Legislative Assembly of Alberta

The 27th Legislature
Third Session

Standing Committee
on
Public Accounts

Alberta Health Services

Wednesday, October 27, 2010
8:30 a.m.

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Third Session

Standing Committee on Public Accounts

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

Anderson, Rob, Airdrie-Chestermere (WA)
Benito, Carl, Edmonton-Mill Woods (PC)
Calahasen, Pearl, Lesser Slave Lake (PC)
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Elniski, Doug, Edmonton-Calder (PC)
Fawcett, Kyle, Calgary-North Hill (PC)
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Groeneveld, George, Highwood (PC)
Kang, Darshan S., Calgary-McCall (AL)
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Olson, Verlyn, QC, Wetaskiwin-Camrose (PC)
Sandhu, Peter, Edmonton-Manning (PC)
Swann, Dr. David, Calgary-Mountain View (AL)*
Vandermeer, Tony, Edmonton-Beverly-Clareview (PC)
Xiao, David H., Edmonton-McClung (PC)

* substitution for Harry Chase

Also in Attendance

Pastoor, Bridget Brennan, Lethbridge-East (AL)

Alberta Health Services Participants

Stephen Duckett	President and Chief Executive Officer
Ken Hughes	Chair, Alberta Health Services Board
Chris Mazurkewich	Executive Vice-president and Chief Financial Officer

Auditor General's Office Participants

Merwan Saher	Auditor General
Doug Wylie	Assistant Auditor General
Jeff Sittler	Principal

Support Staff

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8:30 a.m. Wednesday, October 27, 2010

[Mr. MacDonald in the chair]

The Chair: Good morning, everyone. I would like to call the Standing Committee on Public Accounts to order, please. I would like to welcome everyone in attendance, including the students from Grant MacEwan who have joined us this morning at this early hour.

I would advise all our guests that they do not need to operate the microphones as this is taken care of by *Hansard* staff. Please note that the meeting is recorded by *Hansard* and that the audio is streamed live on the Internet.

If we could quickly go around the table and introduce ourselves. We'll start with the vice-chair, please.

Mr. Rodney: Good morning, everyone. Dave Rodney from Calgary-Lougheed.

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

Mr. Benito: Good morning. Carl Benito, MLA, Edmonton-Mill Woods.

Mr. Fawcett: Good morning. Thank you all for coming. Kyle Fawcett, Calgary-North Hill.

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

Ms Calahasen: Pearl Calahasen, Lesser Slave Lake.

Mr. Groeneveld: George Groeneveld, Highwood.

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

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

Mr. Chase: Harry Chase, Calgary-Varsity. Should you need to avail yourself of your own services, we have Dr. Swann here to assist you.

Mr. Mazurkewich: Chris Mazurkewich, executive vice-president and chief financial officer, Alberta Health Services.

Dr. Duckett: Good morning. Stephen Duckett, president and chief executive officer, Alberta Health Services. It's a great pleasure to have the opportunity to appear before you.

Mr. Hughes: Ken Hughes, chair of Alberta Health Services.

Mr. Sittler: Jeff Sittler. I'm a principal with the Auditor General's office.

Mr. Wylie: Good morning. Doug Wylie, Assistant Auditor General.

Mr. Saher: Good morning. Merwan Saher, Auditor General.

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

Mr. Olson: Good morning. Verlyn Olson, Wetaskiwin-Camrose.

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

Mr. Elniski: Good morning. Doug Elniski, Edmonton-Calder.

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

The Chair: Hugh MacDonald, Edmonton-Gold Bar.

We've been joined as well by Mr. Anderson. Good morning, sir.

Mr. Anderson: Good morning. Rob Anderson, Airdrie-Chestermere.

The Chair: Thank you.

To the members: could I have approval of the agenda that was circulated, please? Moved by Mr. Elniski that the agenda for the October 27, 2010, meeting be approved as distributed. All in favour? Seeing none opposed, thank you.

The approval of the minutes for the April 21, 2010, Standing Committee on Public Accounts as distributed. Mr. Dallas. Thank you. Moved by Mr. Dallas that the minutes for the April 21, 2010, Standing Committee on Public Accounts meeting be approved as distributed. All those in favour? Seeing none opposed, thank you very much.

This comes to, of course, our meeting with the officials from Alberta Health Services. The reports that we will be dealing with this morning are the Auditor General of Alberta's April 2010 report, October 2009, and the report from yesterday, October 2010, obviously. We will also, if members are interested, deal with the annual report of the government of Alberta, 2009-10, which includes the consolidated financial statements of our province; the Measuring Up progress report of the government of Alberta business plans; and, of course, the Alberta Health Services annual report 2009-10, which is also included in the Health and Wellness annual report, which was released a couple of weeks ago.

I would now invite Mr. Hughes and/or Dr. Duckett to make a brief opening statement to the members of the committee on behalf of Alberta Health Services.

Mr. Hughes, please.

Mr. Hughes: Thank you, Mr. Chairman. I am delighted to be here with you today. I look forward to the discussion. I'd also like to say a special welcome to the students from the Grant MacEwan University program. They're media in training. Clearly, their instructor was wise enough to invite them to this exciting session, and we wish them well in their learnings. They play an important role, obviously, in our life as a democracy.

I'd also like to draw to people's attention that right next door across the hall is a flu clinic should you need a shot, and I encourage everybody to get one.

Well, Mr. Chairman, 2009-10 was a year of extraordinary challenges and unprecedented promise. It was also a year of building a foundation for our future. Early in 2009 we made the difficult decisions necessary to realize the financial benefits of consolidating the former health regions and other entities, 12 of them, into one single health system. As a result, we achieved $500 million in savings by reducing duplication and waste, managing vacancies, back office restructuring in finance and human resources, corporate services, support services, information technology, and leveraging the buying power of Alberta Health Services, which is substantial.

These were not one-time savings; these continue. We reduced the rate of increase in expenditures from 12 per cent in the prior year,

year over year, to 8 per cent in the year 2009-10 compared to the prior year, moving us deliberately and decisively toward a more sustainable health system. In plain language, there were more dollars going to patient care.

At the same time, last year we opened 83 more hospital beds and 381 more continuing care beds. We added more addiction treatment, palliative, hospice, and other beds for a total of 591 more beds in Alberta in that fiscal year of 2009-10, all in a time of unprecedented funding pressures. It wasn't easy, but we were able to accomplish those added beds in a time of great difficulty.

Then early in 2010 the government of Alberta announced a five-year funding plan that included a 6 per cent increase in each of the next three years and a 4 and a half per cent increase for each of the remaining two years, the first long-term funding commitment of any provincial government in Canada. Alberta Health and Wellness also provided one-time funding of $343 million to eliminate the accumulated deficit as of March 31, 2010.

We put that commitment to work immediately. In February we announced the first of two surgical blitzes. An $8 million, six-week ramp-up through March was to add 2,230 more surgeries and nonsurgical procedures that have long wait-lists such as urgent cancer care; urgent cancer surgery; orthopaedic surgery, including hip and knee replacements; gynecology; neurosurgery; heart surgery; and cataract surgery. The first blitz also included a planned 3,500 more MRI and CT scans as well. Well, we exceeded those targets in terms of actual number of surgeries and procedures completed, with 2,252 surgeries and procedures and 3,600 MRIs and CTs completed. Incidentally, we continue the ramp-up. In a second blitz through the spring and summer of this year another 1,439 surgeries and procedures were performed.

Backstopped by the five-year funding plan, we also announced in February a renewed commitment to reduce emergency room wait times. These are innovative and creative responses. We are doing things in Alberta for the first time, in many respects, in how we're responding to the emergency room, emergency department challenges. That included the opening of a 12-bed medical assessment unit at the Rockyview general hospital in Calgary, which is the first time a medical assessment unit has been used in this province. It was followed by a virtual medical assessment unit at the Royal Alex hospital in Edmonton and a 21-bed medical assessment unit at the Royal Alex that opened just yesterday. Instead of waiting in emergency, patients who require admission to hospital are transferred to an MAU, a medical assessment unit. That's where treatment by non emergency room physicians continues to determine and to begin the patient's ongoing care. Opening these new MAU beds takes pressure off the emergency rooms by freeing up emergency beds, physicians, and other care providers.

Well, what does the funding commitment do for patients today? Let's look at the most recently announced initiatives, all tied back to that long-term funding commitment. It means patients will be able to call Health Link to get information on where wait times are shortest. It's the first time in Alberta that that's been done. It means patients will be able to get more information on the urgent care options they have as a possible alternative to emergency. It means upgrading diagnostic imaging equipment where needed so that clinicians can provide the prompt service that patients need. It means giving physicians the tools they need to get the information they need to care for their patients more quickly. Will it happen overnight? No. But it is under way now, and it began with the foundation we laid in the fiscal year that we're discussing here today, Mr. Chairman, 2009-10.

I would simply note parenthetically, Mr. Chairman, that as a result of these long-term commitments and our long-term planning we expect to open more than three times the number of continuing care beds this year, the year that we're currently in, than we did last year, so you can see that a very assertive ramp-up is in place in this respect. None of this happens without a long lead time and planning.

8:40

The five-year funding plan in 2009-10 made it possible in this year's budget to set a target to add at least a thousand more continuing care beds. In the first six months of this current budget year alone we have opened 800 community care beds, more than double the number that were opened in all of 2009-10; that number was 381. By the way, last week we increased this year's target from a thousand to 1,373 beds by the end of this fiscal year. We'll add 250 more hospital and community beds from September to December this year as part of that ramp-up in order to reduce emergency room and emergency department pressures. Again, all of this ties back directly to the five-year plan starting in 2009-10.

While reducing emergency room wait times and adding new continuing care beds are our top priorities, there were many other achievements as well in 2009-10. As noted in our annual report, time and travel can make regular breast cancer screenings very difficult to schedule, especially for women in more remote areas of the province. To improve access, two digital mammography mobile units now visit about a hundred communities. This is a real augmentation of access, and it serves about 24,000 women per annum.

