers should be included under the total staff compensation column on page 63 so that all Albertans would easily see the CEO's total salary.

Mr. Dunn: Where the hon. member is is in volume 2. You have to go to the tab Calgary, labelled 3. If you turn to the pages and you look at page 63 with the reference, if you look at the compensation schedule for the president and chief executive officer, it's a very detailed schedule.

If you look at the top line, you will see that the total compensation there was described as $593,000. Then underneath you will see there is a bracketed reference. It's called, "See A on following page," and of course you would then turn to A. Then you'll see there are a number of references under the A. You'll have to go all the way down to (j), which is on the bottom right-hand corner. What the member was referring to was the retirement arrangements, and those retirement arrangements take you over to what's called schedule 2, continued, and the top line there, President and Chief Executive Officer, is made up of two components, which is the SERP, the supplementary executive retirement plan, made up of both the current and then the prior service costs, aggregating $413,000. So, in my opinion, which I've expressed before, the total compensation for that fiscal year is the aggregation of the $593,000 on the previous page and the $413,000, which aggregates, then, to $1,006,000.

Yes, we have made recommendations within the recommendations to the Ministry of Finance that clarity should be directed to these organizations to ensure that it's all contained on one page, and I believe those directions have already gone out. I expect this year, in the '07 year, it'll all be contained on one schedule, Mr. Miller; therefore, there will be no confusion later on in reading the financial statements that the aggregation of the total compensation includes both that which you receive currently and that which is deferred to future periods.

Mr. R. Miller: Thank you.

My supplemental, then, would be for the minister. I'm wondering whether or not any action was taken against the board chair, who publicly criticized the Auditor General by saying – and his exact quote was: summing up some numbers to reach $1 million is just totally ridiculous; it has no basis with any public reporting entity in Canada.

Mr. Hancock: I guess the short answer is no. I certainly haven't taken any action against the board chair, although I can indicate to you that I've met with all board chairs on several occasions now since meeting, and we've talked about accountability, structures, the relationship that we have and the need for openness and transparency, the need for us to appropriately report to the public on the funds that we are expending on behalf of the public so that we have the moral authority to continue to ask for the level of funding that we do out of the province's budget in each year. So I haven't taken specific action against the board chair, nor do I intend to. I think you hire people to do jobs, and you don't necessarily tell them to limit their commentary. That commentary is in the public eye, and the public can make their own judgment as to whether it's appropriate or not.

With respect to the accounting, there is a difference of viewpoint with respect to the order of magnitude. I think what the Auditor General's comments essentially relate to is that all the information should be reported in an appropriate, clear way, and that's been communicated to health authorities.

Mr. R. Miller: Thank you.

The Chair: Thank you.
Heather Forsyth, please, followed by David Eggen.

Mrs. Forsyth: Thank you, Mr. Chair. My questions relate to the Auditor General's report on page 76 in regard to his recommendations on the food establishment inspection programs. When reading through all of the recommendations and all of the comments that the Auditor General has made in regard to this particular area, it's somewhat disturbing to think about all the things that are going on. I'm wondering if you can briefly tell us, under recommendation 6, where you are. Kind of a status report on that, please. That's my first question.

9:00

Mr. N. MacDonald: Thank you. Neil MacDonald, from the public health area. The recommendation is that "the regional health authorities improve their food establishment inspection programs." This recommendation doesn't necessarily apply to the department, but it's our understanding that the RHAs agree with the recommendation.

The recommendation does presume, however, that there is a generally accepted practice that needs to be instituted, and this isn't necessarily the case. There's no validated frequency of inspection regime that can be used to rationalize inspection programs given that the frequency of which you would be required to visit any specific operation is dependent upon a complex set of factors, including being very dependent upon the operator.

Mr. Hancock: Just to supplement on that, we're working on developing a training course in hazard analysis critical control point and training for all health inspectors and developing that protocol with respect to what would be utilized across the province and what health authorities could be tested against with respect to their food safety.

Mrs. Forsyth: Okay. I feel a little better after that supplement from the minister because I was wondering: you know, when you delegate a responsibility down to the authorities you, ultimately, as the minister are still responsible. So thank you for adding that, David.

My other question is that – and I don't have the page – one of the things I hear most often in the constituency is the attraction of family doctors, and people are very desperate to try and find family doctors. Maybe you could elaborate on what you are trying to do to bring more family doctors into this province.

Mr. Hancock: Well, there are two sides to that, and again someone may wish to supplement from the department. But, first of all, the health workforce strategy, which I'm working on with Iris Evans and Doug Horner, involves long-term and short-term strategies. Long-term, obviously, is creating more spaces at educational institutions so that we can grow more doctors and make it more attractive for those doctors to go into the family practice area.

You may have heard yesterday that the new agreement with the AMA was ratified by about 91 per cent of doctors, and in that is a fairly significant push towards being able to assist doctors with community practices. This is a family doctor initiative because particularly in high-growth areas – Fort McMurray, downtown Calgary, places like that where the costs are going up – those doctors who have their own clinics and have the costs associated with it are facing a greater degree of pressure than for, perhaps, a specialist who operates in a hospital environment. So on the funding side of it we're working.

Probably the most significant area is to recognize that we have to change the way we practise. So the primary care networks – now, I mentioned that we had 14 in 2005-2006 covering 700,000 – are now in excess of 19 and covering more than a million Albertans. The primary care networks help to leverage the effect of a family doctor to work in teamwork with nurses and dieticians and other health care professionals to actually provide a better and a broader service. You may have read in the *Edmonton Journal* the other day that we now can boast about primary care networks offering same-day access to Albertans.

