Legislative Assembly of Alberta

The 27th Legislature
First Session

Standing Committee
on
Public Accounts

Health and Wellness

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Standing Committee on Public Accounts

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Linda Miller	Assistant Deputy Minister, Information Strategic Services Division
Glenn Monteith	Assistant Deputy Minister, Health Workforce Division
Janet Skinner	Acting Chief Executive Officer, Alberta Alcohol and Drug Abuse Commission
Charlene Wong	Director, Financial Planning and Revenue Administration, Corporate Operations Division

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8:30 a.m. Wednesday, May 14, 2008

[Mr. MacDonald in the chair]

The Chair: Good morning, everyone. I would like to call this meeting of the Standing Committee on Public Accounts to order, please. On behalf of members of the committee I would like to welcome everyone and advise you that you do not have to touch the microphones. That is taken care of by our able *Hansard* operators.

Perhaps we can start by quickly going around and introducing ourselves, and we'll start with the Member for Rocky Mountain House.

Mr. Lund: Ty Lund, Rocky Mountain House.

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

Mr. Bhardwaj: Naresh Bhardwaj, Edmonton-Ellerslie.

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

Mr. Kang: Good morning, everyone. I'm Darshan Kang, Calgary-McCall.

Mr. Chase: Harry Chase, Calgary-Varsity, and proud representative for the Alberta Children's hospital.

Mr. Chamberlain: Martin Chamberlain, acting assistant deputy minister of corporate operations for Health and Wellness.

Ms Meade: Paddy Meade, deputy minister.

Ms Wong: Charlene Wong, acting executive director for Health and Wellness.

Mr. Ryan: Ed Ryan, office of the Auditor General.

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

Mr. Dunn: Fred Dunn, Auditor General.

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

Mr. Denis: Jonathan Denis from Calgary-Egmont.

Mr. Griffiths: Doug Griffiths, Battle River-Wainwright.

Mrs. Dacyshyn: Corinne Dacyshyn, committee clerk.

The Chair: Hugh MacDonald, Edmonton-Gold Bar.

I would like to advise that the briefing materials for this meeting were posted on our website for viewing and printing last Friday.

It is my pleasure on behalf of the committee now, before we get started, to introduce some guests we have with us this morning. These guests have travelled here from overseas to learn about Alberta's financial management systems. They work in the financial departments of their countries, which are Antigua and Barbuda, Barbados, Montserrat, Seychelles, St. Lucia, Swaziland, and South Africa. They have travelled here to learn about the government of Alberta's financial management systems and take back their findings to improve the financial systems of their own countries.

I would now ask them if they would stand, please, and we could recognize them. From Antigua and Barbuda Sandra Henry, from Barbados Faye Prescod, from Montserrat Nicole DuBerry, from the Seychelles Sitna Cesar, from St. Lucia Charmaine Louis-Justin, from South Africa Ms Euody Manti Mogaswa, and from Swaziland Seneliso Nkambule. Welcome.

Their mission is organized and sponsored by the Institute of Public Administration of Canada, a group that supports sustainable development, good governance, and effective public policy. I understand that our guests will be job shadowing budget and finance staff in various government departments over the next 10 days to learn about Alberta's financial management systems. Their goals are to learn some techniques of linking budgets to longer term social and economic objectives, policies, and programs; more careful monitoring and reporting on trends; performance reports; improving audit systems; reviewing the performance of individual ministries; and ways of tying outcomes to allocations in spending. We are all interested in those things here on this committee as well.

Our committee, the Public Accounts Committee, is an all-party committee of the Legislative Assembly of Alberta with the purpose of reviewing the public accounts of the province as well as the reports of the Auditor General. Today we will be dealing with both sections of the Health and Wellness report from 2006-07 as well as the Auditor General's report from 2006-07, volumes 1 and 2, and also the Auditor General's report from April of this year as well as the consolidated financial statement of the government of Alberta from 2006-07. We are pleased that you are with us today, and if you have any questions after the meeting regarding the procedures of our group, we will do our very best to answer your questions.

I would also at this time like to welcome Mr. Fawcett and Ms Woo-Paw to the meeting. Good morning.

Now may I please have approval of the agenda as circulated? Thank you. Moved by Mr. Denis that the agenda for the May 14, 2008, meeting be approved as distributed. All those in favour? Seeing none opposed, thank you very much.

Item 3, approval of our minutes as circulated. Moved by Mr. Lund that the minutes for the May 7, 2008, meeting be approved as distributed. All in favour? Seeing none opposed, thank you.

This brings us to item 4, our meeting with the Ministry of Health and Wellness. I would like to remind everyone of the research material provided through the LAO research committee and that this material is available to the public from the committee clerk.

If we could now proceed with Ms Meade with a brief overview, please, of your annual report.

Ms Meade: Thank you very much. Good morning. I'm here, as you know, with Martin Chamberlain, who has introduced himself, and Charlene Wong. I also have ADMs of the executive committee and Jamie Curran from the minister's office.

I'd like to extend acknowledgements to the Auditor General, Fred Dunn, and his staff. When you have the ministry of health, you dance quite often with Mr. Dunn and his staff, and we enjoy that relationship.

I will be giving introductory comments about the ministry's '06-07 annual report and, in addition, the Auditor General's '06-07 annual report and his April 2008 report specific to the ministry.

To begin with the financials, looking first at our financial picture, the ministry's original budget for 2006-2007 was $10.3 billion. This was an increase of 7.7 per cent, or $735 million, from the '05-06 forecast. Over $5.9 billion was allocated to the provincial health authorities, with an overall increase of 9.7 per cent, or $541 million, to the regional health authorities.

During the year the department received supplementary funding

of $409 million, specifically for labour and equipment. I'll go through the breakdown: $112 million of that amount went to additional operating funding for the nine regional health authorities and the Alberta Cancer Board to address cost pressures and the impact of the licensed practical nurses' mediated settlement; $147 million of the $409 million in supplementary funding went towards services provided under the trilateral master physician agreement, including physician compensation, the physician office system program, which is their piece of the provincial electronic health record, the physician on-call program, and primary care. An additional $150 million of the supplementary funding went to the regional health authorities and the Alberta Cancer Board for diagnostic and medical equipment.

The ministry's budget also increased by an additional $12 million due to increased revenue from Canada Health Infoway for the diagnostic imaging strategy that we initiated. With this increase the Health and Wellness budget rose to $10.7 billion.

The 2006-07 fiscal year marked the first year in which the Ministry of Health and Wellness had responsibility for health facilities infrastructure projects, and we worked very closely with the Ministry of Infrastructure on that.

I'd like to now look at our accomplishments for 2006-2007 and from our business plan look at our first core business.

Our accomplishments. The business plan linked with the government's overall business plan, which stated that Albertans will be healthy and that Alberta will have a supportive and sustainable infrastructure that promotes growth and enhances quality of life.

Health and Wellness had three core businesses: to advocate and educate for healthy living, to provide quality health and wellness services, and to lead and participate in continuous improvement in the health system. We had a number of accomplishments under our first core business of advocating and educating for healthy living. Initiatives to improve children's mental health: to support those initiatives, we invested $39 million to be distributed over three years. We also provided $30 million to fund several new programs to put children and youth on the path to lifelong health. Through this funding the newborn metabolic screening program was expanded to screen for 17 metabolic conditions in newborns, including cystic fibrosis, and Alberta was the first province in Canada to screen all newborns for cystic fibrosis.

8:40

Also, preschool development screening programs and follow-up services were further developed, and programs to promote healthy weights in children were expanded. The Alberta provincial stroke strategy was initiated to give Albertans enhanced access to appropriate stroke treatment and care. The government committed $20 million over two years to support that program. Through the strategy all nine Alberta health regions will have primary stroke centres, and stroke specialist consultation will be accessible by telehealth links to the main stroke centres of Calgary and Edmonton.

I'll speak now to the Cancer Prevention Legacy Act, which was proclaimed to help build a cancer-free future for Albertans. This legislation established a $500 million Alberta cancer prevention legacy fund to support initiatives in cancer prevention, screening, and education. Under this fund there's $25 million provided annually to the Alberta Cancer Board through grants from the department. A new province-wide colorectal screening program was introduced and will be phased in over five years. The program focuses on research, public education, and more direct treatment for persons at risk for this type of cancer.