A 13-bed unit at the south Edmonton facility of our subsidiary Capital Care supports a program for adults recovering from orthopaedic surgery or bone surgery to get home safer and sooner. Since the program began, patients have on average returned home eight days sooner. That is very material.

In 2009 the Centennial Centre for Mental Health and Brain Injury in Ponoka opened its 25-bed concurrent disorder unit. The unit represents important progress in the integration of addiction and mental health services across the province. According to a study by the Canadian Mental Health Association 30 per cent of adults with mental illnesses also have a substance abuse problem. Yet in the past individuals with severe and persistent mental illness often have had difficulty accessing and remaining engaged in addiction treatment while people with an addiction issue were often excluded from receiving appropriate mental health services. These and many other examples of significant progress are captured in our annual report.

Finally, I'd respectfully ask the committee to remember that 2009-10 was the first year that Alberta Health Services existed as a single organization. Much of the work has been done since then, accelerated by the announcement of the five-year funding plan. We acknowledge that there is much more work to do, but at the same time we think it's important to commend the men and women on the front lines of Alberta Health Services for an extraordinary achievement in a remarkably short time. The 90,000-strong Alberta Health Services team is determined to meet the challenges that we face head-on with a deep commitment to our fellow citizens, persistence, and professionalism.

We look forward to updating you on our progress and responding to your questions. Thank you.

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

Mr. Saher, do you have any comments at this time, please?

Mr. Saher: Yes. Thank you. Doug Wylie, the Assistant Auditor General, will read our brief comments into the record.

Mr. Wylie: Thank you, Mr. Chairman. The results of our 2009 year's audit work at Alberta Health Services are included on pages 256 to 282 of our October 2009 report. We did not have any recommendations to Alberta Health Services in our October 2010 report. The results of our current year's audit work are included on pages 164 to page 171 of our October report. We issued unqualified auditors' opinions on the 2010 and 2009 Alberta Health Services consolidated financial statements. I'll briefly highlight our recent recommendations.

In October 2009 we made 11 recommendations to Alberta Health Services. We followed up on the 2009 recommendations for executive termination payments, budget approval, and compliance with investment policy in 2010 and found that these recommendations had been implemented by Alberta Health Services.

In 2010 we also followed up on an October 2006 report recommendation to monitor the service provider compliance and performance and found that Alberta Health Services had implemented this recommendation as well.

In the current year we made five recommendations. In our first recommendation, on page 164 of the October 2010 report, we recommended Alberta Health Services prepare and implement a formal transition plan for the organization's finance operations. This recommendation, when coupled with our last recommendation on page 169, is intended to reduce the risk of significant errors occurring in financial processing.

Our second recommendation, on page 166, concerns the construction of Villa Caritas. We recommended that Alberta Health Services ensure that funding agreements are signed prior to commencement of construction of capital projects.

Our third recommendation, Mr. Chairman, appears on page 167. We recommended that Alberta Health Services assess the effectiveness of its arrangements with the liability and property insurance plan as a risk management tool and assess the resulting accounting implications.

Our fourth recommendation is on page 168. We recommended that Alberta Health Services implement consistent and efficient accounting processes for externally restricted contributions to assure the Alberta Health Services Board that it is complying with the restrictions attached to those contributions.

Our last recommendation is located on page 169, and that is that we repeated our recommendation that Alberta Health Services improve its year-end financial reporting processes by improving processes to identify and resolve key accounting risks and reporting issues on a timely basis.

Our list of prior year recommendations for Alberta Health Services begins on page 219 of our most recent October 2010 report.

In accordance with our practice, Mr. Chairman, all recommendations will be followed up and reported on in future public reports.

Thank you.

The Chair: Thank you, Mr. Wylie.

We will immediately proceed to questions. We'll start this morning with David Swann, followed by Mr. Benito.

Dr. Swann: Thank you very much, Mr. Chairman. Let me begin by thanking the Auditor General for his timely report – some might see it as rather untimely, but those of us who are on the opposite side do appreciate the service – and to thank the Alberta Health Services Board for the work they've done in a difficult year, acknowledging that they have met the recommendations of the Auditor General in the past year. That deserves to be acknowledged.

Page 167 of the October 2010 Auditor General's report shows that Alberta Health Services, an organization that is supposed to live within its budget, had to go hat in hand to Alberta Health and Wellness for $40 million to complete Villa Caritas, all this because there was no written contract signed prior to construction. My first question: did Alberta Health Services receive the $40 million requested, and was the $40 million the total tab for Villa Caritas?

Dr. Duckett: Could I just start by thanking you, Dr. Swann, for that question. The reason that we had to ask for additional funding for Villa Caritas was not to do with the fact that we had not signed a contract or Capital health had not signed a contract with Covenant, or Caritas, as it then was, but rather because there was a change in the purpose. Because there was a change in the purpose of Villa Caritas, the funding streams that would have applied for a continuing care facility no longer applied for a geriatric mental health facility, so we had to seek additional sources of funding. In terms of the total sum involved, I think the $40 million was indeed the total sum involved.

Dr. Swann: The Auditor General also stated that because the Villa Caritas project has been badly managed, Alberta Health Services may have to delay or cancel other capital projects. Is this the reason why Edmonton and Calgary are still waiting to hear about the capital planning for their facilities?

Dr. Duckett: I can't recall seeing that the Auditor General said that the project was badly managed. I'm looking again through here, and I don't recall seeing that in there. In fact, it's not there.

Obviously, the government determines the timing of the capital plan, and it hasn't been released yet.

The Chair: Thank you.

Mr. Saher: Mr. Chair, maybe I should just supplement that for clarity. I would agree with Alberta Health Services that I didn't and the report doesn't say that the project was badly managed. Our issue is that this project proceeded without all of the funding agreements that we believe should have been in place being in place. One might infer that that means badly managed, but our comment was not that the whole renovation activity, that the whole process was badly managed. The element of bad management was the failure to have all proper funding agreements in place at the beginning and as the project proceeded and its scope changed along the way.

8:50

The Chair: Thank you.

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

Mr. Benito: Thank you very much, Mr. Chairman. I'd like to thank all the guests from Alberta Health Services. This is one of our most important programs that we are doing in our committee these days.

One of the improvements Alberta Health Services is doing is identifying inefficiencies and improving them. I'd like to reference this to the budget we had in 1993 and '94, wherein the Alberta health services' budget was 26 per cent, and Education was more or less 26 per cent as well. The prediction for the 2012-2013 budget is around 42 per cent, and Education is 23 per cent. The prediction for another two decades: Alberta Health Services' budget is around 58 to 60 per cent – you can correct me if I'm wrong – and Education is around 20 per cent. Is this what Albertans want, and can you reference these inefficiencies to, you know, the kind of direction our Alberta Health Services is going?

Mr. Hughes: Mr. Chairman, the question deals largely with the tracking of expenditure in health care relative to other expenditures.

What we have seen historically is very substantial growth in health care expenditures. Every province across Canada is dealing with the same issues. We have taken, I think, in Alberta a slightly different tack than other provinces in that we have collectively as a community, the government and Alberta Health Services, established a five-year funding plan. One cannot overestimate the importance of stability in a large organization that is delivering health care services to people that deliver life-and-death services. One cannot overestimate how important that is. This was an absolutely critical initiative, to have five-year funding.

You know, historically the growth was 10 per cent per annum roughly over the last five to 10 years. In the year prior to the year that we're discussing here today, the growth was 12 per cent. The growth within the year 2009-10 was 8 per cent. The next few years are going to be 6, 6, 6, 4 and a half, 4 and half per cent. What we're doing is bringing to bear some financial discipline in an organization so that every dollar we have is used as well as possible as close to the front line as we possibly can.

Mr. Benito: My follow-up question, Mr. Chairman, is with reference to inefficiencies as well. Checking the Alberta Health Services website, well, going back to the previous organizational set-up of health services in Alberta, there are so many regions – you know, we have Calgary, Edmonton, and other areas – and there are so many presidents and accounts payable departments. Looking at the Alberta health website right now, there are so many vice-presidents at the moment also. Could you comment on this information with reference to inefficiencies?

Mr. Hughes: Sure. Let me start with that. In the 12 previous organizations the number was about 145 vice-presidents throughout Alberta in the 12 predecessor organizations. Our number now is 79, if I'm correct – right? – so we're down very substantially. That just reflects the fact that you only need one CEO, you only need one chief medical officer, you know, those kinds of things. This has been a source of a lot of savings for Alberta by streamlining the administration of the delivery of health care.

I add to that the advantage on the procurement side to be able to say to suppliers, "Okay, now, we want enough of drug X for this many people," as opposed to one-twelfth of that or one-eighth of that or one-third of that previously. That gives you buying power. As a large organization you can take advantage of that as a buyer, and you ensure that you get a better price for your users. Those are some of the savings.

I'd like to turn it over to Dr. Duckett to make additional comments with respect to savings as well.

Dr. Duckett: Thank you very much. I'd just like to correct the number. It's 144 vice-presidents and above in the predecessor entities. But as Mr. Hughes points out, there are a number of examples of that. There is only one CEO of Alberta Health Services versus 12 CEOs of the previous organization. My salary is in the public record as $740,000. I took home $744,000 last year. In the last year prior to amalgamation the CEOs took home $6.2 million of take-home pay.

Another example: we have one chief financial officer. There were 12 chief financial officers before. In terms of the top three levels of the organization, for example, we spent 16 and a half million dollars last year on the salaries of the top three levels of the organization, the vice-presidents and above, essentially. The predecessor entities spent $57 million on those top three levels of vice-presidents, and so on.

I won't say it's their fault, but each of them needed a chief financial officer. Each of them needed someone in charge of corporate services. Each of them had a chief medical officer, and so on, and so on, and so on. In the end, it added up to 57 and a half million dollars of those senior management staff. As Mr. Hughes pointed out, there are other efficiency savings that we're reaping the benefits of right now.

The Chair: Thank you for that, Dr. Duckett.

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

The Chair: We will proceed to Mr. Chase, followed by Mr. Elniski.