So we need to attract more family doctors, but we need to also be able to use the full value of all of our health care professionals, and using them in a teamwork approach, as is done in the primary care networks, really expands the capacity probably faster and better than attracting more doctors. But we need to do both.

Mrs. Forsyth: Thank you.

The Chair: Before we proceed to David Eggen, followed by Mr. Griffiths, the chair would like to remind members that if they look at page 48 of section 1 of the minister's annual report, there's a performance measure there on the proportion of Albertans who have a family doctor. Thank you.

Please proceed, Mr. Eggen.

Mr. Eggen: Well, thanks, Mr. Chair. My questions are in regard to Capital health. My understanding is that Capital health is at approximately 1.7 beds per 1,000 population, but they have indicated that they are requiring at least a minimal amount of 1.9 beds per 1,000 population. I'd like to also add that at least a quarter of the patients that Capital health in fact deals with are coming from outside of the region, which puts extra stress on the very limited resources that they have. So I was just wondering if there was an accounting measure that looked at that extra 25 per cent that Capital health is dealing with. How is that factored into the total bed ratio that Capital health is allocated? Of course, we are facing quite a chronic shortage of beds in Capital health.

Mr. Hancock: I'll ask Ray and Peter to deal with the specific question.

The overarching comment I'd like to make is that I understand that both Capital health and Calgary regional health authority have been invited to appear. So that would be the appropriate time to go into detail with respect to their operations. I think that's a very good and innovative approach to the work of the Public Accounts Committee.

Mr. Gilmour: Just to add from the capital side for Capital health during the '05-06 year. As you mentioned earlier, there is a challenge with the beds and the ratios that they're looking at. Capital health was involved significantly in the capital budget that year. They're doing many significant projects around the city, with the estimation that they're hopefully going to be able to add an additional 400 to 500 beds over the next period of time frame, which will aid them in that ratio as they're going forward. Of course, with the growth going on in the city, I mean, it's a constant balancing act that they're working on, and hopefully through support and the projects they have on the go, they'll be able to meet their objectives.

Mr. Eggen: Right. Well, certainly in Edmonton and in Calgary as well we are constantly seeing a backlog, which could be to do with beds. It could be to do with emergency access. There have been already more code burgundies this year in Calgary than there were all of last year, and my understanding is that the Royal Alex, at least, is in pretty much a constant state of their emergency situation.

I'm looking at this globally. We're spending more than $9 billion on this budget, and the indicators that the system is either backlogged or logjammed or in crisis seem to be mounting. You know, with the increase in expenditures of more than 11 per cent why are we continuing to get this emergency situation in our major hospitals in both Edmonton and Calgary?

Ms Meade: I'll take a stab at that one. Beds are one piece of this issue. But the system has to be re-engineered, and there's work being done on that: looking at different processes in Calgary, Edmonton, Red Deer, Chinook and how we're handling emergency, moving to different protocols so that we can actually handle more people through the acute system, and also looking at moving people both through technology and other systems back into the community.

So beds are one piece of this issue, but it's also looking at lean hospital approaches to better efficiencies and movement of patients through the system. It'll take a full-system approach to get to it, and I think the dollars from that point of view are being well utilized if you go beyond just the capital infrastructure needs. It's not just beds.

Mr. Eggen: Thank you.

The Chair: Thank you.

Mr. Griffiths, please, followed by Harry Chase.

Mr. Griffiths: Thank you. Mr. Minister, I think the public accounts and public accountability is an incredibly important job of the government, and I'm wondering: does your department have something like performance contracts that they enter into with health regions to make sure that they're accountable to you for their performance?

Mr. Hancock: In the 2005-2006 year there was not that kind of relationship. But I can advise that, as I mentioned earlier, we've met several times now with board chairs and put on the table the fact that

the accountability and governance issues are one of the priorities that I have, that I'm dealing with them, and working on both the relationship of executives to boards and boards to the minister and the minister to the Legislature is an extremely important accountability framework. So that is something that is front and centre to the work that we're doing now. But in 2005-2006 there were not, to the best of my knowledge – they provided the health plans, but there was no contract of accountability.

9:10

Mr. Griffiths: Thank you. My second question. I'm not picking on AADAC; I'm just using it as an example. Performance measures are incredibly important, and I think there are three types. I've asked this every time I come to Public Accounts. There are satisfaction surveys that are rather superficial, that just see if everyone is satisfied with the service. There are outputs, which measures dollars in and what volume you have coming out. Then, there are outcomes, which I think is the most substantial form of performance measure for any level of government, any type, any department.

Now, most of the performance measures – I mean, I'm just identifying AADAC – are awareness of services, awareness of effects of alcohol, the amount of people that smoke, the amount of people that drink. Is your department working not just with AADAC but with every one of the provincial mandated groups under your ministry and yourself to help improve the performance measures to show that dollars in are actually getting us some meaningful results and not something like satisfaction surveys?

Mr. Hancock: That's a very important question, and I can't respond with respect to the 2005-2006 year. Maybe you can ask the deputy to respond in that area. But I would acknowledge and indicate that my viewpoint is that outcome measures are the most important way that we can measure. I would want to move the department and this system to performance measures based on outcomes. But I also would raise the concept that we need to be looking as a government and as a Legislature at understanding how outcome measures are reported, that they don't necessarily fall into the variability of a one-year reporting time frame. You have to be able to look at them over time and do both qualitative and quantitative analysis on them.

So it's not just counting what you've always counted. I appreciate the question because that's been one of my personal areas that I've pushed in government for a long time and intend to raise as part of the department of health. But in terms of what was actually measured as performance measures in 2005-2006, I perhaps could ask Paddy to expand.