Alberta's first-ever immunization strategy was developed. The strategy is designed to minimize the risk of vaccine-preventable diseases by increasing immunization rates across the province. Through a new innovation in immunization fund $8 million was given to the nine health regions over two years to enhance Albertans' access to immunization services.

We also had a number of accomplishments that addressed our second core business, providing quality health and wellness services. Five new primary care networks were added as part of the primary care initiative. As of today there are approximately 1,500 family physicians working with a range of other health care providers in 27 primary care networks. The networks serve 1.7 million Albertans through health professions working together in a co-ordinated team approach to health service delivery.

There were 37 allocations filled through the provincial nominee program in 2006-07. This program helps international medical graduates obtain permanent citizenship so that they can provide health services in Alberta. The Alberta international medical graduate program was expanded to offer positions to 48 international medical graduates for the August 2006 program, and that's an increase of 20 over the previous year.

The Health Quality Council of Alberta was granted status as a provincial health board under the Regional Health Authorities Act on July 1, 2006. The council serves as an independent body to measure, monitor, and assess patient safety and health service quality throughout the province.

A number of accomplishments addressed the third core business; that is, leading and participating in continuous improvement in the health system. The department released the draft health policy framework and launched extensive consultations with Albertans to discuss its contents. The framework outlined ways to improve sustainability, flexibility, and accessibility to the health system. The What We Heard document was released in April 2006, and the framework was subsequently revised and reissued that August.

Another achievement was the expansion of Alberta Netcare, which is Alberta's electronic health record system. In 2006-07 it was deployed in 418 physician offices and 530 pharmacies, and that system provides a secure lifetime record of patient health information.

Taking successes learned under the Alberta hip and knee replacement project, the province also continued to fund projects designed to improve access to health services and to reduce wait times. The patient-centred approach was applied to breast and prostate cancer care, coronary artery bypass surgery, MRIs, and CT scans.

Now I'll speak to the Auditor General's 2006-07 annual report, where he made recommendations on the department's information security policy, outsourced information technology, claims assessment system, and health region information systems. Recommendations were also made to four health regions, AADAC, and the Alberta Cancer Board related to financial reporting, improving controls over IT systems, and following policies for awarding consulting contracts. The government takes any recommendations of the Auditor General very seriously, and the department and regional health authorities accepted the Auditor General's recommendations and are implementing changes and processes to satisfy his concerns. The Auditor General was satisfied with the ministry's financial statements and performance measures. The report indicated that our department has fully implemented the Auditor General's previous recommendation to upgrade our computer system security software to safeguard confidential information.

In the Auditor General's April 2008 report long-term care and mental health were examined, and I'm pleased with the overall progress of the department and the health regions towards fully implementing the recommendations of the Auditor General. Alberta Health and Wellness has worked with the health regions and other

providers of seniors' care to develop and implement new standards of continuing care health services. The standards apply to publicly funded health care services delivered in long-term care, supportive living, and home care, and this was done in accordance with the Auditor General's recommendation. The standards are based on the principles of client-centred care, assessments, care planning, integrated care teams, and quality services. For Alberta's seniors this means they will benefit from health services that are focused on meeting their individual and unique care needs.

Continuing care staff in all health regions have been trained and educated on the new standards in accordance with the Auditor General's recommendation. The department is committed to an auditing and monitoring process to ensure compliance as well as a process to regularly review and update the standards. We have created a monitoring and compliance unit within the department and will continue to work with the regional health authorities to achieve full implementation of the recommendations of the Auditor General on compliance.

The Auditor General recognized that the provincial mental health plan was a major step in setting a new direction for the future of mental health services in Alberta and that it resulted in many positive mental health initiatives. These included investments through the mental health innovation fund and children's mental health to address the three strategic directions of the provincial mental health plan, and those are to build capacity to enhance and increase mental health well-being, remove or reduce risks to optimal mental health, and provide treatment and support for those with mental health problems or illnesses. However, in light of the Auditor General's report, Health and Wellness will review and evaluate implementation of the provincial mental health plan, those initiatives done to date, strengthen its accountability, and determine priorities for the future.

To the chairman, this is the conclusion of my introductory comments. I and my team look forward to your questions. Thank you.

The Chair: Thank you very much.

Mr. Dunn.

Mr. Dunn: Thank you, Mr. Chairman. I believe all committee members will appreciate that you again have a large and complex ministry before you, and I'll just supplement what the deputy minister has just mentioned. In the past year we completed two major systems audits impacting the Ministry of Health and Wellness, as you just heard, implementing the provincial mental health plan and the seniors' care programs – and that was a follow-up audit – and those results were described in our April 2008 report.

Following on what the deputy has just mentioned regarding the provincial mental health plan, on pages 63 to 93 we report the results of our audit on the systems that the department and the Mental Health Board have to determine whether the provincial mental health plan is being implemented. We found that the plan has spurred activity on mental health issues in Alberta, as you've just heard. However, systems to monitor the progress on the plan are not well designed and cannot confirm that the plan as a whole has progressed. Thus, we made the two recommendations to strengthen the systems for provincial mental health planning. The department and the AMHB need to improve their processes for planning, monitoring, and reporting on the plan. The department also needs to develop an accountability framework for the plan in mental health services in Alberta. Without these improvements there's a risk that the plan may not be achieved. Also, following up on seniors' care, on pages 95 to 147 we report that the department and the regional health authorities implement care and accommodation standards for long-term care and supportive living and monitor compliance with the standards.

What we found. The department has implemented our recommendation to update the standards. The department has also made satisfactory progress towards developing systems to monitor compliance with the updated standards; however, the authorities' monitoring systems are at different stages of development. More work is needed to establish fully functioning monitoring systems. The department and the authorities need to complete developing their monitoring programs. They also need to complete inspections of all facilities to ensure compliance with the new standards and enforce compliance through future inspections and follow-up action.

8:50

Regarding the department. Other comments on the Department of Health and Wellness can be found in volume 2 of our 2006-07 annual report, starting on page 103. We made three recommendations to the department to improve its information technology system, as you've just heard. We recommended that the department enforce and monitor compliance with its information technology security policy, obtain regular assurance that outsourced systems are properly controlled, and improve the control over the systems that it uses to pay physicians. Improving these controls will help the department to ensure the confidentiality and integrity of the data in its systems.

Regarding the regional health authorities. Comments relating to the audits of the regional health authorities and other entities that report to the minister begin on page 110 of volume 2 of our '07 annual report. In this section we have made several recommendations to the Calgary health region to improve controls over its information technology systems.

Those are my brief opening comments, Mr. Chairman. I and my staff will take any questions that are addressed to us. Thank you.

The Chair: Thank you very much, Mr. Dunn. We will proceed directly to questions, but the Chair would like to recognize Mr. Quest. Good morning, sir. He was at the Premier's annual prayer breakfast. He just arrived, and we appreciate that.

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

Mr. Chase: Thank you very much, Mr. Chair. Before beginning my questions, I would like to recognize and thank Dr. Philip Massolin, committee research co-ordinator for Public Accounts; our also amazing Liberal finance researcher, Kristen McFaden; and, of course, the Auditor General's department, whose preparatory assistance is very much appreciated as we begin the questioning.

Given the concerns with the global funding formula, what merits does the ministry see in adopting a funding model based on real costing information from the health authorities' previous year's expenditures and unique needs?

Ms Meade: Well, I'll speak briefly to the funding formula, which is a way of allocating within the department the amount of money for regional health authorities. The funding formula is always targeted. It doesn't matter what region you are from; you feel that you are disserved by the global funding formula. So if you're in the north, it doesn't recognize your distance. If you're in Calgary, it doesn't recognize your population.

Quite frankly, the funding formula has been reviewed several times, including by the Auditor General several years ago, and has been found to be a fair and equitable way to divvying up the resources. The issue is really more about sustainability of the health

care system and how we're actually going to get an efficient system and less about how you divvy up the pie, quite frankly. I think it is a red herring to continue to look at the funding formula. It does allocate within the resources that we have.

Mr. Chase: Thank you. My follow-up question arises in part from the CHR budget shortfall which is preventing programs from being provided to the million-plus Albertans served in Calgary and surrounding areas, which account for a third of Alberta's population, creating health hostages. What feedback has the minister received from the health authorities regarding improving or eliminating the currently used funding formula?