Mr. Chase: Thank you, Mr. Chair. I'd like to quickly offer three thank yous. I'd like to thank Merwan Saher and his team for their excellent AG report and the smooth transition from predecessor Fred Dunn.

My second thank you is to my committee colleagues, who unanimously agreed to today's meeting with Alberta Health Services.

Last but not least, thank you to Messrs. Hughes, Duckett, and Mazurkewich for providing our committee today with oral answers and, where necessary, written follow-ups.

My first question comes from page 168 of the October 2010 Auditor General's report, which shows that there were many errors related to externally restricted deferred contributions, so many errors that $163 million in adjustments had to be made to the financial statements. My first question, therefore: how many of the total of 7,200 projects funded through deferred externally restricted contributions had errors in their accounting? Will we please receive a list of all of those projects?

Dr. Duckett: The Auditor General raised a very good point in making that recommendation, and it is something that we in Alberta Health Services are addressing. We get lots and lots of externally funded contributions. Sometimes you might get a grant for $2 million or $5 million, but it is subdivided into $100,000 for this, $200,000 for that, and so on. The management costs of tracking at that detailed level, in my view, outweigh the benefit of the grant in some cases.

What have we done in response to the Auditor General's recommendations already? One of the things we've done is to say that we have a delegation of authority within Alberta Health Service which allows people in the organization to make decisions up to certain amounts. In the normal course of events people like Chris, for example, can sign to receive these grants. What I have said is that, if the grant is very, very small, it will come to my office for me to sign personally. That is, I've sort of reversed the delegations because I want to look carefully at all the grants which have these detailed controls, which almost inevitably mean, if you're juggling quite small amounts, you're going to end up with some mistakes.

The second point I'd make is that many of those were about assigning money between the regional entities. So at the end of the day it made no difference to the Alberta Health Services bottom line, but because in the predecessor entities we had to have 12 different organizations and one regional health authority might have been the recipient for multiples, there were intra Alberta Health Services transfer problems. Whether all of that is that I can't say, but there are a lot of them. I can't answer your question about how many of them, and I'm not sure that it would be possible.

Mr. Mazurkewich: We'd have to come back to you. I don't know the answer off the top of my head on that question.

Mr. Chase: No. Nor did I expect you to have it. It wasn't sort of an ambush question, but I would like the committee to receive the accounting details I've asked for.

My follow-up: of all the projects affected, did this accounting error affect the work being done by the projects?

9:00

Dr. Duckett: No.

Mr. Chase: Thank you.

The Chair: Thank you.
Mr. Elniski, please, followed by Mr. Kang.

Dr. Duckett: Could we make an estimate of how long it would take us to answer that question? I see the poor person who's got responsibility to do that shaking his head. Could I crave the committee's indulgence? I know it's an important issue, but if it takes us a lot of time – there are a lot of projects to review – I would appreciate some indulgence on that.

The Chair: Okay. Agreed?

Hon. Members: Agreed.

The Chair: Thank you.
Please proceed.

Mr. Elniski: Thank you, Mr. Chairman. Good morning, gentlemen. It's good to have you here today. I'd like to specifically make reference to page 13, cash equivalents and investments in the notes to the consolidated financial statements. I'll maybe give you a second or two to get there, Chris, and take a look at it. I have a couple of questions for you with regard to this particular page. I'm very interested in the cash holdings of arm's-length entities, and I notice that in your particular organization you've gone from roughly $3 billion in cash holdings to this year down to $2 billion. My first question with regard to this is: what's the target for this particular activity, and secondly, what is your investment strategy around it? If you could, please, Chris.

Mr. Mazurkewich: What Alberta Health Services has done is that we've actually consolidated all of our investments under one investment manager. We redeveloped investment policies and redeveloped our monitoring of investments. I think that's all been transitioned and was effective about May of 2010.

The second piece is that there are two elements with the cash. One is the restricted grants that we just talked about, and one of those portions of restricted grants has to do with capital grants. As we expend the money on buildings, we consume that side of it. We've done cash forecasts and cash-flow forecasts, looking towards: "How much do we need to operate? How much can we invest? When do we have to have it done?" We now have that system in place as well, so we're a lot more comfortable this year than last year.

Mr. Elniski: Wonderful. Thank you.

My second question on that. As an aside, having been involved at some arm's length with AIMCo and looking at the rate of return they've produced on some of the investments we deal with them on, I'd like to talk a little bit for a moment about the qualifications of your financial managers. I can't find them anywhere in here, and I note that the Auditor General makes a fairly specific and somewhat alarming commentary on page 166 with respect to the corporate knowledge of financial operations since the merger. If I could have some discussion for a moment, briefly, about what the qualifications are of the financial manager for the $2 billion fund, I would really appreciate that.

Mr. Hughes: Let me just start, and then I'll turn it over to Chris. From a governance perspective – and I think this question goes to some extent to the governance and oversight of investments – the board early on recognized that there were many pools of holdings throughout the previous legacy organizations and that it was critical that we deal with that in a strategic way. This work was led by the Audit and Finance Committee of the board, led by Chair Don Sieben. That's just one example of the work that they do.

What we did was take a look at that, realizing that clearly, like everything else, scale is important here and also managing a risk and the accountability of the board for overseeing risk within the organization. So we took deliberate steps to ensure, first of all, that we got a handle on all of those resources, had a clear understanding of where they were at, and then went to market to secure advisory services. One of those that we considered was AIMCo. We chose not to go with AIMCo because AIMCo has a different long-term investment strategy and risk profile than what we felt was appropriate for the relatively smaller resources that Alberta Health Services has in place. Our strategy is one that would be characterized as more conservative than AIMCo.

Mr. Mazurkewich: We also chatted with AIMCo, and they actually helped provide us with advice, so they were very co-operative with us. We also looked at government investment policies and tried to align ourselves with those. So that's what we've done. That's why we've brought in the experts: Phillips, Hager & North.

Mr. Elniski: Wonderful. Thank you very much.

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

Mr. Kang: Thank you, Mr. Chair. We keep on hearing that lots of money is being saved and lots of money is being put back into health care, you know, yet things are not improving. They are taking a turn for the worse; every day we hear that. On page 12 of the Alberta Health Services operating budget and business plan it shows that $121 million is actually expected to be saved in the 2010-11 fiscal year through vacancy management and administrative restructuring. My question is: how many front-line nursing positions remain vacant due to this program? Have those vacancies been carried forward into the current fiscal year? How are we improving things by cutting back and putting money back into the system?

Mr. Hughes: Sure. Thank you.
Dr. Duckett.

Dr. Duckett: Thank you very much for the question. We did make some savings because of the vacancy management. The vacancy management scheme was put in place to help us bring down the level of expenditure. As Mr. Hughes has mentioned, the growth rate in expenditure previously was 12 per cent. We brought it down significantly, to an increase of 8 per cent last year. Part of that was being very, very tight on recruitment, being very, very tight on scrutinizing every position that became vacant in the organization.

We achieved significant savings. Even so, even scrutinizing in detail every position that became vacant, we still increased our staffing in Alberta Health Services last year by about 2 per cent; in total, registered nurses, licensed practising nurses, and so on, also increased. So even though we were very, very tight on staffing approvals, we actually increased the employment of nurses in total in Alberta Health Services last year.

We've now signed an agreement, the collective agreement with the United Nurses of Alberta, and one of the provisions of that is that there will be no reduction in registered nurses over the course of the three-year agreement and that we will recruit 70 per cent of all nurses who graduate from every university in Alberta, which is an historic recruitment rate. We obviously had a turnover of nursing staff in Alberta Health Services, so there are vacancies now, but we are committed to having no reduction in total employment of nurses this year and over the next three years.

Mr. Kang: My supplemental. From personal experience – I was in the hospital – I heard that we are understaffed. That's what the staff was telling me. Here we hear that we hired 2 per cent more nurses. I don't know what kind of effect hiring more nurses is having when the service is suffering.

Another question is: how many of the vacant positions that were formerly held by RNs in 2009-10 will now be filled by LPNs? Or will they improve the service by hiring more LPNs?

Dr. Duckett: We are committed to ensuring that every person in Alberta Health Services works to their full scope of practice; that is, every LPN works to the level that the LPN has been trained at, every RN works to the level that an RN has been trained at, and every doctor works to the level that a doctor has been trained at. Over time, because the education of LPNs now is much better than it was 20 years ago, LPNs now can do more than they could do 20 years ago.

Certainly, it is the policy of Alberta Health Services to increase the use of LPNs, to increase the use of health care aides across the province. However, I'll come back to what we said to the United Nurses of Alberta. We have said that even though we want to increase the number of LPNs, we will not reduce at all the number of RNs employed in health care in Alberta. There will be no reduction in the number of registered nurses. What we are talking about is increasing the care provided, increasing the number of LPNs, not reducing the number of RNs.

The Chair: Thank you.

Mr. Olson: Thank you very much for being here today to help us understand some of this information. I appreciate the comments about savings that have been achieved by virtue of eliminating a multiplicity of boards and administrations, but I'm still trying to get my head around some of these things. For example, I look at the consolidated statement of operations, page 78. Referring to the administration costs, I see that there is actually a $66 million increase from the 2009 actual to the 2010 actual. I wonder if you could just talk a little bit about what those are?

9:10

Dr. Duckett: It is partly due to bringing in new, additional services into Alberta Health Services. Some items that were previously not incorporated in our areas of responsibility are now incorporated into our areas of responsibility. For example, we had an increase because of the way pensions were handled. Moving from what was called the public service pension plan to the local authorities pension plan increased our recorded expenditure by $26 million. There was an increase in the costs of flexible benefits provided to Calgary's in-scope staff. As I said, the single biggest item was the $26 million by the transfer of the public service pension plan to the local authorities pension plan, but there were other minor items as well.

Mr. Olson: Thank you. You actually answered my supplemental question as well, which was the cost of the transfer into the other pension plan, so thank you.

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

Mr. Anderson, please, followed by Mr. Fawcett.