Ms Meade: I think it's a good question. It's one that the department is working on, as the minister has said. But at this point you're quite right. These are not outcomes; they're more process measures. I think it's typical of AADAC as well as others. We have to move to more of a public health response in many of our measures.

Mr. Griffiths: Just note for the record that in two years of asking that question, that response from the minister is the best one I've heard yet.

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

Mr. Chase: Thank you. My page reference is page 94 of the annual report, section 1 of 2005-2006. As the past Alberta chair of Friends of Medicare and an ongoing advocate for universal public health care I would like to know why the category Service Contracts has more than doubled from $66 million in 2005 to $142 million in 2006?

Mr. Gilmour: Can I get back to the member on that one, please?

Mr. Chase: Thank you. I look forward to the answer. I believe in in-house public service as opposed to third ways.

My second question: in the name of transparency and accountability will the minister please table in the Assembly a financial breakdown of these service contracts, their names, and their locations?

Mr. Hancock: I'll have to take that one under advisement and have a look at it. Obviously, if the information should be public, I can make it available. I'll have to look into the details of that one and report back to you.

Mr. Chase: I'll look forward to your advice. Thank you.

The Chair: Thank you. In regard to Mr. Chase's questions, if you could provide a written response through the clerk to all members, we'd be grateful.

Mr. Hancock: As always.

The Chair: Okay. Mr. Cardinal, followed by Mr. Miller.

Mr. Cardinal: Thank you very much, Mr. Chairman. First of all, I'd just like to mention that Aspen health and, of course, the Capital health region also fall in my constituency. I have to admit and compliment the department: we do get very few complaints in relation to the whole health care system in those particular regions. One concern that seems to come up quite often now is the growing cost of health care in Alberta. There is a major concern. It seems like every year we add money to the health care system. By all indications, at least in parts of my constituency, in relation to the number of people entering the doctor's door, it has always been a concern. There are all the indications out there that 80 per cent of the people walking in the doctor's door and the health care provider's door are not sick and shouldn't be there, that it is not necessary. Fifty per cent of the prescriptions filled are either not used or not necessary. Now, the Mazankowski report had made some good recommendations specifically in that particular area. I just wondered: what part of that specific recommendation from Mazankowski has been implemented? Are we doing anything with it?

Mr. Hancock: I don't have the specific recommendation in front of me, so I'll ask Paddy or perhaps Annette to address that in detail. But there are a couple of things that are relevant to that. One is the electronic health record and the PIN, the pharmacy information network. It will make better information available as to what prescriptions have been provided to an individual and will allow health care professionals such as a pharmacist to monitor abuse of prescriptions and to make sure that monitoring of utilization is more able to be done.

Also, the Capital Health Link, which has now been expanded across the province, has proved very effective at reducing the increase in the number of visits by providing an alternative way for people to get the information. There's a very difficult policy issue there as to whether you want to discourage people from attending, knowing that, as you say – and the numbers vary depending on who is using them – between 60 to 70 per cent of people appearing may not need to see a doctor. But if you don't know that they don't need to see a doctor or other health care professional, it's dangerous to tell them they can't go, so we provide mechanisms to give people the

information they need in a more effective way and to target them to see the health care professional who can best help them. Again, the primary care networks, even expanding out into the rural areas, I think especially expanding out into the rural areas, will be a very effective way of dealing with that.

I'd ask Paddy to supplement.

Ms Meade: The minister has hit just about all of it with the electronic health record, but I think pharmacists prescribing now will also be allowed when that is fully across the province. People can see a pharmacist. A lot of people go to a doctor for upper respiratory, and that could be handled both through RNs and pharmacists. So, again, with the use of telehealth, primary care networks, and the electronic health record. The last one would be the pharma strategy that the minister is going to bring forward, which will also get at drug use and misuse and how we're going to manage the prescription drug costs. I think it's changing public attitude to: you don't always have to see a physician and to some education around self-care and monitoring.

Mr. Cardinal: Good. That's all.

The Chair: Thank you, Mr. Cardinal.

Mr. Miller, followed by Mr. Dunford.

Mr. R. Miller: Thank you very much, Mr. Chairman. Mr. Minister, in reference to page 95 of section 1 of your annual Health and Wellness report, there is discussion there of contingencies and equity agreements with voluntary hospital owners and, in particular, hepatitis C. I'm wondering if you can elaborate for us on why the department has been named as a defendant in 39 specific legal actions. That would be the question.

Mr. Hancock: I didn't introduce Martin Chamberlain, but I know he's back there.

Mr. Chamberlain: Yeah. Martin Chamberlain. I'm corporate counsel with the health department. Sorry; I missed the end of that question. Perhaps you could repeat it for me.

Mr. R. Miller: I'm just wondering if you can elaborate as to the reasons why the department has been named as a defendant in 39 specific legal actions in 2005.

Mr. Chamberlain: We'd have to look at all of those different legal actions. The reality is that the department has a funding commitment in the blood system and has, obviously, a role to play in the blood system.

On the hep C cases: to be honest, we'd have to look at each of the litigation pieces in order to answer that question. Clearly, there are a number of lawsuits against the Crown. We can't comment on whether or not they are legitimate cases against the Crown. We're defending each of them. Why a plaintiff has chosen to name the Crown would vary depending on the case.

9:20

Mr. Hancock: Perhaps on a more global basis, if you take a look at the note, it's fairly self-explanatory. As you're aware, there was a hep C issue. There was a settlement across the country or a cross-country way of dealing with the hep C cases. There were specific time frames, and people who fell outside those time frames were not happy with the settlements and engaged in legal action, and I would suspect that if we look at it, a lot of them will fall into that category.