Ms Meade: Actually, the funding formula has not been called to be eliminated by the health regions, but each health region, when they run a deficit, is required to submit a three-year deficit plan. I as the deputy deal with each region on their financial management, and we go through it on a regular basis, not at the end of the year. In fact, it will be at the end of June that we'll actually know the real status of the deficits for this year because they're just submitting their final actual accounting and variance.

The issue is a funding formula, but the real issue is how much money they feel they need. My response to them is: how efficient can you be, and what is a better way to streamline the full system that's not at the expense of quality and equitable access? I believe you can do that. All health systems internationally are struggling with this. It's a matter of continual progress and continual renewal of the way our system is working.

The Chair: Thank you.

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

Mr. Denis: Thank you. First of all, I want to thank the ministry staff and the Auditor General and his staff for attending. Mr. Chase has taken one of my questions, so I will be as brief as possible.

I'm referring to page 6 of the Calgary health region consolidated financial statements dated March 31, 2007. The second side of the page deals with the consolidated statement of operations. Now, this indicates that the CHR had a surplus of $7.6 million for 2006. This fell to a deficit of $5.5 million for 2007. During this time period Alberta Health and Wellness contributed $67 million more to the Capital region than to the Calgary health region. I'm interested to know from the deputy minister what measures are in place to deal with the increased rate of growth of people in the Calgary health region's area and how to adjust for this funding gap on an ongoing basis.

Ms Meade: Actually, the way that we do the funding formula does address population, and it does address population increase, but it also addresses population disparity. We know that certain sectors of the population are higher users of health care: women, aboriginal, lower income, et cetera. So it is actually balanced.

The other issue is that the Capital health region serves a much larger feeder area. The Northwest Territories is served more out of Capital than Calgary, and a lot of our significant tertiary or very expensive transplants are done out of the Capital region. The formula can't really be compared city to city when the population served and the types of services are a little different.

Mr. Denis: Just one quick supplemental?

The Chair: Please proceed.

Mr. Denis: Again, just given the increased population rate of growth in Calgary, is this something that's adjusted, then, by your bases?

Ms Meade: It's not adjusted year by year based on population. The population increase of Calgary would be compared as are the other issues within all of the regions when we look at the funding formula.

The other issue here, though – and again we're stuck on the funding formula. We've looked at how services are provided in different regions, and it may be that the population can be served in different ways, whether it's Calgary or some of our other regions. Moving away from acute and more to ambulatory outpatient actually reduces the costs, and you can serve a wider population. While it may be how we adjust and provide budget, it's also how we change our services. For example, that's a discussion I've had with Calgary on two areas of population: one is their seniors and also how the services to accompany the south hospital are going to be delivered. So you can serve a wider population if you change your format and mix of service.

The Chair: Thank you.

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

Mr. Kang: Thank you, Mr. Chairman. On page 23 of the Health and Wellness report it shows that the percentage of Albertans reporting their health as excellent has been declining since 2005. What are the reasons for this decline in the self-reported health status?

Ms Meade: Okay. That comes from the self-reporting through the Health Quality Council survey, as you know, that they do, and it's done through the Population Research Lab. Part of this is, I think, about the aging population. It's also the issue around chronic disease, and Alberta is not unique to having a larger and a growing increase around such things as depression and stress in the work-place and in other areas. It's not unique to Alberta, but as we age – for example, when I got up this morning, things hurt a little bit more.

Mr. Kang: I know that experience, too.

Was the inability to access the health care system a reason given for the decline?

Ms Meade: Could you repeat that? Was it about access? Sorry.

Mr. Kang: Was the inability to access the health care system a reason given for the decline?

Ms Meade: No. It was not linked in this question. I don't have the survey in front of me, but I can certainly supply that information if you'd like a copy of the Health Quality survey. This is how people are feeling in general, and it was not linked to service. In fact, in again a report that came out this week from the Health Quality Council on emergency room service out of Calgary, people actually are quite happy when they get service.

The Chair: Thank you.

Ms Meade, if you could provide that Health Quality Council survey through the clerk to all members, we would be grateful.

Ms Meade: Absolutely.

9:00

The Chair: We're now going to move on to Mr. Fawcett, followed by Mr. Chase, please.

Mr. Fawcett: Well, thank you very much. I'd like to echo my colleague's comments and thank you for being here today to answer our questions.

Again, I'm going to be asking a question on the funding formula, but I want to qualify it first by saying that I don't necessarily think that there is anything wrong with the funding formula, and I don't necessarily think that the answer is just cutting a cheque to the health region. I think we need to look at what is happening there that makes the Calgary health region have to run this deficit.

I like to think that one of the problems is that any time you develop a funding formula, what it tries to do is boil down very complex situations into very simplified terms and criteria. One of the problems in the health care system is that we talk about older populations and aboriginal populations and demographics, but that doesn't necessarily mean that that particularly is going to lead to a certain amount of resources that are needed. For example, usually in the health care system you don't know that somebody is going to need the resources until they actually get sick. It could be somebody that's totally outside of the demographic that needs a bunch of resources because of some unfortunate situation.

Have we looked at and really studied why in the Calgary health region? Is there something there that isn't identified or that we can't even identify in the funding formula that's leading to this deficit?

Ms Meade: Actually, the funding formula does use the research that says that certain populations, certain demographics are higher users of health care. We do know that, and that formula doesn't negate the average younger, male, healthy individual who suddenly gets sick and needs the health care system. It's a balance when they put the formula together.

There's an issue between how much money you're given and how you manage your system, and all health systems internationally are struggling with this. The issue is and my experience is, not having grown up in the health world, that this is an industry that has only started to look at the benefits of other industries. For example, in manufacturing, lean processing and the way you move things through a manufacturing plant are pretty common sense, and they're shared across industries. Not so when you get to health. Lean processing in health is a very new, novel idea, and that's what we're starting to do.

I believe that it's more about introducing new processes, re-engineering, as we did with the success of the bone and joint experience, a totally different way of re-engineering and linking the general physician who makes the referral to specialists to how you isolate and use surgery rooms to impact wait-lists. Money is always very much a part of health. It's probably 98 per cent of my discussion every day, but really the issue is: how do we change health care delivery in a systemic way? That's about looking at this as patient centred and how the patient follows a care path. Calgary is doing that in how we have worked with them to design the south hospital. So that's where it is.

I'm glad you agree that it's not all about the funding formula, quite frankly. I had a huge family of brothers, so I understand how you cut the pie. The girl always got the short end of the pie stick, right? But it's really that there's a pie, and how do we most efficiently use it? In Calgary they do have a large population, but they also have to maximize how they're doing that flow. I'm hopeful that they're starting to show great progress. The work we've done in a couple of areas and how we've relooked at the mix in the south hospital I think will start to lead to some of those efficiencies.

The Chair: Thank you.

Briefly, your second question, please.

Mr. Fawcett: Yeah. My supplemental is this: where does the accountability lie? Who can people from Calgary hold accountable, first of all, for a deficit being run in their health region and it impacting the services that they require?

Ms Meade: Well, I think we have to be very careful. The deficit has not led to a reduction in services. The deficit is a separate issue from how the services are being let. I believe that there can be improvement, like I believe that there can be improvement in every region and outside of the regions, in the primary care, et cetera.

The accountability chain is this. It's the minister of health who represents government. The chair of a health authority is responsible to the minister and therefore the board through the chair, and the CEO of a region and therefore the executive team through the board. Now, that said, I think governance is an issue being looked at; again, not unique to Alberta. There's been great success in Alberta. In fact, we've led on innovation in many, many areas because of regionalization. I know that when I talk to deputies of health across the country, governance and accountability are still issues. I believe my minister has said that in his plan he will address that.

The Chair: Thank you.

Mr. Chase, please, followed by Mr. Quest.

Mr. Chase: Thank you very much, Mr. Chair. I believe that there is a services deficit in the health system. Currently in Calgary the Sheldon M. Chumir urgent health care centre can't fully engage. There's a shortage of health care staff at all levels throughout the Calgary health region which keeps operating beds, operating theatres, and much-needed beds mothballed. The impact of the current economic conditions has meant that a population-based formula is not effectively serving the financial needs of the regions. The question, therefore, is: what has been done to improve the funding formula used by the ministry to address the current needs?