Mr. Anderson: Okay. It's been a tough year, gentlemen. I want you to know that although I want to see your board disbanded and the Wildrose wants to see your board disbanded, I don't blame you. I think you've been given an impossible task; I really do. I think that to ask a massive centralized bureaucracy to manage what should be a locally controlled administered service is simply not doable. I appreciate that you're making the effort, so please don't take the fact that I want your board gone personally.

What I'd like to talk about is your efficiently run health care system here. You just talked about that with the previous two MLAs. I'm really concerned, and I think we all are here, and I'm sure you are, too. In the last year, according to your own numbers, you've had a 54 per cent increase in waiting times for the emergency departments in the Calgary area. Dr. Innes, in charge of that area, has said that things have never been as bad as they are today.

I understand that you're trying to be more efficient. I understand that there are fewer VPs. But part of efficiency is getting more bang for your dollar, and a 54 per cent increase in waiting times is not efficient; it's completely inefficient. I want to know what you're doing to address that because that's the most important thing. People are dying, literally, as we've seen in the last few days with the reports that have emerged. I understand that you've only been at it for a year and a half; I get that. But what are you doing right now to make sure that this gets taken care of right now?

Mr. Rodney: Sorry. Just to clarify – and I know that Mr. Anderson knows this – we are looking at 2009-2010 numbers only, not current policy. That goes for all of our members on all sides of the House, right? What I heard was: what are you doing now? I wonder if you want to clarify so they can address it as the mandate of this committee is last year's numbers only.

Dr. Duckett: I'm happy to try and answer that.

Mr. Anderson: I appreciate that. Thank you.

Dr. Duckett: Last year and historically in this province a large number of beds in our acute-care facilities were taken up by alternate level of care patients. These are patients whose acute care has finished, so they no longer need to be accommodated in an acute-care facility but could equally well be accommodated in a continuing care facility. So starting last year, we said that as an efficiency strategy, rather than spending the amount of money you spend in looking after these people in an acute-care facility, which is not the right place for them to be looked after, you should look after these people in a continuing care facility, which is, one, most importantly, better for them; that is, quieter and staffed by people who are interested in and committed to long-term care. Also, it is better for the taxpayer because it is cheaper for us to look after them in that circumstance. So the policy that we pursued last year was to

actually commit towards an expansion of continuing care facilities to address that problem. By reducing the number of alternate level of care patients, you then free up beds to move people out of emergency departments.

Mr. Anderson: Okay. A second question?

The Chair: Your second question. Please proceed, but the hon. member is correct; we are dealing with the fiscal year 2009-10. We're not dealing with government policy or what's going to happen in the future. Please proceed, Mr. Anderson.

Mr. Anderson: Okay. I thought that's what we were talking about: efficiencies and whether there's been performance for the money given.

Anyway, I'll look at recommendation 20 from this year's Auditor General report on page 166. It talks about AHS needing to ensure that funding agreements are signed prior to commencement of construction of capital projects and are formally amended when there are significant changes to a project's scope. This sounds very familiar, eerily familiar to a court case that you were just involved in. I want to talk about this particular case, but on a go-forward basis, given what just happened with Networc Health, given what is in the Auditor General's report, what just happened here, what are you doing to make sure that you sign contracts before you decide to build buildings or materially change agreements with health care providers and with hospitals? That's not professional.

Mr. Hughes: Let me start with that, and then I'll turn it over to Dr. Duckett and Chris Mazurkewich. We inherited a wide range of practices in previous organizations. What we have done is that we have streamlined those practices and put in place a very professional approach to contracting and to working with providers. That started early on, even in the transition year, and is overseen primarily by the Audit and Finance Committee of the board working with Finance. I couldn't agree more that that's critically important.

First of all, look, you know, I grew up in rural Alberta, where, as the hon. member for High River and area knows, Okotoks-High River, people have a long-standing expectation that you're going to deal with people in a straightforward manner and that you are going to conduct business in a straightforward manner. That's just the Alberta way, and that's how we intend to do that. In addition to that, we're going to make sure it's well papered as well.

Dr. Duckett: Thank you. I think this shows one of the benefits of the consolidation of Alberta Health Services. The particular instance referred to by the Auditor General was the result of a public tender process conducted by Capital health where Covenant Health, which as of then was Caritas, was selected by Capital health to build this facility. For various reasons Capital health did not sign a contract. There are all sorts of reasons why that may have been the case. I would agree with the Auditor General that it is an undesirable practice.

What have we done as a result? As I said, one of the benefits of Alberta Health Services is that we have consolidated our contracting group. We now have a specialist contract group who works with the lawyers to actually do what is just good business practice; that is, before you commit to the construction of a building, there ought to be a contract. That is what Alberta Health Services does, and I agree that it's quite improper for a contract not to have been signed.

The Chair: Thank you.

Mr. Fawcett, please, followed by David Swann.

Mr. Fawcett: Thank you very much, Mr. Chair. My question that I had originally planned to ask has actually already been asked. But I'm curious as to what your budgeting process looks like. Obviously, you know, you mentioned in your opening comments the money that was provided to you to cover your accumulated operating deficit and how that sort of will allow you to move forward with not running a deficit. Have you also changed any practices in your budgeting process as you've learned and merged that will help you, I guess, target a more accurate number in your expenditures over the year so that we do not run into a position where there are future operating deficits being run by Alberta Health Services?

9:20

Mr. Hughes: Let me start with that, and then I'll turn it over to Dr. Duckett. Clearly, one of the advantages of a five-year funding plan where you have a commitment from the province of Alberta over the full five years as to what they're going to provide for funds actually allows you to budget and plan extremely well. Think of the old world where people would wait until they found out what was in the budget, and then they would put together their budget. By that time it was already well into the year. They were already spending their money.

It's my view, actually, that discipline is extremely important and useful for planning and for the expenditure of resources. We're now able to do all of the planning and the budget and have that approved by the board prior to the beginning of the fiscal year, and that will be the practice going forward.

Dr. Duckett.

Dr. Duckett: Thank you for the opportunity to talk about some of the challenges that we're facing as part of the merger. You'll appreciate that in merging 12 predecessor organizations, we have 12 separate general ledger systems, 12 separate payroll systems, 12 separate procurement systems, so the task of monitoring and for a manager down the line to monitor when they might be having to monitor with staff from 12 different payroll systems is, of course, quite difficult. So we have established processes to bring those things together.

I'm required to report to the Audit and Finance Committee on a monthly basis about how we are tracking, so we've developed processes that do that. The Audit and Finance Committee has said to us: if there is a significant variance, you need to explain to us why. The board has made quite clear to me that we have to balance the budget, so we are monitoring very regularly and discussing very regularly what we might do in terms of corrective action. So I am confident that we will come in on budget this year, for example.

You talked about the budgeting process in Alberta Health Services. As it happens, the way we work this year builds on what we did last year. Monday of this week I had my first budget meeting with one of the budgetary units within the organization. The process is that I together with Chris, the chief finance officer, meet with every significant budget unit within the organization around now – we started on Monday; I've got two more this afternoon, for example – together with the vice-president in charge of financial planning.

We have a set format. The set format actually builds on what we did last year. We're getting better all the time, as they say. We review the performance: how they're going on waiting times, how they're going or whatever on the core business of the organization, where they think they'll be on year-to-date and year-end, what their forecast year-end position is so that we can take corrective action now if we need to, and then forecast what the issues are for next year. I signal them to what my expectations are for next year in terms of what savings I might be looking for from them, and also they bring forward what their pressures are.

We've got a process that is going on right now so that we can take the budget to the Audit and Finance Committee in the December-January period so it would get to the board in the February period so we can actually issue the budgets on the first of April. As Mr. Hughes said, we're able to do that because we know now what our budget is next year.

The Chair: Okay. Thank you.

Mr. Fawcett: I just want to say thank you for all the good work that you do. I have no further questions.

The Chair: Okay. The chair would like to note that the Auditor's report from yesterday on page 165 acknowledges that the budget last year was amended three times: in December 2009, April 2010, and May 2010 as well.

We'll move on to Dr. Swann, followed by Mr. Dallas.

Dr. Swann: Well, thank you very much, Mr. Chairman. I'm not satisfied with the answers on Villa Caritas. A project that was $12 million to $14 million for long-term care in its initial description – presumably some of those long-term care people were psychogeriatric – somehow transformed into an over $50 million project, completely psychogeriatric. Can you explain the change that occurred?

Dr. Duckett: There was only a marginal increase in the total cost of the project.

Mr. Mazurkewich: The original funding was $12 million. However, the cost estimates were at $43 million, and then there was an additional $8 million to convert it over: $5 million for construction and $3 million for equipment, roughly.

Dr. Duckett: Yeah. There was another funding source when it was a seniors' facility. As Mr. Mazurkewich said, the difference is only $8 million on the project because of the changed function.

You're quite right that most of the residents in Villa Caritas, as it was originally purposed, would have been people with dementia or other psychogeriatric conditions. So what we have done is repurpose it more directly to people with geriatric mental illness.

Dr. Swann: For a huge increase in costs and a loss of long-term care beds net. How do you rationalize that?

Dr. Duckett: There was no net loss of nursing home beds at all.

Dr. Swann: These were moved from Alberta Hospital Edmonton, no?

Dr. Duckett: There's an increase in the number of beds. At Alberta Hospital Edmonton there are 106 psychogeriatric beds. At Villa Caritas there are 150 psychogeriatric beds, so it's a 44-bed net increase in the system on top of the 501 additional continuing care beds that we're putting into the Edmonton zone this year. So there is a significant increase occurring in the Edmonton zone this year. Of that 501 already 177 have been opened, so Villa Caritas is only one component of our strategy.

Dr. Swann: Could you send me some literature on that?

Dr. Duckett: Yes.

Dr. Swann: Could I follow up with another question, Mr. Chairman?

The Chair: No. That's two questions. You'll have to wait your turn like others.

Mr. Dallas, please, followed by Mr. Chase.

Mr. Dallas: Thank you, Mr. Chair, and thank you, gentlemen, for joining us this morning. Last year we were talking about an accumulated deficit of $1.2 billion, and I know that in the end the deficit was covered. I'm looking at page 79, consolidated statement of financial position, and down on the net asset line there it shows the accumulated deficit at $527.235 million. I'm wondering if you can explain why that number is not the same number that we were batting around seemingly last year.