Mr. R. Miller: Then just a supplemental to that: is there any expectation as to when these will be dealt with? It seems to be taking an awfully long time. The settlement that you referred to, the government of Canada settlement, is several years old already.

Mr. Hancock: Well, the government of Canada settlement with the main group within the time parameters, the year parameters, was settled a number of years ago. Some of the claims outside those parameters have been settled by the federal government more recently, and that's of course putting pressure on all the other jurisdictions to deal with them.

Mr. Chamberlain: Perhaps if I could supplement, Mr. Minister. My apologies. I'm just trying to figure out what this section said because I didn't have it in my hand. That's correct: the hep C cases are currently before the courts in Alberta. The federal government does have a settlement in place, which is currently before the courts for ratification and approval. The provincial matter is on hold, essentially pending determination of that. Once that happens, the province will be determining how aggressively to defend the matter, and the plaintiffs will be determining whether or not to continue with proceedings against the province. Obviously, as the matter is before the courts, it really wouldn't be appropriate to comment on it any further.

Mr. R. Miller: Thank you.

The Chair: Thank you.

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

Mr. Dunford: Good morning. I'm on financial statements, page 82 of section 1 of your annual report. Because there's only one taxpayer – and that's you and me – I look at funding coming from the federal government as recycled dollars, and I think it's a sign of the times that more recycling is better. But I notice that the transfers from the government of Canada for the year we're talking about, the difference between budget and actual, was over $200 million. I wonder if either yourself or perhaps a deputy or one of your officials could tell us the why of what looks like a shortfall?

Ms Meade: Ray, you can have my back on this one, please. I think you're saying that there's an increase or a shortfall? There was actually an increase in health care transfers from the government of Canada in '04-05. It went from $1.19 billion to $1.54 billion in '05-06. The increase of that $0.35 billion was due to Alberta's entitlement of federal transfers, and it was just the basic federal corporate taxable and property based on our population. So we received a higher envelope of the transfer just on the calculation, if I'm on the same number as you are.

Mr. Dunford: No. Maybe I'm misreading. I'm looking at transfers from the government of Canada under Revenues of schedule 1, page 82.

Mr. Hegholz: What ended up happening there was that, in fact, the decrease was as a result of the tax transfers. There's a methodology that Health Canada uses to determine what we're going to get from them in terms of revenue on an annual basis, and that gets updated on a fairly regular basis. There are three components to that. One is the basic federal tax, the other one is corporate tax, and the other one is income of population. Based on that, then, they make a determination as to what the cash transfer is going to be. So the cash transfer actually moves up and down during the course of the year.

Basically, what they end up doing is that they're saying: well, we collected more tax from you; therefore, we're going to decrease the cash going to you.

Mr. Hancock: There is actually an inverse relationship on our health transfer and our social transfer. As our ability to pay goes up because of the tax that we collect, the transfer that we get from the federal government goes down. In this case we had an actual in 2005 of $1.7 billion, we budgeted for $2 billion, and we actually received $1.8 billion, and that's just the adjustment of the formula. As we're more successful at collecting personal and corporate income tax, our payment under the health transfer goes down.

Mr. Dunford: So are you saying that we could provincially tax our way out of the health care act?

Mr. Hancock: In theory. As our income goes up, yes, our transfer from the federal government on the health transfer goes down. So in theory at some point in time you'd reach that crossover. However, the federal government has now announced going to a per capita as of 2011, I think, so that will change.

Mr. Dunford: That was just a clarification. That wasn't my supplemental, was it?

The Chair: You go ahead.

Mr. Dunford: Okay. What strings came attached to that $1.8 billion from the federal government, who does not have any jurisdiction in the delivery of health care?

Ms Meade: Well, there are no strings attached specific to the dollar amount that comes into the government, but they do actually survey and ask us, and we are required to produce information specifically on certain procedures and if there was any public or private delivery. We did not get fined in this year, but historically they have come and told us that if we do certain things, they could fine us. They don't attach the strings to the money; they get you after the fact.

On the general transfer, if they give you money specifically tied to the '03-04 agreement or specific to wait time dollars or whatever, you do have to use that money and show that you've applied it only to those projects. So the money that was just announced around wait time guarantees would have to move specifically to that and meet within their principles and agreed-to program.

Mr. Dunford: But in '05-06 there were no strings attached.

Mr. Hegholz: Well, there would have been for a couple of them. For example, as Paddy had indicated, under the wait times reduction program there would have been strings attached to that.

Mr. Dunford: In '05-06?

Mr. Hegholz: Yes, because we did receive some funding in '05-06.

Ms Meade: It's on the portion, though, that is specific to that program.

Mr. Dunford: Thank you.

The Chair: Thank you.

The chair would like to remind all members of the committee that if they refer to page 24 of the government of Alberta's annual report, you will see that the transfers from the government of Canada in 2005 were $3.2 billion and that in 2006 they were $3.3 billion. Thank you.

Mr. Eggen, followed by Mr. Cenaiko, please.

Mr. Eggen: Thanks, Mr. Chair. Both Edmonton and Calgary have recently imposed smoking bans in public places. I was just curious if your ministry or associated departments have in place a way to measure how these bans will in fact help to save Alberta's public health taxpayer dollars over time.

Mr. Hancock: I'll ask the CEO of AADAC to supplement, but I would indicate that to the best of my knowledge neither of those bylaws was in place in 2005-2006, so that may be a more appropriate question for question period or for Committee of Supply, which will be commencing at the beginning of May.