Ms Meade: Well, I think we have to be very careful here that the funding formula actually doesn't limit a workforce shortage that is international. We do have an international shortage of health care providers. The ministries, three ministers, came out with the health workforce strategy. I addressed in my opening comments several initiatives that we've done around recruitment of foreign-trained graduates of medicine. We have addressed increases around the nurses' settlement and the doctors' trilateral settlement, all of which included not just compensation but retention and new ways of dealing, for example, with family practitioners' costs of doing business.

The issue is more around the workforce issue, which, of course, drives the funding formula, and quite frankly when you have a workforce shortage, you will have some significant reduction. This is an issue that is not unique to Alberta. I think that given the workforce strategy and the work done, which we're continuing, we're addressing that.

There is also a change that has to happen here. Physicians will not be the only point of service. They don't need to be. The workforce shortage will give us a great opportunity to move on the scopes of practice, some of the things we've done here around pharmacists prescribing, some new initiatives around pharmacists, really getting nurses, LPNs, health care aides to work to practise. People now have to adjust.

In the primary care networks – especially I would recommend Chinook, Edmonton, a few other places, all of them in general but some are exceptional – the team is dealing with it so that you get the

right provider at the right time. Even with specialists: through telehealth and electronic records we're able to spread our specialists throughout the province.

I absolutely agree with you that the workforce issue is a challenge. It will be for some time, but I believe we're making progress. There are reductions in OR time normally in a health system. Doctors and nurses, other providers, like all of us, like summer holidays. They like Christmas off. There are general times in the system when we reduce and times when those are complicated with flu, seniors always in the winter. So the balance, which is why there was a recent announcement around long-term care, is to get the right people in acute and those that don't need to be there serviced outside and by other providers. Funding, certainly, is impacted by the workforce, but the funding formula is a bit of a red herring to this issue.

Mr. Chase: Thank you very much. I very much agree that primary care networks are going to form a large part of the solution. Unfortunately, the electronic records aren't functioning as well as they should be: different systems by different health regions.

We have a unique shortage in Calgary resulting from the government closure of half of our hospitals, which drove qualified staff away. That's unique in Canada and, I think, unique in the world, where half of the hospitals of a major city would be closed. My question, therefore, is: how is the information collected across the regions regarding the effectiveness of the current global funding formula? I realize it's not all money, that there is efficiency involved. But money seems to come as one of the ways of hiring staff and building capital.

9:10

Ms Meade: I do believe that if you look at the capital plan for this year and subsequent years, Calgary certainly is being addressed on its capital infrastructure needs and is seen as a growth point. Workforce challenges come with new capital, but I think that that's being addressed, certainly in my working with Calgary around how they will use the different providers.

We look at the regions generally around efficiency. I would suggest that Calgary actually operates as one of our more efficient systems as far as being able to use acute or high-cost infrastructure for the higher need medical issues. One of the issues we have provincially is where we still, in the old mentality of health care delivery, probably use some hospital space less efficiently, where we don't need to keep people as long. Some of the things we look at are lengths of stays for certain procedures, use of a hospital for something that we feel could be done ambulatory: tonsillectomy, for example. These things change over time. Tonsillectomies used to be done in hospitals. Your kid was usually in the hospital for a week or at least a couple of days. Those things are now done in many, many places in the world as an outpatient.

What we have to do is continually look at what the clinical standard is internationally, how we can start to move to this, and ensure that we have training. Physicians, like all of us, you know, are trained, and we're old dogs and we like to stay with the practices as we were trained. Part of the issue is keeping our medical workforce trained to be able to move to less invasive and out-of-hospital care. This is not unique to Calgary. This is something that we're working on with the regions continually. It gets back to efficient use of labour, which will help us with workforce shortages, and efficient use of infrastructure.

The Chair: Thank you.

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

Mr. Quest: Thank you. My question would also be for the deputy minister. What has the department spent to date on the electronic health record?

Ms Meade: I'm going to turn that question over to Linda Miller, who's the assistant deputy minister responsible. Before Linda gets up to the mike, I will tell you that while we all struggle with electronic health records, they are absolutely important to address the workforce issues that we talked about before, to ensure patient safety and quality, and also to ensure that we can use multiple provider teams. In my mind, they're not a distinct IT initiative any longer; they're part of the full delivery tool kit for health care. And Alberta does still lead. While we have a long way to go, it's one of the messiest things that I enjoy working with. That's why I'm going to let Linda do it because I dump to her most times. We are still leading, with lots of scar tissue along the way.

Linda.

Ms Miller: Thank you. As of fiscal year end 2006-2007 we spent approximately $460 million. This included additional support to the regional health authorities for replacement of some of what we call resource systems. This includes costs that we paid for the physician office system program. This included registry developments within the ministry, pharmaceutical information network, interface development to link the many legacy systems that are out in the health authorities. So it's a compilation of costs. Even with that number, it does not include additional dollars that respective regional health authorities have expended on IT as part of their global funding.

[Mr. Lund in the chair]

Ms Meade: That answers your question?

Mr. Quest: Yeah. No supplemental.

The Deputy Chair: Okay. We'll have Mr. Kang, followed by Mr. Griffiths.

Mr. Kang: Thank you, Mr. Chair. On page 34, why is the target for suicide rates higher than what the actual numbers were in the three previous years?

Ms Meade: I'm just looking for my document. Sorry.

We're actually showing a reduction in suicides from 2001 to 2006. The target is reduced because we're reducing the number of suicides.

Is that the number you're asking me about?

Mr. Kang: Yeah.

Ms Meade: From 2001 the target is reduced because we're trying to reduce the number. Well, it's going up from '05 to '06 basically because of the population demographic. We have youth and we have an increase in population, so we gave ourselves a bit of an increase. We're also looking at the trend nationally.

Mr. Kang: Okay. What is the actual number of suicides in 2006-2007? Only the target for that year is reported.

Ms Meade: Yes. Sorry? What's the target for '06-07?

Mr. Kang: What is the actual number of suicides in 2006-07? Only the target for that year is reported.

Ms Meade: Yeah. It would be in our '07-08 business plan that we would have that, but if you're looking at actual numbers of suicides in Alberta, I will have to supply you with that number from that year. This is our target. Okay?

Mr. Kang: Thank you.

The Deputy Chair: Okay. Mr. Griffiths, followed by Mr. Chase.

Mr. Griffiths: Thank you. I have two questions. The first one is on the Health and Wellness annual report, section I, business plan, page 90. I'm mostly curious about the physician services. There is almost a $200 million increase on what was budgeted over what was actually paid out to physicians. I'm wondering if you can explain where the increase came from, if you have an understanding of why it was $200 million more?

Ms Meade: First of all, that was part of the two-year financial reopener of the eight-year agreement. During that we had the $147 million supplemental that went to that. So that's part of that increase.

Mr. Griffiths: Okay. Thank you very much. That's what I thought.

I always talk about rural Alberta and rural development and the RPAP and some of the initiatives the department has undertaken themselves and done a fantastic job in putting more physicians out into rural Alberta and encouraging more people entering med school to give them the opportunity to experience rural Alberta. I looked everywhere, but I didn't find any performance measures to see if the money that's spent on RPAP or your other initiatives actually does put more physicians in rural Alberta to improve health care. Do you have some I just missed, or are you working on developing something?

Ms Meade: It's not in there. Part of RPAP is in our physician agreement, how we're dealing with the stabilization initiative that was negotiated as part of the last financial reopener, and a lot of that targets rural and remote physicians to try and ensure that retention. So it would be buried because it's in the trilateral agreement.

The other piece is on the workforce. Some of the initiatives we started in this year, rolling out more – I don't know if you saw the article in the *Journal* on the weekend around trying to get our physician graduates to do part of their circuit training out in rural and remote. Some of them were interviewed in Edson.

Performance measure at the high level of the business plan is something that we track more in the department, and we have been successful. The primary care networks will be the other tool that through their general evaluation we'll be able to look at rural and remote.

It is a good point, though. I will take it away as something I'd better figure out how to do better.

Mr. Griffiths: Thank you.

The Deputy Chair: Mr. Chase, followed by Mr. Dallas, please.

Mr. Chase: Thank you, Mr. Chair. Page 28 shows that the diabetes rates for First Nations people are double that of the general population. The mobile diabetes screening initiative is helping to screen for the disease, but there is no mention of what is being done beyond the diagnosis stage. What initiatives did the ministry take to specifically address the growing diabetes rate for First Nations people?