Mr. Hughes: Some of it has to do with timing. I'll ask Chris Mazurkewich or Dr. Duckett to give the specific answer on that. But it depends upon the year in which funds were actually received.

Mr. Mazurkewich: There are two factors to it. One is that the government gave us some one-time funding to reduce the cumulative deficit of $343 million plus H1N1 costs of approximately $59 million of funding as well as some additional capital dollars of $83 million. Against those we also had some of the savings that we've been talking about, and that's what brought the projected deficit down to what was actually recorded.

Mr. Dallas: Okay. In the same vein now I'm looking at page 93, which is actually a note, note 7, in the statements. At the bottom of that, basically, what they're summing up are the total funded H1N1 costs. Again, the numbers that we were discussing last year, which I think is a cost to Alberta Health and Wellness and ultimately delivered by Alberta Health Services, were significantly more than the reported costs of $58.7 million. I wonder if you can speak to that.

9:30

Dr. Duckett: Part of the answer is that we estimated, I think, the H1N1 costs of being around $116 million, $120 million or so. That was because we assumed that there was going to be a third wave. There was a first wave back in 2009, a second wave in late 2009, and then we assumed that there was going to be a third wave. The third wave essentially didn't materialize to any great extent, so we didn't incur the costs that we had projected. So the $58.7 million ended up as the total actual costs.

Mr. Dallas: Thank you.

The Chair: Thank you very much.

Mr. Chase, please, followed by Ms Calahasen.

Mr. Chase: Thank you. As a member of Public Accounts my greatest concern is expressed by the Auditor General on page 169 of his 2010 report, where he states that Alberta Health Services could not provide accurate financial statements because so many staff decided to leave. Therefore, my first question – and, again, keep in mind that I'm not expecting an answer on the spot, but I am looking for the committee to receive as expedient a follow-up as possible. What is the list of the $59 million for capital contributions that were recorded as receivable but not confirmed by Alberta Health and Wellness? If you'd like to begin the explanation, that's great.

Dr. Duckett: Yeah. The first point, I'd say, is this: it is important to remember that despite the difficulties we had in completing the '09-10 accounts, they were completed on time, and the Auditor General gave us a clean bill of health. In terms of our accounting to the people of Alberta: one, the Auditor General said we've got a clean bill of health, and two, we produced it on time. So despite the difficulties that Alberta Health Services had and despite our opportunities for improvement: on time and a good result.

In terms of the $59 million of capital contributions I don't think we have that information here, so I will have to provide it to you later.

Mr. Chase: Thank you. My follow-up question. The Auditor General only provides an explanation for $191 million of the total $311 million in errors that were made. What are the other errors that amounted to the remaining $120 million that was unaccounted for?

Dr. Duckett: Don't forget that an audit is to some extent a co-operative process, and some of these errors would have been found by Alberta Health Services, as the Auditor General has acknowledged. The Auditor General has identified the most significant, but we could, if you wish, provide a list of the others in descending order of magnitude.

Mr. Chase: That would be appreciated. Thank you.

The Chair: Thank you very much. If all that information that's coming forward, Dr. Duckett, could be sent to the clerk, the clerk will distribute it to all members. That would be terrific.

We'll move on. Ms Calahasen, please, followed by Ms Pastoor.

Ms Calahasen: Thank you very much. Welcome, first of all. Good to see you again. I have so many questions, but I'm going to try to stick with only two. Darn.

My first question, then, has to do with what's topical today, and that has to do with emergency department visits. You have on page 17 identified approximately 1.9 million emergency department visits in acute care. Then I see that you have a number of areas where you are trying to do some accomplishments – on page 9 "Emergency Department Reduces Wait Times," on page 13 "Emergency Preparedness," and, of course, on page 46 you have "Emergency Clinical Network" – that you have in terms of progress and results and how you want to do implementation. My question is: if we have all the emergency visits that are happening today, can you tell me the previous number of visits prior to this report, just so that I can have a sense as to where we're at with what you're doing?

Dr. Duckett: I don't have that information on me, but I can certainly provide you with trend information on emergency department visits. Certainly, over the last few years the number of visits has been going up at least 5 or 7 per cent per annum. I don't have that information on me at the moment. It is a significant increase. I'll need to provide that to you.

Ms Calahasen: Okay. I'd appreciate that. If it goes up 5 to 7 per cent and that's a trend, is there an average number of emergency department visits that AHS budgets for? What's your budgeting from last year to this year?

Dr. Duckett: The pressure point in emergency departments last year and currently, for that matter, is that there are people in the emergency department who the emergency department has effectively finished their care of. That is, they have said: we have done the stabilization assessment and so on, and it is now necessary for this person to be admitted to an acute in-patient bed. There is no acute in-patient bed for them to be admitted to, so they stay in the emergency department. Because they stay in the emergency department, there is nowhere in the emergency department for someone else to take that trolley. A lot of the problem with the emergency departments is not a problem of the emergency department at all but a problem of the whole hospital and the whole system.

Why aren't they being admitted to the acute beds?

Ms Calahasen: Thank you. I was going to ask that question.

Dr. Duckett: I took your supplementary question, so you've got another spare question there.

One of the critical reasons that they're not being admitted to an acute bed is because those acute beds are filled up by patients who shouldn't be in the acute bed either. They should be in a continuing care bed. One of our principles that we're working towards is the right person being treated in the right place at the right time. Our strategy, that commenced last year, is to significantly expand the number of continuing care beds so that people who are in the acute beds can be accommodated in the continuing care beds. That is a critical way of addressing the ED issue. As I said, the ED issue is not particularly a problem about the emergency department; it's a problem with the whole system, so we're addressing it as a systems response.

Ms Calahasen: Thank you.

The Chair: Thank you. For your information, since 2007 the emergency and outpatient services budget has increased by $270 million.

Ms Calahasen: What's the percentage?

The Chair: Its actual now is $1.1 billion, but in the last four years it's gone up by that much. Percentage I do not know; sorry.

The chair would like to note to all members that any Member of the Legislative Assembly can participate in our proceedings, but they just cannot vote.

Ms Pastoor, please, followed by Mr. Xiao.

Ms Pastoor: Thank you, Mr. Chair. The previous questions have been a great segue into where I wanted to go. If I might make a suggestion, I think that part of the increase in emergency is because people do not have family doctors. Rather than remain ill, they go to emergency because it's the only place they can get medical attention.

Having said that, I'd like to go back. You were speaking about the fact that you had said that there would be no reduction in RNs. Now, is that FTEs, or are you keeping it at what it is now because there are many casuals, .8s, et cetera, et cetera? The reason I'm bringing that question up is because if you carefully look at the mandate of the Nursing Homes Act, it does restrict the RNs' behaviour in, my favourite, long-term care, and it does restrict them from actually working to their full scope of practice. Things like IVs are often not allowed in there.

The Chair: Ms Pastoor, please, could you get to your question?

Ms Pastoor: Thank you. I guess I just wanted you to address if you're actually staying on the FTEs or if you're just mirroring what

exists right now and that we can use RNs to their full scope of practice in long-term care to clear up those beds that you're talking about.

Dr. Duckett: There is a precise definition that has been negotiated with the United Nurses of Alberta. I don't have it with me, but it is essentially an FTE-based definition, so we have to keep – I think it's defined in terms of hours – essentially the same number of hours of registered nurse employment in the system. In terms of the full scope of practice we are, as I said, aiming to increase the full scope of practice of registered nurses everywhere.

9:40

Ms Pastoor: Thank you.

The Chair: That's it? Okay.

Mr. Xiao, please, followed by Mr. Kang.

Mr. Xiao: Thank you, Mr. Chair, and good morning, everybody. I guess I have a question which refers to note 14 on page 104 regarding the supplemental pension plans. There has been some reporting in the media that these pension plans are going to be eliminated, so my question to you is: are these supplemental pension plans going to be eliminated?

Mr. Hughes: Let me start, and Dr. Duckett can augment my response. We all recall the practices of previous regions – and it was not unique to Alberta; it was other provinces as well – with respect to supplementary retirement plans. When we as a board looked at this, it was our view that there needed to be a sea change with respect to compensation practices in general. You want to be fair to people, but in public service there's an element of public service. So we wanted to ensure that we could attract the best people that we could. This is one of the most exciting places in the country to come and to be part of a leadership team of health care to take on the challenges of health care. There are other reasons why people would come other than just compensation, so we started off by setting more modest expectations for compensation, starting with Dr. Duckett.

We also looked very closely at the supplementary retirement plans as well that were in place, which, I believe, were deployed in a fairly generous manner. So what we have done is that we have decided to move from a defined benefit model – as members of the Legislature you'll be familiar with the difference, having seen this in the Legislature in the last 20 years, those of you who were there or saw the history of it – to a defined contribution model for supplementary pension plans, where a contribution which is known is made each year.

This is actually a sea change, I believe, in the public service model in Canada, where we're setting a new tone in Alberta. It is a more predictable model, where you know what your exposure is as an organization every year, and it takes us in the direction of greater accountability. People then have a pool of contributions that they can rely upon from a pension perspective, but it's not a layered-on cost to the system that the system will have to pay for for years and years and years down the road. So this is a sea change in the way in which supplementary pension plans are administered in the public system in Canada.

Dr. Duckett: To give you an example, the problem we're trying to solve is that a person's postretirement income and preretirement income needs to have some sort of relationship. Under Revenue Canada rules our base pension, the local authorities pension plan, cuts out at the Revenue Canada cap, which is $139,000 a year roughly. So what we've done is introduced a new pension to go above the $139,000 Revenue Canada cap, which is, as Mr. Hughes points out, a defined contribution. So we say that we will put into a pension plan a 10 per cent payment above that Revenue Canada cap. How did we choose 10 per cent? Well, it's the same as the local authorities pension plan, so it's just a continuation, moving from a defined benefit plan below the cap total to a defined contribution plan above the cap. It's, as Mr. Hughes says, revolutionary in the public sector and is a much more fiscally responsible arrangement while still meeting the legitimate requirements of our staff, who legitimately expect a pension scheme. In my view, the principal problems of the previous arrangements were overgenerosity in randomly recognizing years of service, which led to, I think, quite inappropriate payouts in some circumstances.