Mr. Eggen: Well, we're looking for performance indicators for the efficiency of public expenditures, so measuring this over time, I suppose, would be useful, particularly with my supplemental question then, of course, which is the inverse. The absence of a provincial ban for smoking in public places undoubtedly has a negative effect on the public expenditure of health care dollars. Again, similarly, would the ministry or associate departments have a way to estimate the measurement of how much extra we are spending on health in view of the absence of a provincial smoking ban in public places?

9:30

Mr. Hancock: Important questions, but again, I mean, in terms of accountability for the 2005-2006 year, they're probably more appropriate for either question period or Committee of Supply, and I would be more than delighted to deal with those because I think those are very important questions.

Murray?

Mr. Finnerty: Thank you, Mr. Minister. Mr. Eggen, the only way we would have of capturing that kind of data is to measure the total cost of substance abuse in Alberta, which is $1.4 billion, and of that it's estimated that 41 per cent of morbidity and mortality is attributed to tobacco. So you could arrive at a number, but those are general survey numbers.

Mr. Eggen: Okay. Thanks.

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

Mr. Cenaiko: Thank you very much. Mr. Minister, thank you very much for being here this morning. I want to thank you for a clarification of Mr. Miller's question earlier this morning regarding the present CEO of the Calgary health region. For some reason the Liberal opposition continues to slag the president and CEO of the Calgary health region, and I just want to bring to his attention that on page 135 he can look at the Capital health CEO's salary. The base salary there shows about a $200,000 difference between what the CEO of the Calgary health region gets. Obviously, a larger sum of monies as well is paid to the CEO of Capital health. So I'm not sure why they continue to bring irreparable damage to the credibility and the personality of Mr. Jack Davis. But that's not my question.

My question. Over the years and since regionalization took place and the regions were reduced to nine, two regions, Capital health and Calgary health, really serve about 60 to 70 per cent of the population, with seven regions providing a service to about 1 million

people. Was the department in 2005-06 and is the department today even looking at considering reducing that? Obviously, through economies of scale organizations and regions can be more effective and more efficient. I'm just wondering what the department had looked at or is looking at with regard to seven regions looking after a million people.

Mr. Hancock: Well, again, some of the questions perhaps could be dealt with more appropriately in Committee of Supply in terms of going forward. I certainly believe that form follows function, and I would answer this by saying that we've been talking with the regional health authorities about governance. One of the tasks that I have in front of me is to make sure that the health regions work in a more collaborative process within a provincial policy framework and that we get the efficiencies of purchasing and scale and delivery that can be done in collaboration. In other words, those things that we ought to be doing on a provincial scale working together, we will do that. A lot of the areas in terms of chronic disease management, in terms of prevention, and those sorts of things can be done that way.

But we have not engaged and I don't believe there was any discussion in 2005 about further redefining the boundaries, not to say that that wouldn't come once you have the discussion about governance and accountability frameworks and structure. Form should follow the function, and we're working on the function and accountability. If there are anomalies, if there are better ways to do it, then we should always be alive to that.

Ms Meade: If I could just add, it's important, too, that the percentage that's served by Edmonton and Calgary is because they do the high tech. You know, we're not doing transplants in every region. So the service delivery model is actually efficient. Not only that, but we do things in western Canada. So Winnipeg, Calgary, Edmonton, and Vancouver: we all have specialized to, again, capitalize on efficiencies. The percentage served is a little skewed because of the specialization.

Mr. Cenaiko: Along with the regional health authorities' input into various programs throughout the year in working with your department, on page 72 of the Health and Wellness annual report it's noted that the crystal meth task force involved AADAC, and the president and CEO of AADAC is a member of the task force. I'm just wondering if we can get an update of where the recommendations are.

Ms Meade: Well, once the report was provided to government, it did not go through at that time the standing policy committee, so it was handed off to myself to have a deputy minister's committee to look at the recommendations. That work has been completed. AADAC was a member, as were others, and that will be coming forward through the minister for government. That's on a full, comprehensive youth substance abuse plan.

The Chair: Thank you.

Mr. Chase and Mr. Hancock, before we proceed, I would like to remind you that we're dealing specifically with the annual reports for the year ending March 31, 2006. Whenever you refer us to continue the debate in Committee of Supply, that will be for the budget year 2007-08, so if you could make every effort, you and your staff, to answer the members' questions, we would be very grateful.

Thank you.

Mr. Hancock: It would be helpful if the questions focused on that as well.

The Chair: The questions are quite focused, I think.

Mr. Chase: Thank you. Just a quick response to Mr. Cenaiko. We don't consider questions about health care leadership and taxpayer accountability as slagging. We are very aware of the pressures placed on regional health authorities to keep up with growing demands.

With regard to questions, liabilities on page 93 of the annual report, section 1, why have the liabilities due to health authorities and provincial boards increased 172 per cent in one year? In 2005 they were $119 million. By 2006 they had risen to $323 million.

Mr. Hancock: Can you direct us to the number that you're working on? You said page 93?

Mr. Chase: That's correct.

Mr. Hancock: Are you referring to line 3 under note 7?

Mr. Chase: Yes, that's correct.

Mr. Hancock: So rising from $187 million to $193 million?

Mr. Chase: That's correct. No. Sorry. It's $118 million to $322 million.

Mr. Hancock: The one below, $118 million to $322 million. Okay. Thanks.

Mr. Chase: It's the third line.

Mr. Gilmour: In this area when you do your year-end, a lot of the time the amounts due to health authorities are accrued liabilities or accounts payable. It's a timing issue because it's a snapshot as of that date, March 31. Many a time if you've got a payable adjustment or the amounts due, that would be variable, kind of based on that date in time. Actually, when you look at the amount of funding that flows through the health authorities, even though it is $118 million to $322 million, and it is significant, it's something that is covered or captured generally based on something that's happened right on that date or either side of it.