Ms Meade: We do have an aboriginal program which we use specifically for prevention initiatives and to supplement, but in general there are always aboriginal components and target populations in all of our wellness initiatives. Some of the things I mentioned in my introductory remarks, regarding the youth wellness initiatives. The obesity issues, diabetes, clearly, as most chronic diseases need to be dealt with way upstream. By having in schools the healthy living, the healthy active children initiative, basically, we'll target that. The other issue is working with Aboriginal Relations and – I was going to say northern development because that's what it was when I was there as the deputy. We're also looking at some of the knowledge transfer and using the elders.

9:20

On diabetes there's been some recent preliminary research coming out of B.C. around balancing a healthy but traditional diet to address the diabetes maintenance. This is also an issue we're in conversation with the federal government about because they do have responsibility for on reserve, and we share all information with prevention co-ordinators, nurses on reserve. We also deal directly with the settlements. So we have not neglected this population; in fact, I would say that we've targeted it further because of what they're going to deal with now and in the future.

Mr. Chase: Thank you. My supplementary. Given the rapid growth of First Nations families and exodus from reserves and the traditional nourishment kind of thing that the department is promoting, this has dramatically reduced federal funding transfers. How much money has been allocated towards addressing aboriginal health, or how much was designated?

Ms Meade: We have $1 million specific to aboriginal health that we use to partner with urban settlements through the friendship centres and other aboriginal organizations as well as other unique initiatives. For example, up in Fort McMurray we help fund the Nunee health committee, that is the five First Nations up there. Most of the money would be pieces of our regular wellness or health initiative, but also we do have an extra million targeted to try and lever federal money as well as other money specific to aboriginal delivery.

I'm going to also add that we fund specific to the Careers: the Next Generation program to try to get young people into a health area. That has targeted aboriginal people in the north, trying to get aboriginal people into the health provider world. Through that and through Careers work there's also the spinoff of conversations in the community about general health, and as we train more aboriginal people – you're probably aware that we have specific aboriginal seats at the medical school, and we do target trying to bring aboriginal nurses, dentists, et cetera, quite successfully. Then there's a return, and that's a better vehicle for knowledge transfer for wellness in general for those communities.

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

Mr. Chase: If you could add me to the list again, please. Thank you.

The Deputy Chair: Mr. Dallas, go ahead.

Mr. Dallas: Thank you, Mr. Chair. My question, and I apologize if there's a reference to it in the material; I've obviously missed it. I was pleased to hear the discussion around primary care networks, that the numbers that the deputy minister used were that the number of Albertans accessing these networks has increased to 1.7 million.

I can only presume that the benefit of that is well established and that the program would continue to expand.

[Mr. MacDonald in the chair]

My questions are around how we will measure and what measurements are currently taking place in terms of the cost benefit with respect to the delivery of those services. In other words, as a cost driver do we anticipate that the establishment of more networks will create efficiencies and reduce costs of delivery of service? Or do we see those as neutral? Or, in fact, are we having to make investments to enhance client service delivery as a result of the primary networks?

Ms Meade: I'm going to ask Glenn Monteith, ADM for our workforce area, to speak to that because I know he's involved in some things.

Through the trilateral there was an initial investment for primary care, but the reality is that that was allowing physicians to actually bring other providers in either full-time or link, so again you've got more people dealing with and able to see more patients. Also, on some of the chronic disease monitoring being done, we're using primary care networks and other providers to manage chronic disease outside of acute settings, so there is a cost benefit. The issue is that in a complex system you have to measure and look at several areas. We do have an evaluation. We do have panelling.

Maybe, Glenn, you can jump in here for me, please.

Mr. Monteith: Yeah. Thank you, Deputy. Can you hear me fine? When the primary care networks were designed, there were 16 key factors for which they were to meet a business plan objective. They're all designed individually, so every primary care network in concert with their regional health authority, and then on the business plan approval, the trilateral process, actually, agrees to the plan, and then that plan is monitored in terms of its execution over the number of years. They're all quite different, although they have some common themes based on those 16.

We have put an evaluation process in play to in fact measure them, and there are two levels where we're doing it. One is on the financial flow: are they meeting their business objectives in terms of the money spent for the purposes? This is what the deputy is referring to with regard to the use of other health care providers, the adoption of new technology, new techniques, et cetera.

The other is to take a look at fundamental system performance measures. For example, we are looking at how we introduce the measurement and the tracking of blood pressure for males over the age of 50 as a routine measure. In fact, we know that half of males over the age of 50 are hypertensive, and we also know that if a physician does that, it triggers a whole series of other treatment behaviours that come forward. There are up to 10 of those measures that are currently being tested to determine whether we will include them, so this will be the clinical evaluation of the process for primary care networks as we move forward in addition to the monetary benefits. From a cost benefit point of view we have to measure the health changes as well as the economic changes.

Mr. Dallas: Thank you. Then just to supplement that: any sense of the cost drivers around the network with respect to how localized those services are? I guess an example that I would use, being from Red Deer, is that we're served by the David Thompson health region. There are a variety of surgical procedures that for one reason or another – we attract specialists to the region, but they don't practise the full range of services that they might render. As a result, clients are accessing services in either of our two larger urban centres or elsewhere. Do we take a look at the impacts both to clients and to the system in terms of accessing services outside of our immediate geographic areas?

Ms Meade: Well, without knowing the cases, I would speculate that there might be many reasons why some of your specialists are not providing all of the services. It actually can be a quality issue. For example, when you stop to do a procedure under a certain number – and this is specific to the procedure. I'll use birthing as an example. When you hit a certain number of births per month, it becomes a patient safety issue regardless of whether that physician and nurses were trained, in particular the nurses, who may not be with the physician doing the four or five a month. As clinical standards change and some of the complexities of health increase, then some of these things have to be rethought. It may be an efficiency issue and a cost issue within the system, that some of the things are spent where we have the nucleus of the really trained support teams. There could be other issues where the physician is doing that, but in fact they could actually be practising to their full scope of practice and somehow that hasn't been worked in administratively to the system. So it's going to be very specific.

I'm going to give you an example of where I think we have to go in the future, though. We have a very specialized, overspecialized in my mind, and growing specialization of health care, and there will be a need to get back to basic health care in many ways. That means a change in the thinking of all providers, the ways that they're taught, and the expectations of people so that we're not just body part by body part or disease by disease. We have to have more generalists. That's the discussion we're having with the medical schools. Now, the trick is that people get concerned about how many specialists we train, you know, dermatologists, to family care doctors. But when people go through law school, we don't tell them whether they have to be criminal lawyers or corporate lawyers. Right? So there is a choice of business and a big difference.

9:30

My point is that we do have to maximize and look at this, and we have to look at this economically and from a quality clinical speciality area, no longer region by region. The integration has to be there. The workforce is driving that. The complexity of need is driving that. So there could be lots of reasons why. Your health region doesn't just serve you locally. Through telehealth and the electronic health records your specialists actually may serve other regions.

The Chair: Thank you.

Mr. Kang, please, followed by Ms Woo-Paw. If you could be brief and direct in your questions and brief and direct in your answers, we would be very grateful. There is a long list still, and we have limited time.

Mr. Kang: ER wait times are a big concern. Does the ministry collect survey or patient feedback on wait times or other concerns in ER waiting rooms?

Ms Meade: Yes. The Health Quality Council did a survey. It came out this week. We'll get you a copy of that. It is posted on their website. I think it was actually released yesterday. It wasn't a large release because it's geared to the providers in the system. Patient satisfaction was measured. People were actually pleased when they got there. What they weren't pleased with is perhaps enough

communication by providers and being checked on. It really was a review to provide information back to the system to help correct and continue to progress.

This is an issue around wait times in many parts, and ER is not separate from the full system. To measure an ER and try to correct your ER problems around your processes can't be done in isolation of what's happening in your acute and what's happening in your ambulatory outpatient. If you have a lot of people in the acute system, which we do often in the winter, waiting for home care or long-term care beds, your ERs get backed up, which is not anything to do with your processes in ER. Or your neonatal gets backed up if you suddenly have a birthing boom and a lot of low birth weights. So we have to look at it systemically. I will tell you that the report that came out for provider-specific information – it is on their web, and we can get you that report – will show you that, in fact, Albertans were in general quite satisfied.

The other issue here, though, is that we still have to advertise things like Health Link and improve, as was raised earlier, our primary care system so that we're using the ERs for the kinds of things that need to be in an ER and seen right away and not because there isn't a family physician or a clinic to go to.