Mr. Xiao: As the result of amalgamating all the regional health authorities, can I assume that there must be some savings realized? How much?

Dr. Duckett: Thank you very much for that question. We expect that our new pension plan will cost us about less than a million dollars a year. About $700,000 a year to cover 325 people is our estimate. The old SERP schemes cost almost exactly the same for 62 people. You can see the demonstrable difference in the programs and still, in my view, providing a responsible program.

The Chair: Thank you for that, Dr. Duckett.

Mr. Kang, please, followed by Mr. Benito.

Mr. Kang: Thank you, Mr. Chair. The government of Alberta's continuing care strategy, which was released in December 2008, identified that one of the initiatives to be pursued was to increase home care funding. Dr. Duckett, you were talking about increasing continuing home care beds. Yet page 78 of the Alberta Health Services '09-10 annual report shows that home care spending was actually $9.9 million lower than the year before. Even worse was that home care spending was intended to be cut by $25 million. How is it going to help for you to move the patients from acute care to continuing care and help the emergency department when you're cutting the funding?

[Mr. Rodney in the chair]

Dr. Duckett: Thank you. Those numbers that you refer to on page 78 are brought to you by the magic of accounting. There are people here who understand the magic of accounting better than I, but I'll put it to you this way. If you look at the line called Home Care, you will see that we spent $393 million in 2009, going down to $383 million in 2010, the $9 million reduction to which you refer. On the other hand, if you look at the line above, community-based care, it went from $545 million to $684 million, an increase of $140 million or so. In my view, it's a classification issue. If you put the two together, there's been a $130 million or so increase, a significant percentage increase, combining community-based care and home care. In my view, the reason you're seeing the reduction is simply a classification issue.

Can I just supplement that by saying that home care can be provided by nurses who also provide community-based care? That's why you end up with a classification issue.

Mr. Kang: Okay. What is the current wait-list of people who are waiting for the home-care services?

Dr. Duckett: I don't have information on that. I think it would be very, very low because what happens is that the problem with home care is not, I think, waiting for home care but getting the amount of home care that might be necessary for your needs. I think what happens is that they give you some rather than as much as the ideal recommendation might be. So the waiting in the community listing tends to be for people in the community wanting access to supportive living rather than to home care, is my understanding.

Mr. Hughes: I believe that's true. From what I've seen and heard, I believe that, you know, for example, if you need home care, you might be allocated six or eight hours a week or something like that, and then family would have to supplement around that.

9:50

The Deputy Chair: Thank you very much, gentlemen. Continuing on our list, next will be Carl Benito, but I would like to apprise members of the fact that I have just inherited this list from our good chair. Following Mr. Benito are Anderson, Sandhu, Swann, Vandermeer, Groeneveld, and Elniski. Is there anyone else who would like to add their name to the list? I see Mr. Chase and Ms Calahasen.

Mr. Chase: Hopefully, Vice-chair, we have the option of reading in the questions for expedient written follow-up.

The Deputy Chair: I would hope so. I'm sure that the other side will be extremely reasonable, and I would trust that you would be the same. I hope we don't have a litany of questions at the end because, as has been indicated by our prior question and answer, time is valuable on everyone's part.

With that in mind, we do have almost 40 minutes left, starting with Mr. Benito.

Mr. Benito: Thank you very much, Mr. Chair. On your consolidated schedule of comparatives for the year ending March 31, 2010, you have some multimillion dollar donations that went to Alberta Health Services. Are you doing more things so that, you know, we could encourage more people to make a donation? In reference to that as well, is part of your plan accepting out-of-country patients so that you can gain income for your Alberta Health Services?

Mr. Hughes: There are two questions there, one with respect to donations and one with respect to out-of-country patients as a revenue source. With respect to donations, there are 75 foundations that support the work of Alberta Health Services throughout the province. Some of them are quite small, and some of them are quite large, like the foundations in the major centres in Calgary and Edmonton. Those foundations do extremely good work in working with the community, working with donors and people who want to make a contribution back to the community.

There have been some exceptional examples of that, particularly in the larger centres, where there tend to be more donors, but even in small communities like Canmore. The Canmore foundation raised a million dollars to improve the cancer care unit at the Canmore hospital. I mean, small communities can do big things, too, and the big communities have done exceptional work. I'd just like to note with pride the good work of many foundations to engage the community. These foundations do tremendous work as volunteers on behalf of their fellow citizens in the province, and there are 75 of those foundations around the province doing that work.

[Mr. MacDonald in the chair]

Secondly, with respect to out-of-country patients, it's not a deliberate strategy of Alberta Health Services to try to attract health care tourism to this province. We do have plenty of folks who come here anyway and do end up in the health care system occasionally, but that's not part of our deliberate strategy.

Dr. Duckett: If I could just supplement that briefly by saying that as you are aware, waiting times for Albertans to wait for elective procedures is in many cases too long, so we aren't pursuing that strategy even though I think that over time there might be a place for it. We have been recently, in the past week, reviewing our charges for international patients, and I would be looking to increase the charging per patient rather than to dramatically increase the number of patients.

Mr. Benito: My follow-up question is still on the other sources of revenue. I would like to qualify this question before I ask it. It is not my intention to really have this idea pushed through, but the restoring of health care premiums: do you think, Dr. Duckett, if you would be the one to propose this, that this is a bad idea?

Mr. Hughes: Can I start with that, and then perhaps Dr. Duckett can augment? That would be a policy decision unrelated to Alberta Health Services.

The Chair: Perhaps the committee can address that with Health and Wellness.

Mr. Anderson, please, followed by Mr. Sandhu, who has been very patient.

Mr. Anderson: Thanks, Chair. I'm assuming that in the '09-10 budget some money was spent on capital, and I'm assuming one of those buildings that the '09-10 budget was used for was the McCaig centre. Now, the McCaig centre opened this last little bit here at what I understand is about 5 per cent capacity. You know, we also have the Peter Lougheed, with lots of empty beds in there. We have the south-central hospital in Calgary going up with lots of room. I guess I just want to know what budgeting rules you are using here to make sure that we don't continue to open up empty buildings with no staff in them? I mean, these things cost billions of dollars. What are we doing to make sure that when we open a building, it's ready to fully staff so we're not burning through the cash unnecessarily?

Mr. Hughes: It's a very good question. You're absolutely correct. We recently opened the McCaig centre, which cost a little over $500 million and was a long, long time in planning and building and augments the Foothills footprint in Calgary and the services to Calgarians. As expensive as it is to build health care facilities, it's also very expensive to staff them. What one does in an orderly fashion is: if you're going to build, you build more than you need today so that you have room to expand over time. It just makes good common sense that if you're going to build a building, you're going to build more than you need today so that you can grow into it. If you're a family and you've got two children and you've got a third one on the way and you have to move, you're going to buy a house where you have a fourth bedroom for the third child. You plan. You build. That's just a practical way to do it.

Dr. Duckett: I have nothing to add.

Mr. Anderson: Well, at 5 per cent capacity, that'd be like me, with my four kids, buying a 20,000 square-foot house to live in.

Mr. Hughes: You could have a lot more children.

Mr. Anderson: I know we could, especially at the rate I'm going. There's no doubt about that.

Anyway, back on track, Mr. Mazurkewich, in a recent document that was publicly released, talked about the safe-and-warm policy that Alberta Health has, where if you have an empty building that you've built, we obviously have to hire security to make sure no one gets in there, and you have to keep it heated. It's the safe-and-warm policy, as he said. From the '09-10 is there anywhere in this document where you can point out how much was spent on this safe-and-warm policy? How much was spent on just heating empty buildings?

Dr. Duckett: The safe-and-warm is a broad definition, and it is essentially not for heating empty buildings but, rather, that the buildings that we're building nowadays are larger in size for the same number of patients as the buildings we built 10 years ago. Typically, now we have a greater proportion of single rooms. Typically, now in the recent buildings we've built, whether it's good idea or not, we've distributed nursing stations, for example. That means that if we move people from old, inappropriate accommodation into new accommodation, like we're doing at Foothills and Peter Lougheed and other places, there is just extra space to be cleaned. There is just extra space to be heated, occupied by patients. There might be extra places where we have to have someone stationed for way-finding and so on. The safe-and-warm policy is not about pumping hot air into empty buildings. This may be an appropriate place to talk about pumping hot air.

Mr. Anderson: Don't start down that road, Dr. Duckett.

Dr. Duckett: It is about the fact that we do have extra space for the same number of patients. So, yes, it is heating places where patients are.

Could I just add that in our operating budget that we released earlier this year, we allocated $25 million for those relocating services into new facilities.

Mr. Anderson: Okay.

The Chair: Mr. Sandhu, please, followed by David Swann.

10:00

Mr. Sandhu: Thank you very much, Mr. Chair, and thank you, Ken Hughes and Dr. Stephen Duckett and the Auditor General. My questions were mostly answered, but I'm looking at Alberta Health's annual report, and on page 54 there is a recommendation to implement a cost-saving procurement strategy. What is the status of Alberta Health's cost-saving procurement strategy?

Dr. Duckett: Thank you very much for that question. There are two components to the question. First of all, we're consolidating down all of the procurement processes across the organization from the 12 predecessor procurement processes into a single integrated procurement system called procure to pay, a new information system and procurement system that we are implementing. This is on track for implementation and will be implemented right across the province on the 15th of February of this financial year.

In terms of the savings we have achieved, Mr. Hughes has already referred to the fact that by being larger as an organization, we can benefit from increased purchasing power. Not only that, but we're linking up with some of the other western provinces to actually leverage additional purchasing power on top of that.

In terms of our savings, in 2009 we achieved $62.6 million in savings; in 2010-11, $73.4 million in savings. I mentioned earlier that I've already started my budget discussions, and the first budget discussion was with the contracting, procurement, and supply management group. They are looking forward to further savings in '11-12.