Mr. Chase: Okay. Thank you. Possibly, some more written clarification would be helpful.

On the same topic but this time on page 95 with regard to liability: pending a loss in the pension lawsuit, does the department have sufficient funds to absorb its portion of the $1.3 billion pension lawsuit? I hope that our accounts are sufficiently deep that these liabilities are coverable.

Mr. Hancock: Subject to clarification, I think that's noted as a contingent liability, in which case it's not being accrued. It's just being noted.

The Chair: Thank you.

Mr. Herard, followed by Mr. Miller, please.

Mr. Herard: Thank you very much. My good colleague and friend from Lethbridge-West is fond of calling himself a rookie in this. I guess I'm even more of a rookie because I'm a bit younger.

I don't even know if I can do this, but you know, we keep coming back to certain questions of total compensation for this person or that person. Quite frankly, I don't understand how the numbers were arrived at, so I'm not sure if this is even in order, but I'd like the Auditor General to explain to me whether or not there are any differences in the way that expenditures with respect to the total compensation of the CEOs of the Capital health region or the Calgary health region are in fact described. If we were looking at an apples-to-apples comparison, what would the numbers be?

9:40

Mr. Dunn: Okay. Thank you very much for the question. The notes that are described within these financial statements are in accordance with generally accepted accounting policy. I never said that these financial statements were not in accordance with generally accepted accounting policy. But in order to get the total compensation, you must go to not just the schedule but the attachments. In aggregate the total compensation for the CEO of the Calgary health region is slightly over $1 million. The total compensation for the CEO of the Capital health region is slightly under $800,000. They do watch each other on a periodic basis; they do make comparisons. Obviously, you would expect that they would watch each other.

The difference becomes sometimes a bit of a timing difference, especially around what is now known as the supplementary retirement plan, the executive retirement plan. That in the future will be included on the same schedule with your base salary. Your bonuses, incentive comp, a kind of a cash base, together with that which is deferred, which brings it into the aggregate of a million or $800,000, will now in the future be included on the one schedule.

The purpose of our trying to get that put into clarification in the Treasury Board directive was to avoid the sort of miscomparisons where one might just compare a base and not the incentive comp. One would only compare the direct salary of the current year, not the total compensation package. Thus in the future it will become clear. That will be done for all agencies, boards, and commissions. So the universities will do it. The colleges will do it. Any other entity or organization will do it all the same way.

Is there support for this? Yes. The public companies and the private sector are doing it. It's being required by these regulators to do it that way, and all these organizations that talk about good governance – you hear about the Canadian Coalition for Good Governance – have all promoted that same clarity. So the province of Alberta from '07 on will be in accordance with all the other guidance that's coming out around that clarity.

Hopefully, that's answered your question.

Mr. Herard: Well, I think it's going a good long way to answering it. I had read a note, which I can't put my finger on right now, when reading the Capital health statements that they did not record amounts for pension benefits in their financial statements, and I didn't quite understand that regarding the overall picture. I'll try and find that note again so that maybe I can ask you later. I guess the bottom line is that if there are pension benefits that were in fact earned in a different part of government versus the current position, I would imagine that that would make a difference as to what the total compensation might be in the end.

Mr. Dunn: It would, but it also should be included in the same schedule.

Mr. Herard: So what you're suggesting, then, is that in the future we'll see it that way.

Mr. Dunn: Right.

Mr. Herard: Thank you.

Ms Meade: If I could just add a little point here. There are two other issues. I think that what has been clarified is the Auditor General's comments on reporting procedures and transparency of full compensation. But I will tell you that we and the regional authorities continue to provide comparable salary information based on market in the health system. The comparable salary information from Ontario is that a president and CEO salaries there are all in the range of $500,000 to $600,000, but those people are responsible for one large hospital. So it's very difficult to compare the salary of a CEO in Toronto, albeit St. Michael's in Toronto is very large, or something like that. Yes, they do specialized procedures, but to compare to the size of the regions and, in particular, with expanded regional co-operation in western Canada, it is difficult to do that.

On a final note I also want to add that – I never thought I'd be defending Jack Davis, but here I am – in fact, when Jack left government, he was required to leave the public service pension plan, and that created a problem because of his resignation. So he had to leave the full pension plan after many years in government, and part of his total compensation looking higher than others was to compensate for that loss as he moved into, at the time, taking on the health authority.

Mr. Herard: Thank you.

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

Mr. R. Miller: Thank you, Mr. Chairman. I'll try to be quick. The annual report of the ministry, section 1, page 129, shows a schedule of financial statements. Under 1.0.3, public communications, there was a rather dramatic increase in the spending for communications. It was budgeted to be $1.4 million, and it ended up being $2.2 million. I'm wondering if there's an explanation for that.

Mr. Hancock: In that year, as I mentioned in my opening remarks, there was a considerable amount of activity, which you probably will recall, including the international symposium and a fairly broad-based public discussion on the way forward.

Mr. R. Miller: Which way was that?

Mr. Hancock: There were many ways. The third way was one of them. There was a lot of public consultation and communication around future directions.

The Chair: Thank you.

Mr. R. Miller: In the same vein, then, on page 82, information technology: actual expenditures in 2005, $55 million; budgeted for 2006, $86 million; and the actuals for '06, $243.6 million. I'm wondering if there's an explanation for that as well.

Mr. Hegholz: The reason for that was that there was an additional $116 million provided for the electronic health record as a supplementary estimate.

Mr. R. Miller: I suspected as much. Thank you.

The Chair: And that still doesn't add up to $243 million.

Ms L. Miller: There are additional dollars spent by the department budget that we had for that year, and that would make up the difference.