Mr. Kang: What are some of the main concerns raised by the survey? Like, how could we improve this? Is there any feedback on that part?

Ms Meade: Yeah, basically, again to the providers, to the stakeholders running the system. I don't have the report – I do have the report. Dang, now I've got to read it. From memory, though, people were concerned that there wasn't communication, that they weren't checked on and told how long they'd be waiting. People actually will wait if they know that someone comes in with a higher acuity than theirs. They felt they wanted communication. They felt that even when they were seen, sometimes the communication wasn't enough for them. They like to hear more from the providers, not necessarily a physician but from the providers. Really, the key takeaway was the communication. It was really around the staff care and the communication and the checking while they were waiting. I mean, everybody would like to be seen immediately, but as long as you know you're in the queue and you're being looked at and triaged, then people seem to understand. There were a lot of issues specific to what providers should do around sharing information, managing, and triaging patients. It was really a report geared to how the system can improve itself. It was specific to Calgary with learnings for others, but we will provide the report.

The Chair: Thank you. We would be very grateful if you could provide it through the clerk to all members. We'd appreciate that.

We'll move on, please, to Ms Woo-Paw, followed by Mr. Chase.

Ms Woo-Paw: Thank you, Mr. Chairman. Albertans located in our rural and urban centres all have their unique needs, so I'm pleased to see that there's a rural development strategy. But when I look at page 37, under Improved Access to Health Services, "find innovative and culturally appropriate ways to improve access," I notice that there aren't any performance measures identified to measure the access and satisfaction rate by the immigrant population. I assume that the ministry is well aware that immigration would be our number one source of population growth within the next decade. Most of the immigrants who are born outside of the country come with excellent health; however, their health deteriorates within the first 10 years in Canada due to a lot of determinative health issues. My question is: does the ministry have performance measures identified that I missed, or do you have plans to develop them?

Ms Meade: No and no. The system is so broad and complex that drilling down – I will tell you that programs and access issues are looked at in the regions, in particular regions with different populations, some that have a higher aboriginal population, some that have a higher immigrant population. The access is really around the first tranche, how are we doing the communication, outreach, and the training of staff. I'm not going to negate that we won't look at it in the future, but I think right now with where we're at in the system and some of the pressures we have, we have to get some of our general access issues to be able to highlight better. I don't think we'd do a good job at this point because it would be a performance measure that would be lost in some of the systemic change.

Ms Woo-Paw: My supplementary: how do you hold the RHAs accountable for addressing those specific populations within the catchment area?

Ms Meade: They have health plans that are submitted. We meet then, our executive team that you see here, with the regional health executive team. We go over things specific to some of their measures, some of their targets, some of their programs, and that's where that discussion occurs. But measurement in general is at this point still being refined in a very high level, length of stays, hospital mortality rates. The accountability, then, would be: what are they doing for their specific populations in their health plans?

The Chair: Thank you.

Ms Woo-Paw: My last . . .

The Chair: No. At this committee we only have an opportunity for one question and a supplemental.

Mr. Chase, please, followed by Mr. Drysdale.

Mr. Chase: Thank you very much, Mr. Chair. In terms of addiction prevention and treatment funding AADAC, for example, receives barely 3 per cent of the revenue generated by casinos, slots, and VLTs, which are highly addictive both for individuals and groups, including underfunded school councils, arts, culture, and recreation associations. Given that mental health and addiction are issues that span every aspect of our society and health system, can the ministry explain why on page 90 it reports that the expense for mental health innovation came in under budget?

Ms Meade: The innovation fund was established with the mental health plan. This is $600,000 under budget, and at that point it was bridging a year where a program had not yet been approved and implemented, and the money hadn't flowed. I don't see this as any less a commitment to mental health. In fact, we've been trying to address mental health more and more, as you see in this business plan and in the one we looked at last night.

Mr. Chase: On the same page why did the expense for addiction prevention and treatment services come in under budget?

Ms Meade: On that one, basically, again we had PCHAD and some other initiatives, and they didn't start up right at the beginning of the fiscal year, so there were some start-up costs on PCHAD and some of the other youth programs.

Janet, do you want to add to this?

Ms Skinner: No. That's the story there. There were some delays in the startup because of delays in contracting and delays in recruiting staff for this particular initiative.

Ms Meade: They're on track now, Janet?

Ms Skinner: Yes, they are.

Mr. Chase: Thank you.

The Chair: Thank you very much.

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

Mr. Drysdale: Yeah. Thanks. I know you were in the House late last night getting grilled, and now you're back early this morning, so thanks very much for all your answers.

Since becoming a new MLA, most of my calls and concerns in the Grande Prairie area are on long-term care and extended care. I notice in the Auditor General's '08 report on page 101 that the number of beds since '05 has actually been reduced by 50, so maybe that's why I'm getting so many calls. You know, it's a big concern. With the one private care provider we have there, the standards aren't good, and that's a lot of the complaints, too. So just a question of why we're going down.

9:40

Ms Meade: I'm just checking around my capital just to see what's going into Grande Prairie. So they'll scramble for a minute and I'll dance. This is what this is: dancing.

In general, on long-term care there are two things I want to talk about. We had pilots out of Chinook – our minister spoke to them last night – and we have to look at that more. We have to be very cautious that we've got the right people in long-term care and that we are supporting seniors around their ability either with health care and other supports to stay at home or with the lodges and the daily assisted living. We've had quite good success in a few areas that have really moved to that.

The assessment tool that is used, again, by health care providers, nurses in general, to assess and the standards brought in as a result of the Auditor General's report and our enforcement I think are going to hit the second part of your question, which is: what are the standards around that? Long-term care, in general, first of all, is outside the Canada Health Act. So it's not, although many Canadians believe it is, part of health care. The health provider and the health-specific services are, but not the long-term care part of that.

On the capital I want to tell you that I had a discussion with the regional health authority CEOs who have been telling me for the last year that long-term care is their priority, that they need capital there. But when I reviewed their capital plan submissions, I had to get a microscope out to find long-term care. That is now changed, so it'll be a future priority.

You're not on the current approved capital list for Grande Prairie for long-term care, but you did hear my minister speak to both in his 3-6-9 plan, how he will have a seniors' continuing care support strategy coming forward. He's working with Minister Jablonski. We do have to address this. We have to address this because seniors are really cycling through the health care system, whether it's not being dealt with by primary care or whether it's not being out of acute or in-home. In general, we have some catch-up to do, as the population has boomed here. There is some coming into High Prairie, but it's limited for Grande Prairie.

Now, given the capital discussions we're having up there, I think that's part of what's the right mix of service, just as we went through with the south hospital build, from their original plan to what the mix would be to what they need in the area.

Mr. Drysdale: Yeah. You answered my supplement, which was: what are you going to do in the future? I don't need to tell you, but because the long-term care is backed up, those people are in hospital in your acute beds, and that's what's causing you trouble down the road, too. But I'm sure I don't need to tell you that.

Thanks very much.

The Chair: Thank you very much.

Perhaps we should stop this portion of our questions, Ms Meade. In this committee if we do not have enough time and we have a long list of people interested in directing questions, we would ask if you could provide written answers through the clerk to all the committee.

Perhaps we can start by reading our questions into the record, please, for all those members who have been patiently waiting. We'll start with Mr. Kang. If you could read your questions into the record, we will get them answered.

Mr. Kang: On page 39 it states that the ministry has made access to mental health services for children a priority and that the health authorities have begun planning towards the achievement of wait time goals. What are the specific actions that have been taken to improve access to mental health services for children, and how much money was allocated to this planning and implementation process?

Thank you.

The Chair: Thank you very much.

Mr. Quest: A question again for the deputy minister. Forgive me if this was covered earlier and I missed it. On page 35 of Health and Wellness section 1 with respect to seniors flu immunization, I see that number has dropped in '06-07 well below its target. Obviously there's a huge impact to the system and to the individual if they get the flu at that point in life, so I'm just wondering what's being done to reach that target number for immunization.

No supplemental.

The Chair: Thank you very much.

Mr. Chase, please.

Mr. Chase: Thank you. During the 2006-07 year what research reviews were conducted internally or externally and at what approximate cost that recommended the reduction of local health care authority through centralization? Also, what research in 2006 or 2007 or financial justification was given to revisiting the Mazankowski delisting report, and was the Romanow universal medicare report also thoroughly researched for its potential cost savings?