But I might get Mr. Mazurkewich to talk about some of the interprovincial work that's going on in procurement.

Mr. Mazurkewich: We are working with B.C. We went with a national buying group between B.C. and Alberta. We've done over 180 contracts nationally, which have resulted in significant savings. As well, we're into further discussions now with Saskatchewan, Manitoba, and Nova Scotia, looking at how we can align our purchasing practices for health care and what opportunities arise.

Mr. Hughes: I would just augment that, if I could, Mr. Chair. You know, in this case Alberta is a real leader. The creation of Alberta Health Services has created the momentum for really pursuing a strategic procurement strategy, a game plan here. We were able to link up very quickly with British Columbia. You know, I have personally spoken with the leadership in Saskatchewan, and they're clearly interested and on board and other provinces. You saw at the most recent Premiers' meeting that they were talking about this as well. But this is an Alberta leadership project. The momentum created as a result of creating Alberta Health Services has actually created benefit for others as well.

Mr. Sandhu: Thank you. You've already answered my second question.

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

Dr. Swann: Thank you. Well, just a quick preamble. Like my Wildrose colleague, I would not be looking for the demise of Alberta Health Services.

Mr. Hughes: Thank you, sir.

Dr. Swann: The system has been disrupted and disconnected enough. We need to have some stability, and I look forward to working with you.

The April 2010 Auditor General highlighted that there are still six outstanding recommendations from the October '08 report that would directly improve services to Albertans living with mental health problems. The most disturbing recommendation that has not been responded to is to reduce the gaps in service. How many mental health professionals have been added to the points of entry in the health care system?

Dr. Duckett: I don't have the exact number, but I would agree that improving mental health care is, indeed, one of the critically important issues that we need to address in this province. Obviously, the Villa Caritas strategy was in fact part of our desire to improve mental health care here. I will find out the number of – could you please repeat exactly the information you are asking for?

Dr. Swann: New mental health professionals.

Dr. Duckett: New mental health professionals. I'll see what I can find. Yeah, I'll provide some information.

Dr. Swann: Can you comment, then, further on the budgeting for mental health and how that is going to address some of the backlog and challenges?

Dr. Duckett: We've developed an action plan with implementation priorities for mental health care. One of the things we've done is establish a mental health network – I attended a meeting in the last three or four weeks – which brings together professionals from across the province to share information, to share knowledge, and to develop best practices. There are a number of initiatives that they're working on: developing standard referral processes, standard care paths, and also developing training programs to assist family physicians to manage people with mental illness in the community.

Certainly, one of the issues that we're looking at right now is providing some assistance to expand the accommodation available in the community for people with mental illness, and that's an issue that I'm working on addressing over the next couple of weeks. I agree with you that it is an important issue, and we are acting on it.

Dr. Swann: Is there a budget change planned for mental health?

Dr. Duckett: Yes, there is.

The Chair: Okay. We're going to move on if you don't mind, please.

Dr. Swann: Can you send that along?

Dr. Duckett: That will be revealed in next year's budget. What I can provide is the change in budget between '09-10 and '10-11.

The Chair: Mr. Vandermeer, thank you for your patience.

Mr. Vandermeer: Thank you, Mr. Chair. Thank you very much for coming. I sure appreciate all the work that you're doing and the task that you have. It must at times be overwhelming.

My question is in regard to the Alberta Health Link and how cost-effective it is. My family has used it a few times in the past. Typically, you get advice, and then in the end they say: if you still need help, please come to emergency. My understanding was that we don't want people to be in emergency any more than we have to. I think every time that we've phoned, they've said: come to emergency. So my question is: are you actually saving money with Health Link, or is it costing you money?

Dr. Duckett: The protocols that are used are designed by health professionals. I have a niece who has three kids, who lives here in Edmonton, who swears by Health Link. I have the impression that she uses it for reassurance. So the protocols that are used: they ask a set of questions and that leads to a particular path, and depending on the seriousness of the question, that protocol would lead to a recommendation to visit an emergency department. It is one of the things that we are looking at, as part of our addressing of the emergency department issues, about whether the protocols can be reviewed to see whether we can say to people: this is an issue, and you should go to a family physician tomorrow.

What we are actually improving our ability to do is say: this primary care network has an out-of-hours clinic or has an extended-hours clinic, and you can visit that primary care network. So we're improving the information flow from the primary care network to Health Link so that they can say: on Wednesday nights there's an out-of-hours clinic at this particular location. So that will help to divert people away from the emergency department but still make sure people get care in a relatively timely manner.

Mr. Vandermeer: Okay. Thank you.

The Chair: Thank you, Mr. Vandermeer.

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

Mr. Chase: Thank you, and I appreciate the extra half-hour that's being provided. This is such an important organization that we're meeting with, and I hope, as I mentioned to the deputy chair, that we'll be able to offer a read-in question if time would allow.

The Chair: We'll make that happen.

Mr. Chase: As a former Alberta chair of Friends of Medicare who believes in publicly administered, publicly funded, and, especially important, publicly delivered services, I note with concern that page 17 of Alberta Health Services 2009-10 annual report shows that there was a total of 6,994 elective primary hip and knee replacements in 2009-10. Page 60 shows that a total of 1,045 orthopaedic procedures were completed by HRC at a total cost of $9.6 million, giving an average cost of $9,222 per procedure performed by HRC. Will you please tell us what the average cost of a procedure is when it's performed in a public hospital?

10:10

Dr. Duckett: We will be releasing in the very near future a public benefit assessment that was performed by Alberta Health Services with respect to HRC, and that will incorporate a comparison between HRC and Alberta Health Services. The argument for HRC as put forward in the public benefit test was that we needed HRC because there was just not sufficient capacity in Calgary at the time. So the argument for the use of HRC was not based on relative efficiency but was based on the need for HRC to provide care for Albertans.

Mr. Chase: Thank you. I would note that had the General, the Holy Cross, and the Grace not been either blown up or mothballed, HRC taking over the Grace wouldn't have been necessary. That's an aside.

My second question is: what role has Alberta Health Services played in the cost-benefit analysis of contracting out to private service providers, which the minister of health promised would be done in the House on February 17 of this year? Have you now supplied the information the minister would need? If so, when was this information given?

Dr. Duckett: I'm not sure that's a question I should answer. You're asking me about the nature of advice we provide to the minister, and I'm not sure that's related to the period under review. However, what I will say is that public benefit tests are publicly available, and as I said, we're releasing the one we did in '09-10 in the very near future.

The Chair: Thank you.

Mr. Groeneveld, please, followed by Mr. Kang.

Mr. Groeneveld: Thank you, Mr. Chair. Just some quick information for Mr. Hughes, that Highwood is still Highwood, and as of yesterday it's gonna stay Highwood.

Mr. Hughes: When I was a kid, it was High River-Okotoks.

Mr. Groeneveld: Yeah. I know. You were falling into the future, which you shouldn't have done. That's just for your information.

Mr. Chair, I think I struggle with this process that we do here, and we all do as we flip from last year into the present day. I would like to thank the AG's office for what they've done, but I think that

traditionally you've made us very lazy around this table because we like to look back into your book and say: well, this is what happened; why did it happen? But I do thank you for clarifying when we try and misinterpret what you've put in the book, twist it to a different purpose, and I appreciate that. It's always easier for me to look ahead rather than back – well, it's more fun anyway – but like the AG I will continue today to look back.

I can't remember which page I found this on, but it's common knowledge anyway. Alberta Health Services had $1.5 billion in capital reserve, presumably for capital projects, at the beginning of 2009-10. How much, if any, of this reserve would be left?

Dr. Duckett: At September 30, 2010, I think we had about $650 million left in reserve.

Mr. Groeneveld: Well, thank you for that. Now that the government is responsible for delivering most of the capital projects, what would you do with that particular fund?

Dr. Duckett: Well, in fact, it's not ours. So what we're doing right now is an audit to actually make sure that we can allocate that money to the projects that are continuing under Alberta Health Services' auspices and the projects that aren't, and we will transfer the money back to Alberta Infrastructure because, in a sense, it's money that's been allocated for a specific purpose, and that purpose transfers responsibility, so the money goes with it.

Mr. Groeneveld: So it stays in the system?

Dr. Duckett: It stays in the system to deliver big buildings that are necessary throughout the province.

Can I just take this opportunity, Mr. Chair, to respond to Ms Calahasen. Ms Calahasen asked a question earlier about the growth in emergency department visits. I now have the information at hand. Basically, over the period 2002-2003 to 2009-10 we increased from 33,706 visits to 40,970, Edmonton zone. I think you were asking for the province, weren't you? Sorry. Wrong information. Don't worry.

Mr. Hughes: We'll get that for you.

Ms Calahasen: Thanks. That would be great.

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

Mr. Kang: On page 37 of the Alberta Health Services 2009-10 annual report it says that a total amount of $5.3 million was disbursed to support a total of 164 self-managed care patients. Yet page 142 of the exact same annual report says that the total number of clients on self-managed care is 1,222. Will you clarify, sir, which page is actually correct? Is this $5.3 million funding going toward 164 people or supporting 1,222 people?

Dr. Duckett: The difference could be that one is the total number of clients on self-managed care. I'll provide the information as a supplementary answer.

Mr. Kang: Okay. How does this level of funding compare to what was spent in 2008 and '09 on self-managed care, and what was the total number of people supported through this program in 2008 and '09?

Dr. Duckett: I'll provide that as supplementary.

Mr. Kang: Thank you, sir.

The Chair: Thank you.

Mr. Elniski, please, followed by Mr. Anderson.

Mr. Elniski: Well, thank you very much. As enthusiastic as I am to pursue your surplus finances, I'm also equally concerned about contingencies and uncontrolled liability. On page 108, I believe, of your report you talk about contingent liability with respect to some claims that you have outstanding with regard to some legal pursuits and some claims you have outstanding with respect to an entity which was referred to as the liability and property insurance plan, which you later go into on page 115, and you give us a little bit of a description of the liability and insurance plan.