Ms Meade: Internally.

Ms L. Miller: Internal dollars. Sorry. Yes. That was already part of the budget for Alberta Health and Wellness during that year.

Mr. Hancock: So expanding the electronic health record with the addition of the supplemental estimate and some internal transfers.

Ms L. Miller: Yes. To approximately $232 million.

Mr. R. Miller: Mr. Chairman, I'm not sure about the math there. Could we maybe just expand on that explanation? It doesn't seem to add up.

Ms L. Miller: I'll just get my sheet of paper.

The Chair: Sure.

Mr. Hegholz: The increase does consist of the two components. The increase, if I'm reading this correctly, is roughly $147 million or $150 million, in that neighbourhood. Okay; $116 million of that was through the supplementary estimates – that was for the electronic health record – and the balance also was through internal reallocations for the electronic health record. That's added to the base that was there.

The Chair: Thank you.
Linda, would you have anything to supplement this?

Ms L. Miller: No. That's correct.

The Chair: Okay.

Mr. Hancock: The purpose for that was the commitment to meet the 2008 goal of having every Albertan on the electronic health record, so there was a speed-up of the process.

The Chair: Okay.
Dr. Brown, followed by David Eggen, please.

Dr. Brown: Thank you, Mr. Chairman. My question is for Ms Meade. The Auditor General's report dealt with the issue of global funding for RHAs. The Auditor General stated that the complexity of the calculation, especially the existence of adjustments, allows stakeholders to argue that certain regions enjoy an advantage or suffer a disadvantage. I would suggest that one such disadvantage is the Calgary health region, which receives about 20 per cent of mental health funding but at the same time serves over 35 per cent of the provincial population. I wonder if the deputy minister could advise under what global funding criteria that mental health funding is allocated.

9:50

Ms Meade: First of all, I think that the Auditor General also said that as complex as it was, it was a very good allocation model, the funding model. And it is an allocation model. It doesn't tell you how big the pot should be; it tells you how to split the pot up. We also had different facilities, so we are balancing facilities outside of the Calgary region that deal with the more complex mental health cases and forensic. Most of that is in Edmonton; some of that is in Red Deer.
We have, however, so we'll be able to speak to it next time we see you, moved to looking at different specific funding around mental health issues.

Dr. Brown: My question was related to allocation and the criteria, but I'll go on to my second question. In the same vein the Auditor General found that the department has failed to assess whether the global funding allocation methodology is meeting defined goals and objectives. I wonder if you could advise the committee what is being done to rectify that situation and to ensure that the global funding allocation methodology is meeting defined goals and objectives of the department.

Mr. Hancock: I'll let the deputy deal with that latter one, but I want to make sure that it's on the record with respect to the mental health funding that there are two real components that need to be taken into the allocation: the fact that Alberta Hospital Edmonton is being operated out of the Capital health region and also, I think, the Ponoka facility. Those two facilities would skew the funding. If you take a look at it in terms of a per capita basis, the fact that those two facilities are located in two specific regions takes it off the normal model.

Ms Meade: Well, again, I think that the Auditor General's report indicated that our global funding model is still the best way to provide fair and equitable funding to the health authorities. We certainly are continuing to review that, and we've even had discussions with the Auditor General and others around how we can better address mental health funding as well as the specifics of the demographic changes. I think it's a work in progress at this point. I don't know if Ray or Peter wants to add to that.

The Chair: Mr. Dunn, do you have anything to add to that?

Mr. Dunn: Yes. The method that Dr. Brown is referring to is covered on pages 152 and 153 of our report. Just to put it in the aggregate, it's $231 million for mental health, which is transferred in. This is not a population based funding.

Mr. Hug: As we indicate in here, it's an adjustment that essentially falls out of the pop-based funding model. At the time we did the work, the allocation was more historically based as opposed to a model which is based on the population, so that could give rise to the type of difference that you're noting. As we indicate in here, the department has indicated that they do have plans to revise the basis of allocation to be more consistent with the global funding methodology.

The Chair: Thank you.
David Eggen, please, followed by Mr. Strang.

Mr. Eggen: Okay. Just very quickly, on page 117 of the Auditor General's report the ministry identifies their number one cost escalator, I think, as being pharmaceuticals. So identifying pharmaceuticals as the number one cost escalator, can the ministry provide a calculation of how much money the public would in fact save if we put in place a public pharmacare scheme?

Ms Meade: Okay. Well, what we wouldn't be doing is saving; we'd

be actually addressing the cost escalation. Pharmaceutics will continue to be a bunch more designer specific and very costly. It also will depend on the comprehensiveness of the pharmaceutical strategy. The minister is bringing that forward for government to consider. Again, we have many items and many areas in that, so the more comprehensive and the more multifaceted the strategy is that we bring in, the more you're going to be able to impact that cost curve and impact it on an earlier basis. But because it's going to be brought forward . . .

Mr. Hancock: The other thing to focus on there is the difference between what you are asking and what this is reporting. What this is reporting is the costs to the public in terms of the public system for pharmaceuticals, and of course as the deputy mentioned, targeted pharmaceuticals, the new drugs targeted to specific particularly to exotic or orphan areas, are very expensive. That's separate and apart from the amount that an individual Albertan would pay if they do or do not have their own particular drug plan.

Mr. Eggen: Right. Presuming that pharmaceuticals are if not the most significant cost escalator then certainly close to it, the ministry would have endeavoured to do research to provide a model of alternatives to see where you've gone. So I'm asking if, in fact, you have modelled a pharmacare program, and if so could we have the information that would demonstrate those results?

Mr. Hancock: Yeah. Again, cognizant of the chair's admonition to deal with 2005-2006, I can tell you that we are bringing forward a pharmaceutical strategy for discussion, and it will have modelling, et cetera.