The Chair: Thank you.

Ms Woo-Paw: This is focused on your ministry's dedication to continuous improvement as well as the real or perceived systemic gaps experienced by the various RHAs. I'd like to know what plans you have in place to improve data collection, you know, going to the global funding formula.

That's it.

The Chair: Thank you.

Mr. Lund.

Mr. Lund: Thank you. Mine is along the funding area between the Capital region and the Calgary region. Looking at the numbers for '06-07, I see that the per capita in the Calgary region was some $1,663 and in the Capital region, $2,058. So there's a fair – on the population. Now, my questions would be: this dollar number that you have for each of the regions, is that after the reconciliation between the other regions? There would be a lot of import dollars in each of those. I know the tertiary care, of course, for all of Alberta is done in those two regions. But I'm also very aware that in the Capital region there is a lot of import from the north in secondary, and in fact it's getting to be in some cases primary. Mr. Drysdale's comments about Grande Prairie: I'm well aware that there are times when there are people being flown to Edmonton that really should only be going to Grande Prairie, but there's no room.

The other question I'd like to know is how the air ambulance is charged out. Is it to the department, or is it to the individual regions?

The Chair: Thank you very much.

That concludes this portion of the meeting. We look forward to getting your written responses, Ms Meade. On behalf of the committee I would like to thank you and your staff for your time and diligence this morning. The very best to you and all your officials. We have other matters to deal with this morning. Feel free to exit. Thank you.

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

Mr. Dunn: No. I'll wait to see if there are any other questions from the committee.

The Chair: Okay.

We're going to move on to item 5 on our agenda this morning, Other Business. We had a brief discussion last week regarding the committee schedule. First of all, the committee schedule has ministries booked on June 4, 11, 18, and 25 of this year. In the event that the session ends prior to June 25, is it the committee's wish to hold these meetings as scheduled?

9:50

Mr. Dallas: What are the dates?

The Chair: The dates would be every Wednesday, June 4, 11, 18, and 25. The chair took the liberty of scheduling these meetings. We had no idea how long session would last. These meetings and these ministries are booked.

Mr. Lund: Well, Mr. Chairman, I would propose that we stick with the schedule as long as the House is sitting, but I think we need a much broader discussion on whether we're going to meet out of session. Also, if the decision is made that we are going to meet out of session, then whether it be ministries or other identities that we would invite to the table. We need to have some idea of who we want to invite. I would hope that we would have some idea this morning. If I might make a comment, I hope that we're not just meeting for the sake of meeting. If we pick entities, they're ones that we really want to drill down and find out what is going on.

The Chair: Okay. In the past whenever session ends, Public Accounts ends. If session was to end, for instance, on a Tuesday, the Wednesday meeting that was scheduled in advance would not occur. Is that the wish of the committee, the direction of the committee?

Mr. Fawcett: I was just wondering as a new person if I could get the explanation of why that was the case. What was the rationale behind that?

The Chair: Well, initially it was indicated that we would be meeting in June, and it has been the tradition that while the session is on, each Wednesday morning between 8:30 and 10 the Public Accounts Committee would refer to the appropriate annual report of a department and deal with the matters that were identified, if any, by the Auditor General.

We've had difficulty in the past in scheduling meetings. In order for Corinne to be able to do her job and co-ordinate the schedule, we have to know well in advance which department we're going to bring forward. It is the direction of the committee that we get departments here in an orderly and timely fashion. So that's why we scheduled those meetings out into June on each Wednesday morning.

Mr. Lund: I think what Kyle was asking, though, was: why wasn't the committee meeting out of session in the past? Last year was the first year that they met out of session. It was just a decision of the committee's before. There's nothing stopping us from meeting out of session, but up until last year the decision was that they would not meet. That was a decision of the committee.

The Chair: Mr. Dallas, followed by Mr. Chase.

Mr. Dallas: Thank you, Mr. Chairman. Just further to that, you know, I suppose I'm not particularly concerned about whether we meet out of session or not. However, I am concerned with respect to how the committee establishes strategically which ministry reports they would like to review. I suppose to some degree we might spend some time thinking about if there are some specific themes in terms of reporting that we might like to focus on, which would then direct us to the ministries that we might invite to appear before the committee.

This might take some meeting time to determine whether or not we could come to an agreement in terms of how to strategize as opposed to just sort of rolling through the ministries. I realize it's a little more strategic than that, but we're going to be doing this for some time, and I wonder if the committee would be well served to invest an initial period of time to determine just that. Are there some specific areas that Public Accounts should be reviewing? Would that, then, direct us to certain invitees to the meeting earlier in the process rather than later?

The Chair: I appreciate that. Any member who has an interest in seeing any respective department appear before the committee, the chair or the committee clerk would be delighted to hear your interests. In the past we have dealt with the ministries which have, naturally, the bigger budgets. That would be the first criteria. The second criteria would be: when was the last time they appeared before the committee? The ministries change. The size of cabinet expands and shrinks and expands. Sometimes two and three years go by and a department may not appear before the committee. That's also part of the criteria, but if you have a ministry that you have an interest in, please, we would be delighted to arrange the schedule.

Mr. Dallas: Just to the point, then. I wonder if the support could provide to the committee – and I realize it's a matter of public record – a history of the ministry reviews that took place prior to the formation of the current committee. Then, further to that, I guess, I would like at some point to have the committee set aside some time

to perhaps discuss whether there are some themes in terms of public accountability that we might work on. Just as an example but not necessarily where I'm heading with this, if a consistent theme running through the Auditor General's recommendations might be in the area of information technology, the costs and efficiencies thereof, we might determine that we should focus on ministry reports where there's substantial investment or a lack of investment in those types of systems and then move on to some other reports.

The Chair: That's a good idea.

Mr. Dunn, do you have anything to comment before we get to Mr. Chase, who is very patient down in the corner there?

Mr. Dunn: Well, very, very briefly. This discussion, for committee members, took place a couple of years ago. The concern of the committee at that time was that they did not get very far through the total of the government of Alberta. In fact, I believe, Corinne, from the surveys that were taken out that the committee may have met 10 to 13 times a year.

Mrs. Dacyshyn: That's correct.

Mr. Dunn: So maybe about half of the ministries might have been covered. What you're sensing already from your meetings is that you don't get to drill down below the department very well. You have departmental officials here, although some questions came from the Calgary health region or the Capital health region. The discussion of the committee at that time was: can't we get to the envelopes that are spending the money, the actual physical spending of the money at the regional health authorities and questions around their accountability or their understanding of that? The same with advanced education.

So picking up on your point, Mr. Dallas, the committee actually did adopt a thematic approach. That's why four health authorities were invited and four postsecondaries. The challenges that were coming out were around: what is the health plan throughout all of Alberta? Could we have two rurals and two urbans and speak to them and get a chance to ask similar questions of the four?

The same with advanced education: the number of seats, affordability, access in advanced education. Do we have a sufficient number of universities and those colleges that may have in their strategic plan wishes to become universities? We had the two very large universities, which allowed you to also ask questions around their research plans versus education plans, and then the ability of those other entities possibly to become universities should they so wish and what their costs were that were incurred.

By going to the out of session, it was thought that that would allow the committee members to get through the departments and into some of the other entities. By way of a good example, you will see that the ministry of finance will be here. Underneath the ministry of finance are some very large financial institutions, such as the Alberta Treasury Branches. By the time you get through to the department of finance and you just understand its complexity, you do not ever see the bank. The bank has a lot of its interests. You also have a very large investment management company now, which handles $75 billion of investments, public sector investments. Those would tend not to be seen and drilled into.

Thus, Mr. Lund, the suggestion for meeting out of session where it was convenient to do so. I appreciate that committee members have to come from a distance. If the committee was able to make use of the time prior to the House going back into session, it will allow committee members to be more comfortable after they have a better understanding of what's involved in some of these large, complex ministries and departments.

10:00

The Chair: Thank you.

Mr. Chase, please.

Mr. Chase: Thank you very much, and I'll be as quick as possible. I want to echo what the chair and Auditor Dunn indicated, that we now have 23 ministries. While I appreciate the fact that on October 14 we'll be returning, we can't possibly cover them even in a two- and sometimes three-year period, so that's a reason for having extended time periods.