Then I was pleased to note that when I went over to the Auditor General's report, the Auditor General had yet again beaten me to the punch. He talked about this particular plan and that the appearance, certainly, is that you are, in fact, self-insured. I'd like a bit of commentary from you if we could about this particular plan, what it's intended to achieve or what it was intended to achieve and what the path forward looks like with regard to this.

Mr. Hughes: It's a very good question with respect to managing risk. Alberta Health Services faces a different risk profile now collectively than was the case when there were 12 regions and different groups that sought to insure together under this reciprocal arrangement. This is one of those legacy organizations that had real purpose in the previous world, where a small regional health authority couldn't self-insure and a larger one probably didn't want to in all respects. Also, there are other parties as well, like contractors that provide services to us, who are party to this agreement. So, clearly, this is one of those things that's on the to-do list for the next few months, and in the next four to six months the board will be receiving recommendations from management about the future of that plan.

Dr. Duckett: If I could just supplement that in a couple of ways. First, as Mr. Hughes said, there are a number of other organizations which hang off this plan, Covenant Health being probably the largest but also, I think, the government of the Northwest Territories health services and small organizations. So we have to be careful about what we do.

As the Auditor General pointed out, an organization as large as Alberta Health Services can effectively self-insure whereas the previous entities were too small to do that. We are looking at it. We are about to issue a request for proposals to give us advice on some of that issue, but it is a complex issue both of accounting and management and of policy. As Mr. Hughes said, we are reviewing that to look to a recommendation. It may be this financial year.

10:20

Mr. Mazurkewich: Yeah. As Mr. Hughes indicated, we'd like to bring something to our board this financial year on a go-forward basis taking into account the complexity of it. We're also working with Alberta Health and Wellness and various ministries as well. There are a number of stakeholders involved and being consulted as we wind our way through this complex issue.

Mr. Elniski: Wonderful. Thank you very much for that because it was fairly evident as you read through the details that now that you are of a size necessary to be self-insured, a number of these agencies and organizations could really face some increased costs as a result of that depending what kind of decision you make. Thanks for that.

Dr. Duckett: Can I just respond to Mr. Kang's earlier question, please? We are right that there are no waiting lists in Calgary for home care. Everybody is seen within 48 hours for an assessment.

Mr. Hughes: For Edmonton and Calgary.

Dr. Duckett: Edmonton and Calgary.

The Chair: Mr. Anderson, please, followed by Ms Calahasen.

Mr. Anderson: Okay. Thanks, Chair. Part of the '09-10 budget was spent, obviously, as was pointed out earlier, on publicly funded services being delivered by private health providers. As someone who believes strongly and whose party believes strongly that the lack of competition and innovation espoused by my Liberal colleagues across the way is one of the biggest reasons for our massive wait times both in the emergency rooms and in other surgeries across the province, I have a question about that money that was spent in '09-10.

One of these private providers that you spent money on, obviously, as you alluded to, was Networc Health. Now, according to the Alberta Bone & Joint institute, which is funded by you folks, Networc Health was providing hip and knee replacements at 40 per cent the cost and 40 per cent faster than those performed in your public hospitals, Alberta Bone & Joint, of course, being an independent organization funded by you. I was a little concerned about your answer. When you do release that report, can you satisfy me that that will be an apples-to-apples comparison taking into account things like infrastructure, overhead, and all parts of that surgery?

Dr. Duckett: The report that's to be released is the report that was done previously, so it was done on, I believe, a comparable basis. The issue with the comparison is this, that one of the reasons that they are relatively cheap is that they are doing relatively simple cases. We have to actually screen the cases that are done at HRC to be those cases which are appropriate and safe to perform in the facilities that HRC provided.

I do not want it to be thought that we did not support and do not support the use of HRC for orthopaedic surgery. In my view, it was a good model. I think Calgary health region made that decision, and I think it was an appropriate decision to make. But the comparison is quite complex to make because of the issue of trying to standardize for the complexity of patients and that HRC does not do any emergency work. Emergency work disrupts care, so it adds to the cost. It is a very complex comparison to make, but we are going to be releasing it in the very near future.

Mr. Mazurkewich: I just want to add one other complexity, which is that it changes over time as techniques and how the service is provided change, so things are at a given point in time. When you look at it, that's one of the complexity factors, and you have to look at five or six key assumptions.

Mr. Anderson: I realize that, and I hope you can find patients that are similar in both systems to do the comparison with. I don't think that that will be too hard.

Second question. I'm looking at this '09-10 budget and seeing the amount of money that was spent on it, alluded to in the last question. Are you open on a go-forward, then, to continue to contract out where it is appropriate, where it can save the public system money? Are you willing to contract out publicly funded services or at least let private and public compete for publicly funded services, surgeries, and other medical treatments?

Mr. Hughes: Our view has always been that we're agnostic on that. I think Albertans want services and, by and large, are not as concerned about where those services are delivered or by what organization they're delivered. If you look at the way in which we deliver services today, there are a lot of services delivered by not-for-profits, by faith-based groups like Covenant Health and others, that under very strict guidelines and contract to Alberta Health Services provide those services, and I don't think Albertans have a problem with that in any respect.

Our goal has always been to ensure that the services are available, and we were very determined to ensure that that was the case through the transition of circumstances that none of us anticipated in Calgary. The fact that the McCaig centre is opening within days to provide those services to Albertans and we have been able to meet the needs of Albertans through this piece is a great credit to the work of the team at Alberta Health Services who have worked at this – the physicians, the clinicians, and the management team – through a very difficult circumstance that nobody anticipated.

The Chair: Thank you.

I would like to remind all hon. members that there is the annual poppy ceremony at 11 o'clock in the rotunda, and we're going to have to conclude this meeting quickly. There are still a lot of members with questions, if they could read them into the record.

Mr. Hughes, if you could have Alberta Health Services respond in writing to the clerk to all members, we would be grateful.

We will start with Ms Calahasen.

Ms Calahasen: Thank you. I'm always concerned about the health of aboriginal people, and on page 30 you have "improving population health." However, the concern that I've always had is that there's no baseline information or studies that have been done or used to be able to track whether or not we have made any progress or any kind of results. I'm wondering if Alberta Health is looking at whether or not in the 2009-2010 target major initiatives there are any kind of percentages to find out whether we have made any progress or results on aboriginal health.

The Chair: Thank you.

Dr. David Swann, please.

Dr. Swann: Yes. Thank you, Mr. Chairman. Page 170 of the October 2010 Auditor General's report again suggests that Alberta Health Services make public in their annual reports how many public dollars are at risk when executive managers are terminated. So (a) will you commit to reporting in the annual reports the total possible liability when executive managers are terminated, and (b) how many executives of Alberta Health Services are still eligible for lavish payouts if and when they are terminated?

Ms Calahasen: This is last year's. You're asking about last year, right?

The Chair: That's fine. No. That's totally in order.

Mr. Olson, please.

Mr. Olson: Thank you. I have a question. It's a very specific question about support services and laundry costs. This is as a result of some conversations I've had with people who have concerns about the inefficiency of our laundry's steam generation, using presses instead of using permanent-press type of material. Can you give me some information as to what those costs are, and has any cost comparison been done in terms of a transition over to a new system?

The Chair: Thank you for that.

Mr. Chase, please, followed by Mr. Kang.

Mr. Chase: Thank you. Page 167 of the October 2010 Auditor General's report shows that work began on the conversion of Villa Caritas to a geriatric site facility before a contract was even signed, and as of May 2010 a contract still was not signed. First question: with both HRC and now Villa Caritas as clear examples, how often has Alberta Health Services undertaken a project without a written contract? Secondly, does Alberta Health Services finally have a contract with Covenant Health for the Villa Caritas facility?

Mr. Kang: How much of the total $10.4 billion in expenses that Alberta Health Services recorded in '09-10 was fees for management consultants, which consultants were contracted, and what projects were the consultants contracted for?

The Chair: Thank you.

Mr. Hughes, Dr. Duckett, and Mr. Mazurkewich, I thank you for your time. I have a question if you don't mind. You spent $68 million in food supplies in 2009-10. I and, I think, other hon. members have received complaints about the quality of food in the hospitals as well. Of the $68 million you spent, what, if any, was spent on Vegemite?

10:30

Dr. Duckett: The answer, Mr. Chair, is an appropriate amount.

The Chair: An appropriate amount. Okay.

Mr. Rodney: What is Vegemite?

Dr. Duckett: It's an Australian delicacy.

Mr. Rodney: Gentlemen, I too would like to thank you. I just have three points to offer. I appreciate that you at AHS have agreed to all of the Auditor General's recommendations, and I know you're taking steps to implement them, and I applaud you for that.

I know that merging 12 health entities, the nine plus the three specialized, into one is very complex. We know it can't be done overnight. Just as an Albertan I want to thank you for fusing those entities, approaches, and systems.

I have written down this last point. Consolidating varying financial systems from the previous health regions into one integrated accounting system I know is a priority for you. It's under way, and I just want to say thank you. We all know that there is great growth, but there are growing pains, and as an Albertan I want to thank you for that.

Dr. Duckett: Thank you very much.

Mr. Hughes: Thank you.

The Chair: On behalf of the committee we wish you the very, very best in the fiscal year 2010-11.

Dr. Duckett: Thank you very much.

Mr. Hughes: Thank you very much.

The Chair: Now if I could move on to item 5 on our agenda, please, other business. Is there any other business?

Ms Calahasen: It's past 10:30, Mr. Chair.

The Chair: It's past 10:30; I realize that.

Ms Calahasen: So you need to have us agree that we should go past 10:30.

The Chair: We will be very quickly finished if you would co-operate, please.

Is there any other business to raise at this time? No. Okay.

Our next meeting is scheduled for next Wednesday, November 3, with the office of the Auditor General. We are going to deal with the Auditor General's report for an hour, and we're going to have half an hour for discussion on future organizational changes or who you would like to see appear. The chair would urge all members that if you have any suggestions or any requests from ministries, let us know, please.

Mr. Sandhu moves that the meeting be adjourned. All in favour?

[The committee adjourned at 10:32 a.m.]

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