Ms Meade: The Aon report started some of the actuary modelling on that.

Mr. Eggen: Yeah. Okay. I was just asking that if you had some of that, if we could see that as part of the 2005-2006 analysis of your budget, if we could be provided with that information.

Ms Meade: Well, Aon was a public report that came out.

Mr. Eggen: Right. So you have that model. Okay.

The Chair: Thank you.
Mr. Strang, and that will end our formal questions. There are a few more members that have questions we'll read into the record, but please proceed, Mr. Strang.

Mr. Strang: Thanks, Mr. Chairman. To the hon. minister. I guess that with the myth that we always have that health care is free, I want to refer you to page 120 of volume 2. When are we going to correct that? I see where the Auditor General has said that he's repeatedly asked for this recommendation. I mean, everybody is human, so I'm just wondering why we haven't got that handled. One of my second supplemental questions, quickly, is: what is being done to do with all the outstanding recommendations from prior years that the Auditor has asked for you to bring forward?

Mr. Hancock: Page 120 of the Auditor General's report?

Mr. Strang: Page 120, volume 2, recommendation 33.

Mr. Hancock: Yes. There is work happening. In fact, you'll recall that there's a bill in the House now which provides us with better access to physician records for the purposes of doing audits.

Ms Meade: Okay. Yeah. Well, I think the issue is that we do a percentage review, and the discussion we've had with the Auditor General is what our risk is in this area and the percentage that we need to do. There was a discussion earlier with the minister, so we're continuing to look at how we can monitor and deal with the coding and the billing practices of physicians.

Mr. Gilmour: Just to add to that, to the deputy minister's comments. The department has acquired skilled staff to conduct its audits. There's staff training going on to improve the competencies and the functions in the investigations. There are analytical tools that are being put in place to allow for a more thorough analysis of the records that are coming in, to allow the department to do that.

Mr. Hancock: We're also initiating discussions with Workers' Compensation to be able to match data, which is another area of concern.

The Chair: Thank you.
We still have some questions on the list. If we could read them into the record, please, and get written responses to us from the department, we would be grateful. We will proceed with Mr. Chase.

Mr. Chase: Thank you. A single question: given the dramatic influx of individuals and families from outside Alberta in 2005-2006, is Alberta Health able to adequately track and retrieve compensation from other provinces and countries for whose citizens we are, at least initially, providing services?

The Chair: Thank you.
Mr. Miller, followed by David Eggen and then Mr. Herard. You're okay? Mr. Miller.

Mr. R. Miller: Thank you, Mr. Chairman. In a follow-up to recommendation 33, which talks about physician billing and tougher systems to be put in place to follow that, and probably in the same vein as the question from Mr. Chase, I would like to know what steps were taken to ensure that payments that we are making to other jurisdictions for charges to your department for services that were supposedly received by Albertans out of province – what systems do we have in place to ensure that those services were actually received?

10:00

My second question would be in follow-up to a story that was in the news on the weekend where a woman in Ontario discovered that her OB/GYN was billing Ontario health for the past 30 years for prenatal checkups 30 years following a hysterectomy. On page 121 of the Auditor General's volume 2 it talks about types of services, and it describes some steps that have been put in place to catch various services. I'm wondering whether or not that scenario would be covered by the system checks that are in place right now.
Thank you.

The Chair: Mr. Herard, please.

Mr. Herard: Thank you. Just a clarification. I couldn't find the section before, and I thought the Auditor General looked like he was confused about what I was talking about, and maybe it was me. But

page 121, note 2, Significant Accounting Policies and Reporting Practices, Employee Future Benefits, Pension Obligations, and (ii) Other Future Benefits is where perhaps my confusion came from. I just wanted you to know where it came from.
Thank you.

The Chair: Thank you.
The chair would like to formally apologize to Mr. Strang. He still had some information to receive in regard to his second question on systems findings, progress, and past recommendations from the Auditor General's report. Correct?

Mr. Strang: That's right.

The Chair: Mr. Hancock, if the department could in writing reply to Mr. Strang's request, we would be very grateful.

Mr. Hancock: We'd certainly be pleased to reply, and we'll also review the record and determine if there are any more comprehensive responses needed in any of the areas that were raised today. We appreciate the opportunity to appear before you.

The Chair: On behalf of the committee we would like to thank you and your staff for your time and your diligence, and we wish you the very best. As we wrap up our meeting, feel free to leave, and thank you again.
Now, item 4, Other Business. I would like to advise the committee that we received a positive response from Capital health to our invitation to meet with the committee on September 12, 2007. Our information is that although some officials may not be able to attend due to other scheduled arrangements, there are others who are available and can attend.
Is there any other business that the members would like to discuss at this time? No? Okay.
Before we move to adjourn, Mr. Dunn, am I correct: are you getting a legal opinion done on who we can and cannot request to come to appear before this Public Accounts Committee?

Mr. Dunn: We are asking our internal counsel to look at the school boards, specifically, as to which ones you would be entitled to invite to your meetings. I believe it's also being done through Parliamentary Counsel.

The Chair: Yes, it's being done through Parliamentary Counsel. Are you going to share that legal opinion with the committee?

Mr. Dunn: We will do that, yes.

The Chair: Interesting. Thank you.
Before we have the motion to adjourn, two weeks from today we are meeting with the Minister of Education. Next week is our constituency week.
Motion to adjourn by Dr. Brown. All in favour?

Hon. Members: Agreed.

The Chair: Thank you. Seeing none opposed, I appreciate your time and patience with me.

[The committee adjourned at 10:04 a.m.]