Also, it's not just the ministries that necessarily have the largest budgets but those that have a tremendous effect on the province, such as Environment and Sustainable Resources. Their budgets aren't that large, but their impact and their importance are significant, so they need to be covered. Also, some organizations that bring in large amounts of capital, including the ministry responsible for lotteries, casinos, slots, and so on, which accounts for half of Alberta's revenue or are second in terms of generating revenue after Energy: I think these need to be looked at.

My recommendation would be to have Dr. Massolin included to assist us with out-of-session recommendations for organizations that we might wish to request. I personally felt that it was very worth while when former Chairman Rodney called for an AADAC review, and I believe it was Ms Calahasen who called for the Métis settlements review. Those were worth while as were the postsecondary and health region reviews. However, for the sake of meeting efficiency and travel concerns, as the Auditor also pointed out, I would suggest that rather than a weekly session we meet every two weeks but two days at a time; for example, have a Monday-Tuesday or a Tuesday-Wednesday session to maximize our time for those of us that have to travel 300 and more kilometres but consider it very worth while to do so.

The Chair: Okay. It was Mr. Danyluk who was on the committee and Mr. Rodney in the past. The first meetings we held that occurred outside of session were with the Northern Alberta Development Council and AADAC. AADAC had at that time I think a $90 million budget, larger than some individual respective portfolios.

Mr. Dallas: Mr. Chase is right to my point, other than the question I would ask: rather than meet every week, would it be possible to do two sessions of these back to back with a 15-minute break, which would have us finishing at 11:45? We could do them every other week.

The Chair: Were you talking about inside session, Mr. Dallas, or meetings outside of session?

Mr. Dallas: If we were to meet outside of session, given that travel is involved, why don't we cut that in half by meeting and doing two continuous sessions, one beginning at 8:30 a.m. and another one at 10:15 a.m., with two different guests?

The Chair: Yes. What we have done in the past is that there were two-hour meetings. Incredibly, after the two hours there were still items to be discussed. We had one in the morning from 10 to 12 – lunch was provided – and then one from 1 until 3. We co-ordinated it with the government caucus meeting in the city. I cannot remember; it was either before we held these out-of-session Public Accounts meetings or the day after. It was co-ordinated with government caucus coming to the city of Edmonton. I think that's how we did it to make it easier for members to attend.

Do you have anything to add? Your memory is better than mine.

Mrs. Dacyshyn: Thanks, Mr. Chair. All I want to add is that those meetings were two hours, and we allowed those entities a longer period for their introductory comments. They usually had a PowerPoint presentation and maybe even up to half an hour for their presentations and then questions following that. So that was, I think, the rationale for the longer, two-hour meeting.

Mr. Chase: Would it be helpful to make a motion such that if meetings are to be held out of session, if agreed upon by members of Public Accounts, they be held on a biweekly basis, every two weeks, as opposed to the weekly schedule? I don't know whether that would be helpful or not.

The Chair: Every two weeks outside of session may be problematic. Mr. Drysdale and Mr. Bhardwaj.

Mr. Drysdale: Yeah. I was just going to suggest that because it's a long way to come for some of us, if we could even set it up with our CPC meetings. We meet every other week on Monday and Tuesday. I'd hate to have it the other week, so then every week all summer I'd have to be here.

Mr. Bhardwaj: I was just going to point out the same thing. Why don't we try co-ordinating it with when we have government caucus meetings?

The Chair: Mr. Lund, please, and then we have to conclude this matter.

Mr. Lund: I think that we've got a lot of scheduling issues here because it's my understanding that the CPCs are going to be meeting possibly all day or one in the morning and one in the afternoon, so we're going to have to work around those. I think the idea of piggybacking on those is extremely important for the travelling issue. It sounds to me like it's the wish of the committee to have out of session, and that's great.

I'm curious: when do some of the '07-08 reports start coming through?

The Chair: September.

Mr. Dunn: The actual financial statements and ministry reports with the public reforms reporting will be available by September 30. That's the normal time frame when the financial statements and annual reports are released. We will also have an early October '08 report. That will be the second of our semiannual reports.

Mr. Lund: The reason I raise that issue is that, personally, the closer we can be to the action the better. I'm just tossing around the idea of trying to incorporate those into our discussions. Of course, that would probably preclude the months of July and August. I don't know if the committee would prefer to meet on some departments in that time frame. It'll be the wish of the committee.

Mr. Dunn: We met, I believe, last year in September and October. In September those that were invited to attend did make available their March 31 financial statements, although the respective ministry, by way of saying the health authorities, actually did provide the March 31, 2007, reports for discussion. But the ministry's annual report had not been released until the end of September. For those that we met with in October, all information was therefore current, from the last fiscal year.

The Chair: If I could remind members at this time that Corinne circulated a list of agencies, boards, and commissions to each member. If you could have a careful look at that. If you wish to have any of those agencies, boards, or commissions appear before us, we need to start getting this organized now. It would be unreasonable to expect Corinne to have this all organized by June. It would have to be, certainly, in the fall, at some point in September. If you could take your Day-timers to next week's meeting and if there is an appropriate time and it is your wish to have meetings outside of session with any of these respective organizations, then we will do our best to facilitate it.

It takes a lot of work, and it is also unreasonable of us to request an agency, board, or commission to appear before us, in my view, in a short period of time. I think we have to give them some advance notice. That's only respectful, in my view. So if we could do that, and next week or after question period any time between now and next week if you have any suggestions or any questions, please, I would be delighted to try to answer them and facilitate this for the committee.

In June if the legislative session is finished, there will be no Public Accounts meetings on Wednesday mornings with the ones that were scheduled.

10:10

Mr. Chase: Just a notification to all members of the Public Accounts Committee that I will not be able to attend the next two Wednesdays. Replacement individuals will be taking my spot and will have full voting rights while I am away doing constituency business.

The Chair: Okay. Thank you for that. Is that fair enough with committee members?

Please let us know what direction you want us to take. Mr. Chase, we are correct in assuming that that was a suggestion and not a motion to have biweekly meetings?

Mr. Chase: I was just trying to facilitate the discussion. If a motion is necessary, I would offer it.

The Chair: Okay. Thank you.

That concludes item 5(a) on our schedule.

Item 5(b). I appreciate your patience on this; I know everyone has busy schedules. At last week's Public Accounts Committee meeting the following motion was passed. It was moved by Mr. Dallas that

> the chair, the deputy chair, and the committee clerk be approved to attend the 2008 Canadian Council of Public Accounts Committees conference in Whitehorse, Yukon, from September 7 to 9, 2008, and that an alternate be determined by lottery in the event that any of the approved delegates are unable to attend.

Mr. Bhardwaj subsequently asked whether there was a possibility that additional members of the Public Accounts Committee would be able to attend the conference. I reminded everyone that the 2008-09 committee budget provided for the attendance of two members only plus the committee clerk, following the committee's long-standing tradition. I advised that there would likely be two members of the Standing Committee on Legislative Offices attending this conference as well.

Mr. Bhardwaj then moved the following motion that was passed by the committee: moved by Mr. Bhardwaj that the Standing Committee on Public Accounts investigate the possibility of finding supplementary funds to send an additional two members to the CCPAC conference in Whitehorse, Yukon, in September 2008. To follow up on this motion, the Speaker has now approved the

attendance of the three individuals named in the motion last week: the chair, the deputy chair, and the committee clerk. Should the committee wish to increase the number of members attending future conferences, besides the one being hosted by Alberta in 2009, a motion should be proposed and agreed to by the committee to budget for this provision, which would subsequently be submitted to the Special Standing Committee on Members' Services for approval. We don't need to do this until the year 2010 because next year the conference is in Alberta.

In the meantime, we still need an alternate attendee in the event that any of the approved delegates are unable to attend. So far the only member who has put his name forward as an alternate is Mr. Vandermeer. Would other members please advise the committee clerk as soon as possible of their interest and availability in being considered as an alternate, and we will conduct the lottery at next week's meeting. Is that fair enough? Okay. Thank you.

Now, are there any other items of business to attend to this morning? No?

The date of our next meeting with Mr. Lindsay or his officials is next Wednesday morning, May 21.

If I could have a motion to adjourn? Mr. Drysdale. Thank you very much. Mr. Drysdale moved that the meeting be adjourned. All in favour? None opposed. Thank you very much. Have a good week.

[The committee adjourned at 10:14 a.m.]

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